Schedule for FOI Briefing for Ministers Reilly and Fitzgerald

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ABORTION

Background

The European Court of Human Rights heard in December 2009 an application by three women that it is a breach of their rights under the Council of Europe Convention on Human Rights for the Irish State not to provide abortion in circumstances where a woman wishes to undergo an abortion (the *A, B and C* case). The object of the application was stated to be to demonstrate that the constitutional and criminal law of the Irish State breaches the Applicants' rights. The Government submitted that the application be deemed inadmissible primarily on the basis that the Applicants failed to exhaust their domestic remedies.

The judgement of the Court confirms that Article 40.3.3 of the Constitution is in conformity with the European convention on Human Rights.

The Court held:

- In the case of the first and second applicants, Ms A and Ms B, the Court dismissed their applications, finding that there had been no violation of their rights under the Convention.
- In the case of the third applicant, Ms C, the Court found that Ireland had failed to respect the applicant's private life contrary to Article 8 of the Convention, as there was no accessible and effective procedure to enable her to establish whether she qualified for a lawful termination of pregnancy in accordance with Irish law.

The Court ruled that "no criteria or procedures have been... laid down in Irish law... by which that risk is to be measured or determined, leading to uncertainty…" and held that further legal clarity was required. The Court acknowledged that the implementation of Article 40.3.3 "would be a sensitive and complex task" and confirmed that it was not for that Court to indicate the most appropriate means for Ireland to achieve this.

The judgement of the European Court of Human Rights is **binding** on Ireland. Supervision of Ireland's execution of the judgment falls to the Committee of Ministers of the Council of Europe. The Council of Europe have proposed that supervision of the judgement in A, B and C v Ireland would be under a new enhanced procedure for supervision of judgements rather than the standard procedure of simplified supervision. Enhanced supervision concerns complex cases to which the Committee of Ministers give priority and which would also entail more intensive involvement of the Secretariat. Enhanced supervision will not add to our existing obligation to implement the judgement.

Action Plan

Steps will need to be taken to ensure no future similar violations of Article 8 occur. Ireland is required to submit an action plan to the Committee of Ministers within six months of the judgement (in this case by the **16th of June** 2011). The action plan must set out the measures Ireland intends to take to implement the judgement. Where it is not possible to identify all the measures immediately, the plan must set out the steps to be taken to determine the measures required, including an indicative timetable for such steps.

The Social Inclusion Unit is currently preparing a paper on viable options for the implementation of the judgement with the Department's legal advisors. This paper will then be submitted for managerial and Ministerial approval.

✶ This is one of two issues pertaining to the remit of the Social Inclusion Unit to appear on the Risk Register, along with Assisted Human Reproduction (AHR). The Unit is hoping to be able to prepare options for an Action Plan in relation to the ABC v Ireland ruling as well as policy proposals for AHR. However, in light of current resources, a decision will then have to be made as to which of these issues will be prioritised for the development of regulations/legislation.

Social Inclusion Unit
24th February 2011

Briefing Material for the Minister

Administration of Morning-After Pill by Pharmacists

Background

In January, 2011, Boots Ireland wrote to the former Minister advising of their intention to offer a pharmacist-led Emergency Contraception Service to women over 18.

This involved the Boots medical director setting out in a formal protocol or "patient group direction" the specific patient types, circumstances and procedures to be followed by a Boots pharmacist in determining whether an emergency hormonal contraceptive would be appropriate for the patient presenting at the pharmacy. The protocol required the patient to be interviewed by a Boots pharmacist in the private consultation area to determine whether it was appropriate for the patient to be administered the product.

(By way of background, in July 2010, Minister Harney launched the Boots Ireland Patient Group Direction Services and in particular its seasonal influenza vaccination service which commenced in October 2010).

Patient Group Directions under Irish Medicines Legislation

The initiatives taken by Boots relied on Regulation 4A(1)(c) of the Medicinal Products (Prescription and Control of Supply) Regulations 2003-2009. This provides that it is not a contravention of the Regulations for any person to administer a prescription medicine to a patient in accordance with the directions of a medical practitioner.

During the Swine Flu Pandemic in Autumn/Winter 2009/2010 this provision was used by the HSE to allow the administration by nurses and other health professionals at HSE clinics of pandemic vaccines (which are prescription medicines) to patients in accordance with the directions of a HSE medical officer, without the requirement for that practitioner to assess every patient and write a prescription in each case.

Patient Group Directions have been used in the UK for some time and are used for managing single treatment episodes rather than chronic illnesses.

Legal Advice in relation to Regulation 4A(1)(c)

Legal advice was sought by the Irish Medicines Board in regard to the emergency hormonal contraception service provided by Boots. This opinion concluded that the scheme operated by Boots did not comply with Regulation 4A(1)(c). Boots were so advised and have suspended the Emergency Contraception Service launched in January.

The Department's Legal Unit has been consulted and, in summary, it concurs with the advice obtained by the IMB. In view of the potential implications of this advice for patient group directions generally, further legal clarification is being been sought.

Current Position with regard to Emergency Hormonal Contraceptive Products

On 15th February, 2011 the Irish Medicines Board announced its decision to allow the sale of NorLevo without prescription. It is one of two emergency contraception pills currently licensed for use in Ireland. It may now be supplied from pharmacies without a prescription.

On 17th February the Pharmaceutical Society of Ireland issued guidelines to pharmacists under the Pharmacy Act 2007 requiring that the emergency hormonal contraceptive may only be supplied by the pharmacist personally and following a private consultation between the patient and pharmacist. This is to ensure that the pharmacist can determine the appropriateness of the supply and to provide an opportunity to undertake appropriate patient counselling.

ASSISTED HUMAN REPRODUCTION

Current Work on Legislation

The Department of Health and Children is currently developing policy proposals to regulate the area of Assisted Human Reproduction. Patients are currently availing of these services in a legal vacuum, as there is no specific legislation in Ireland governing AHR. As indicated in the Supreme Court ruling in the *frozen embryos case* (see overleaf) and by the Attorney General following the same, legislation is urgently required in order to regulate this area appropriately.

The legislative framework must protect, promote and ensure the health and safety of parents, donors and children born as a result of assisted reproductive technologies. The legislation will outline what practises are prohibited, what practices are allowed and how they should be regulated. The work involved in developing these proposals will examine and consider - among other things - the issues arising from the *frozen embryos* Supreme Court judgment.

Current Position

The handling, processing, storage, etc, of human tissue, including gametes and embryos, is currently regulated under the *European Communities (Quality and Safety of Human Tissues and Cells) Regulations (Statutory Instrument No.158 of 2006*) came into law on 7 April, 2006. The Regulations apply to tissues establishments that are involved in the donation, procurement, testing, processing, preservation, storage and distribution of human tissues and cells intended for human applications. The aim of the Regulations is to ensure a high level of protection of human health. The Regulations include criteria for assessing the status of prospective donors, inspection and control measures, traceability of donations and qualifications and training for persons working in tissue establishments.

Fertility clinics are tissue establishments under the Regulations and thus, they must be inspected and authorised by the Irish Medicines Board (IMB), which is the competent authority under the Regulations, to ensure that they meet quality and safety standards.

The Medical Council include specific guidance in the area of AHR in the ethical guidelines issued periodically to registered medical practitioners for application in the clinical situations in which they work. Section B (20.1-20.4) of the 7th Edition of the Medical Council Guidelines provide as follows:

> 20.1 Assisted human reproduction treatments, such as In Vitro Fertilisation (IVF), should only be used after thorough investigation has shown that no other treatment is likely to be effective. You should ensure that appropriate counselling has been offered to the patient and that the patient has given informed consent before receiving any treatment.
>
> 20.2 Assisted reproduction services should only be provided by suitably qualified professionals, in appropriate facilities, and according to international best practice. Regular clinical audit and follow-up of outcomes should be the norm.

20.3 If you offer donor programmes to patients, you must consider the biological difficulties involved and pay particular attention to the source of the donated material. Such donations should be altruistic and non-commercial. You should keep accurate records for future reference.

20.4 You should not participate in creating new forms of life solely for experimental purposes. You should not engage in human reproductive cloning.

Frozen Embryo Case

The background to the frozen embryos case is that the Plaintiff (wife) sought an order from the High Court to have three frozen embryos stored in an Irish fertility clinic released to her against the wishes of her estranged husband. The woman argued that the embryos had a right to life under Article 40.3.3 of the Constitution. The High Court found that such frozen embryos did not constitute the unborn for the purposes of 40.3.3. The Plaintiff then appealed against the High Court judgment and the Supreme Court decided last December that the frozen embryos at issue in the case did not have the constitutional protection of Article 40.3.3 of the Constitution.

In effect, the appeal of Mrs. R from the High Court was dismissed by all five judges and the Court was unanimous in deciding that the frozen embryos did not enjoy the protection of Article 40.3.3 of the Constitution. The judges agreed that, on an analysis of the text of the Constitution, the language describes a foetus which is adversely affecting the right to life of the mother. This can only arise in the situation where they are in a physical relationship with each other, in other words, where the embryo has implanted in the uterine wall and there is a pregnancy.

Mr. Justice Geoghegan acknowledged that it is not an easy task to provide guidance on these matters. Indeed the Commission on Assisted Human Reproduction itself recognized that using technology to assist human reproduction raises important ethical issues for our society.

✶ This is one of two issues pertaining to the remit of the Social Inclusion Unit to appear on the Risk Register, along with Abortion. The Unit is hoping to be able to prepare policy proposals for AHR as well as options for an Action Plan in relation to the ABC v Ireland ruling on abortion. However, in light of current resources, a decision will then have to be made as to which of these issues will be prioritised for the development of regulation/legislation.

Social Inclusion Unit
18th February 2011

Briefing arrangements

Minister

1. I attach a set of briefing papers which have prepared on a thematic basis as follows:

(1) ***Primary care*** including primary care teams, GPs, pharmacy, medical cards, community drug schemes and oral/dental health;

(2) ***Acute hospitals*** including activity/capacity, reconfiguration, EDs, waiting times for elective surgery, ambulance/patient transport, maternity, the national paediatric hospital, the Lourdes Hospital redress scheme, symphysiotomy, the Drogheda review, cystic fibrosis and co-location;

(3) ***Cancer*** including cancer services and the national plan for radiation oncology;

(4) ***Social care*** including services for children, disability, mental health and older people, and other work of the Office of the Minister for Children & Youth Affairs, the Office for Disability & Mental Health, and the Office for Older People;

(5) ***Public health*** including health protection, health promotion, chronic disease management, social exclusion, food, medicines, head shops, dugs and tobacco control;

(6) ***Patient safety/quality*** including the Madden Commission, licensing and other legislative proposals, HIQA, professional regulation, the Patient Safety First initiative, the national framework for clinical effectiveness, healthcare associated infections, blood safety and organs/tissue issues;

(7) ***Governance*** including HSE accountability arrangements, estimates and expenditure management, capital funding, employment control, pensions and the Department's direct funded agencies;

(8) ***Private health insurance;***

(9) ***Enablers*** including Croke Park, clinical programmes, information, ICT, research and workforce planning;

(10) ***The Department*** including its mandate, staffing, administrative budget, legislative programme, parliamentary work and international work; and

(11) ***Other topics*** including assisted human reproduction, abortion, female genital mutilation, the early childhood care and education scheme, other childcare schemes, palliative care, rare diseases.

2. I am also attaching the following documents:

(a) a copy of *Health in Ireland Key Trends 2010*;

(b) an organisation chart for the Department;

(c) a summary of each Division's business plan for this year;

(d) a copy of the HSE's National Service Plan for 2011;

(e) a copy of the Public Service (Croke Park) Agreement 2010 – 2014;

(f) the latest sectoral plan for the health service; and

(g) a copy of the latest "Significant Issues" (a document which is prepared each month for the MAC).

3. I propose, if you agree, to arrange a series of early meetings with each member of the MAC (management advisory committee) so you can meet their senior management teams and they can provide you with more detailed briefing on their work areas. Indeed, I think a regular schedule of such meetings – at least twice a year – is a useful/necessary way of allowing you to update yourself in a pro-active and structured way on developments in the Department.

4. The MAC meets every week – generally on a Monday morning. We have a separate "Min/MAC" meeting every two months attended by the Minister, Ministers of State and the MAC.

5. I recommend you also have an early meeting with the HSE chairman and CEO. You may also want to have an initial meeting with the HSE senior management team. You are likely to have regular contact with the chairman/CEO (and individual members of the senior management team) but I think you would find it useful to continue a previous practice of regular (every two months) scheduled meetings between yourself, myself and the chairman and CEO.

6. Heretofore, there was a similar arrangement (meeting every two months) with the chairman and CEO of HIQA which you might also like to maintain.

7. As you know, the Government generally meets on a Tuesday morning when the Dáil is in session and a Wednesday morning when the Dáil is in recess. I think it would be useful to keep a regular slot in your diary for us to meet briefly (30 minutes or so) on either Monday evening or early Tuesday morning ahead of the weekly cabinet meeting.

8. From time to time, I meet the CEOs of the agencies under the Department's remit as a group to discuss issues of mutual interest. You might like to attend the next such meeting which will take place around the end of March.

Michael Scanlan

Secretary General
9 March 2011

Briefing Material

for

Minister for Children

Role and Functions

of the

Office of the Minister for Children and Youth Affairs

March 2011

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Section 1 OMCYA Key Priorities

Background

The Office of the Minister for Children and Youth Affairs comprises four internal units – Child Welfare and Protection Policy Unit (with three PO/Equivalent led teams); Children's Legislation Unit; Childcare Directorate and the Children and Youth Services Development Unit - as well as cross-divisional support from the Citizen Participation Unit and the Research Unit. In addition, it has strong and important cross-departmental relationships including, in particular, with the co-located Early Years Education Unit of the Department of Education and Skills and the Irish Youth Justice Service of the Department of Justice and Law Reform.

The Office has a unique remit to model, develop and support cross-divisional and cross-departmental activities supporting improvements in the lives of children and young people. This means not only carrying out specific functions relevant to the Health and Social Care field but also leading and driving co-ordinated action across sectors.

There continues to be a very challenging agenda of work in the Office. There are important constitutional and legislative items on the agenda for 2011; there is a large scale programme of internal change management underway within the children's area in the HSE which makes oversight of the implementation of key priorities with the health system especially challenging. However, the early finalisation and alignment of 2011 HSE service Plan, Budgetary and Employment Control Framework is helpful. The early childhood education and care system has undergone significant changes in funding arrangements in the last number of years which are still bedding down. Finally, the development of innovation in children and youth services is being tackled in the context of shrinking budgetary resources.

Key Priorities

The Office has a wide range of deadline items for 2011 reflecting the size and scope of the Office's remit. High level deadline priorities for 2011 include the following:-

Children's Legislation Unit (with inputs from Child Welfare and Protection Unit)

Priorities
Legislation Programme including 1. Childcare (Amendment) Bill; 2. National Vetting Bureau Bill; 3. Adoption (Information and Tracing) Bill 4. Amendment to the Constitution Bill; 5. Childcare (Amendment) Bill (depending on outcome of Supreme Court case on Section 3 of the 1991 Act).

It should be noted that developments in relation to the proposed Amendment to the Constitution could have significant implications for legislative priorities in 2011.

Child Welfare and Protection Unit

Priorities
1. Children's Referendum – policy lead
2. Publication, promulgation and implementation of Children First and introduction of requisite implementation framework
3. Management and response to investigations, inquiries and reviews including Cloyne Commission of Investigation; HSE Report on Audit of Catholic Dioceses and Religious Orders; Child Death Review.
4. Oversight of the implementation of the Ryan Implementation Plan including specific deadline items to be achieved by the HSE relating to the recruitment of SW; implementation of the PA report on reconfiguration; and improved business and ICT processes.
5. Monitoring and evaluation of HSE National Service Plan including key deliverables and KPIs

Children and Youth Services Development Unit

Priorities
1. Development of the new National Children's and Young People's Strategy for the period 2012-2017
2. Development of a new policy framework for youth work and youth service provision
3. Implementation of the Strategic and Communications Plans for the *Working Together for Children* (WTC) Initiative
4. Ireland's 3rd and 4th Report to the UNCRC

Childcare Directorate

Priorities
1. Effective operation and development of the three major early childhood programmes which comprise the: ▪ free Pre-School Year in Early Childhood Care and Education (ECCE) ▪ Community Childcare Subvention (CCS), and ▪ Childcare Education and Training Supports (CETS)
2. Review of the regulatory environment of pre-school and after school services including the existing provision of pre-school inspections.

Cross-Divisional Projects

There is a special relationship between the core units and the Research Unit (RU) and Citizen Participation Unit (CPU) under the OMCYA umbrella. High level priority issues relevant to the children's field in 2011 are as follows:

Citizen Participation Unit

1. Oversee effective development of Comhairle na nÓg and Dáil na nÓg
2. Publish the report and lead the follow-up on consultations with children living in the care of the State

3. Develop the policy on children's participation for the National Children's Strategy and consult with children on development of the Strategy
4. Build an evidence-base on the effectiveness of children's participation through a national audit and commissioned research

Research Unit
1. Assist with the consultation for the national children's strategy
2. Agree and publish a national data and research strategy
3. Develop and write the Research Goal for the new national children's strategy
4. Award three fellowships

It is also worth noting that there are ongoing cross-divisional links particularly with the Office of the CMO and the Office of the Minister for Disability and Mental Health. These include specific co-supported projects and in 2011 will focus on the development of the child health aspects of the new National Children's Strategy.

Cross-Departmental Projects
The CDYSU is also undertaking a major project in the NCS which will involve other significant cross-divisional and cross-departmental liaison and support over the course of the year. This will be managed both bilaterally and through the National Children's Strategy Implementation Group on which all Government Departments and key children's services agencies are represented.

The Childcare Directorate will continue progress in co-ordinating strategic policy and funding decisions with the Early Years Education Unit of the Department of Education and Skills in order to leverage support and momentum for shared objectives in the development of both access issues, quality and harmonisation of childcare provision with educational infrastructural arrangements and curricula.

There are also strong links with between the OMCYA and the Irish Youth Justice Service. These will continue around a number of projects over 2011 including the development of standards; deaths in care review; development of youth policy framework; and our shared involvement in the Limerick Regeneration project.

Conclusion
The biggest challenge in 2011 will be to find the right balance between work required to respond to recently identified shortfalls in child welfare and protection services and developmental work including the cross-departmental remit. In an area where operational (both internal and within the HSE) and financial risk are high compared to some other divisions, the focus on longer term strategic objectives can easily be diverted.

A major programme of change within child services is underway in the HSE – business processes, systems and staff configuration. To achieve the objectives demanded will require sustained leadership, careful relationship management and clear objective setting and monitoring of progress by the OMCYA over the course of this year.

In 2011, the Office has the challenge of not only leading on a Constitutional Referendum but also producing a follow-on National Children's Strategy – two major

cross-government projects in their own right. At the same time, a number of important longer term projects have been progressing in early years education and care services, the development of prevention and early intervention programmes; and the development of interagency working through the Children's Services Committees.
If the Office is to capitalise on the progress already made and ensure ultimate achievement of strategic objectives equal attention will have to be paid to this latter work and emerging knowledge. This will require close attention to cross-departmental relationships and the development of cross-departmental leadership's understanding of and capacity to mainstream good innovative practice; to use emerging evidence; and to continue to improve information systems for collection and analysis to inform policy decisions.

OMCYA
9th March 2011

Section 2 – Overview of OMCYA

MAC Area: Office of the Minister for Children and Youth Affairs

MAC Member: Mary Doyle, Director General

The Office of the Minister for Children and Youth Affairs (OMCYA), an integral part of the Department of Health and Children, was set up by Government to bring greater coherence to policy-making for children and young people. The OMCYA focuses on harmonising policy and programmes that affect children and young people in areas such as early childhood care and education, youth justice, child welfare and protection, support and promotion of non-formal education and developmental opportunities for young people, children and young people's participation, research on children and young people and cross-cutting initiatives for children and young people.

The OMCYA supports the Minister for Children and Youth Affairs in:

- Implementing the National Children's Strategy (2000 – 2010)
- Implementing the National Strategic Plan 2011-2013 for the implementation of the Early Childhood Care and Education Scheme, the Community Childcare Subvention Scheme and the Childcare Education and Training Support Programme,
- Developing policy and legislation on child welfare and child protection,
- Implementing the National Quality Standards Framework for Youth Work,
- Implementing the Children Act (2001)
- Implementing the Child Care Act (1991)

The OMCYA also maintains a general strategic oversight of bodies with responsibility for developing and delivering children's services.

The OMCYA has brought together functions within the Department of Health and Children with the Early Years policy functions of the Department of Education and Skills and the Youth Justice policy of the Department of Justice and Law Reform to provide a joined-up Government approach to the development of policy and delivery of services for children and young people.

Key objectives:

The objectives of the OMCYA are:

- To bring together in the Office of the Minister for Children and Youth Affairs functions relating to children and young people and their well-being.
- To develop a co-ordinated policy and legislative framework for all children's health services, incorporating the "whole child perspective" as outlined in the National Children's Strategy.
- To implement the free Pre-School Year in Early Childhood Care and Education (ECCE) programme in addition to childcare support programmes which target disadvantaged and low income parents.

- To bring about more effective implementation of services and interventions for children and young people at local level, through cross-departmental and cross-agency working.
- To support and promote non-formal education and developmental opportunities for young people through which they can enhance their personal and social kills and competencies.
- To support and advance best practice in consultation with/participation of children, children's research and data/information on children's services

Main policies, strategies and plans:

Department of Health and Children

Implementation of:

- National Children's Strategy [2000]
- National Play Policy [2004]
- National Recreation Policy [2007]
- National Strategic Plan 2011-2013 for the early childhood programmes.

Department of Justice and Law Reform

- National Youth Justice Strategy, 2008 – 2010

Department of Education and Skills

- National Workforce Development Plan [2010]

Key organisational linkages:

The OMCYA works closely with the following:

- Other Government Departments and Agencies,
- The Health Service Executive,
- The voluntary youth sector/organisations and Vocational Education Committees,
- Local authorities and County/City Development Boards,
- City and County Childcare Committees
- Atlantic Philanthropies [in relation to PEIP],
- NGOs,
- The research community.

Section 3 - Constituent Units of the OMCYA

The OMCYA has four core Units that include -

- **Child Welfare and Protection Policy Unit** which has responsibility for developing the policy and legislation in relation to child welfare and protection.

- **Children's Legislation Unit** which is responsible for all legislation relating to children.

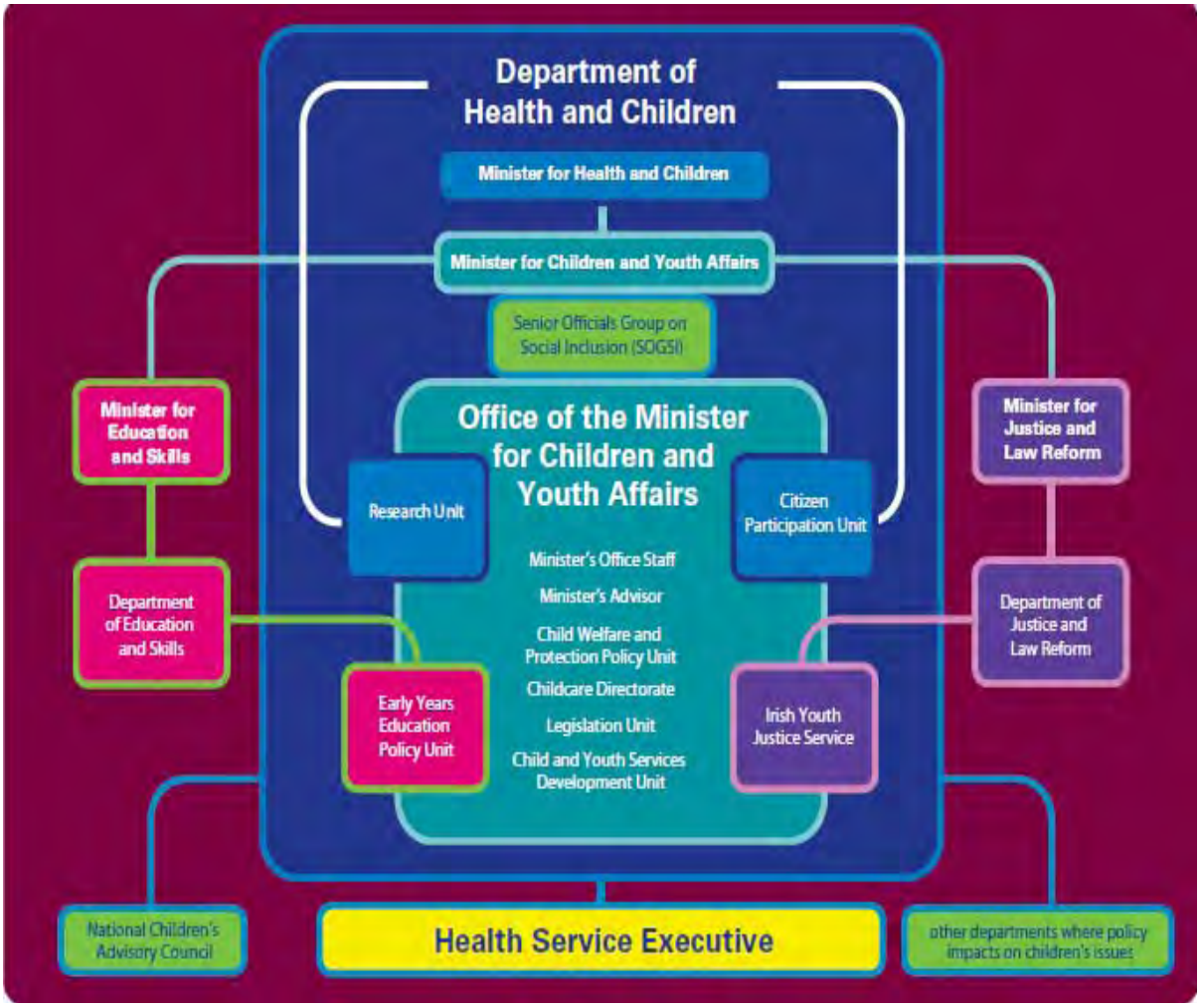
- **Childcare Directorate** that has responsibility for the development and implementation of childcare policy and strategies.

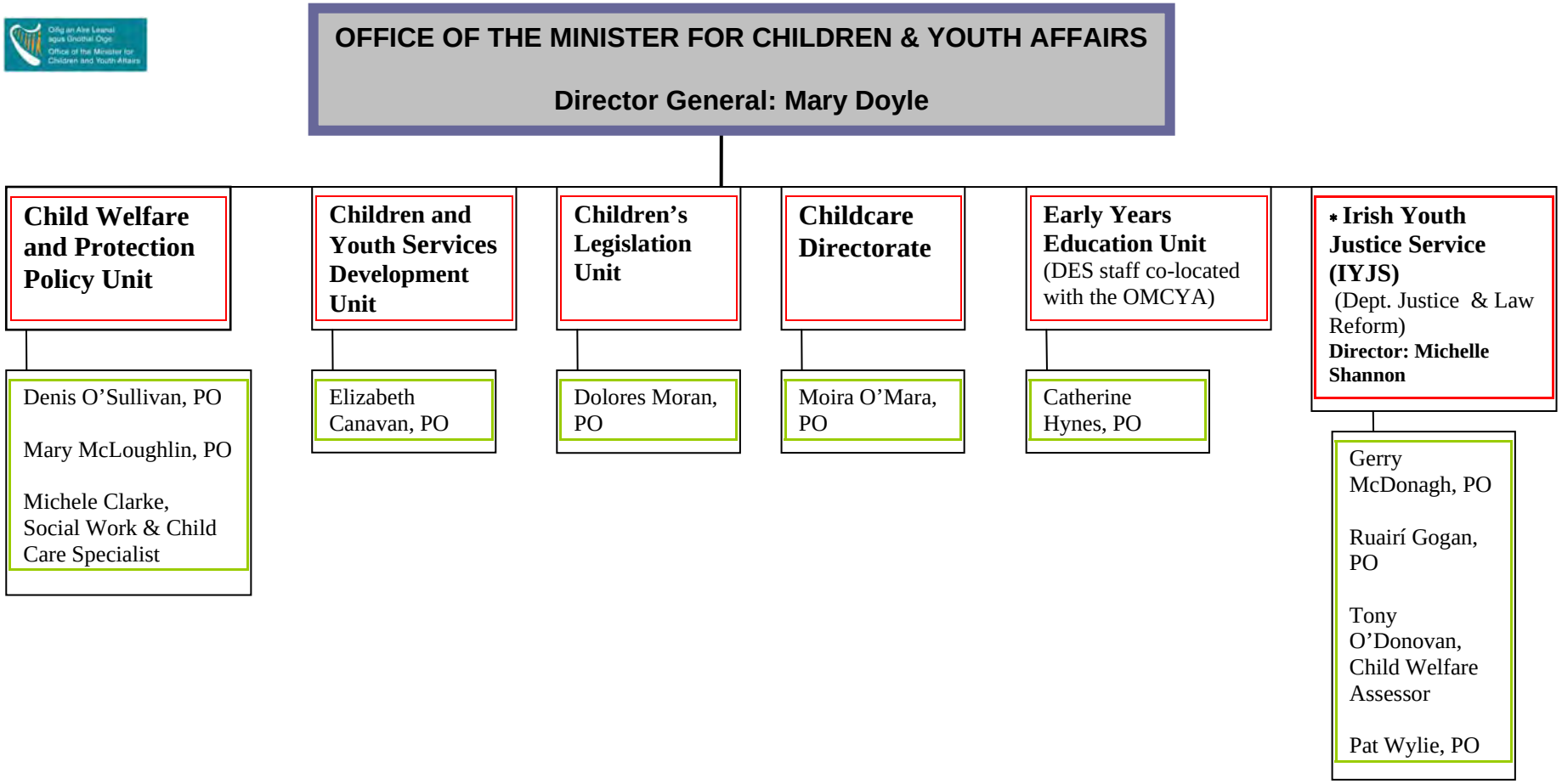
- **Children and Youth Services Development Unit** which is principally concerned with overseeing the provision of supports and services for children and young people in line with the commitments in the National Children's Strategy.

The Office also has cross-divisional support from other Units within the Department of Health and Children that include -

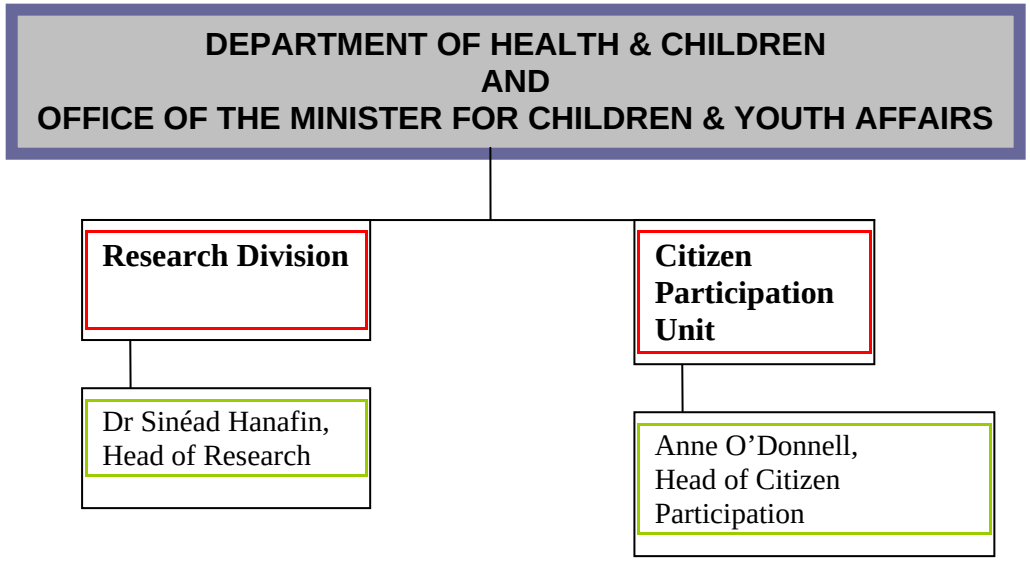
- **Citizen Participation Unit** which supports and promotes the participation by children and young people in matters that affect them.

- **Research Unit** which leads and drives implementation of a national Children's Research Programme.


Department of Health and Children
Minister for Health and Children
Minister for Children and Youth Affairs
Senior Officials Group on Social Inclusion (SOGSI)
Office of the Minister for Children and Youth Affairs
Research Unit
Citizen Participation Unit
Minister's Office Staff
Minister's Advisor
Child Welfare and Protection Policy Unit
Childcare Directorate
Legislation Unit
Child and Youth Services Development Unit
Early Years Education Policy Unit
Irish Youth Justice Service
Minister for Education and Skills
Department of Education and Skills
Minister for Justice and Law Reform
Department of Justice and Law Reform
National Children's Advisory Council
Health Service Executive
other departments where policy impacts on children's issues



* IYJS, 2nd Floor, Montague Street, Dublin


DEPARTMENT OF HEALTH & CHILDREN
AND
OFFICE OF THE MINISTER FOR CHILDREN & YOUTH AFFAIRS
Research Division
Dr Sinéad Hanafin,
Head of Research
Citizen Participation Unit
Anne O'Donnell,
Head of Citizen Participation

PO's: Mr. Denis O`Sullivan
Ms. Mary McLoughlin
Ms. Michele Clarke, Social Work and Childcare Specialist
Unit Name: Child Welfare and Protection Policy Unit

1. Child Welfare and Protection Policy Unit Overview

The primary objective of Child Welfare and Protection Policy Unit is to develop a policy and legislative framework which supports the delivery of a modern and integrated child welfare and protection service. The Unit also has a strong oversight function monitoring and evaluating the implementation of policy, particularly by the HSE, which has statutory responsibility in this area.

In recent years there has been a particular focus on overseeing the implementation of the findings and recommendations of the Report of the Commission to Inquire into Child Abuse (Implementation Plan) and the recommendations from other investigations, inquiries and reviews into child welfare and protection services. The Unit also promotes and oversees the development of a modern framework for adoption services in line with the Adoption Act, 2010, including the ongoing development of the Adoption Authority of Ireland.

2. Adoption

The Adoption Act, 2010, commenced on 1 November 2010. The new legislation, which incorporates the provisions of the Hague Convention, is designed to provide a framework to ensure that appropriate procedures have been followed and that all adoptions are effected in the best interests of the child. . It gives force of law to the Hague Convention on the Protection of Children and Co-operation in Respect of Inter-country Adoption, which entered into force for Ireland on1 November 2010.

The Adoption Authority was also established on 1 November 2010. The Board of the Authority meets fortnightly and is currently dealing with a range of practical issues following its establishment. However, the new framework of adoption will mean that major change is required, and it will be some time before all aspects of the new system are in place. This is causing some concern in the adoption community. The OMCYA is working very closely with the Adoption Authority to ensure that change happens as quickly as possible.

The Adoption Act 2010 limits adoptions into Ireland to countries who are signatories to the Hague Convention on Inter Country Adoption or with which Ireland has a bilateral agreement. There are currently no bilateral agreements in place. Hague officials take the view that countries should be encouraged to achieve a Hague standard and adopt the Hague Convention. They would see bilateral agreements as a watering down of this approach.

3. Children's Referendum

The Minister for Children and Youth Affairs presented a copy of the third and final report of the Joint Committee on the Constitutional Amendment on Children to Cabinet in early March 2010. The Cabinet decided that, in view of the complex nature of the issues involved, all Ministers and Government Departments as well as the

Attorney General should consider the report and examine the implications of the proposed wording for their individual areas of responsibility. A range of unintended policy and resource implications were identified, including concerns that the concept of continuity of care might lead to children being left in inappropriate care situations. There were also concerns about implications for immigration policy as someone due to be deported could claim it is in their child's interests that they remain in the country and about the way in which the voice of the child provisions could lead to unwieldy and inappropriate arrangements; for example, where a child is being suspended from school it could result in legal representation being on both sides.

In view of these difficulties, the Minister for Children and Youth Affairs presented to Government the policy objectives for the Referendum and was granted Government approval to develop revised wording for an amendment, in co-operation with the office of the Attorney General. New wording, which takes into account the proposals put forward by the Committee, has been drafted by the Attorney General's Office with policy support provided by the Office of the Minister for Children and Youth Affairs.

On January 12th the Government approved

- the policy objectives now proposed for the amendment of the Constitution in relation to children's rights
- the wording for the referendum
- the drafting of a Referendum Bill

The Office of the Minister for Children and Youth Affairs is giving consideration to the following tasks in preparation for the holding of a Referendum possibly in conjunction with the Presidential election later this year;

- Drafting of a Referendum Bill
- Preparation of a policy paper on the adoption legislation proposals
- Undertaking research into public awareness and understanding of the issues involved.

4. Family Support Services

The dominant focus in child care services since the early 1990s has been on the protection and care of children who are at risk. More recently, the policy focus has shifted to a more preventive approach to child welfare, involving support to families and individual children, aimed at avoiding the need for further more serious interventions later on. The principle of having health and social services provided on the basis of the child being supported within the family, within the local community is a core principle of the Agenda for Children's Services

Action 27 of the Health Strategy (Quality and Fairness A Health Strategy for You) details an expansion programme for family support services which includes:

- Child Welfare budgets will be refocused over the next seven years to provide a more even balance between safeguarding activities and supportive programmes
- Springboard Projects and other family support initiatives will be further developed
- Positive parenting supports and programmes will be expanded

- Priority will be given to early intervention for children with behavioural difficulties.

Family support programmes are provided by services such as the Community Mothers, Family Support Workers, Teen Parents Support Projects, and Spring Board Projects and encompass specific interventions such as Parents Plus programme, the Family First Parenting Initiative as well as a range of general parenting programmes and supports.

5. Children in Care

The primary legislation governing services is the ***Child Care Act 1991***. Under this Act the Health Service Executive (HSE) has a statutory duty to promote the welfare of children who are not receiving adequate care and protection. The definition of a child is a person under 18 years of age who is not or has not been married.

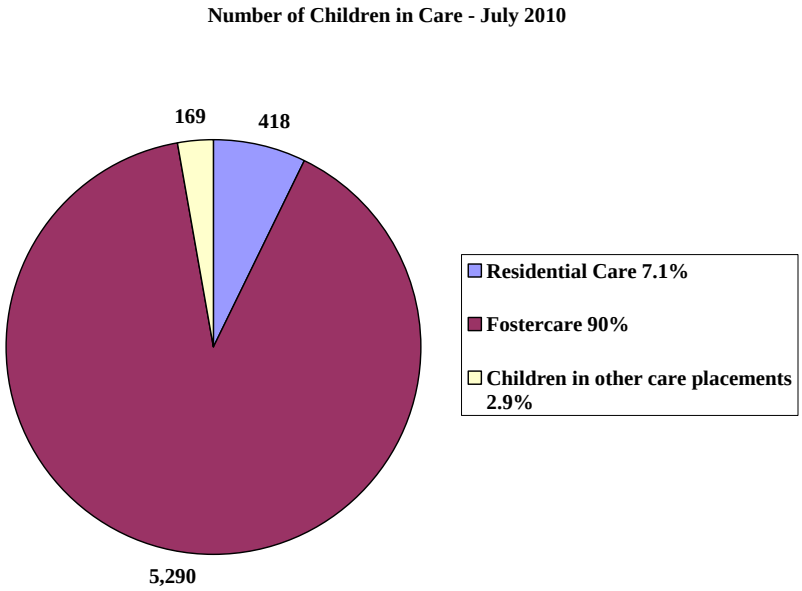
If a child is in need of care and protection and is unlikely to receive it at home, then the HSE has a duty to ensure they receive appropriate care. In cases where parents are unable to cope due to illness or other problems they may agree to their children being taken into the care of the HSE on a voluntary basis. In these cases while the HSE has care of the children it must consider the parents' wishes as to how the care is provided. The HSE is obliged to provide care for these children for as long as their welfare requires it.

In cases where the HSE has concerns for the care and wellbeing of a child it may apply to the courts for a care order. These orders give the HSE a range of powers regarding care planning and care placements. Children in the care of the HSE may be accommodated in a range of settings as detailed in the following table.

Children in Care as at December 2010	
Care Setting	**No. of Children**
Foster Care	3447
Foster Care with relatives	1674
Residential Care	437
Other Residential Care Placements	169
TOTAL	**5,727**

The following sections provide further detail on the range of care options available.

5.1 Number of Children in Care



5.2 Types of Care

Fostering

The HSE where possible will place a child in foster care. Many children living in foster care have been living with their foster families for most of their lives. Others have shorter placements. The majority of separated children seeking asylum are now placed in foster care. Two thirds of children in foster care are cared for in general foster care and approximately one third are in relative foster care.

Relative Foster Care

Relative carers go through an assessment and approval, in a similar way to general foster carers. The child is allocated a social worker who visits regularly and a Care Plan is developed and reviewed regularly.

Residential Care

For young people that are unable to live at home or in an alternative family environment residential care may be considered suitable. Residential care can be in a home run by the HSE or by a voluntary or private company. It is the policy and practice of the HSE not to place children aged twelve years and under in residential care unless for exceptional reasons.

Special Care/High Support

Special Care involves the detention on an exceptional basis of a non-offending child for his or her own welfare and protection in a special care unit with educational and therapeutic supports. The child's behaviour, and the risk of harm it poses to his or her life, health, safety, development or welfare is addressed in the care setting. Future care requirements are also explored.

Number of centres classified as children's residential centres by HSE region on 24 October 2010

HSE Region	Statutory (72)	Non-statutory (94)	Total (166)
HSE Dublin Mid-Leinster (52)	17	35	52
HSE Dublin North East (56)	21	35	56
HSE South (45)	24	21	45
HSE West (13)	10	3	13
Total	72	94	166

68% of Non-HSE Residential Centres are now in the private sector.

5.3 Allocation of social workers and care plans for children in care

This table details the allocation of social workers to children in care and existence of care plans at end Q3 2010:

Percentage of \Children in Care with allocated social worker	**92%**
Target for 2011 for allocated social worker	**100%**
Percentage of children in care with Care Plan	**88%**
Target for 2011 for Care Plan	**100%**

5.4. Special Care Amendment Bill

The primary objective of the Child Care (Amendment) Bill, 2009 is to create a statutory framework for the High Court to deal with Special Care cases, instead of the High Court employing its inherent jurisdiction. The feasibility of a single district judge hearing these cases was examined, but due to various difficulties with this approach the current approach was deemed the most effective.

The Bill allows Special Care Units to be registered and inspected by HIQA. It also provides for the dissolution of the Childrens Acts Advisory Board. The Bill had completed Report Stage prior to the dissolution of the Dáil.

5.5 Aftercare

The provision of an appropriate aftercare service has been highlighted as a key element to achieving positive outcomes for young people leaving care. Aftercare services assist young people leaving care to achieve a successful transition from the care environment to independent adult life in the community. In response to calls that the provision of Aftercare Services be put on a statutory basis, legal advice was sought and the Attorney General's Office confirmed that the obligation contained in Section 45(4) of the Child Care Act 1991 is in substance mandatory. Accordingly, the Act creates a statutory power and the HSE, as recipient of this power, must put itself in a position where it can exercise the power should the need arise. The HSE is finalising its Aftercare Policy and Implementation Plan.

6. Youth Homelessness

A Strategy for Youth Homelessness was developed in 2001. A review of progress in 2008 by the HSE in conjunction with other agencies found much progress had been made, especially in interagency cooperation, early prevention and an out of hours service. There are information deficits on numbers of children using the service. Incorrect information has been published in the media. Work is in progress to improve

information on the number of young people under 18 years who are homeless, and to establish what areas of the service are working well and were improvements are needed.

7. Implementation of Ryan Report

The Report of the Commission to Inquire into Child Abuse (the Ryan Report) was published in May 2009. The then Minister for Children and Youth Affairs was tasked with producing an Implementation Plan for the Report's recommendations. The Implementation Plan was accepted by Government and was published in July, 2009. In drawing up this Implementation Plan, key stakeholders with particular knowledge and expertise in the area of child welfare and protection were consulted.

The Implementation Plan sets out 99 proposals to address each of the 20 recommendation in the Ryan Report, and includes proposals considered essential to further improve services to children in care, in detention and at risk. An amount of €15m was allocated by Government in 2010 to progress the implementation of Ryan actions. A further €9m is being provided in the current year.

The Minister for Children and Youth Affairs is required to chair a high level group to monitor the implementation of the actions specified in this Plan. The group includes representatives from the Office of the Minister for Children and Youth Affairs (OMCYA), the HSE, HIQA, the Irish Youth Justice Service (IYJS), the Department of Education and Science and An Garda Síochána. The group meets twice a year and a progress report is presented to Government each year. The first progress report was laid before both Houses of the Oireachtas in July 2010.

8. Child Protection: Children First guidelines and implementation plan

Children First, the National Guidelines for the Protection and Welfare of Children were first published in 1999. Over the last eleven years they have operated as the over-arching national Guidelines for individuals and agencies that come into contact with children. The aim of Children First is to direct the identification, investigation, assessment, reporting, treatment and management of child abuse.

The Children First Guidelines are being updated and revised in light of a detailed review and to reflect policy and legislative changes since 1999. The OMCYA is also engaging with other Government Departments on the development of a supporting implementation framework to ensure more consistent application of the revised Guidelines, once launched.

The HSE, in parallel, is reviewing its existing arrangements to support the implementation of the revised Children First. The HSE has a key role to play in terms of providing training and advice to organisations working with children and to the general public. The Ryan Commission Implementation Plan also committed to the drafting of legislation to provide that all bodies in receipt of exchequer funding would have a duty to comply with Children First, the policy position in this regard is currently being considered by OMCYA.

8.1. Out of Hours Service

The HSE has put in place a standardised national system whereby Gardai can access an appropriate place of safety for children found to be at risk out of hours under Section 12 of the Child Care Act 1991. This service conforms with Child Care Regulations and with the National Foster Care Standards. The provision of this service aims to ensure that children presenting as 'at risk' outside of normal working hours are provided with an appropriate emergency place of safety thereby reducing or eliminating social admissions of children in an acute hospital setting.

In addition, the HSE is undertaking a pilot out-of-hours social work service in two locations as provided for in the Government's Implementation Plan for the findings of the Report of the Commission to Inquire into Child Abuse.

9. HIQA: Inspection of Services for children in care and child protection

Under the Child Care Act 1991 HIQA inspects and reports to the Minister on HSE Children Residential Centres and Foster care. The HSE inspects and registers the private and voluntary centres. HIQA is preparing to inspect the HSE and Health funded child protection services.

10. 'Information

The HSE Child and Family Services has an interim data set, published on their websites, providing information on child welfare and protection activity, on children in care and related areas. Due to a lack of standardisation and common definition, aspects of the information are not reliable. The HSE has been asked to insert a comment to this effect on their website.

The HSE in developing a National Child Care Information System to provide accurate data on a national basis. Standardised definitions are agreed and are being rolled out across the 32 LHO areas. The HSE says this project will be complete by end December 2011. This should allow for accurate collation and comparisons across the country. The tendering and installation of the IT system follows the standardisation programme.

The OMCYA agreed a new set of Performance Indicators with the HSE for 2011 to improve this units capacity to evaluate the HSE's implementation of national policy relating to children in need of care and protection. '

11. HSE Service Plan

The annual HSE Service Plan is the annual contract for services between the State and the HSE. The 2011 Service Plan was agreed by the Minister for Health & Children in late 2010. The Plan contains a number of commitments in the area of children and family services under three broad headings as follows:

1. Delivery of statutory services
2. Implementing strategies to support service delivery
3. Ryan Report Implementation Plan

Among the specific areas highlighted under the three headings are:

- Aftercare services
- Allocation of social workers to children in care
- Capacity review of Special Care and High Support
- Review progress on Strategy for Youth Homelessness
- Management of Children First implementation plan
- Implementing provisions of the new Adoption legislation
- Development of the National Child Care Information System
- Implementing restructuring of children and family services

12. Supreme Court Case

A Supreme Court appeal is due to be held shortly challenging the HSE's powers to assess and respond to allegations of third-party abuse under Section 3 of the Child Care Act, 1991, while a criminal prosecution is ongoing. The appeal had been due to be heard in the Supreme Court on 18 October, 2010 but was been deferred following a request for a short adjournment by the State's solicitors.

The case could give rise to a requirement for emergency legislation to amend Section 3 of the Child Care Act, 1991.

13. Investigations & Reviews

13.1. Commission of Investigation into the Diocese of Cloyne

[redacted]

13.2. HSE Audit of Catholic Church Dioceses and Religious Orders

The HSE is due to report shortly to the Minister setting out the findings of a national audit of child protection practices in each Catholic Church Diocese.

It is expected that the Commission of Investigation's report into the diocese of Cloyne may be published before the Minister receives the HSE's Audit report.

A separate audit of **Religious Orders** is also being undertaken. It is not at as advanced a stage as the audit of the Catholic Church dioceses.

13.3. Review into the Deaths and Serious Incidents of Children in Care and known to the Child Protection Services 2000-2010

a. The Minister established the Independent Review Group on Child Deaths on March 8th 2010. The Group is composed of Ms. Norah Gibbons and Mr. Geoffrey Shannon.

b. The Independent Review Group on Child Deaths is examining existing information in respect of deaths of children over the period of 1 January 2000 to 30 April 2010 who were:

a) in care within the meaning of the Child Care Act, 1991 at the time of their death

b) in receipt of aftercare within the meaning of Section 45 of the Child Care Act, 1991 at the time of their death

c) known to the child protection services within the meaning of the HIQA guidance to the HSE of 20 January, 2010 at the time of their death.

- The Review Group has completed a preliminary examination of all files received from the HSE and is now compiling learning and recommendations.
- The Review Group intends to interview families of the deceased who may wish to have the opportunity to air their views.
- It is expected that the Group will report to the Minister shortly.

14. Guardian Ad Litem

'Under the Child Care Act 1991 Guardian ad Litem (GALs) provide a service to the Courts, where a judge **may** request that a GAL is appointed to a child who is the subject of Care Proceedings. The GAL prepares a report for the Court, following meeting/s with the child, family members and professionals involved, setting out the child's wishes and making recommendations based on the overall situation. Under current practice GALs are always appointed where a child is subject to a Special Care Order (that is, detained for reasons of safety). GALs are frequently represented in the High Court by a junior and senior counsel, adding significantly to their costs. Under the Act costs are paid by the HSE.

The Ryan Report Implementation Plan provides that 'the Minister for Children and Youth Affairs will engage with Ministerial colleagues to agree a future policy of management and funding of the service.' In this regard, the OMCYA has had preliminary discussions with the Department of Justice and Law Reform with a view to furthering this commitment. The possibility of the establishment of an Executive Office to provide GAL services is being considered.

PO: Dolores Moran
Unit name: Children's Legislation Unit.

Unit objectives:
The Unit provides support to the Minister for Children and Youth Affairs in progressing the Government's legislative programme for children. Key legislation for the Unit includes:

- Child Care Acts 1991 to 2007
- Children Act 2001
- Adoption Act 2010

The work of the Unit includes liaison with policy divisions, other Government Departments, statutory agencies and other stakeholders. It requires research and analysis to prepare the Heads and General Scheme of Bill, Regulatory Impact Analyses, Memoranda for Government, drafting of Bill for publication and passage of Bill through the Houses of the Oireachtas. Liaison with the Department's Legal Section and Office of the Attorney General is ongoing during the preparation of legislation. The Unit has the lead role in supporting the Minister in the passage of Bills through the Oireachtas.

Adoption Act 2010

In 2010 the Adoption Act 2010 was enacted and commenced. In addition the Hague Convention on the Protection of Children and Co-operation in respect of Intercountry Adoption was ratified. The following regulations were also made:

- Adoption Act 2010 (Establishment) Order - S.I. 511 of 2010.
- Adoption Act 2010 (Commencement) Order - S.I. 512 of 2010.
- Adoption Act 2010 (Section 85) (Fees) Regulations 2010 - S.I. 518 of 2010.
- Adoption Act 2010 (Consent to Adoption Order) Forms) Regulations 2010 - S.I. 519 of 2010.
- Adoption Act 2010 (Pre-Placement Consultation Procedure) Regulations 2010 - S.I. 520 of 2010.
- Adoption Act 2010 (Register of Intercountry Adoptions) Regulations 2010 - S.I. 521 of 2010.
- Adoption Act 2010 (Accredited Bodies) Regulations 2010 - S.I. 524 of 2010.

The other main areas of work for the Unit in 2010 related to the progression, through the Oireachtas, of the **Child Care (Amendment) Bill 2009** and the development of Heads of Bill in respect of the **National Vetting Bureau Bill** (please see below).

Child Care (Amendment) Bill 2009

The Child Care (Amendment) Bill 2009 provides a statutory scheme for the High Court to have exclusive statutory jurisdiction to hear special care applications. A unique feature of the legislation is that it provides that the HSE should seek to provide, or continue to provide, special care to a child where such need is determined including situations where a child is going through the criminal justice system, up to and including the child receiving a criminal sentence that is not a custodial sentence

i.e special care can run side by side with a criminal sanction except at the time a child is in custody serving a criminal sentence.

The current procedure to provide special care requires the HSE to apply to the High Court for a detention order. The application is heard under the High Court's power of inherent jurisdiction in the context of its Constitutional obligation to defend and vindicate the personal rights of the citizen. In a series of landmark special care judgments given by the High Court, Justice John MacMenamin, stated in 2007 that the '*court has jurisdiction in proceedings brought by way of judicial review for the placement of young persons at risk in Ballydowd ….. and that it must be re-emphasised* ***that this is an exceptional jurisdiction and should be placed within a statutory framework.'*** (Emphasis added)

The High Court will only invoke its power of inherent jurisdiction where there is a serious danger that justice would not be done. In relation to the area of special care, the High Court has had to make use of its powers of inherent jurisdiction since 1996, largely due to the absence of an adequate statutory basis for such applications.

In view of the complex Constitutional and European Convention on Human Rights issues involved, particularly in the context of the civil detention of children, it is considered that the statutory scheme provided by the Child Care (Amendment) Bill 2009 will allow for the structured presentation and consideration of applications for special care orders and related applications before the High Court in the best interest of children.

As well as dealing with the substantive issue of applications to the High Court for special care orders, the Bill also includes a number of other amendments to the Child Care Act 1991. For example, a very important amendment which was included on the strong advice of the Attorney General is the amendment to section 12 of the 1991 Act. Currently a Garda can enter a building without a warrant if there is not sufficient time to make an application for an emergency care order under Section 13 and there is immediate and serious risk to the health or welfare of the child. The effect of the amendment to section 12 is that a Garda, who believes that there is an immediate and serious risk to the health or welfare of a child, can also enter a building without a warrant if there is not sufficient time in the circumstances to obtain a warrant under section 35 of the Child Care Act 1991 for the purpose of executing an order which has been made by a Judge directing that a child be placed or maintained in the care of the HSE. This amendment would become effective on the enactment of the Bill (i.e it would not have to await commencement of the Act.)

The Bill also includes amendments to the Health Act 2007, the effect of which will be that special care units will be subject to the inspection provisions of the Health Act 2007.

The Bill also provides for the dissolution of the Children Acts Advisory Board (CAAB). Most of the functions of the CAAB are now being undertaken by the OMCYA.

The Bill had been passed by Seanad Éireann and had commenced Report Stage in Dáil Eireann where only 2 proposed amendments were outstanding on the dissolution of the Dáil.

National Vetting Bureau Bill.

In September 2008 the Joint Committee on the Constitutional Amendment on Children published an Interim Report to the Oireachtas recommending that legislation should be prepared to establish a statutory scheme for the vetting against both 'hard' and 'soft' information of all employees involved in working in any capacity with children or vulnerable adults

The National Vetting Bureau Bill will provide a statutory basis for the vetting of applicants for employment and employees, including vetting to identify, in particular, information relating to the endangerment or sexual exploitation of children. The OMCYA, in conjunction with the Department of Justice and Law Reform, is preparing the Heads and General Scheme of the Bill which are well advanced and currently are being considered by the Office of the Attorney General.

In relation to including vulnerable adults in this legislation, consideration is now being given to dealing with vulnerable adults in separate legislation.

Adoption (Tracing and Information) Bill

Preparatory work is ongoing on a proposed Adoption (Tracing and Information) Bill which will provide for an information and tracing service to applicants seeking information about adoptions. The Bill is required in order to provide a statutory basis for the National Adoption Contact Register which was established in 2005 together with addressing, as far as possible, issues which arise in the context of tracing and information in respect of intercountry adoptions. The Heads of Bill are well advanced and will be forwarded to the Adoption Authority for consideration at an early date.

PO: Moira O'Mara
Unit Name: Childcare Directorate

Unit Objectives:

- To ensure the effective implementation and development of the free Pre-School Year (ECCE) programme
- To ensure the effective implementation and development of the Community Childcare Support (CCS) programme
- To ensure the effective implementation and development of the Childcare Education and Training Support (CETS) programme
- To oversee the closure of the NCIP capital programme and introduce a new capital maintenance programme from 2012
- To review the regulatory environment of pre-school and after-school services, including the existing provision for pre-school inspections

Main features of work in 2011

- Implement and develop the ECCE programme including the next steps towards greater quality provision and supports.
- Implement and develop the CETS and CCS programmes to ensure they meet parental needs and support labour measures.
- Oversight and management of estimates and budgetary processes relating to 76% of Vote 41 (€253 million).
- Oversight and management of the closure of the NCIP capital programme and consideration of a new capital scheme.
- Undertake a review the regulatory environment with a view to improving and extending the existing provision which is implemented by the HSE Pre-School Inspectorate.

Early Childhood Care and Education - the Role of the Childcare Directorate

Since its establishment in 2006, the Office of the Minister for Children and Youth Affairs (OMCYA) has provided a focal point for policy and services which impact directly on the lives of children. The OMCYA brought a number of key areas of policy and services for children together, enabling a more co-ordinated approach to be adopted to implementing change. A key area which was incorporated into the OMCYA was the Childcare Directorate which had been established under the Department of Justice, Equality and Law Reform in 1997 to develop the first policy for childcare services in Ireland.

Between 1997 and 2006, the Childcare Directorate had been to the forefront in developing and implementing a new policy for a State supported childcare infrastructure. The initial focus of this policy, was to grant-aid private childcare providers to increase the availability of childcare places which would meet the regulatory standards introduced for the first time in 1997. This was accompanied by the establishment of a network of 33 City and County Childcare Committees, which worked with the Childcare Directorate to improve quality standards in the sector.

The Childcare Directorate also allied itself with the main national voluntary childcare organisations, to secure additional resources at local level to upskill personnel within childcare services. These developments were further supported at national level by the National Childcare Co-ordinating Committee (NCCC) which the Childcare Directorate established in 2000 and which continues to provide a national policy forum for all relevant stakeholders.

By 2007, the Childcare Directorate had completed enough of the developmental groundwork to enable it to expand its policy objectives to include additional programmes targeting disadvantaged and low income families. In particular, in 2008, the Childcare Directorate introduced the Community Childcare Subvention (CCS) scheme which enabled parents to access affordable quality childcare, including pre-school provision. In 2009, the Childcare Directorate built on the success of the CCS to successfully introduce a universal programme for pre-school education, from January 2010.

The Childcare Directorate ensured that the free pre-school year, known as the Early Childhood Care and Education (ECCE) programme, was introduced as a universal programme for all children, to ensure that there would be equality of access to early learning which would carry through to primary education. With 94% of eligible children participating in the programme in its first year, this objective has been successfully secured.

In devising the ECCE programme, the Childcare Directorate made it a requirement for participating services that the Pre-School Leaders hold minimum qualifications and that the Síolta Framework for Early Learning is implemented. Both of these conditions made a direct linkage to the work of the Education Policy Unit of the Department of Education and Skills, which is co-located with the Directorate within the OMCYA. In 2009, the Childcare Directorate asked the Education Policy Unit and the national voluntary childcare organisations which are funded by the Directorate, to work together from January 2010 in a new role supporting the Síolta Framework in services participating in the ECCE programme.

The Childcare Directorate plans to incrementally develop the ECCE programme in the coming years, gradually increasing the qualification requirements for Pre-School Leaders and incentivising higher standards in specific areas such as children with special needs. It will be important that these developments are supported by an on-going interaction between the Directorate and the Education Policy Unit, including implementation of that Unit's 2010 Workforce Development Plan.

NCIP

The National Childcare Investment Programme 2006-2010 (NCIP) was introduced in 2006 as an Exchequer funded programme to succeed and build on the EU co-funded Equal Opportunities Childcare Programme (EOCP) which operated during 2000-2006. Both the EOCP and NCIP were multi-annual investment programmes designed to improve the availability and quality of childcare and provided for large-scale capital grant funding to increase the number of childcare places available to parents. 45,000 new places were created under the EOCP and a target of 50,000 childcare places was set for the NCIP. The original NCIP capital allocation was €358m over 5

years. However in April 2009, due to the economic downturn, the capital programme closed to new applicants for large-scale funding. Existing capital commitments have continued to be met over the course of 2009/2010 and are expected to be fully met during 2011. This will bring the total capital expenditure to €185m and result in the creation of approximately 25,000 childcare places.

The free Pre-School Year in Early Childhood Care and Education (ECCE) programme

The Early Childhood Care and Education (ECCE) programme was introduced in January 2010 and provides for a free Pre-School Year for all eligible children in the year before commencing primary school. In 2010, the ECCE scheme cost approximately €155 million. Children are eligible when they are aged between 3 years 3 months and 4 years 6 months in the September of the relevant year. In January 2010 53,000 children (83% of the eligible cohort for that year) availed of the free Pre-School Year. In September 2010, the first full year of the scheme, the participation rate increased to 63,000 children (94% of the eligible cohort for that year). The ECCE programme is delivered through participating pre-school services, including daycare services, and some 4,300 (95% of pre-school services) have entered, ensuring wide availability of the pre-school year. Services are required to adhere to the principles of Síolta, the National Quality Framework for Early Learning and Pre-School Leaders must hold minimum qualifications in a relevant field. It is a fundamental principle of the scheme that it is delivered free of charge to parents. As a result, all children have equal access to an appropriate early learning setting at a key developmental stage.

The Community Childcare Subvention (CCS) programme

The Childcare Directorate also implements the Community Childcare Subvention (CCS) programme, which was introduced in September 2010. It was introduced in its original format in 2008 and revised in September 2010. This programme supports disadvantaged and low income parents to access affordable childcare by providing support funding to community childcare services. Eligibility is determined on the basis of a verified entitlement to a social welfare/FIS payment or GP/medical card. Almost 1,000 community childcare services are participating in the CCS and charge reduced fees to qualifying parents in respect of 25,000 children at a cost of approximately €50 million per annum.. The subvention rates result in reductions of up to €100 per week for each full daycare place, with proportionate reductions where children attend for shorter hours. It is estimated that 2,000 of the 25,000 children subvented under the CCS are attending a pre-school sessional service which is broadly similar to the ECCE year. In effect, these children are availing of a second pre-school year, subvented by between €33 and €23 per week, indicating an average parental weekly fee of between €30 and €40.

The Childcare Education and Training Support (CETS) programme

A third programme, the Childcare Education and Training Support (CETS) programme, was introduced by the Childcare Directorate in September 2010. This is a labour activation measure to support parents attending training and educational

programmes, provided by the Department of Education and Skills through FAS and the Vocational Education Committees (VECs). Over 700 childcare services are participating in the CETS programme, providing approximately 4,000 free childcare places to qualifying parents in locations across the State at a cost of approximately €25 million per annum. As the places are available to parents for the duration of their course, the number of parents benefiting from the programme in any one year is significantly higher than the total number of places available.

City and County Childcare Committees

The Childcare Directorate of the OMCYA provides funding to thirty three City and County Childcare Committees (CCCs), to provide a local network of administrative support for the three major early years programmes. This support is provided to more than 4,500 services participating in the ECCE, CCS and CETS programmes. In addition, the CCCs promote quality improvement through a range of activities including training and other supports for childminders, parent and toddler groups, and pre-school service personnel. The CCCs also collaborate with the eight national voluntary childcare organisations which are funded by the Childcare Directorate in implementing Síolta, the National Framework for Early Learning. In December 2010, the Childcare Directorate launched a new National Strategic Plan 2011-2013, for the CCCs and VCOs, to provide a clear framework for their roles in supporting the three early childhood care and education programmes during 2011-2013.

National Voluntary Childcare Organisations

The Childcare Directorate of the OMCYA provides funding to eight national voluntary childcare organisations (NVCOs) to assist them to provide organisational supports to their members. In addition, the NVCOs are funded to support services participating in the ECCE programme to meet the programme's requirement to adhere to the principles of Síolta. In December 2010, the Childcare Directorate launched a new National Strategic Plan 2011-2013, for the VCOs and CCCs, to provide a clear framework for their roles in supporting the three early childhood care and education programmes during 2011-2013.

Child Care Regulations

The Childcare Directorate of the OMCYA is responsible for the Child Care (Pre-School Services) (No. 2) Regulations 2006 which are implemented by the Health Service Executive (HSE). In December 2010, the Childcare Directorate launched National Quality Standards for Pre-School Services which are based on the Child Care Regulations. These are intended to guide and assist service users and providers in working toward high standards based on the statutory requirements.

National Childcare Co-ordinating Committee

The National Childcare Co-ordinating Committee (NCCC) is chaired by the OMCYA and provides a national forum for representatives of the early childhood care and education sector. The NCCC continues to advise and assist the OMCYA in promoting a co-ordinated national approach to early childhood care and education policy and provision.

Other educational supports for disadvantaged pre-school children, implemented by the Department of Education and Skills

The Department of Education and Skills (DES) has a number of existing educational supports for disadvantaged pre-school children, which are outlined below. Some of these have been reviewed as a result of the introduction by the Childcare Directorate of the OMCYA in 2010 of the ECCE programme. A review of the other measures may also be undertaken.

In 2004 DES piloted the Early Start Programme, under which 40 schools in designated disadvantaged areas provide a one-year preventative intervention programme to approximately 1,600 children in the year before primary school. The programme is delivered through a mix of one primary school teacher to one childcare worker costs. Early Start was informed by an earlier DES pre-school project, the Rutland Street Project, which is also still in place. Given the participation rates of the ECCE programme, the rationale for continuing Early Start/the Rutland Street Project may no longer exist and DES plans to cease its funding programme for segregated Traveller pre-schools by mid 2011.

DES launched the Delivering Equality of Opportunity in Schools (DEIS) programme in 2005. Apart from the DES measures referred to above, DEIS does include a direct DES role in the provision of pre-school education within its ambit. Instead, it aimed to build on existing, privately operated pre-school services and assist them to meet the care and education needs of children, through providing them with education related professional support and training, including support and training in the Síolta framework (2006) and Aistear curriculum (2009). To date, DES funding for this element of DEIS has not been made available however the Childcare Directorate of the OMCYA is providing funding to support the implementation of Síolta in pre-school services participating in the ECCE programme, which would include feeder pre-schools in DEIS areas.

With some exceptions, all pre-school services participating in the CCS are required to participate in the ECCE programme. This means that CCS services are providing an appropriate age based programme in early education to children in the ECCE and are likely to follow a similar approach for younger children. The CCS programme is well-positioned, therefore, to provide an additional layer of targeted educational support for disadvantaged children given that it is already doing so. As well as having similar policy objectives in terms of ensuring that all pre-school children have equal access to quality early childhood care and education, the CCS and ECCE programmes are very strongly inter-linked in terms of administration and audit controls. A pre-school service may be in both programmes and it is open to a parent using a CCS service to avail of the pre-school year through CCS subvention rather than ECCE funding. It is important, therefore, that the programmes are jointly administered.

PO: Liz Canavan
Unit Name: Children and Youth Services Development Unit

The Unit has a key role in supporting Goal 3 of the National Children's Strategy as regards

- Harmonisation of policy issues across sectors;
- Harmonisation of policy and consolidation of funding for services which have cross-sectoral aspects to them;
- Supporting the development of service delivery and local implementation mechanisms which align with national policy and, in particular, the intersectoral/inter-agency aspects of local services.

Harmonisation of Children's Policy

National Children's Strategy
The National Children's Strategy, *Our Children — Their Lives*, published in November 2000, was a 10-year plan with a vision of:
'An Ireland where children are respected as young citizens with a valued contribution to make and a voice of their own; where all children are cherished and supported by family and the wider society; where they enjoy a fulfilling childhood and realise their potential.'

The Strategy was a ground breaking document for its time and facilitated a paradigm shift in how policy and operational matters relating to children and young people were examined and delivered upon. Ireland received many plaudits (UN, UNICEF etc.) for its inception in the early part of this century. As a consequence of the strategy, in real terms, there have been significant improvements in service provision and policy across many child related areas.

With the completion of this initial stage, a framework for the further strategic and considered development of areas focusing on children and young people is required – not only to map a vision for future policy direction but to embed the effectiveness and efficiencies presented by the utilisation of an outcomes focus, evidence based decision making and integrated working practices. The production of a new Strategy, the preparatory work for which is being advanced by the OMCYA, would be invaluable in this regard and would draw strong parallels with key elements of Transforming Public Service, which also focuses on these areas.

In the creation of the new strategy, it is proposed to draw on the framework of the current NCS and its 3 goal structure –

Goal 1: Voice of the Child
Goal 2: Understanding Children's Lives
Goal 3: Supports and Services

coupled with the outcome based themes cited in the Agenda for Children's Services that include –

Healthy both physically and mentally

Supported in active learning
Safe from accidental and intentional harm and secure in the immediate and wider physical environment
Economically secure
Part of positive networks of family, friends, neighbours and community, and included and participating in society

Work on the new Strategy has commenced. An initial request for inputs issued to Departments in December and first inputs have been received. The National Children's Advisory Council has been re-established and has had an initial meeting and a workshop day around the new NCS. A full public consultation process is envisaged for the April-end May period – preparations are underway in relation to that process. A separate consultation process with children and young people is also planned, preparations are at an advanced stage and the consultation process is scheduled for 28th March to the 1st April, 2011.

An initial indicative time-line of end September for a first draft of the new Strategy has been set. Adherence to this time-line is predicated on successful completion of the consultation process before the summer period.

International Children's Rights

The Children and Youth Service Development Unit currently has some responsibilities for International Affairs for children and young people. Active engagement with our European and International colleagues has allowed the OMCYA to keep abreast of international perspectives and developments as well as contributing with our EU partners to the shaping of policy relating to children and young people.

The key international commitment regarding the children's field is the **United Nations Convention on the Rights of the Child.** Ireland ratified the UNCRC without reservation on 21 September 1992. The Convention entered into force for Ireland on 21 October 1992. Ireland signed the European Convention on the Exercise of Children's Rights in 1996 and arrangements to ratify the Convention will be made when certain provisions of the Children Act 1997 are brought into force. Similar to other common law countries, Ireland has a 'dualist' system under which international agreements, to which Ireland becomes a party, are not automatically incorporated into domestic law.

In line with the requirements of the Convention, Ireland has already reported twice to the UN Committee on the Rights of the Child. Ireland's 3rd and 4th Reports (combined) were due in April, 2010. Considerable preparatory work has been undertaken, however, the changing economic situation has meant that the achievements and future plans being cited have been changing rapidly. It is hoped to bring this work to a conclusion in the first half of 2011 for formal report to the Committee. Examinations of the Committee are running behind, this is one of the reasons Ireland has been asked for a combined 3rd and 4th report. It is anticipated that the examination will take place as much as a year after the actual submission of a report.

The European Commission issued a communication in relation to the rights of the child in February 2011. This communication outlined the European Union's priorities

such as child friendly justice, parental responsibility, participation and child protection in the broadest sense focusing in the dangers associated with the internet as well as more obvious dangers such as sexual abuse/exploitation and child abduction. It also outlined the desire of the Commission that the broad principles of the EU Charter of Fundamental Rights as ratified by Lisbon 2 be put into practice. The question of the competence of individual member states in relation to these issues is generally acknowledged and appreciated at EC/EU level (guarantees obtained by Ireland before Lisbon 2 referendum refer). It is clear however that the EC/EU intends to maintain a keen and increasing interest in this area given the potentially wider impact of provisions contained in the EU Charter of Fundamental Rights in terms of Human Rights generally.

Ireland participates in a number of key European fora (see below) where the main issues/priorities at EU level are discussed and explored. It will be necessary for the State to carefully monitor developments at EU level in the coming years in terms of how the various provisions of the Lisbon treaty are implemented and the possible implications for Ireland. Particular attention will need to be paid to the impact of the provisions of the EU Charter of Fundamental Rights and further exploration of the interaction of this document with the Lisbon 'Guarantees' obtained by Ireland in relation to the rights of the family etc.

The Council of Europe also prioritises children's rights through its programme "Building a Europe for and with Children". The main focus of COE approaches is to guarantee an integrated approach to promoting children's rights. In recent years the Council launched its 3 year programme/strategy 2009-2011 covering the social, legal, educational and health dimensions relevant to protecting children's rights and protect children from various forms of violence. The COE programme comprises two closely related stands: the promotion of children's rights and the protection of children from violence. The COE have recently launched a specific campaign on the protection of children from all forms of violence as well as continuing to develop policies on the wider EC/EU related agenda of protection of children in care, child participation, child friendly justice etc. The campaigns in relation to violence continue to include policy aspects relating to the complete abolition of all forms of coroporal punishment in member states (including in the home setting) such as the COE campaign 'raise your hand against smacking' in 2009.

The Office interacts with a number of European Fora which have been informing both European Commission and Council of Europe deliberations regarding the Children's Rights agenda.

EU Forum on the Rights of the Child is a permanent group promoting children's rights, and meets twice yearly usually in Brussels. They advise and assist the Commission and other European Bodies on matters concerning children. The Forum is chaired by the Commission and draws members from various groups (statutory and NGO) in member states.

Europe de l'Enfance is a permanent intergovernmental group comprised of officials from EU member states. It promotes EU wide comparison of conditions for children and adolescents, to assess policies followed at national level and to encourage cooperation and debate on mainstreaming children's rights in EU policies.

ChildONEurope is the European Network of National Observatories on Childhood stemming from L'Europe de l'Enfance. ChildONEurope aims to create a forum for discussion and exchange of knowledge and best practices on children's policies, mainly through research and study activities.

Corporal Punishment

The issue of a ban on corporal punishment in the home setting continues to arise at international level in the context of a complete prohibition of all forms of violence against children. Ireland has made significant progress in recent years towards the elimination of all forms of violence against children, however these stop short of an outright ban in the home setting. The position has been kept under continuous review. Legal advice from the office of the Attorney General in relation to this matter was requested and received in late 2009. Following a review of the position by the then Minister the issue was advanced further with the DOHC Legal Unit in 2010 to seek clarification of the legal implications of possible amendments to Section 46 of the Children Act 2001. The advice is awaited.

Harmonisation of Policy and Consolidation of Funding

Play, Recreation and Youth-related Services

National Play Policy/National Recreation Policies

The Office has had co-ordinating and oversight responsibility for the development and implementation of the National Play Policy (2004) and the National Recreation Policy (2007). While the implementation of these policies lie largely with the Departments of Environment and Local Government / Arts, Sports and Tourism, there are also actions relevant to the Department of Community, Equality and Gaeltacht Affairs, Department of Education and other agencies.

Ready, Steady, Play! A National Play Policy in March 2004, was one of the first countries in the world to produce a detailed national policy on play. *Teenspace, National Recreation Policy for Young People* aimed at the 12-18 year olds followed in 2007.

Recent developments co-ordinated and supported by the OMCYA include the provision of grant aid to Local Authorities to promote an official National Play Day on Sunday 4th July and a National Recreation week from 29th Oct – 4th November. These activities aim to raise awareness of play and recreation facilities and opportunities for children and young people and their families. In addition, they have been used to support improved networking for and collaboration between local providers of services including, inter alia, local sports partnerships, arts and heritage officers, youth services and others.

The announcement of a designated €1.5m Youth Cafés funding scheme was a key area of activity in 2010. This nationwide competitive scheme (operated for OMCYA by POBAL) saw a total of 50 existing youth cafés receiving funding supports during the year and a further 16 sites being awarded significant funding for the development of new youth café sites in 2011/12. The launch of the scheme coincided with the formal launch and publication of 2 important OMCYA policy documents; youth cafés

a guide and youth cafés toolkit: a practical guide to setting up and running a youth cafés in Ireland, a best practice guide and youth café toolkit.

Youth Services

In January 2009 Youth Affairs Unit and the Young Peoples Facilities and Services Fund moved to the Office of the Minister for Children and Youth Affairs (OMCYA) from their parent Departments. It is hoped this centralised approach will provide a more integrated and cohesive service for children and young people. Current funding streams include the Youth Service Grant Scheme, the Special Projects for Youth Scheme, the Young Peoples Facilities and Services Fund, certain Local Drugs Task Force projects and other provisions including the Local Youth Club Grant Scheme, Youth Information Centres, European Youth in Action Programme (administered by Léargas – The Exchange Bureau) and Gaisce – the President's Award.

The Budget for the youth sector in 2011 is €60.954m which compares to €64.89m in 2010. The youth sector has seen a reduction of 20% in its funding over the past three years and they warn that any further cuts will put jobs and projects in jeopardy. Current numbers of projects directed supported under the various programmes number around 516. In addition, 1,600 youth clubs are aided under the Local Youth Club Grants Scheme.

Recent achievements and developments in the Youth Sector in 2010 include:

- Development and launch of the National Quality Standards Framework in 2010
- Introduction of new standardised reporting and funding application process for youth organisations/projects
- Development of the Code of Good Practice: Child Protection for the Youth Work Sector
- Publication of Homophobic Bullying Guidelines
- The transfer of 21 Local Drug Task Force Projects from Dept of Education and Skills to the OMCYA.

Key next steps for the youth sector include roll out of the NQSF throughout the sector and the development of a new Youth Policy Framework. While recent changes have brought together funding arrangements for the bulk of youth sector provision, it has highlighted the need for a consolidation of Government efforts in relation to youth provision in the informal education sector. A clear need has been identified for an overarching policy framework to accommodate youth work and related areas which fall within/related to the OMCYA's remit. The purpose of the new framework is to articulate clear and measurable policy objectives of the Government in relation to youth:

- to enhance the development, participation and support of young people in the 10 – 21 year age range;
- to provide greater co-ordination and coherence in youth service provision; and
- to ensure such provision is both quality- and outcomes-based.

It is anticipated that the YPF will result in the following outcomes:

- Clearly identified remit and role of the OMCYA in relation to Youth
- Clearly identified common principles underpinning the respective policy areas for Youth
- Stated constituent policy objectives underpinning funding schemes and directing the work of services and supports

- Established outcomes-focused approach in structuring and directing services, programmes, initiatives and interventions
- Defined and efficient structure(s) and systems for the oversight, administration, measurement and assessment of quality youth services and supports for young people

Work on the new framework has commenced. An international expert reference group has been set up to assist in the work. The work is also being supported by the Centre for Effective Services (see below). The National Youth Work Advisory Committee (established under the Youth Work Act, 2001) will be an integral part of the consultation process on the new framework. A public consultation process and consultation with young people is also envisaged. While the focus will be on the core funding of the OMCYA it is anticipated that a broad framework which accommodates youth services in a broader variety of settings can be developed. For that reason, an interdepartmental group comprising those departments who fund other targeted youth services "adjunct" to those departments remits will also be guiding the process. A target date of end year has been set for the finalisation of a draft framework. It is also envisaged that the policy framework will have implications for the Youth Work Act, 2001 which has, largely, not been commenced.

Supporting the Development of Service Delivery and Local Implementation Mechanisms

Working Together for Children Initiative

Towards 2016 makes provision for the establishment of a **National Children's Strategy Implementation Group** (NCSIG), a high-level group chaired by the Office of the Minister for Children and Youth Affairs and linked to the HSE's Expert Advisory Group. The National Children Strategy Group (NCSIC) was established in November 2006. The Functions of the NCSIG are:

- To provide leadership and support to the implementation of integrated services and interventions for children at local level (Towards 2016),
- To support the development and implementation of local Work Plans for Children's Services,
- To support the OMCYA with the development of the National Children's Strategy
- To support the Office of the Minister for Children and Youth Affairs in specific cross-sectoral commitments.

Led by the OMCYA and driven by the NCSIG nationally, the *Working Together for Children* initiative is being developed since 2007. Based on the learning from four pioneer children's services committee sites, a strategic plan for the development of the *Working Together for Children* has been agreed. Ten **Children's Services Committees** (CSCs) have been established and at February 2011 a further 4 applications had been received to establish a CSC locally. The objectives of the CSCs are to develop cross agency working relationships, secure support for the joint implementation of policies/initiatives requiring inter agency action and to maximise integration of service delivery at a local level.

The view of the National Children's Strategy Implementation Group is that the development of local CSCs should be locally determined and led within a flexible

framework devised and agreed at national level. The NCSIG and OMCYA have provided a number of supports including, inter alia,

- Technical assistance required by the initial four CSCs to support the change management process involved in the development of a Children's Services Committee.
- A Toolkit to assist with the development of a Children's Services Committee informed by the learning from the initial four sites has been agreed as the broad framework for the development of a work programme for the Phase II CSCs.
- Change management facilitation for the all sites if they require it.
- A standardised Children's and Young People's Workplan template.
- An internal Communications Plan for the *Working Together for Children* with local and national actions and supports currently being implemented.

Phase II CSCs are at varying stages of "readiness" it is hoped that at least five of the six them will have Work Plans in place by mid 2011. The initial four sites are implementing their work plans and as issues emerge it is hoped to be able to offer assistance to them through the NCSIG and OMCYA.

Most recent developments include the finalisation of a Governance Framework for the Initiative. It is anticipated that this will be brought to Government for information shortly in order to ensure the highest level mandate is affirmed for the *Working Together for Children* initiative – this mandate and leadership is understood to be central to the successful implementation of interagency processes such as this.

Prevention and Early Intervention Programme and other Innovative Projects

Since 2006, the OMCYA has been involved in supporting collaborations between funders to develop a better understanding of "what works?" in complex community interventions for children and their families. The model of approach underpinning this programme is based on evidence of need in the community and an evidence based approach to what works. This approach is gained from professional and personal experience; research literature from successful models tested elsewhere as well as needs assessment on the ground. The approach demands that the underlying set of assumptions are clear, i.e. why the activity or activities proposed are a good solution to the identified problem(s). It is outcome oriented, i.e. it is driven by the benefits or changes for individuals or populations during or after participating in the programme activities. A key element is the ongoing monitoring and evaluation of the outcomes of the activities undertaken and learning from the individual sites. This evaluation is intended to promote a process of continuous improvement and helps to assess what interventions work best and how and where they can be best employed in improving delivery of services or the development of new policy. It should also guide the re-orientation of current services where the evidence indicates that this should happen.

The Prevention and Early Intervention Programme is the flagship fund within the OMCYA. The Programme aimed to examine innovative methods for improving outcomes for children in an integrated way and will run for a five-year period with a fund amounting to €36 million in total. €18 million of this is being provided by the Government and €18 million by Atlantic Philanthropies (AP). The Programme is being managed by the OMCYA and administration of the fund will also be overseen by it. The Government agreed that the best use of this funding would be to focus

initially on a small number of projects in severely disadvantaged communities. Three projects submitted proposals to the OMCYA under the Programme as follows:

- *Childhood Development Initiative - A Place for Children in Tallaght West*
- *Preparing for life (Northside communities of Belcamp, Darndale and Moatview)*
- *Youngballymun*

Service Level Agreements were agreed between the OMCYA and the three projects were announced by the then Taoiseach on 23rd February 2007 at Tallaght West CDI.

Since then the Office has also been actively involved in overseeing the administration or co-ordination of funds in respect of a number of projects including inter alia:-

- Barnardo's Brighter Futures Project in Knocknaheeny in Cork – an early years, family support, literacy and pro-social behaviour model for children and families (funded under the Dormant Accounts Flagship Programme with small grant input for evaluation from the OMCYA);
- St. Ultan's School in Cherry Orchard – a "community" school model centred around St. Ultan's Primary School in Cherry Orchard (mainstream and philanthropic funding sources with small grant for strategic planning from OMCYA);
- Longford Westmeath Parenting Partnership – a universally provided parenting support model based on the internationally evaluated Triple P parenting programme (mainstream (HSE) and philanthropic funding with small grant for training and baseline data for evaluation from OMCYA);
- A Barnardo's/One Family Contacts Centres initiative – a child and family contact centre model based in 2 sites to examine and evaluate the potential role of a supported contact for children and parents providing handover or letter box services, supervised or supported contact. These services are aimed at (i) children and their non-resident parents where there are child protection or welfare concerns or relationship difficulties between adults leading to a need for supported contact or (ii) siblings who are in care in separate placements; or (iii) children who are in care. (Once-off funding from mainstream sources including the OMCYA);
- The National Early Years Access Initiative – a new capacity building early years programme aimed at demonstrating inter-agency community based response to the provision of early years education and care. This will target at minimum of 11 sites nationally quality, family support and literacy elements. (Philanthropic funding with small OMCYA and Department of Education and Skills grant funding toward evaluation.)

The Office works collaboratively with a number of philanthropic organisations in both funding and overseeing individual projects and programmes but also in working to develop a clear "what works?" evidence based in the Irish context. See the Centre for Effective Services work referred to below.

Centre for Effective Services

As part of ongoing collaborations with The Atlantic Philanthropies, the OMCYA and the Department of Community, Equality and Gaeltacht Affairs spent some time exploring how Ireland could develop the competencies and capabilities for the design and evaluation of services so as to achieve better outcomes. The Centre for Effective

Services which is a North/South project jointly funded by Government and philanthropy was established.

The aim of the Centre for Effective Services (CES) is to provide a means to enable access to the relevant expertise on a timely and supportive basis. This would enable projects/programmes to be focused on tangible outcomes and lend themselves to robust objective evaluation. Support for service design and innovative practice will also be key elements of the Centre's work programme.

It has been agreed that the CES is the way to approach the design and evaluation of children's programmes, essentially to connect the design and implementation of programmes with scientific and technical knowledge of what actually works. This will enable the OMCYA to develop its own competence for rigorous design and evaluation of programmes based on what actually works.

The CES is assisting the OMCYA with the further roll-out of *Working Together for Children* Initiative and the development of a youth policy framework. The is also working with OMCYA and philanthropic partners in assessing the implications for policy and practice arising from the evaluations of the PEIP projects and other innovative children's services projects referred to above. As a co-funder, the OMCYA has a role in agreeing work plans for the CES. The 2011 Work Plan is currently under discussion with the CES and co-funders but will include these elements.

PO Equivalent: Anne O'Donnell
Unit Name: Citizen Participation Unit

Unit Objective:

The Citizen Participation Unit, established in September 2010, spans both the health and children remits of the Department of Health and Children. The Unit works as part of the OMCYA in relation to participation by children and young people in matters that affect them. The main OMCYA related objective is:

- To oversee implementation of Goal 1 of the National Children's Strategy (2000), which states that 'children will have a voice on matters that affect their lives and their views will be given due weight in accordance with their age and maturity'.

Role of OMCYA in children and young people's participation

The OMCYA has the lead role under *the National Children's Strategy* (2000), in ensuring that children and young people have a voice in the design, delivery and monitoring of services and policies that affect their lives, at national and local level. Goal 1 of the *National Children's Strategy* (2000) states that 'children will have a voice in matters which affect them and their views will be given due weight in accordance with their age and maturity'. The *Strategy* is based on the principles of the United Nation's Convention on the Rights of the Child. The *Report of the Taskforce on Active Citizenship* (2007) also promotes the need for all citizens, including children and young people, to become involved in social and community life.

The OMCYA is committed to ensuring best practice, robust and evidenced-based outcomes and the inclusion of seldom-heard children and young people in participation structures and initiatives.

Significant Issues:

Children and Young People's Participation

Structures
In the last eight years, the OMCYA has worked to ensure the establishment or consolidation of the following key structures:

Comhairle na nÓg (local child/youth councils)
- Comhairle na nÓg were set up under the National Children's Strategy in the 34 City and County Development Boards to give children and young people a voice in the development of local services and policies. From their inception, Comhairle na nÓg received baseline funding from the former National Children's Office and subsequent OMCYA.
- In 2007, the OMCYA set up the Comhairle na nÓg Development Fund to improve the operation of Comhairle na nÓg. The three Reports of the Independent Evaluator for the Comhairle na nÓg Development Fund (2007-2010), highlight significant improvements in the operation of many Comhairle na nÓg as a result of this Fund. The Reports showcase good practice and identify issues that require improvement in ensuring that young members of Comhairle na nÓg are being

provided with opportunities to work on issues of importance to them and have formal and sustained links with adult decision-makers.

Dáil na nÓg (national youth parliament)

- Dáil na nÓg is the annual national parliament for young people aged 12-18 years. The OMCYA funds and oversees Dáil na nÓg, which is hosted annually by the Minister for Children and Youth Affairs. Delegates are elected to Dáil na nÓg by the 34 Comhairle na nÓg.
- Successive independent evaluations note that Dáil na nÓg has gone from strength to strength, with more challenging and contentious debate each year.
- 200 delegates attended the ninth annual Dáil na nÓg which took place on 5 March 2010 in Croke Park, Dublin and discussed the issues of mental health and access to education.
- Dáil na nÓg 2011 will take place in November .

OMCYA Children and Young People's Forum (CYPF)

- OMCYA Children and Young People's Forum (CYPF) was established in 2004 as a reference panel to:
  - advise the OMCYA and the Minister for Children and Youth Affairs on issues of concern to children and young people;
  - undertake projects at the behest of the Minister or the OMCYA in advising on policies that require an input from children and young people.
- There are 35 young people on the CYPF aged 12 – 18 years, from all parts of the country, nominated through Comhairle na nÓg and organisations representing seldom-heard children.
- The CYPF has been an invaluable resource to the OMCYA and its members have been consulted on, or been involved in many initiatives.

Children and Young People's Participation Partnership Committee

- OMCYA Children and Young People's Participation Partnership Committee oversees implementation of strategic plans that ensure the effective development of Comhairle na nÓg, Dáil na nÓg and other children and young people's participation structures. NYCI jointly chairs and supports the committee with the OMCYA.
- Comprises representatives of the OMCYA, four other government departments, the SLSS student council support service, the HSE, the youth sector (NYCI, Foróige, Youth Work Ireland and other youth organisations), City and County Development Boards, young people and other key stakeholders. The committee meets four times a year.

Inclusion Programme

- During 2007, the OMCYA established the Inclusion Programme to develop best practice in participation, by providing new opportunities for seldom-heard young people to become involved in decision-making structures. This decision was taken in recognition of the difficulties often faced by seldom-heard young people in effectively taking part in decision-making forums for young people.
- An independent evaluation was carried out 2007 – 2009. It highlights the benefits accrued from the programme, but identifies considerable challenges in providing relevant participation opportunities to seldom heard children.

- To address these findings and build on the work of the programme, in December 2010, the OMCYA commissioned a literature review and identification of good practice on participation of seldom heard children and young people relevant to the Irish context.

Student Councils
In 2009, the OMCYA entered into a formal partnership with the Department of Education and Skills to support the effective development of student councils and oversee the running of the student council support service.

Consultations/Dialogues
The OMCYA has conducted consultations/dialogues with children and young people on a range of issues including:
- The development of the Children's Code of Advertising (2004)
- The development of the National Recreation Policy (2005)
- The development of the *Taskforce on Active Citizenship* (2006)
- The age of consent for sexual activity (2006)
- The development of the Irish Youth Justice Strategy (2007)
- The misuse of alcohol among young people (2007)
- Teenage Mental Health: What Helps and What Hurts (2008)
- Consultations with children and young people in the care of the State (Jan – Dec 2010)
- Consultations with young people on reform of Junior Cycle in second-level schools (Nov 2010)
- Consultation with young people on the White Paper on Crime (Nov 2010)

Mental Health Consultations with Teenagers
In October 2008, the OMCYA conducted nationwide consultations with 277 teenagers aged 12-18 years entitled, *Mental Health: What Helps and What Hurts*, to inform the development of more effective HSE services and a HSE advertising and public awareness campaign on mental health aimed at teenagers. Young people from the Dáil na nÓg Council and the OMCYA Children and Young People's Forum were involved in supporting these consultations and in developing the HSE TV/Cinema advert, which continues to be screened in cinemas throughout the country.

Consultations with Children and Young People in the care of the State
- The Report of the Commission to Inquire into Child Abuse (2009) recommended that *children in care should be able to communicate without fear*. In response, a consultation process with children and young people in State care was conducted by the OMCYA during 2010.
- The consultation process was spearheaded by the OMCYA, in co-operation with an Oversight Committee comprising key stakeholders including, the HSE, the Irish Youth Justice Service (IYJS), HIQA, the Irish Association of Young People in Care (IAYPIC), the Probation Service and other key stakeholders. Seven teenagers who are themselves in care are also members of the Oversight Committee and formed a Youth Advisory Panel for the consultation process.
- 15 consultations were conducted with 211 children and young people between January and July 2010. A separate process was conducted with children in care with limited or no capacity to communicate in November and December 2010.

- A report of the consultations has been compiled and will be launched by the Minister for Children and Youth Affairs during 2011.

Consultations with Children and Young People on the new National Children's Strategy (2012-2017)
A consultation process with children and young people will feed into the new Strategy, identifying what's good, what's not good and what they would change about being a child or young person. This nationwide consultation process will take place from 28th March – 1st April 2011.

Policy development

Development of a Policy on Children and Young People's Participation under the new National Children's Strategy
The new National Children's Strategy (2012-2017) will follow the structure of the first strategy and will have the same national goals. A Thematic Group on the development of Goal 1 of the new strategy was established in February 2011, comprising representatives of government departments, state agencies and other key stakeholders. A consultant has been appointed to work with the Group and develop an outline policy paper on children and young people's participation in decision-making for inclusion in the new strategy.

Audit of children and young people's participation in decision-making
In January 2010, the OMCYA commissioned a nationwide audit of children and young people's participation in decision-making to document activity and the impact of participation in both statutory and non-statutory organisations. The audit will be completed by March 2011 and will inform the development of the new National Children's Strategy.

Building an evidence-base on children and young people's participation
In December 2010, the OMCYA Participation Team commissioned two pieces of research:
- an examination of children and young people's perspectives on the impact of participation in decision-making;
- a literature review and identification of good practice on participation in decision-making of seldom heard children and young people relevant to the Irish context.

The objective of these studies is to feed into the development of more effective and evidenced-based policy and practice on children and young people's participation in decision-making.

PO Equivalent: Sinead Hanafin, Head of Research
Unit Name: Research Unit

Unit Objectives

To manage:

- A Funded Research Programme, which includes *Growing Up in Ireland – the National Longitudinal Study of Children*;
- A Research Capacity Building Programme, which includes Research Placement and Research Scholarship Programmes; and
- A Research Infrastructure and Dissemination Programme, which includes the development of a National Set of Child Well-Being Indicators, the production of a biennial State of the Nations Children Report based on the indicator set, the development of a National Data and Research Strategy on Children's Lives and other initiatives.

Funded Research Programme

Growing Up In Ireland: A National Longitudinal Study of Children in Ireland
The aim of the National Longitudinal Study of Children in Ireland is *'to study the factors, which contribute to or undermine the well-being of children in contemporary Irish families, and, through this, contribute to the setting of effective and responsive policies relating to children and to the design of services for children and their families'*. This Study monitors the development of almost 20,000 children – an infant cohort of 11,100 9-month olds and a child cohort of 8,570 9-year olds – yielding important information about each significant transition throughout their young lives. In April 2006, the contract to undertake the first phase of this Study was awarded to a research consortium led by the Economic and Social Research Institute (ESRI) and Trinity College Dublin (TCD). The first waves of data collection for both cohorts (infant cohort at 9-months and child cohort at 9-years old) have been completed and the second waves of data collection (infant cohort at 3-years and child cohort at 13-years old) will take place in 2011. The first phase of this Study, which spans approximately seven years will cost €24m in 2005 prices (€29m inclusive of VAT).

National Children's Strategy Research Series
The National Children's Strategy Research Series was established in 2004 to provide a source of policy relevant research on children's lives. All studies are commissioned in line with good public procurement practices and legislation. A total of 26 research projects have been funded to date.

Co-funded Research
In 2010, the OMCYA entered into a joint funding arrangement with the Irish Research Council for the Humanities and Social Sciences (IRCHSS) Research Development Initiative to support research to meet information needs identified in the development of the National Data and Research Strategy on Children's Lives. The principal focus of this programme is to optimise the use of existing data and information sources to meet these needs. Three research projects in the areas of children's participation and child protection were funded under this scheme. It is planned to continue this partnership in 2011 with a focus on capacity building and to explore options for other co-funding initiatives with a particular emphasis on research utilising the Growing Up in Ireland dataset to meet policy information needs.

Research Capacity Building Programme

National Children's Strategy Research Scholarship Scheme

In 2001, the National Children's Strategy Research Scholarship Scheme was established with the aim of developing the research capacity in relation to children and supporting research directly related to the National Children's Strategy. Under this Scheme, successful applicants receive an annual maintenance grant of €16,000 and also have university fees paid in full by the OMCYA. Up until 2006, maintenance grant amounted to €12,700 per annum. To date thirty-five scholarships have been awarded. The call for proposals under the 2011/2012 Scheme was issued in February 2011.

National Children's Strategy Research Placement Scheme

In 2004, the National Children's Strategy Research Scholarship Scheme was extended to include Research Placement Awards. This gives students the opportunity to work with the Research Division at the OMCYA. To date 16 research placements have been awarded.

Other capacity building initiatives

In 2010, funding was made available to the Children's Research Centre, Trinity College Dublin for this purpose. The Centre is unique in Ireland in terms of its expertise in children's research and commitment to mentoring and facilitating novice researchers in this area. This funding contributed to the development of the new full-time Structured PhD Programme in Child and Youth Research which is offered by the Children's Research Centre, Trinity College Dublin and National University of Ireland Galway as part of the emerging Life-Course Studies research and education agenda.

Research Infrastructure and Dissemination Programme

National Set of Child Well-Being Indicators

The National Set of Child Well-Being Indicators was developed in 2005. The methodology applied to develop these indicators incorporated four main components, as follows:

- a background review of indicators sets in use elsewhere and the compilation of an inventory of key indicators, domains and selection criteria;
- a feasibility study of the availability of national statistics to construct the indicators identified in the previous step;
- a study on 'children's understandings of well-being'; and
- a consensus process referred to as a Delphi technique, where participants on 'a panel of expertise' agreed indicators for use in the Irish context.

The State of the Nations Children Report

The third State of the Nations Children report was published in December 2010. This Report is published in fulfilment of a commitment given in the National Children's Strategy and reflects an international effort to measure and monitor child well-being. The Report, which is based on the National Set of Child Well-Being Indicators:

- Describes the lives of children in Ireland
- Tracks changes over time

- Benchmarks progress in Ireland relative to other countries

National Data and Research Strategy on Children's Lives

This Strategy is being developed under a commitment given in the social partnership agreement *Towards 2016*. Key inputs to its development have included a public consultation, a review of policy documents over the period 2000-2008, and an inventory of data sources on children's lives. Analysis of these inputs, and subsequent consultations to ensure current developments are reflected in the strategy, have resulted in the development of an action plan which is currently being agreed with around 24 key Departments and agencies. The action plan is structured on a life-course approach with 5 themes based upon the National Service Outcomes of the Agenda for Children's Services and draws on a socio-ecological conceptualisation of children in society. Its principal focus is on making better use of existing information sources and harnessing existing resources to produce improved information on children's lives. The strategy is scheduled for publication in 2011, however in order to take advantage of opportunities that have arisen to progress the aims of the strategy, some implementation has been initiated in 2010 such as the partnership with IRCHSS mentioned under the National Children's Research Programme.

Research Ethics Guidelines for Children's Research

A Working Group has been established with to develop good practice guidelines in the ethical review of children's research on behalf of the OMCYA. These guidelines will be published in 2011.

Other initiatives

- www.childrensdatabase.ie which was created by the OMCYA to provide access to research and information on children for policy makers, government departments, academics, voluntary organisations and the general public. This portal site also hosts a number of databases developed or supported by the Office.
- Dissemination of research through policy briefing papers, seminars, public lectures etc.
- Contribution to a National and International children's research agenda.

Section 4 – OMCYA Funding Provisions

The 2011 funding allocation for the provision of services under Vote 41 in respect of the Office of the Minister for Children and Youth Affairs amounts to €326 million which includes a provision of €315 million in current expenditure and €11 million in capital expenditure. The allocation represents a decrease of €25 million or 7% on the 2010 estimate allocation of €351 million.

2010 Provisional Outturn				**2011 Estimate Allocation**		
€000				**€000**		
Current	**Capital**	**Total**	**Subhead**	**Current**	**Capital**	**Total**
10,950	-	10,950	**A** Early Childcare Payment	1,000	-	1,000
72,369	25,000	97,369	**B.** National Childcare Investment Programme	76,278	10,000	86,278
2,966	-	2,966	**C.** Early Intervention Programme for Children	4,374	-	4,374
153,544	-	153,544	**D.** ECCE Pre-School Year Scheme	166,000	-	166,000
22,583	1,198	23,781	**E.** National Longitudinal Study and other Programmes	26,644	800	27,444
8,000	-	8,000	**F.** General expenses of youth organisations	8,756	-	8,756
38,599	-	38,599	**G.** General expenses of youth organisations (part funded by National Lottery)	35,836	-	35,836
-	-	-	**H.** Referendum on Children's Rights	3,000	-	3,000
309,011	**26,198**	**335,209**	**GROSS TOTAL**	**321,888**	**10,800**	**332,688**
2,966	-	2,966	**I.** Less Appropriations - in-Aid	6,700	-	6,700
306,045	**26,198**	**332,243**	**NET TOTAL**	**315,188**	**10,800**	**325,988**

The resource allocation includes financial provisions for a range of services in respect of children and young people including:

- **€1 million** to support residual payments to claimants under the Early Childcare Payment which was abolished with effect from the end of 2009.

- **€166 million** for the free Pre-School Year in Early Childhood Care and Education which was introduced in January 2010 and is currently benefiting approximately 63,000 children in the key developmental period prior to starting school. Children are eligible for the scheme when they are aged between 3 years 3 months and 4 years 6 months on 1st September of the relevant year.

- **€86 million** in capital and current funds under the National Childcare Investment Programme to meet the needs of parents and their children for quality childcare services. This includes support for the Community Childcare Subvention (CCS) and Childcare Education and Training (CETS) which support some 30,000 disadvantaged and low income parents, including many parents availing of FÁS and VEC courses, with their childcare costs.

- **€4 million** to support targeted measures for children and young people, including those in disadvantaged areas. The funds will facilitate the continued implementation of the Prevention and Early Intervention Programme for Children which aims to support better outcomes for children through more innovation, effective planning, integration and delivery of services. They will also support the Youth Café Funding Scheme and ensure that a new targeted set of youth café facilities will be made available around the country in areas where none presently exist together with essential upgrades for many existing facilities.

- **€27 million** towards *Growing Up in Ireland* **-** the National Longitudinal Study of Children in Ireland, the Young People's Facilities and Services Fund and a range of other programmes and services being advanced by the Office of the Minister for Children and Youth Affairs to improve the lives of children and young people.

- **€45 million** to support the delivery of a range of youth work programmes and services for young people, including those in disadvantaged communities, by the voluntary youth work sector. The focus of the financial support in 2011 will be on the consolidation of existing provision for young people and on the safeguarding of frontline programmes, services and jobs particularly in disadvantaged communities.

- **€3 million** to support costs which may arise in connection with the holding of a Constitutional Referendum on Children.

Section 5 – Irish Youth Justice Service

Director: Ms. Michelle Shannon,

The Irish Youth Justice Service (IYJS) was established in December 2005, as an executive office of the Department of Justice and Law Reform, with responsibility for leading and driving reform in the area of youth justice. The main responsibilities of IYJS are to:

- Develop a unified youth justice policy
- Devise and develop a national strategy to deliver this policy and service
- Link this strategy where appropriate with other child related strategies
- Manage and develop children detention facilities
- Manage the implementation of provisions of the Children Act 2001 which relate to community sanctions, restorative justice conferencing and diversion
- Co-ordination of service delivery at both national and local level
- Establish and support consultation and liaison structures with key stakeholders including at local level to oversee the delivery of this service and response
- Develop and promote information sources for the youth justice sector to inform further strategies, policies and programmes

Working with the Office of the Minister for Children and Youth Affairs, the IYJS is committed to dealing with young offenders through rehabilitation as enshrined in the Children Act 2001, as amended, using detention only as a last resort, when all other options have been explored.

The IYJS funds organisations and projects providing services, including Garda and Probation Projects, to young people under 18 years who find themselves in conflict with the law. These children may be involved with An Garda Síochána, the Probation Service and the Courts Service. The IYJS is also responsible for the management and development of children detention facilities.

The Government's policy on youth crime is set out in detail in the National Youth Justice Strategy 2008-2010. This strategy is underpinned by the principles of the Children Act 2001 and focuses on young people who have already had some contact with the criminal justice system.

The IYJS budget for 2011 is €39,341 million.

Immediate/Urgent Issues

- Development of Phase 1 of the new national children detention facilities at Oberstown, Lusk, Co. Dublin to provide sufficient detention places for young people under 18 years ordered to be detained by the Courts. Phase 1 of the project will prioritise the provision of sufficient new detention places to enable the transfer of responsibility for 16 and 17 year old boys, currently housed in St. Patrick's Institution, from the Irish Prison Service. This development is subject to Government approval and the necessary funding being made available.

- Continue the capacity-building change management programme of the 100 Garda Youth Diversion Projects (GYDPs) to enable them to focus on local youth crime problems. This change programme comprises a national programme of training for youth justice workers and Garda JLOs, 15 trial sites have been selected to help develop best practice approaches and a closed web-based on-line forum for staff and Gardaí to share organisational wisdom, facilitate on-line discussion and learning and provide access to the latest youth justice research.

- Major reforms are underway in the delivery of services in the 3 detention schools. This includes a plan to integrate policies, practices, and the development of shared services and common rosters. This work is being progressed by IYJS in conjunction with the Board of Management and the relevant unions.

- A new Youth Justice Strategy will be developed in tandem with the new National Children's Strategy which is currently being developed. The first National Youth Justice Strategy covering the period 2008-2010 is almost fully implemented with outstanding issues being progressed as soon as possible.

- Facilitate appropriate usage and sharing of personal data in the best interests of children in the youth justice sector and within the safeguards of data protection legislation. A general guide setting out the main principles of personal data protection and sharing was drafted by IYJS and received positive endorsement from the Office of the Data Protection Commissioner.

Medium/Longer Term Issues of Importance

- Minister's approval in principle will be sought to proceed to draft the heads of a Bill in respect of amendments to the Children Act 2001. Legal advice has been received around particular issues and lacunae in the legislation have been identified.

- Facilitate the establishment of local Youth Justice Teams which will improve service delivery at local level.

- Ensure availability of community sanctions in conjunction with the Young Persons's Probation division of the Probation Service.

- The development of new national children detention facilities will be completed in phases in order to ensure the continued operation of the existing schools until such time as new facilities are available. On completion, the project will result in safe and secure detention places and the delivery of child centred detention services for all under 18 year olds in a single location.

- Develop and implement a youth justice research programme to enable further enhancement of the evidential basis for policy development.

Section 6 – Early Years Education Policy Unit

PO: Catherine Hynes

UNIT OVERVIEW

The key role of the Early Years Education Policy Unit (EYEPU) is to improve the quality of educational provision in line with the policy set out in the 1999 White Paper on Early Childhood Education. The unit is co-located within the OMCYA.

The Early Years Education Policy Unit works closely with the Child Care Directorate in the OMCYA and the Unit's expertise in Early Childhood Education has become increasingly important with the introduction of Universal Pre-school Provision in January 2010. This Scheme, for children aged between 3 yrs 2 months and 4 yrs 7 months in September of the relevant year, provides for free pre-school for 3 hours a day for 38 weeks of the year or for 2 hours and 15 minutes a day for 50 weeks of the year. Administration of the Scheme is the responsibility of the Child Care Directorate. The EYEPU provides policy advice and direction in relation to the contractual criteria for the Scheme, with particular emphasis on issues relating to the qualification profile of staff in pre-school settings and programme quality.

FINANCIAL PROVISION (DES VOTE ONLY)[1]

Service	Outturn 2009	Outturn 2010	Provision 2011[2]
Early Childhood Education	€284,495.33	€389,240.39	€789,000.00

PRINCIPAL CURRENT ISSUES

Implementation of Síolta, the National Quality Framework for Early Childhood Education

BACKGROUND

Síolta was published by the Centre for Early Childhood Development and Education (CECDE)[3] in 2006. Síolta was developed through a rigorous programme of research and consultation and has been highly endorsed both nationally and internationally. The Quality Framework comprises Principles, Standards and Components of Quality in Early Childhood Education and addresses all dimensions of practice. Síolta complements Aistear, the Early Childhood Curriculum Framework for children aged 0-6 (NCCA, 2009) and the Child Care Pre-School Services (No. 2) Regulations (DHC, 2006).

[1] The Office of the Minister for Children and Youth Affairs have a budget of €166m for universal pre-school provision

[2] The Unit took over responsibility for the Early Start Programme in 2011 and the financial provision includes capitation payments for this Programme

[3] The CECDE was established in 2002 to develop a Quality Framework for Early Childhood Education. Its remit was extended for a further 3 years in 2005. The Centre closed in November 2008

CURRENT POSITION

Currently, a field test of Síolta materials, tools and processes is being managed by the Unit. A number of organisations including the Voluntary Childcare Organisations (VCOs)[4] and Prevention and Early Intervention Programmes[5] funded through the OMCYA and Atlantic Philanthropies are participating in this process. Suitably qualified staff, within these organisations, have been trained by the EYEPU to provide support for 138 pre-school services to participate in the Síolta Quality Assurance Programme. Participating services represent the broad spectrum of pre-school services in Ireland including sessional pre-school services, full daycare, infant classes in primary schools and childminders.

NEXT STEPS

AN EVALUATION OF HOW SÍOLTA IS IMPACTING ON THE PRE-SCHOOL SECTOR IS PLANNED FOR 2011. THE RFT HAS BEEN PUBLISHED ON THE E-TENDERS SITE.

Implementation of the Workforce Development Plan

BACKGROUND

The generation of a Workforce Development Plan for the ECCE Sector is a key element of the Government's commitment to quality early childhood care and education. Research has established a clear correlation between the qualifications of staff in early childhood care and education (ECCE) settings and the quality of early childhood experiences. Achievement by all staff, of a set of specialised skills and knowledge in ECCE combined with leadership from staff who have achieved a higher level (e.g., bachelor degree) qualification in ECCE will deliver better outcomes for children across all domains of development.

An extensive programme of research and public consultation was undertaken in 2009 and culminated in the publication of *A Workforce Development Plan for the Early Childhood Care and Education Sector in Ireland* in December 2010. This initiative is particularly timely given the introduction of the Free Pre-school Year Scheme in January 2010. Pre-school services participating in the Scheme are required to employ staff with a minimum of a FETAC Level 5 award in ECCE or equivalent. There is an interim measure whereby staff who cannot fully meet this criterion are allowed to participate in the Scheme on the understanding that they will achieve compliance by end 2012. Implementation of the Workforce Development Plan will be central to ensuring that all ECCE settings participating in the Scheme will be compliant by the 2012 deadline.

[4] The Voluntary Child Care Organisations include the National Children's Nursery Association (NCNA), the Irish Preschool Play Association (IPPA), Barnardos and the Border Counties Childcare Network. The NCNA and the IPPA are merging to form Early Childhood Ireland (ECI).
[5] The Prevention and Early Intervention Programmes are YoungBallymun, Preparing for Life (Darndale) and Tallaght West Childhood Development Initiative

CURRENT POSITION

The implementation of the Workforce Development Plan is contingent on the Further and Higher Education sectors, in particular FÁS and the VECs, delivering flexible, modular courses that meet the needs of the existing workforce. Discussions are underway with these agencies and with the awarding bodies such as FETAC, HETAC, Universities and Institutes of Technology regarding potential action in this regard. Achievements to date include development and publication (February 2011) with FETAC of Common Award Standards for Early Childhood Care and Education at Levels 4, 5 and 6 of the National Framework of Qualifications. Completion of these Award Standards are a necessary prerequisite for the establishment of programmes of learning that will meet the future skills needs of the ECCE sector. They are also the necessary foundation for Recognition of Prior Learning (RPL) and other mechanisms to afford learners greater access, transfer and progression across education and training programmes at all levels of the system.

NEXT STEPS

MONITOR PROGRESS AGAINST BENCHMARKS THAT WILL BE AGREED WITH THE FURTHER AND HIGHER EDUCATION SECTOR.

Early Start

BACKGROUND

The Early Start programme is a targeted intervention for children at risk of educational disadvantage. It was launched in 1994 with the establishment of pre-school projects in 8 centres. These projects involved a total of 13 pre-school classes. In September 1995, a further 32 pre-school projects involving 43 classes were established. Each Early Start half unit can cater for a total of 30 children - 15 in the morning and 15 in the afternoon. A full unit with 2 teachers and 2 childcare workers can enrol 60 children. There is a pattern of declining enrolments, possibly because of the introduction of the free pre-school year. A half unit closed in 2010 because the number of children enrolled meant that the unit was no longer viable. The remaining 55 classes have a total capacity for 1,650 children. The Early Start Programme has not been expanded since the mid 1990s and evaluations of the impact of the Early Start programme have been inconclusive.

CURRENT POSITION

The Programme will continue to be funded for the 2011/2012 school year. In January 2011, responsibility for policy and administration in relation to Early Start transferred from Social Inclusion Unit to EYEPU.

NEXT STEPS

A review of the Early Start Programme is planned for 2011.

Primary Care, Food Safety, Tobacco Control, Medicines, Controlled Drugs and Eligibility

Business Plan 2011 - Overview

1. Introduction

The principal objectives of the Division might be summarised as follows:-

- To secure value for money in State expenditure on the GMS and other Demand Led Schemes

- To ensure that appropriate legislation, policies and systems are in place relating to primary care services (including dental and ophthalmic services), the safety of food, medicines and cosmetics, the control of illegal drugs and tobacco, and environmental health risks.

- To update the Eligibility framework

2. Key Deliverables in 2010

- Reviewed all fee reductions imposed under the FEMPI Act in 2009 and completed statutory processes resulting in further reductions in GPs fees to yield savings of €48m 2011.

- Implemented Government decision to introduce prescription charges.

- Secured reductions in the price of generic drugs and further reductions in prices of drugs supplied by IPHA companies.

- Abolished the Office for Tobacco Control and transferred its functions to the HSE.

- Transferred the Competent Authority role relating to Cosmetics to the IMB.

- Placed “legal highs” under the control of the Misuse of Drugs legislation.

- Seventeen Statutory Instrument enacted –
  Food Safety x 11, Medicines x 2, Medical Products x 3 and IMB fees

- Completed negotiations on EU proposals relating to Pharmacovigilance and Counterfeit Medicines

3. Priorities for 2011

- Make recommendations relating to possible further reductions in pharmacists' fees under the FEMPI Act and, before 30 June 2011, review fee reductions imposed to date on all health professionals.

- Introduce legislation to provide for reference pricing and generic substitution.

- Introduce legislation to regulate the use of sunbeds.

- Bring further "legal highs" under the Misuse of Drugs Acts, introduce additional controls on benzodiazepines and develop policy on medicinal cannabis.

- Abolish restrictions on GPs who wish to obtain GMS contracts.

- Set date for the introduction of graphic warnings on tobacco packaging.

- Develop Heads of Bill to update Eligibility framework.

- Complete negotiations at EU on (Pharmaceutical) Information to Patients proposal.

- Manage legal challenge by Philip Morris Ltd against Tobacco Acts

Acute Hospitals/Cancer/Private Health Insurance Division

Business Plans 2011: Overview

Introduction

The Division faces a very challenging year in all four units, with significant deadline items in relation to Private Health Insurance (risk equalisation, minimum benefits, milestones in preparing for the authorisation and sale of VHI), Cancer Policy (Government agreement to funding arrangements for Phase II of the National Programme for Radiation Oncology) and Acute Hospitals (public/private mix issues, governance of National Paediatric Hospital, budgeting for orthopaedic procedures). In addition, there will be the usual high volume of day to day work, especially in supporting the Minister and the parliamentary process.

The volume and complexity of the work involved will again underline the importance of prioritising the 'must do' items and looking critically at how we do our work to see if there are areas that can be delivered differently with less input of scarce resources.

Ongoing work

It is very important to acknowledge the regular work across the Division, which occupies a considerable part of available time and resources. The ongoing work includes:

- Supporting the Minister through briefing material, attendance at meetings, speech material, response to media requests etc.

- Supporting the parliamentary process through preparing PQ replies, adjournment debates, notes for leaders' questions, Ministerial representations etc.

- Overseeing the performance/governance of agencies including the HIA, VHI, NTPF, IBTS, PHECC

- Participating in a range of groups such as those on emergency planning, haemophilia and blood products, north-south paediatric surgery, Type C contract. (We have sought to keep participation on these groups to the minimum appropriate level and will continue to look critically at each group to see if our participation is necessary)

- Monitoring implementation of cancer screening programmes including the preparations for the promised new colorectal cancer screening programme to be introduced in January 2012

- Liaising with Patient Safety Unit in relation to the patient safety protocol

- Managing contracts with agencies, including Milliman in relation to PHI issues

- Daily/weekly monitoring of performance on ED waiting times

- Monthly monitoring and evaluation of the performance of acute hospitals against activity targets in the HSE National Service Plan.

Priority Deadline Items

The PHI Unit joined the Acute Hospitals, Cancer and Blood Policy Units under one MAC member with effect from 29 November 2010. The volume of work and the number of critical deadline items in the PHI area alone will add considerably to the already large workload and priority items already faced in the other units.

In the context of the Department's high level objectives, the Division as a whole will be particularly concerned with the following in 2011:

- **Governance and political accountability:** Most notably the ongoing parliamentary and Ministerial support items discussed above.

- **Policy review and development:** Supporting the HSE in the Acute Hospitals reconfiguration process and in identifying the next set of priorities for implementation under the National Strategy for Cancer Control.

- **Legislation and regulation:** Extensive legislative requirements in the regulation and reform of the PHI market. There may also be legislation required in relation to public/private mix and the governance of acute hospitals.

The key deadline items may be summarised as follows.

PHI

- Legislation on transitional RE Scheme for implementation from 1 January 2012

- Legislation on full RE Scheme for implementation from 1 January 2013

- Proposals on
    - Rebalancing of PHI market by Q2
    - Sequencing and structure of VHI sale by Q4, including completion of application for VHI authorisation

- Minimum Benefits legislation by Q4

- Lifetime Community Rating regulations by Q2

Acute Hospitals

- Policy measures on public/private mix by Q3
- Governance proposals for new NPH by Q2
- Support for HSE's work on acute hospital reconfiguration by region

Cancer and Blood Policy

- Hepatitis C Compensation Tribunal legislation in Q1
- Government approval to funding arrangements for Phase II of NPRO by Q2
- Revised governance arrangements for national haemovigilance between IBTS and IMB by Q2
- Subsuming of National Cancer Registry into National Cancer Control Programme of the HSE as soon as Health Information Bill can provide for it.

Conclusion

The biggest challenge will be to deliver the priority/deadline items above within existing resources, while maintaining delivery of the ongoing work that will continue to be required.

It will be important to review the Business Plans of the four Units regularly and to revise them during the year in light of any changing circumstances. We will need to be open to dealing with workloads in different ways, particularly to see if it is possible to deal with the ongoing work using less of our 'day to day' time.

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Fergal Lynch
Assistant Secretary
Acute Hospitals/Cancer/Private Health Insurance

5 January 2011.

Division of the Chief Medical Officer
Business plan 2011
Overview

Introduction
This year's business plan is based on a taking stock of existing and emerging priorities. It recognises that progress is being made in a number of important areas, particularly related to health system performance, safety and quality but that progress in other areas has been more difficult. Much time has been spent on acute pressures such as the pandemic, responding to patient safety and other service related issues and supporting the service development agenda in HSE. It has been more difficult to maintain a focus on less acute issues. As a result we have made specific provision in the plan in a number of areas to critically examine our engagements in particular issues and determine how best to consolidate and integrate so as to better manage our existing resources in accordance with priorities.

Development of business plan
- One business plan for division
- Prioritise Department's core priorities
- Focus on what is achievable
- Support each other on areas where one individual leads but work is relevant to others

Approach
- Leadership – externally with the medical profession and the public health community
- Prevention and health promotion
- Impact on public health and emerging health issues
- The patient and the service user at the centre
- Use of information and evidence
- Performance measurement especially quality and effectiveness
- Process reconfiguration and modernisation
- Health inequalities

Focus on how we work
- Access evidence base and expert opinion
- Working collaboratively
    - Key personal relationships
    - Key agency relationships
- Working corporately
- Advisory function analytically and evidence based
- Emphasis on relationships with other divisions
- Mobilising Health System Knowledge

Objectives for business plan
- To lead on patient safety and quality in health care
- To lead on public health (health promotion, health protection including emergency planning, health improvement)
- To lead on reproductive health and social inclusion
- To provide expert medical evidence, analysis and advice to the Minister, Ministers of State and to the Department

- To contribute to the development and implementation of policy and services in relation to the health services as a whole
- To work with the medical profession on policy and professional matters and play a lead role in maintaining good working relationships between the Department and the profession
- To develop good working relationships with relevant external agencies and stakeholders, both nationally and internationally, particularly the HSE, HIQA and the Medical Council
- To communicate Departmental positions in the media and at national and international fora
- To provide a high quality training environment and experience for the Specialist Training Programme in Public Health

Review of 2010: Key Achievements

- Completed implementation phase of Commission Report on Patient Safety and Quality Assurance
- Established National Clinical Effectiveness Framework
- Launched "Patient Safety First" brand
- Established office leadership and modus operandi on patient safety and quality
- Management of departmental response to patient safety incidents
- Established HSE engagement process in relation to quality and safety
- Managed corporate relationship with HIQA
- Oversaw implementation of National Standards for the Control and Prevention of HCAIs
- Bill to prohibit Female Genital Mutilation completed and published.
- All Ireland Traveller Health Study completed and launched.
- National Aids Strategy Committee agreed addition of HIV as a notifiable disease.
- Finalised joint performance information framework with performance evaluation and information management units
- Strengthened analytical basis of advisory function through enhanced use of performance information derived from existing sources
- Published cardiovascular policy following approval by Government
- Finalisation of governance arrangements with HSE for cystic fibrosis screening
- National Substance Misuse Strategy Steering Group established and work progressing
- Report of the Working Group on Sport Sponsorship by the Alcohol Industry published
- Tobacco Policy Review commenced and workshop completed
- Physical activity guidelines published
- Management of health system and national response to Pandemic Influenza H1N1 (2009)
- Established National group to develop National Polio Plan
- Established accountability arrangements with HSE on health protection
- Reviewed roles and responsibilities of National CJD Committee, SARI
- Agreed with Blood Policy Division plan for finalisation on Hep C testing scheme
- Established group to oversee implementation of international health regulations
- HPV immunisation programme commenced
- Policy on neurorehabilitation finalised
- Established arrangements for engaging medical profession and relevant external agencies and stakeholders on policy and professional matters

Any Items not completed in 2010

- Policy framework for health technology assessment
- Policy Proposals for Assisted Human Reproduction.
- Integration of the Drug Treatment Centre Board into the HSE.
- Policy on non-cancer screening
- Assessment on Vaccine Damage Report
- FEMPI reductions on GP fees under immunisation programme
- National Nutrition Policy not completed
- Publication of Public Health (Alcohol Labelling) Bill

Priority Items for 2011

- Finalise policy proposal for licensing of health care, including related proposals
- Establish monitoring arrangements on patient safety including adverse event surveillance
- Finalise policy on health technology assessment
- Support for national clinical effectiveness committee, including quality assurance of first health guidelines
- Quarterly reports using national data and national and international evidence for policy development on areas of concern within HSE
- Draft policy proposals on Assisted Human Reproduction and related issues including surrogacy.
- Scope out options to implement the judgement of the European Court of Human Rights in the case of A, B, and C v Ireland.
- Submit an action plan to the Committee of Ministers on measure Ireland intends to take to implement the Court's judgement in A, B, and C v Ireland
- Complete merge of Drug Treatment Centre Board into HSE
- Issue updated clinical guidelines on Benzodiazepine prescribing in accordance with new national framework for clinical effectiveness and assist policy development for same.
- Completion of symphisiotomy report in conjunction with acute hospitals division
- Develop new policy on public health
- Publication of the Report of the National Substance Misuse Strategy Steering Group
- Publication of revised Food Pyramid and Health Eating Guidelines
- Complete Tobacco Policy Review
- Publication of Public Health (Alcohol Labelling) Bill
- Development of proposals for a Strategy on Rare Diseases
- Finalise policy framework for non cancer screening
- Review of National Response to Pandemic Influenza H1N1 2009
- VFM on Immunisation Programmes
- FEMPI reductions on GP fees under immunisation programme
- Review Part IV of 1947 Health Act and Regulations on Infectious Diseases
- Assessment on Vaccine Damage Report
- Negotiating on EU Health Threats Package and Pandemic Vaccine Joint Procurement
- Finalise with HSE the National Focal Point for chemical and radiation incidents.
- Finalise information Governance with HSE re incident(s) alerts.
- Finalise HIQA health technology assessment re prion filtration.
- Support IBTS in finalisation on Hep C testing scheme.

Areas not comprehended by 2011 business plan

- Maternity and Infant Care Scheme
- Home Births

Finance, Performance Evaluation, Information, ICT, International, Research & Resource Allocation – Business Plan Overview

Introduction

The Division comprises seven units, as follows:

Unit	Led By
Research*	Sinéad Hanafin
Performance Evaluation	Tracey Conroy
Information	Hugh Magee
ICT	Kevin Conlon
Capital, EU/International & Research Policy	Audrey Hagerty
Finance	David Smith
Resource Allocation	Laura McGarrigle

** Objective B (National Children's Research Programme) of this Business Plan will be dealt with at the OMCYA Business Plan meeting.*

There are significant common strategic objectives across these units and joint working, although equally there are discrete responsibilities which are specific to particular units. The latter includes responsibilities in areas such as Internal ICT and Accounts which require ongoing operational delivery in order to maintain the wider functioning of the Department. More generally the Division seeks to support other units in the achievement of their work objectives through ICT, financial processing and analysis, research, library, information provision (including Datapoint) and analysis, etc – this means that the quality of relationships with staff in other Divisions is very important to success.

Relationship with Statement of Strategy

The Divisions key relationship with the HSE means it has been central to efforts to redefine the role of the Department and increase its effectiveness during the course of the last Statement of Strategy. While the ORP offered positive assessments regarding the performance oversight of the HSE and the greater use of research and information analysis by the Department, it also pointed to considerable scope for further development in these and other areas. This challenge is being addressed in the new Statement of Strategy under the following headings (examples of relevant work underway in these areas within the Division are shown):

(a) Leadership and communications
- Lead cross-Government health research agenda through Health Research Group and communicate with stakeholders (e.g. industry, charitable sector, research community)
- Coordinate shared approach to health information across DoHC, HIQA & HSE through Health Information Inter Agency Group and facilitate communication with industry
- Lead the development of new and more effective approaches to resource allocation on foot of the Resource Allocation report.
- Communicate health service achievements through Health Trends and other publications

- Support the Department's communication effort through website provision, etc.

(b) Governance and political accountability
- Support the Minister in bringing the Estimates, Supplementary Estimate and Annual Output Statement through the Dáil
- Report to the Oireachtas Scrutiny Committee on EU developments in health.
- Lay Annual Financial Statements of health bodies before the Oireachtas
- Negotiate Memorandum of Understanding with the HSE
- Manage national lottery approval process
- Oversee SLA process within HSE
- Policy support to the Minister and Taoiseach (LQs), particularly on financial situation and Service Plan delivery
- ICT support to the PQ, reps and LQ systems.
- While not a large as some Units with a very high volume of service related PQs and reps, the support for the Minister on PQs, briefings, meetings, reps and FOIs can be significant including in modestly staffed areas such as Capital, Accounts, etc

(c) Policy review and development
- Develop policy on health information and eHealth in conjunction with HIQA and HSE.
- Support the policy analysis role of other Divisions through research, information and financial analysis.
- Liaise with Cancer Policy (NPRO), Primary care (Primary Care centres), Mental Health (proceeds from disposals) and others on the delivery of infrastructure to support national policy
- Ensure the potential of the National Longitudinal Study on Children to improve policy is realised.
- Input to policy review as part of the Value for Money & Policy Reviews (VFM&PR) process.
- Support the review of medical card qualifying criteria through the CEIST team.
- Support policy implementation in OMCYA through, for example, roll-out of ECCE scheme

(d) Legislation
- Input to the Health Information Bill on unique health identifier and reform of research ethics committees
- Oversee progress on transposition of EU Directives
- Negotiate draft EU legislation, including Cross-Border Directive

(e) Performance evaluation/management
- Key role encompassing HSE Service Plan approval and monitoring, HSE Corporate Plan, HSE Capital Plan and ICT approvals
- Development of a Performance Evaluation Framework to underpin the new Statement of Strategy
- Oversee VFM&PRs and undertake reviews in respect of Private Charges (complete) and Immunisation (2011)
- HRB performance oversight
- Liaise with the HSE and CMOD in the development of new national financial systems

- ICT and Capital approvals for HSE and direct funded agencies
- Financial, capital and ICT unit support to other units responsible for direct funded agencies

(f) Quality

- Preparation for the roll-out of a Unique Health Identifier, subject to passing of Health Information Bill
- Deliver Health Information Inter Agency Group work plan, incorporating relevant recommendations from Madden Commission.
- Support analysis of quality through performance indicators, HIPE analysis and international comparison

(g) Cross-sectoral and international

- Lead cross-sectoral approach to health research
- Assist other Departments with regard, for example, to Services Directive (D/ETI), EU Affairs, International Aid (both D/FA), Research (D/ETI), Tax Strategy (Finance), Economic Renewal, North/South (Taoiseach), Post Codes (D/CENR), etc
- EU affairs, including preparations for 2013 EU Presidency
- North South health cooperation
- Coordinate Department's WHO involvement
- Represent Ireland at EU Audit Board on Migrant Workers and negotiate bi-lateral agreement with UK authorities
- Participate in European Observatory on Health Systems and Policies

Jim Breslin
14/1/2011

National HR & Workforce Planning Division

1. Introduction

The Division comprises:

National HR Unit (Simonetta Ryan),

Professional Regulation Unit (Deirdre Walsh),

Workforce Planning, Agency Governance & Clinical Indemnity Unit (Chris Fitzgerald).

Professional advice on nursing and midwifery matters is provided to the three units by Sheila O'Malley, Chief Nursing Officer.

The principal functions of the Division are as follows:

- to oversee the control of employment levels and adherence to Government pay, pensions and HR/IR policy in the health sector,
- to oversee the implementation of the Crooke Park Agreement and associated action plans for modernisation/reform in the health sector,
- to develop a modern legislative framework for the regulation of health care professionals,
- to ensure that the Government's programme of health agency rationalisation is implemented, and that agencies are complying with corporate governance requirements,
- to ensure that there is an adequate supply of appropriately trained people for the health service.

2. Key Achievements in 2010

- restructuring of Division (second in past 2 years) to take account of loss of senior managers on retirement,
- negotiation of health sector elements of Croke Park Agreement and finalisation of sectoral Action Plan,
- implementation of voluntary early retirement/redundancy schemes for management/ administrative and support grades in the public health sector,
- development and implementation of a refined employment control framework for health sector that better meets policy requirements in this area,
- transfer of Community Welfare Service and associated staffing resources from the HSE to the Department of Social Protection,
- finalisation of new Pension Scheme for HSE employees,
- introduction and processing of new Nurse & Midwives Bill to Report Stage,

- finalisation and circulation of draft heads of Health and Social Care Professionals (Amendment) Bill,
- completion of strategic framework for role expansion of nurses and midwives promoting quality patient care,
- introduction of new caps on medical indemnity insurance for consultants in private practice who are not covered by the State's Clinical Indemnity Scheme.

3. Priorities for 2011

- support Sectoral Implementation Body and HSE in driving transformation agenda set out in Action Plan under Croke Park Agreement,
- monitor progress by HSE and other health agencies in achieving targeted reduction in staffing levels,
- complete negotiations on outstanding IR issues relating to transfer of Community Welfare Service,
- complete passage of Nurses & Midwives Bill through Oireachtas and commence implementation of legislation, including appointment of new Nursing and Midwifery Board,
- process Health & Social Care Professionals (Amendment) Bill through Oireachtas,
- progress health agency rationalisation programme, including dissolution of National Nursing Council and National Social Work Qualifications Board,
- finalise legislative response to Deputy James Reilly's Private Members Bill on professional indemnity for doctors,
- progress strategic issues in relation to clinical indemnity and manage day to day issues arising.

Office for Older People

Business Plan 2011

The Office for Older People comprises three units: Services for Older People Unit, Strategy Development Unit and Long Stay Charges and Litigation Unit. The individual business plans for the three units for 2011 are attached.

The key objectives of the Office are to:

- provide strategic direction and leadership in developing policy and legislation and monitoring and evaluating service delivery and development in relation to services for older people, palliative care services, the health repayments scheme, healthy ageing and litigation, and

- act as an agent for change in driving the development of comprehensive joined-up policy across all Departments in relation to older people.

The proposed activities of each of the three units for 2011 are set out in detail in their business plans and all of them fall under one or more of the suite of headings to describe the Department's 'High Level Objectives' in the Statement of Strategy. The proposed activities also take account of the various risks included in the Office's Risk Register. The following would be the priority 'deadline' and 'ongoing' items for the Office in 2011 and this prioritisation does not diminish in any way the importance of those activities not listed beneath. There is no suggestion either that the 'deadline' items are more important or significant than the 'ongoing' items.

Deadline Items

Actions	KPI's/Outputs	Delivery Dates	Person Responsible
Completion of Health Repayment Scheme	Orderly wind-down of Scheme, including Appeals Office but excluding residual and follow-up issues.	April	CC
Health (Provision of Long Term Community Services)Bill	Memo to Gov with Scheme agreed. Bill drafted and initiated in Oireachtas	End March End June	G F
Development of Positive Ageing Strategy	PAS published. Development of operational Plans for PAS.	End April End September	MK

	Structures and reporting arrangements designed and in place and functioning	End September.	
Review and revision of Care and Welfare Regs for Residential Settings for Older People	Revised regs drafted and enacted	End June	GF
Review of HSE provision of Long-Term residential care for Older People	Analysis and policy position paper produced, including costings	End June	GF
Implementation of recommendations from Review of Long Stay Charges	Consultations undertaken and Heads of Bill prepared.	September	CC
Commencement of work on Dementia Strategy	Research completed, analysed and Working Group, TOR etc. agreed	End Year	GF

Ongoing Items

Activity	**Person Responsible**
Efficient management of long-stay and disability litigation and ongoing review of policy in this respect	CC
Ongoing active supervision of Nursing Homes Support Scheme	GF
Lead DoHC's preparation for participation in European Year for Active Ageing 2012	MK
Liaise and work with Resource Allocation Unit on future funding model for long-term care	GF
Oversee and participate in roll-out of TILDA	MK
Deliver on DoHC commitments on Elder Abuse	MK
Ongoing analysis and monitoring of NSP KPI's	GF, MK, CC
Supporting the democratic process	GF, MK, CC
Staff management, support and training	GF, MK, CC

Parliamentary and Corporate Affairs Division – Overview of Business Plans for 2011

Changes to Division during 2010.
The Units which make up Parliamentary and Corporate Affairs are primarily operational in nature and all are concerned with the internal functioning of the Department. Two main changes to the organisation of the Division took place during 2010 as follows :

- As part of an interim restructuring in September, responsibility for Internal ICT was merged with External ICT and moved to Jim Breslin's areas of responsibility. Records management was reallocated to HR and Corporate Development Unit (Barry Murphy) and FoI to Parliamentary Affairs and Communications (Larry O'Reilly).
- A new Legislation Unit was established in December 2010 headed by Bernie Ryan. This Unit has responsibility for the Health Information Bill (already being dealt with in Parliamentary Affairs led by Peter Lennon AP) Licensing Bill (had been dealt with by Bernie Ryan in Patient Safety Unit) and the Human Tissue Bill (had been dealt with by Acute Hospitals and Lara Hynes moved with the Bill to Legislation Unit).

Achievements in 2010
Overall the main achievement during 2010 was to continue to provide "more with less" (ie coping with reductions in staffing while taking on additional responsibilities) in regard to effective ICT, HR, corporate services, training, FoI, records management, parliamentary affairs, communications and legal services functions.

Specific achievements in regard to 2010 included

- Subsuming responsibility for the OMCYA communications function into the main Press and Communication Unit with minimal additional staffing.
- Reviewing and improving arrangements for Leaders Questions, preparation of PQs, handling FoI requests, quality assurance of Oral PQs and liaison with PAD in the HSE.
- Introduction of new tracking system for priority representations.
- Launch of Healthupdate.ie.
- Preparation of ORP Action Plan and commencement of implementation.
- Introduction of revised arrangements for risk management involving stronger role for the MAC.
- Completion of interim restructuring including cross-stream reporting.

Overview of Priorities for 2011

Context
2011 will be a challenging year for the Department in a HR context. The moratorium means that staff who leave will not be replaced and we need to ensure we meet our end year ECF target. One positive development will be the Intern programme under the FAS scheme and there has been a lot of interest from managers in this scheme. The implementation of the Dept's Action Plan under the Croke Park agreement will

increase productivity and over time will result in financial savings and will proceed in tandem with implementation of the ORP Action Plan.
If there is a change of government this may give rise to changes in priorities which in turn will have implications for the current deployment of staff and organisational structures. Under the ORP Action Plan it is planned to restructure the Department during 2011 and this will presumably follow finalisation of the new Statement of Strategy.

Ensuring Implementation of ORP Action Plan
The main priority for the Division in 2011 is to ensure full implementation of the ORP Action Plan. While implementation is a corporate responsibility, it will need to be driven centrally to ensure that agreed changes are implemented and that momentum is maintained including consultation with staff . It will be necessary to redeploy staffing resources to the change management area as there are very few dedicated staff now assigned to this work. It is suggested that this should be seen as a specific project to be progressed over the next one to two years. The implementation of the Action Plan is relevant to all of the Units in Parliamentary and Corporate Affairs Division as follows

HR and Corporate Development Unit : Actions 3 to 8 on empowerment of staff Actions 12 and 13 on improving business processes and Action 15 on review of the structure of the Department.

Parliamentary Affairs and Communications Unit : Action 2 on Statement of Strategy/communicating the leadership role of the Department in the health sector more effectively and Action 14 on reviewing our systems for serving the democratic process.

Corporate Legislation Unit : Action 15 on review of structure of the Department including provision of more "protected time" for longer term strategic work.

Legal Unit: Action 1 on MoU with the HSE to define the "business rules" to govern working relationship between the staff of the two organisations.

Other Priorities
Other priorities during 2011 are as follows

HR and Corporate Development Unit

- Implementation of the Department's Action Plan under the Croke Park Agreement
- Devising a more effective mechanism for allocating staff within the Department which of necessity will involve redeployment.
- Development and implementation of policy on managing underperformance.
- Review of future role of HR Unit including further devolution of HR functions to Line Managers and plan for shared HR service under TPS.

Parliamentary Affairs and Communications Unit

- Working with HSE to achieve improved parliamentary affairs service/better communications with the political system.

- Continued quality assurance of service the Dept provides on parliamentary affairs.
- Improving the understanding and image of the Dept by achieving greater publicity on positive actions and the role of the Dept generally.
- Joint working with the HSE on major news stories and maintaining effective early warning arrangements.
- Improving internal communications including new arrangements for information sessions on /staff briefings by MAC and POs.

Corporate Legislation Unit

- Publication of Health Information Bill as early as possible in 2011.
- Finalisation of Heads on Licensing Bill and progression of drafting.

Contribution to the Wider Goals of the Department

The draft Statement of Strategy refers to the need for the Department "to improve leadership, organisational and communication capacity to meet all challenges effectively" in line with the ORP Action Plan. It places a very strong emphasis on building our internal capacity including the need for an analysis of staffing needs and skills to discharge our functions effectively. The draft Statement of Strategy also refers to the need to publish with the Minister's approval an integrated medium term legislative programme so that all stakeholders are clear about legislative priorities. Legislation and Governance/political accountability are identified as core functions of the Dept in the draft Statement of Strategy both of which reflect the work of Parliamentary and Corporate Affairs Division.

Frances Spillane
5 January 2011

Cancer Services

Key Points

The HSE has been working to implement the National Cancer Control Strategy which aims to achieve better cancer prevention, early detection (including screening programmes) and well organised programmes of treatment that maximise survival through a co-ordinated national service, based on international evidence and best practice.

The HSE has a separate National Cancer Control Programme (NCCP) headed by Dr. Susan O'Reilly, an eminent oncologist who worked in the Canadian system prior to her appointment to Ireland in September 2010.

The Cancer Strategy is organised around four designated cancer control networks and eight cancer centres.

The NCCP has made substantial progress in centralising cancer treatments so as to improve outcomes – for example reducing breast cancer surgery from 33 centres to 8. It is now reorganising other site specific cancers including lung, prostate and rectal cancers. It has also put in place rapid assessment clinics for lung and prostate cancers.

The NCCP's chief priorities in 2011 are the provision of new radiotherapy facilities (Phase II of the National Programme for Radiation Oncology) and a new colorectal cancer screening programme, to be introduced in 2012.

Expenditure

HSE-National Cancer Control Programme (HSE-NCCP)

- €63.2m in new development funding provided for NCCP since establishment of Programme in 2007 (additional to base funding).

In addition, in 2011 the HSE-NCCP includes:

- St Luke's budget – €34.34m for 2011
- National Cancer Screening Service funding - €62.82m in 2011**.**

National Cancer Registry

- 2011 allocation is €2.826m.

Activity, outputs, performance

- Approximately 119,000 women screened by BreastCheck in 2010. Target for 2011 is 140,000.

- CervicalCheck screened 250,834 women in 2010 (figures to be validated). Target for 2011 is 240,000.

- 108,600 treatment episodes for cancer patients in 2009 **plus** over 75,000 day case admissions for chemotherapy and over 90,000 day case admissions for radiotherapy (source: HIPE)

- HSE reports compliance with HIQA standards on waiting times for breast centres overall and continuing good performance in relation to waiting times for urgent colonoscopy.

- Estimates of five-year relative survival rates (National Cancer Registry) show improvements in survival for almost all types of cancer diagnosed in the period 2002-2006 compared with people diagnosed in 1998-2001.

Structural Change

The National Cancer Screening Service (NCSS) encompassing BreastCheck and CervicalCheck was subsumed into the HSE-NCCP in April 2010.

The National Cancer Registry of Ireland (NCRI) aims to collect high quality information on cancer and to promote the use of this information in reducing cancer incidence and improving survival. It is proposed that the NCRI will be subsumed into the HSE-NCCP following the enactment of the Health Information Bill that is at an advanced stage of preparation.

Progress achieved

Establishment of cancer centres: Four designated cancer control networks and eight cancer centres nationally have been established, with a satellite centre in Letterkenny owing to Donegal's unique geography (for breast and rectal cancers specifically; linked to Galway). The Programme is working to ensure that for individual tumour types the cancer centres have adequate case volumes, expertise and concentration of multi-disciplinary specialist skills.

Beaumont Hospital	Dublin-North East
Mater Hospital	Dublin-North-East
St Vincent's, Dublin	Dublin-Mid Leinster
St James's, Dublin	Dublin-Mid Leinster
Cork University Hospital	South
Waterford Regional Hospital	South
University Hospital Galway	West
Midwestern Regional Hospital Limerick	West

Reorganisation of acute cancer services: Breast complete. Reorganisation of lung and prostate cancer diagnosis and surgery almost complete, including establishment of Rapid Access Diagnostic Clinics in most cancer centres. Significant progress in reorganisation of rectal cancer surgery. National centre for pancreatic surgery established in St Vincent's with satellite unit in Cork. Brachytherapy for ocular cancer in place in St Luke's Hospital in conjunction with Royal Victoria Eye & Ear.

Primary care: GP referral guidelines and standard forms are developed for some cancers. GP and community nurse education is ongoing.

Radiation oncology: Establishment of St Luke's Radiation Oncology Network (SLRON) with new radiation oncology units at St James's and Beaumont Hospitals in Dublin completed and soon to be operational.

Cancer screening: Preparatory work underway since early 2010 for introduction of colorectal screening programme to commence in 2012. 15 candidate colonoscopy screening units now identified for the programme. BreastCheck is screening in all counties since 2009 and Round 1 breast screening is ongoing in South and West (which includes the NorthWest), scheduled for completion in 2011.

Main next steps

Colorectal cancer screening: 20 candidate Advanced Nurse Practitioners (ANPs) to be appointed in colonoscopy with a view to 15 graduations in 2013.

Radiation oncology: The new radiation oncology units at Beaumont and St James's Hospitals which were scheduled to open in December 2010 will open in the near future, increasing capacity by 50% in the Eastern region. This development completes the St Luke's Radiation Oncology Network. Planning for Phase 2 of the NPRO, which aims to deliver further increased capacity by 2014 through PPP, will continue. A draft Memorandum for Government is at an advanced stage.

Acute cancer services: continue reorganisation of services for individual tumour types. Enhance theatre and ICU services to support cancer surgical throughput in cancer centres. Initiate measures to support optimal management of cancer drugs.

National Cancer Registry: to be subsumed into NCCP following enactment of Health Information Bill, currently being drafted.

BreastCheck: NCCP / NCSS has been requested to review the potential for efficiencies and cost-savings in areas identified by HIQA (2009).

Issues to note

- Phase 2 of the NPRO is a major capital development which, subject to Government approval, would need to proceed as soon as possible so as to meet our radiotherapy requirements. A Memorandum will shortly be submitted to Government seeking approval to go to tender for the project. There are significant financial implications for this programme. A separate note on the NPRO is provided in this Brief.

- The NI Health Minister Mr. McGimpsey announced in 2008 that a new satellite radiotherapy centre would be established at Altnagelvin Hospital. The business case for the centre is awaiting final approval. The Irish Government committed to providing a capital and revenue contribution to the project. It is proposed to enter into a service level agreement with the NI authorities. It is expected that approximately one third of patients will come from Donegal and surrounding areas. The expected date for completion of the project is 2016.

- The Department monitors carefully the service levels provided under the NCCP. It is working with the NCCP to address issues affecting both screening and symptomatic breast cancer services arising from staff vacancies. It is also monitoring the provision of urgent and non-urgent colonoscopies to ensure that they meet maximum waiting time targets.

Briefing for New Minister on Chronic Diseases

Department's Role

The Department's role on chronic diseases is to develop strategies to prevent and reduce the burden of chronic disease and to monitor and evaluate the continued implementation of the aims and objectives contained in published strategies to promote health improvement.

Burden of Chronic Disease

Chronic diseases are the leading cause of death and morbidity in developed countries. Approximately 80% of the overall disease burden in Europe is attributed to chronic disease and the pattern in Ireland is similar. It is estimated that three quarters of people over 75 have at least one chronic condition and over a third of men over 60 years of age have two or more chronic diseases. Mental health conditions are one of the leading causes of morbidity affecting approximately one in four people in their lifetime. There are significant health inequalities in chronic disease rates and the lifestyle factors that lead to these conditions are also unevenly distributed across society, in particular, smoking, alcohol consumption, diet and physical activity.

Patients with chronic conditions are heavy users of the health services. It is estimated that three quarters of healthcare expenditure relates to chronic diseases. In practical terms, this translates to 80% of GP consultations and 60% of hospital bed days. Chronic disease accounts for two thirds of emergency medical admissions to hospitals. Healthcare utilisation trends for certain chronic conditions are outlined below.

The economic burden is considerable not only for the health system but also in terms of families and society as a result of reduced income, early retirement, an increased reliance on social care and welfare support and diminished productivity and absenteeism. The World Health Organisation in Europe has estimated that the 10-15% increase in chronic diseases will reduce a country's GDP by an order of 1% over the next decade.

Management of Chronic Diseases

The general management of chronic diseases has been set out in the Department of Health and Children policy framework which was published in 2008. This describes an approach centred on **disease management programmes** to treat and delay the onset of complications and reduce emergency hospital admissions. It addresses the management of chronic diseases at different levels through a reorientation towards primary care and the provision of integrated health services that are focused on prevention and returning individuals to health and a better quality of life. The main elements include:

- The development of models of shared care which set out the roles and responsibilities of primary care and specialist services (These would be

established initially for diabetes, heart disease, stroke and chronic destructive pulmonary disease)
- The development and implementation of clinical protocols and guidelines for use in primary care and specialist services
- The central role of primary healthcare in the management of patients with chronic disease
- The development of programmes of **self-care** for patients which would allow better self-monitoring and treatment in chronic disease
- Clinical information systems, quality assurance and evaluation as an integral part of disease management.

This approach is being adopted across many diseases and specific disease programmes are now in place in the HSE for diabetes, COPD, arthritis, cardiovascular disease and asthma.

Chronic Disease Trends

A more detailed analysis of some of the more chronic conditions follows. This analysis is based on recent hospital utilisation data, primary care prescribing through the PCRS and population modelling for certain chronic conditions provided by the Institute of Public Health which in certain cases, incorporate changes in lifestyle factors such as obesity and smoking. The specific conditions include:

1. Diabetes
    a. Total hospital discharges were 5,847 in 2000 rising to 10,013 in 2009
    b. PCRS data on one of the diabetic drugs (Metformin) indicated a 64% increase over the period 2005-9.
    c. In 2007, 144,000 adults (4.5%) had diabetes and by 2020, this is expected to rise to over 233,000 (5.9%). This represents a 62% increase, an additional 89,000 adults in less than 15 years
2. Cancer
    a. Total discharges in 2000 were 64,144 rising to 108,474 in 2009
3. COPD
    a. Total hospital discharges in 2000 were 8,928 rising to 13,559 in 2009.
    b. PCRS data 2005-9 for Salbutamol indicated a 47% increase at a cost of 4.5m per annum.
    c. In 2007, it is estimated that nearly 94,000 adults (2.8%) had COPD and by 2020, this is expected to rise to over 131,000 (3.1%). This represents a 40% increase or an additional 38,000 adults in less than 15 years.
4. Musculoskeletal (arthritis)
    a. In 2000, there were 32,537 admissions rising to 55,760 in 2009
    b. PCRS data for 2005-9 for Diclofenac (for arthritis) indicated a 32% increase at a current cost of 5.7m per annum
    c. Similar PCRS data for Lansoprazole (a PPI for gastric conditions but often used with anti-arthritis drugs) indicated an increase of 65% at a current cost of €25m per annum.

5. Circulatory system diseases
    a. In 2000, there were 65,580 hospital admissions rising to 73,650 in 2009
    b. Of these, there were 4,994 acute heart attacks in 2000, rising to 6,209 in 2009
    c. In 2007 82% of the population had raised cholesterol, 60% had high blood pressure and 32% obese. Almost 1 in 5 adults had all 3 risk factors, putting them at significant risk of coronary heart disease in the future.
    d. PCRS data indicated a 76% increase of Atorvastatin use (Statin to reduce cholesterol) from 2005-9, costing now over €70m per annum.
    e. In 2007, approximately 131,000 adults (3.8%) have ever had a coronary heart disease. By 2020, this is expected to rise to over 195,000 (4.6%). This represents a 50% increase or an additional 65,000 adults in less than 15 years.
6. Hypertension
    a. Total hospital admissions were 3,367 in 2000 and this fell to 2,282 in 2009
    b. PCRS data from 2005-9 for Bisoprolol (for hypertension) indicated a 91% increase, costing now €6.9m per annum
    c. However, in 2007, nearly 852,000 adults (25.1%) had high blood pressure. This is forecast to rise to 1,192,000 (28.3%) by 2020. This represents a 40% increase or an additional 341,000 adults in less than 15 years
7. Stroke
    a. There were 7,117 hospital admissions for stroke in 2000, rising to 7,577 in 2009
    b. In 2007, almost 59,000 adults have ever had a stroke. By 2020, this is expected to rise to almost 87,000 (2.1%). This represents a 48% increase or an additional 28,000 adults in less than 15 years
8. Heart Failure
    a. Total hospital admissions in 2000 were 5,391 rising to 5,790 in 2009.

Currently, it is estimated that approximately 2% or 80,000 people of the adult population have heart failure.

Cardiovascular Health

In June 2010 "*Changing Cardiovascular Health: Cardiovascular Health Policy 2010 -2019"* was launched. The policy establishes a framework for the prevention, detection and treatment of cardiovascular diseases, including stroke, which seeks to ensure an integrated and quality assured approach in their management, so as to reduce the burden of these conditions.

The Policy provides a framework for acute service and primary care developments in the coming decade. It aims to provide for safe, effective and equitable services, within an over arching commitment to prevention and early management of cardiovascular health problems. The Policy acknowledges the key role that primary care plays in raising awareness, in risk assessment, and management of cardiovascular disease.

The Policy is concerned with optimising and enhancing services that are already in place within the healthcare system. With regard to hospital and emergency care services, the report proposes that cardiac services and stroke services be reconfigured on a network basis. Each network will provide specialist cardiovascular services by a blend of hospitals designated as (i) local/general and (ii) regional/comprehensive centres**.** Under the reconfigured hospital network system, patients who experience acute heart attack or stroke will be brought directly to the appropriate centre for initial treatment. An improved ambulance service will seek to ensure that 80% of the population will be brought to the appropriate centre within the accepted critical timeframe.

The HSE have established 3 programmes to implement the different elements of the Cardiovascular Policy covering acute coronary syndrome, heart failure and stroke and appointed clinical leads to each of these programmes. They are developing a range of initiatives to improve service delivery in these areas. The Department continues to liaise with the HSE on the implementation of the Strategy.

Acute Coronary Syndrome

The HSE plan to develop and implement a Primary PCI protocol in 2011 to address the key areas of public awareness of symptoms, pre-hospital services and the designation of PPCI centres working with networked general hospitals. They will standardise national care pathways and protocols, guidelines, and patient information material and develop information/ICT mechanisms to assure timeliness of treatment.

Heart Failure

HSE's initial focus in 2011 will be to improve the care of patients admitted to hospital. Structured heart failure programmes in hospitals will be provided through specialist services. On admission patients will be referred promptly to the heart failure service to ensure optimum medical care. Following discharge close clinical follow up will decrease 3 month readmission from 30% to 20%.

Stroke

HSE plan to increase the availability of intravenous thrombolysis so that it is provided by all acute admitting hospitals. This should result in the proportion of patients receiving thrombolysis increasing to 7.5% (from a current rate of 1.5%). They plan to have acute stroke units fully established in 90% of acute hospitals by the end 2011, providing care to at least 50% of patients. TIA rapid specialist access and diagnostic investigations will also be made available to all patients.

Diabetes

The Department of Health and Children published a policy document "*Diabetes: Prevention and Model for Patient Care*" in 2006. Following that, an Expert Advisory Group on Diabetes was established to draw up standards of care for Diabetes. A Health Service Executive (HSE) National Diabetes Programme has been established to progress a national diabetes plan and a Clinical Programme Director for Diabetes has been appointed. Priority areas have been identified, including national diabetes foot care and retinopathy screening programmes and these have been included in the

HSE Service Plan for 2011. These initiatives are currently in an advanced planning stage.

Chronic Obstructive Pulmonary Disease (COPD)

The HSE plan to provide correct and early diagnosis so as to provide treatment based on best practice guidelines across the acute and primary care sector. They will provide patients information, support patients self management programmes and implement national COPD pulmonary rehabilitation and Outreach programmes. They aim to establish the former services in 30% of acute admitting hospitals (12 new sites) during 2011.

Conclusions

- The trend analysis from recent hospital utilisation data clearly indicate significant increases (20-70%) for certain chronic conditions over the past decade.
- Primary care prescribing using GMS, LTI and DPS show significant increases relating to chronic diseases over the period 2005-9.
- Population forecasting indicate that chronic conditions will generally increase by around 40% between 2007 and 2020 as a result of the ageing population and the impact of lifestyle factors.
- This trend is not sustainable from a cost or hospital capacity perspective in future years.
- A new model of structured integrated care involving primary care with an emphasis on prevention will be required.

Health Promotion Policy Unit

February 2011

BRIEFING NOTE FOR MINISTER ON THE DEPARTMENT

(1) Role and functions

The Minister for Health & Children is responsible, as a member of the Government, for determining and articulating policy on health and social care, for agreeing the annual expenditure estimates and reporting thereon to the Minister for Finance, for the overall performance of health and personal social services, and for ensuring adherence within the public health services to Government policies on issues such as public service pay, conditions and employment numbers.

The Department supports the Minister (and any Ministers of State) in meeting these responsibilities. Its functions include:

- leading and manage the ongoing changes required to improve policy, service delivery and health outcomes;

- evaluating the performance of all health sector agencies, prioritising areas for improvement and working with a wide range of stakeholders to achieve better services and outcomes;

- reviewing and advising on policy development, including an appropriate legislative and regulatory framework; and

- public and parliamentary accountability.

The Department's engagement and relationship with the HSE - by far the biggest agency operating under the Department's remit – is an essential and central element of our work. However, the work of the Department extends to many areas outside those dealt with by the HSE. For example, the Department

- makes payments to some 4,500 pre-school services under schemes to support early childcare services and education;
- administers funding to national and local youth services provided to some 420,000 young people;
- develops policy and legislation to underpin food safety, in which regard, for example, the Department took a central role in the national response to the dioxin contamination of pork;
- develops policy in relation to medicinal products, cosmetics, poisons and medicinal devices including through close cooperation with other members states at EU level;
- develops and oversees regulatory policy on issues like private health insurance and the recognition and conduct of health professionals;
- deals with other agencies such as HIQA, the NTPF, Health Research Board, Irish Medicines Board, Mental Health Commission, the Ombudsman for Children and the various professional regulatory bodies; and
- deals with a wide variety of issues at international level such as the smoking ban at work and in public places, and the European Health Insurance Card

system which provides emergency health care for travellers to other EU countries.

Relationship with the HSE

The HSE is a separate legal entity with its own board and essentially has the same status as a non-commercial state agency. As with most such agencies, the governing legislation (the Health Act 2004) assigns certain statutory "approval" functions to the Minister. This legislation, along with requirements imposed by various Government decisions, means the Department plays a key role in advising the Minister on issues such as the negotiation of the annual expenditure estimates, in-year expenditure management, the development and approval of the annual service, capital and ICT plans, health service employment control, pay and terms of conditions, procurement policy, and the public service transformation agenda.

It is neither possible nor appropriate to demarcate entirely separate roles for the Department and the HSE: there is an inextricable link between policy and service delivery, and there are many areas where the two organisations must collaborate for the overall good of the health system and those who need its services. Generally speaking the Department takes the lead role on policy review/development, legislation, dealings with other Government departments and other countries while the HSE has primary responsibility for service delivery and performance.

Organisational Structure

The work of the Department extends across nine Divisions with one member of the Management Advisory Committee (MAC) responsible for each Division. Four of these Divisions relate to key policy and corporate support areas: Parliamentary and Corporate Affairs, National HR &Workforce Planning, Finance and the Office of the CMO. The other five relate to the three cross-cutting offices (Office of the Minister for Children & Youth Affairs, Office for Older People and Office for Disability & Mental Health), to Primary Care and to Acute Hospitals/Cancer Services.

Business processes

As required by the Public Service Management Act, the Department prepared and submitted to the Minister at the end of December 2010 a revised draft Statement of Strategy. It will be necessary to prepare a further revised Statement of Strategy on foot of the appointment of a new Minister and to reflect the Programme for Government.

The Department operates an annual business planning process. Summaries of each Division's business plan for 2011 are being submitted separately. The Department's annual report for 2010 is currently being finalised.

The Department also operates the PMDS system and has a very good "compliance" record in that regard.

The Department also operates a risk management policy/process which includes a risk register (further details available) and regular reviews at MAC, divisional and unit levels. There is an internal audit unit, an audit committee and a MAC sub-committee on internal financial controls and VFM.

(2) Administrative Budget for the Department

The cost of running the Department has been falling over the past number of years.

Administrative Budget 2008 - 2010	Outturn 2008 €000	Outturn 2009 €000	Outturn 2010 €000
Summary			
Subhead A1: Salaries, wages & allowances	32,010	32,679	28,989
Subhead A2: Travel & Subsistence	953	538	426
Subhead A3: Incidental Expenses	1,735	1,065	864
Subhead A4: Postal & telecommunications services	788	599	550
Subhead A5: Office Machinery & office supplies	2,152	1,507	1,463
Subhead A6: Office Premises Expenses	958	561	637
Subhead A7: Consultancy Services	1,483	524	701
Subhead A8: VFM	36	27	34
Grand Total	**40,115**	**37,500**	**33,664**

The Department's Administrative Budget for 2011 is €38.2m (see below). This is higher than the provisional outturn for 2010 because of (a) the full year costs of staff who transferred into the Department during 2010 from the Irish Council for Bioethics and the Children Acts Advisory Board and (b) a number of exceptional items including installation of a new phone system in the Department, replacement of lifts in the Department and the provision for consultancy services in relation to the VHI.

As in previous years, we will be doing our utmost to secure further savings and ensure that actual expenditure is below budget.

Admin Budget 2011	REV 2011 €000
Summary	
Subhead A1: Salaries, wages & allowances	30,625
Subhead A2: Travel & Subsistence	779
Subhead A3: Training & Development & Incidental Expenses	1,005
Subhead A4: Postal & telecommunications services	840
Subhead A5: Office Equipment & External IT Services	1,600
Subhead A6: Office Premises Expenses	1,063
Subhead A7: Consultancy Services & VFM and Policy Reviews	2,278
Grand Total	**38,190**

(3) Staffing

There were 436 staff (whole time equivalents) employed in the Department at the end of January 2011, including 10 employed in the Office of the Disability Appeals Officer and the Health Repayments Scheme Appeals Office.

This represents a net decrease of 93 since the end of 2008 during a period when we took in 38 staff as a result of rationalisation of agencies and a transfer of functions relating to child care from the Departments of Education & Science and Community, Gaeltacht & Rural Affairs (i.e. the actual reduction, on a like-for-like basis, was 131).

Employment Control Framework
Target reductions in overall public service employment levels are now set out by way of Employment Control Frameworks (ECF). The targets for this Department are:

- 452 by end December 2010
- 437 by end December 2011
- 421 by end December 2012
- 406 by end December 2013
- 390 by end December 2014

The Department more than met its target for end 2010. We have to reduce our numbers by a further 46 between now and end 2014 but we only have 10 people due to retire on compulsory age grounds (age 65 years) over this period. There will be others eligible to retire (i.e. have/will reach minimum pension age of 60 years) who may or may not retire over the period.

The Department is organised on a divisional basis each headed by a member of the Management Advisory Committee (MAC). The following table provides a breakdown of staff numbers by Division.

Division	Grand Total
Ministers' Offices	31.60
Secretary General's Office & MAC Support	6.00
Acute Hospitals, Cancer & Associated Services	22.70
CMO's Office	30.83
Food, Primary Care & Eligibilty	42.13
Health Insurance	9.50
Finance, Performance Evaluation, Information & Research	57.40
National HR & Workforce Planning	34.50
Office for Disability & Mental Health	25.80
Office for Older People	26.83
Office of the Minister for Children & Youth Affairs	63.63
Parliamentary & Corporate Affairs	75.13
Total Department	**426.06**
Disability Appeals Office	4.00
Health Repayments Scheme Appeals Office	6.00
Total Other Offices	**10.00**
Total Department & Offices	**436.06**

Appendix 1 provides a further breakdown by section and grade at end January 2011.

(4) Parliamentary Affairs

Parliamentary/ministerial work consumes a lot of time and resources. In recent years, the Department has handled the highest volume of Parliamentary Questions and Adjournment Debates of any Government Department.

In 2010, the Department dealt with 5,925 Parliamentary Questions. Where the question concerns an operational or service issue it is referred to the HSE for direct reply. Of the total PQs taken by the Department in 2010 2,546 were referred to the HSE for reply. Of a total of 7,279 representations received 1,599 were referred to the HSE. In addition, 222 Dáil Adjournments were raised (88 selected), 88 Seanad Adjournments raised (60 selected) and 108 Leaders notes prepared.

Well established processes are in place to ensure the Department continues to meet all deadlines in relation to parliamentary questions, adjournment debates, Leaders' Questions notes etc.

Recent initiatives
A new priority reps tracking system has recently been introduced. The more urgent/ significant representations are now tagged as "Priority". Priority reps must be dealt with as a matter of urgency and, where a response has not been issued within 2 weeks, a reminder e-mail issues to the person to whom the rep is assigned requesting an early response to be drafted and issued.

A new data base has recently been introduced to facilitate "real time" access to the status of all requests for notes for Leaders' Questions.

HSE Parliamentary Affairs Unit
The HSE has a dedicated Parliamentary Affairs Division which has responsibility for ensuring that PQs and adjournments referred to it are dealt with within the appropriate time frame. Currently the HSE aims to answer 75% of PQs within 15 working days.

The HSE has recently introduced a number of initiatives to improve its performance in the area of democratic accountability:

- new protocols for dealing with Parliamentary Questions were introduced;
- a new IT system is being rolled out;
- regional co-ordinators have been identified to deal with parliamentary matters;
- development of a dedicated page on their website for members of the Oireachtas, with links to other topics of interest.

Cabinet Committee on Health/Senior Officials Group on Health
The (former) Cabinet Committee on Health comprised: the Taoiseach (Chair), the Minister for Health & Children, the Minister for Finance, and the Minister for Children & Youth Affairs. The Ministers of State at the Department of Health & Children also attended Committee meetings if the agenda of the meeting so required, while other Ministers were invited to attend as appropriate.

The Chief Executive Officer and the Chairman of the HSE also attended meetings in relation to items within their responsibility.

The Cabinet Committee was supported in its work by the Senior Officials Group on Health, which was chaired by the Department of the Taoiseach, and included officials from the Department of Health & Children, the Department of Finance and the HSE. The Cabinet Committee held four meetings in 2010, with the Senior Officials Group meeting on six occasions.

During 2010, the working arrangements and operation of all Cabinet Committees were reviewed and the entire Cabinet Committee structure was streamlined, to ensure a strategic focus for Cabinet Committees on key issues requiring direction or decision.

Joint Committee on Health and Children
The Committee may consider:-

(i) public affairs administered by the Department including bodies under the aegis of the Department in respect of Government policy;
(ii) matters of policy for which the Minister is responsible;
(iii) related policy issues concerning bodies which are partly or wholly funded by the State;
(iv) proposals for EU legislation and related policy issues;
(v) the Strategy Statement of the Department as laid before the Houses;
(vi) certain annual reports (and accounts) of bodies under the aegis of the Department;
(vii) such other matters as may be referred to the Committee from time to time.

Recent previous practice was that the Minister for Health and Children appeared before the Joint Committee on a quarterly basis.

Freedom of Information
The Department received 176 Freedom of Information requests in 2010. There were 8 internal review and 6 appeals to the Information Commissioner.

(5) Press and Communications Office

Press & Communications
This unit has a very substantial workload and there is close liaison with the HSE, HIQA and other health agencies.

The remit of the Press and Communications Office was broadened in June 2008 with the rollout of a new Departmental Communications Plan, and the appointment of an

Assistant Principal Officer, in order to develop a more strategic approach to the communications function as well as ensuring the delivery of the Department's Communications Plan. A new plan will be developed and implemented in 2011.

In 2010, the press function of the Office of the Minister for Children & Youth Affairs (OMCYA) was merged with that of the Press and Communications Office which now has responsibility for media management on behalf of the entire Department.

On the 'press side' the office's duties include:

- undertaking media liaison and activity in respect of press queries, press releases/statements and press conferences;
- undertaking a more proactive approach to media issues including seeking right of reply to adverse or incorrect articles/features in publications as well as participation on groups planning for future events;
- providing support to Ministers of State on media engagements.

On the 'communications side' it is responsible for issues such as:

- business ownership of the Department's internet and intranet websites;
- development and maintenance of www.healthupdate.gov.ie;
- co-ordinating and updating of the Departmental Fact Sheets which are uploaded to our website;
- maintenance of Department's achievements document following consultation with colleagues;
- providing material for other Ministers media appearances;
- sitting on various working groups such as the Communications Group for Patient Safety; and
- co-ordinating bi-annual constituency briefs for the Minister, Ministers of State and Taoiseach.

www.Healthupdate.gov.ie
This is a new web area which was developed internally and will be maintained by the Press and Communications office with a view to providing the media and the public with access to information on health topics which may be of current interest.

Workload
On the press/media side in 2010, there were 122 press releases issued, 15 press conferences held and approximately 20,000 emails received and suitably processed. An average of 20 phone calls per day were also received which can increase depending on the news profile that day. Prior to the merging of the offices, in 2010 the OMCYA Press Office issued 43 press releases and 12 press conferences held.

External Agency relationships
Contacts with key stakeholders including HSE and HIQA have developed substantially in the past two years. There is daily contact between the AP in the Press and Communications Office in the Department and the Head of Media in the HSE. A conference call is held on Fridays between Press Office officials from the Department

and the HSE to prepare for forthcoming events. Contacts with HIQA have also been increased with details regularly exchanged on current and emerging issues.

(6) Legislation

Preparing legislation and progressing it through Government and the Oireachtas is a resource/time-consuming task for the Department. The Department has an extensive legislative programme. An average of four Bills has been enacted in each of the last five years, some of which have had to be drafted at very short notice. The Department has also prepared in excess of fifty Statutory Instruments in each of those years.

Overview of Legislative Proposals – February 2011

1. Published Bills	Object	Current position
Child Care (Amendment) Bill 2009	To amend the Child Care Act 1991 to provide a statutory scheme for the High Court to have exclusive statutory jurisdiction to hear special care cases.	Lapsed on dissolution of Dáil. Had been passed by Seanad and scheduled for report stage in Dáil.
Nurses and Midwives Bill 2010	To modernise the regulatory framework for nurses and midwives	Lapsed on dissolution of Dáil. Had been passed by Dáil Committee and scheduled for report stage in Dáil.
Criminal Justice (Female Genital Mutilation) Bill 2011	To prohibit female genital mutilation. It is very important that this Bill is included into the next legislative programme as it provides essential protection to children against an internationally recognised human right abuse. Ireland will be questioned on this issue in this year's review by UN Committee on the Rights of the Child. The Bill also enjoys cross party support.	Published January 2011.

Note: It is open to a new Government to have a lapsed Bill restored to the order paper. Subject to agreement by the House, a Bill can be re-introduced at the stage it was at when it lapsed or an earlier stage.

2. Other legislative proposals

Working Title of other legislative proposals	Object of proposed Bill	Current position
Health Information Bill	To provide a legislative framework for the governance of personal health information throughout the health system, to introduce specific patient safety initiatives, to provide the legal basis for an identifier to be used in the health system and to establish a streamlined ethics approval structure for health research. This Bill is a priority because the issues it addresses are essential if information is to be better used for individual patient care and safety, and for the achievement of wider health service goals.	This complex Bill is at an advanced stage of drafting by Parliamentary Counsel but certain matters require further legal consideration in the AGs Office.
Medical Practitioners Act, 2007 (Amendment) Bill	To make it mandatory for registration purposes for doctors to have clinical indemnity/insurance.	A draft Memorandum for Government has been prepared.
Health and Social Care Professionals (Amendment) Bill	To make technical amendments to the Health and Social Care Professionals Act 2005 to (a) remove difficulties in relation to the effective operation of the Health and Social Care Professionals Council, in particular to urgently provide for the Minister to continue to appoint professional representatives to the Council from the designated professions under the 2005 Act whose term of office is due to expire in March 2011, and (b) implement Directive 2005/36/EC on the recognition of professional qualifications in respect of the professions designated under that Act and other technical amendments related to qualification recognition.	General Scheme of Bill circulated on eCabinet. Engagement with AGs Office is continuing.
Reference Pricing for Drugs Bill	To introduce a system of reference pricing and generic substitution for drugs prescribed under the GMS and community drug schemes. The introduction of generic substitution and a system of reference pricing will result in lower	Policy decisions are required to facilitate completion of Heads. Submission will be made to Minister at an early date.

	drug prices for both the State and private patients. It is important that this legislation is enacted in 2011 as a number of high volume medicines are expected to come off patent in the coming years. These reforms will ensure that lower prices are paid for these medicines resulting in significant savings for taxpayers and patients.	
National Vetting Bureau Bill	To provide a statutory basis for the vetting of applicants for employment and employees, including vetting to identify, in particular, information relating to the endangerment or sexual exploitation of children and vulnerable adults.	The OMCYA in conjunction with the Department of Justice and Law reform is preparing the Heads of the Bill. A number of legal issues in respect of 'soft information' have arisen and legal advice has been sought from the Department's Legal Section.
Children First Bill	To implement recommendations of Ryan Report including matters related to "Children First".	At preliminary stage. Policy position under consideration by OMCYA.
Mental Health (Amendment) Bill	To provide for some of the amendments to the Mental Health Act 2001 which were recommended following the review of the Act which was undertaken by the Department of Health & Children in 2007, and by the Mental Health Commission in the context of their review of the operation of Part 2 of the Act in 2008.	Heads drafted. In discussions with AGs office.
Health Insurance (Miscellaneous Provisions) Bill	To provide for a new risk equalisation scheme for health insurance. This legislation may need to be prioritised due to the imminent European Court of Justice hearing on VHI derogation from the 3rd non life directive.	Heads of Bill - Q2 2011.
Human Tissue Bill	To meet the key recommendation of the Madden Report on Post Mortem Practice and Procedures that no post-mortem examination should be carried out and no tissue retained for any purpose whatsoever without authorisation and to address related issues such as consent for the use of donated tissue from living persons for the purpose of transplantation and research.	The outcome of the public consultation on the draft General Scheme of the Bill is being considered and further legal advice is being sought.
Public Health (Sunbeds) Bill	To introduce a number of measures	Work is ongoing on the drafting of a

	to regulate the use of sunbeds including a prohibition of their use by those under 18 years of age.	General Scheme of a Bill.
Licensing of Health Facilities Bill	To provide for a mandatory system of licensing for public and private healthcare facilities to ensure compliance with core standards.	Legislative proposals are being prepared.
Public Health (Alcohol Labelling Provisions) Bill	To provide for the inclusion of health advice/warnings on alcohol drink containers (bottles, cans) and on promotional materials. Providing advice to pregnant women on the dangers of consuming alcohol during pregnancy and providing other health information to the consumer at the point of consumption are an important means of informing the consumer about the dangers associated with the alcohol product being consumed.	Work on the Bill is on hold at present to await the recommendations of the National Substance Misuse Strategy (NSMS) Steering Group. The scope of this Bill may be expanded as a result of the recommendations made by the NSMS Steering Group which is due to report before the Summer.
Health (Miscellaneous Provisions) Bill	To provide for subsuming the Opticians Board into the Health and Social Care Professionals Council.	A Working group has been established to examine issues involved and it is hoped to make significant progress in the drafting of Heads over the coming months.

3. Other issues

A. The Medical Council have also sought amendments to the Medical Practitioners Act, 2007. These amendments are being examined and scoped at present.

B. Preparatory work is ongoing on a proposed Adoption (Tracing and Information) Bill which will provide for an information and tracing service to applicants seeking information about adoptions. The Bill is required in order to provide a statutory basis for the National Adoption Contact Register which was established in 2005.

C. Amendment to the Constitution Bill on Children's Rights – the Bill is required for the purpose of holding a constitutional referendum on this issue.

D. Eligibility Legislative Framework: The Department undertook extensive preparatory work on the issue of eligibility for health & personal social services and completed a draft review of the eligibility framework with a view to seeking government permission to draft the Heads of a Bill. However, with the calling of the election, there was insufficient time for Government to consider this work and the proposal. Pending new Ministerial guidance on this issue, on foot of the appointment of a new Government and Minister, this work item has been suspended.

(7) International

The Department fulfils its international obligations and responsibilities while promoting and progressing Ireland's interests with regard to health policy and related matters. Cooperation and engagement is conducted at three levels:-

- north-south;
- EU level; and
- international level (other than EU).

North-South Cooperation
North-South Cooperation on health matters takes place at two main levels: - North South Ministerial Council (NSMC) level and Joint Departmental Projects.

Aside from these structures Co-operation and Working Together (CAWT) is the main vehicle for North-South cooperation with a specific focus on the North and the six border counties of the Republic of Ireland mainly in the area of facilitating cross-border projects (including EU INTERREG projects[1]).

North/South Cooperation takes place in five designated areas of health:-

- Accident & Emergency/Acute Services;
- Emergency Planning;
- Cancer Research;
- Health Technology; and
- Health Promotion.

Collaborative work in a number of other/related areas is being pursued by both Health Departments including:-

- paediatric and congenital cardiac services;
- radiotherapy (Altnagelvin);
- pandemic flu planning;
- child protection; and
- suicide prevention.

Both Health Departments agreed to undertake a *Feasibility Study* on the potential for future co-operation[2]. The Study has made a number of recommendations across an extensive range of health services. The Study was approved by the Minister for Health and Children. The Minister for Health, Social Services and Public Safety in Northern Ireland, although supportive of closer working between the Health Departments to progress individual projects, considered that it was not the right time (particularly in the straightened financial times) to create any new or additional administrative or

[1] €30m for 12 Projects over the lifetime of the 2007-2013 programme (part-funded by the EU)
[2] This was overseen by a Project Board which included representation from the Department of Health & Children, the Department of Health, Social Services and Public Safety NI, the HSE, and Cooperation And Working Together (CAWT).

bureaucratic structures around cooperation in the health and social care sector, and was not persuaded that the report should be progressed at that time.

Cross-border working on health has existed for many years and both Departments continue to collaborate on a wide range of health and social care issues referenced above.

North-South Ministerial Council
There are two Plenary NSMC meetings each year (a Plenary took place 21 January 2011) with the next Plenary scheduled for 10 June 2011. There are also two sectoral (i.e. health) meetings per year which review progress on the areas of cooperation. The next health sectoral meeting will take place before July 2011 and requires the attendance of the Minister for Health & Children, his or her counterpart from the North, and another cross-community Minister from the North.

The Minister and the Department will need to identify any specific areas for discussion and liaise with Northern Departmental counterparts.

EU engagement
Ireland's primary engagement at EU level in the area of public health and related matters is with the Council of the European Union and more particularly the **Employment Social Policy Health & Consumer Affairs (EPSCO) Council.**

Each Member State, or more specifically the relevant Minister from each Member State, chairs the Council for the duration of its Presidency of the EU. The Department is actively involved in preparations for and engagement at Council meetings of which there are two formal (and possibly two informal) meetings a year relating to health[3]. The Health Attaché in Brussels works closely with the EU Commission and other Member States identifying issues of relevance to the Department and representing Ireland's interests.

Current EPSCO Issues

Directive on the application of patients' rights in cross-border healthcare
The purpose of this Directive is to establish a clear legal framework to facilitate access to safe and high-quality cross-border healthcare and also to promote cooperation on healthcare between Member States, in full respect of national competencies. It gives a person the right to be reimbursed for health care received anywhere in the EU (subject to certain conditions).

On 15th December negotiations between the Presidency, Parliament, and Commission concluded with agreement being reached on the wording of the Directive. Member States are required to be compliant with the Directive within two and a half years after enactment, (28th February). Ireland will be expected to be compliant with the Directive by end 2013/early 2014. It will be necessary for the Department and the HSE to develop a detailed approach to the considerable preparations that will be

[3] preparation is done by way of 'working party' meetings which are attended by Department officials

required for its implementation as early as possible in 2011. It is likely that this matter will also feature in future North South Ministerial Council meetings.

Novel Foods Regulation
Foods or food ingredients that do not have a history of consumption in the EU prior to May, 1997 must be authorised under the Novel Food Regulation. The Commission published a proposal for an updated Novel Foods Regulation in January 2008. While the Department has lead responsibility on this dossier, it works with the Department of Agriculture, Fisheries and Food (DAFF) and the Department of Enterprise, Trade & Innovation (DETI) as appropriate. To date no agreement has been reached between Parliament and the Council on the Regulation. There are major differences within the Council and between the Council and Parliament in relation to issues surrounding food from cloned animals and the offspring of cloned animals.

Given the differences within Council and between Council and Parliament there is a reasonable likelihood that the draft Regulation will fall. The Commission has indicated that separate legislation to deal with all aspects of cloning will be introduced in mid 2012; this means the matter is likely to be one of the proposals for progression during the Irish Presidency (see below).

Food information to consumers
The Commission submitted its proposal for a Regulation on the Provision of Food Information to Consumers in February 2008. The Regulation aims to update rules applicable to Food Labelling. It merges legislation applicable to labelling in general and to nutrition labelling into a single Regulation. One the main issues of concern for Ireland is Country of Origin Labelling (COOL). Negotiations are ongoing and it is hoped that negotiations will be concluded by summer 2011.

Proposal for a Falsified Medicinal Products Directive
The objective of the Falsified Medicines Proposal is to strengthen the EU legal framework on pharmaceuticals with the aim of preventing falsified (counterfeit) medicinal products entering the legal medicines supply chain. The proposal also contains measures to address situations where medicines are supplied over the internet. Agreement has been reached on this proposal and formal adoption is expected shortly.

EU Presidency
Hungary holds the current EU Presidency (January – June 2011). The timetable for future Presidencies is as follows:-

July-Dec 2011	Poland
Jan-June 2012	Denmark
July –Dec 2012	Cyprus
Jan-June 2013	**Ireland**
July –Dec 2013	Lithuania
Jan- June 2014	Greece

Presidencies select an overarching theme (e.g. current Presidency Hungary chose "*Patient and Professional Pathways in Europe*") and 4/5 priorities. Presidencies

work in groups of three Member States (referred to as trio partners) and agree priorities. Priorities to be progressed during the Hungarian Presidency include investment in health; human resources in health; eHealth; mental health; health security; Childhood Vaccinations (with a focus on marginalised groups and immigrants).

The next EPSCO to be hosted by the Hungarian Presidency 6 June in Luxembourg, will focus on Pharmaceutical Package (information to patients on medicinal products), directive on the prevention of entry into the legal supply chain of falsified medicines, Proposal for a Recommendation on H1N1 pandemic, European Mental Health Pact, investing in healthcare systems, healthcare professionals – issues at EU level, eHealth, and cross-border aspects of childhood vaccination.

Other EU engagement

The EU Health Programme 2008-2013 is the European Commission's main instrument for implementing the EU health strategy. The programme aims, through projects and other actions it funds, to improve the level of physical and mental health and well-being of EU citizens and reduce health inequalities throughout the Community. In particular, the Programme supports health-promoting and preventive actions that address the major health determinants e.g., nutrition, physical activity, or smoking. The Health Programme is implemented in the form of annual work plans, which the European Commission adopts

A Joint Action is a funding instrument under the EU Health Programme and it involves a group of Member States collaborating on a given issue. One country leads but there are various levels of participation with work divided into work packages. Ireland is participating in Joint Actions on Rare Diseases, Organ Donation, Health Technology Assessment, eHealth, Patient Safety and Cancer.

The Minister may wish to take the opportunity at the forthcoming EPSCO meetings to meet with Ireland's 'trio partners' Lithuania and Greece, and other EU Ministers for Health. The Department of Foreign Affairs' advice to Departments is that in preparation for the Presidency Ministers should also take the opportunity when visiting Brussels to meet with Commissioners and key MEPs leading relevant Committees.

Ireland's Presidency January - June 2013

Ireland assumes the EU Presidency in January 2013. The Department is currently devising a *preliminary* list of priorities for further consideration and discussion. Follow-on items from preceding Presidencies/legislative obligations will also determine priorities as will discussion with the EU Commission.

It is likely that Ireland will be dealing with legacy issues that include:-

- Pharmaceuticals (including draft directive on information to patients);
- Clinical Trials;
- Recast of the Medical Devices Directive;

- Review of the Transparency Directive, which relates to the transparency of measures regulating the pricing of medicinal products for human use and their inclusion in the scope of national health insurance systems;
- Tobacco: a review of the Tobacco Products Directive (2001/37/EC) concerning the manufacture, presentation and sale of tobacco products. Expected to commence under Danish Presidency with negotiations to continue under our Presidency;
- Rare diseases (possibly arising from a Joint Action that Ireland is participating in); and
- Ageing.

Other international engagement

The Department engages with other international fora in the area of health and related matters. This includes the World Health Organisation, the OECD and the Council of Europe as appropriate. The Department also facilitates visits to/from other countries in order to assist in exchange of information and expertise in the area of health.

IMPORTANT DATES FOR THE MINISTER'S INFORMATION:-

North South Ministerial Council Meetings (March – June 2011)

10 June	Armagh	NSMC Plenary
TBC	TBC	NSMC Sectoral Meeting (Health)

EU Presidency key dates (March – June 2011)

Conferences at Ministerial level

4 - 5 April	Godollo, Hungary	Ministerial Informal EPSCO
10-12 May	Budapest	eHealth Ministerial Conference
6 June	Luxembourg	Employment Social Policy Health & Consumer Affairs (EPSCO)

International Meetings (March – June 2011)

16 – 24 May	Geneva	World Health Assembly

(8) Organisational Review Programme (ORP)

The Department volunteered to take part in the ORP because it was felt this was a good time to take stock of itself. The Review commenced in early 2009 and was published last September.

Main findings
The ORP highlights many positive elements of the Department including:

- the ability, skills, knowledge and commitment of staff; a track record of policy development (Primary Care Strategy, Cancer Control Strategy and Vision for Change);
- proven capacity to lead the response to crises such as the recent influenza pandemic;
- the progress made in evaluating the outputs, outcomes and performance of the HSE through the Service Plan process; and
- a willingness to engage openly with stakeholders and users.

However, the ORP also identified deficiencies and areas where improvement is needed, including:

- the need for greater clarity about the Department's role relative to that of the HSE and other agencies;
- better management of the delivery of outcomes by the HSE and other agencies;
- a clearer focus on the needs of all stakeholders and customers; and
- improved HR management within the Department itself.

The Department accepted the findings of the review and sees it as a valuable opportunity to improve performance.

Action Plan
The Department's priority Action Plan, responding to the Review findings, was developed and drafted in consultation with staff. It is based on the following framework:-

(a) the role of the Department;
(b) empowering our staff;
(c) interactions with service users, agencies and external stakeholders; and
(d) our internal business processes and structures.

The Action Plan identifies 15 specific actions. It was decided that the best approach would be to identify a limited number of priority actions which are capable of being delivered within a reasonably short period and which, when implemented, would produce demonstrable progress in addressing the key issues identified in the ORP.

Eight actions identified for Phase 1 of implementation are either at, or approaching final report stage. Implementation of the remaining seven actions has commenced.

Progress in relation to all 15 actions will be reviewed after twelve months and, in the light of that review and other developments in the meantime, a further iteration of the Action Plan will be developed with specific timelines for a further set of actions.

(9) Public Service Agreement 2010 – 2014

The Public Service Agreement 2010 – 2014 (Croke Park) is designed to support continued delivery of public services in a climate of reducing resources and staff numbers. Sectoral Action Plans have been produced for the civil service, the health sector, the education sector, etc., but each Government Department is also required to have its own Action Plan. This Department's Action Plan provides for the following:

Reducing staffing & improving human resource management and allocation

- Reducing staffing levels by 60 whole time equivalents by end 2014 by non-replacement of people leaving (retirement etc.) and co-operating with redeployment protocols as necessary
- Re-configuring the organisation as required to meet business priorities within reducing resources
- Reviewing how work is organised and the grade level appropriate to particular tasks to ensure optimum use of resources
- Ensuring cross stream reporting is working effectively across the Department and thereby increasing capacity at management level in a situation of shrinking resources (professional & technical staff represent around 5% of overall staffing)
- Implementing the Action Plans arising from the Organisation Review Programme (ORP)
- Improving people management skills within the Department, including dealing with performance issues
- Increasing flexibility of management and staff in relation to staff mobility and assignment
- Ensuring appropriate allocation of resources to meet strategic business priorities
- Reviewing existing shift patterns and overtime costs across the Department with a view to identifying financial savings
- Reducing absenteeism levels by 10%. This will be achieved by strengthening absenteeism management through improved monitoring and reporting systems at a central level and empowering local managers to deal with issues
- Reviewing the operation of existing flexible working arrangements within the Department to ensure they are meeting the Department's business needs and are being applied equitably for all staff
- Utilising existing office accommodation to reducing overall office space requirement

Business Improvement

- Developing a "*Memorandum of Understanding*" with the HSE to help define and clarify the "business rules" which will govern future working relationships between both organisations

- Maximising the provision of shared service to the newly created Adoption Authority (e.g. back-office support for functions such as payroll, procurement, IT, HR etc.)
- Co-operating with the wider public service development of larger shared-services for areas such as HR, Finance, & IT
- Utilising shared procurement facilities to the maximum extent possible and exploring possibilities for common approaches with other organisations on a bi-lateral or group basis
- Reviewing internal business process such as team meetings, risk management and business planning in order to improve efficiencies and streamline work practices
- Conducting a skills analysis to identify skills needed for the Department to discharge its functions more effectively
- Exploring the potential for meeting future skills needs and developing our own staff through staff exchanges between relevant organisations
- Developing a series of best practice guidelines and protocols on working practices starting with cross-Divisional working, analytical evaluation and the implementation aspects of policy development
- Reviewing current systems used for serving the democratic process to ensure they are as efficient and effective as possible
- Ensuring the Department's Risk Management Policy is fit for purpose and ensuring risk management is bedded down into day to day management activities
- Completing the remaining elements of the rationalisation programme relating to agencies being subsumed into the Department. The staff of the Children's Act Advisory Board have been transferred to the Department on an administrative basis; however, the abolition of the agency cannot be finalised pending the enactment of the Child Care (Amendment) Bill 2009.

Delivering for the Citizen

- Improving delivery systems for the Early Childhood Care and Education (ECCE) and the Childcare Education & Training Support (CETS) schemes administered in the Office of the Minister for Children & Youth Affairs (OMCYA)
- Reviewing the regulatory environment for pre-school services

Appendix 1 – Staffing Levels by Unit (January 2011)

	Grand Total	MAC	PO	AP	HEO	AO	EO	SO	CO	SERV	Min	Prof
Total Department	426.06	10.00	29 30	83.13	79.73	14.30	74.20	10 83	80.43	10.00	11.00	23.13
Total Other Offices	10.00	0.00	0.00	1.00	2.00	0.00	2.00	0.00	2.00	0.00	0.00	3.00
Total Department & Offices	**436.06**	**10.00**	**29.30**	**84.13**	**81.73**	**14.30**	**76.20**	**10.83**	**82.43**	**10.00**	**11.00**	**26.13**

Section	Grand Total	MAC	PO	AP	HEO	AO	EO	SO	CO	SERV	Min	Prof
Minister's Office	7.00	0.00	0.00	0.00	0.00	0.00	3.00	1.00	3.00	0.00	0.00	0.00
MoS Andrews	8.80	0.00	0.00	0.00	2.00	0.00	1.00	0.00	2.80	0.00	3.00	0.00
Mos Brady	9.00	0.00	0.00	0.00	0.00	0.00	2.00	0.00	3.00	0.00	4.00	0.00
MoS Moloney	6.80	0.00	0.00	0.00	0.00	0.00	1.80	0.00	1.00	0.00	4.00	0.00
Ministerial Offices	**31.60**	**0.00**	**0.00**	**0.00**	**2.00**	**0.00**	**7.80**	**1.00**	**9.80**	**0.00**	**11.00**	**0.00**
Secretary General's Office	5.00	1.00	0.00	0.00	1.00	0.00	1.00	0.00	2.00	0.00	0.00	0.00
MAC Support	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.00	0.00	0.00	0.00
Sec Gen Office & MAC Support	**6.00**	**1.00**	**0.00**	**0.00**	**1.00**	**0.00**	**1.00**	**0.00**	**3.00**	**0.00**	**0.00**	**0.00**
Acute Hospitals I	8.20	1.00	1.00	2.00	1.40	0.00	2.00	0.00	0.80	0.00	0.00	0.00
Acute Hospitals II	7.80	0.00	1.00	2.00	0.80	1.00	2.00	0.00	1.00	0.00	0.00	0.00
Blood Policy & Cancer Policy	6.70	0.00	1.00	1.60	2.00	0.50	1.60	0.00	0.00	0.00	0.00	0.00
Acute Hospitals, Cancer & Associated Services	**22.70**	**1.00**	**3.00**	**5.60**	**4.20**	**1.50**	**5.60**	**0.00**	**1.80**	**0.00**	**0.00**	**0.00**
Chief Medical Officer's Office	5.60	1.00	0.00	0.00	0.00	0.00	0.00	0.00	2.00	0.00	0.00	2.60
Bioethics Unit	3.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	3.00
Health Promotion Unit	5.20	0.00	0.00	1.00	1.80	0.00	0.80	0.00	0.60	0.00	0.00	1.00
Health Protection Unit	6.73	0.00	1.00	2.00	2.00	0.00	0.00	0.73	1.00	0.00	0.00	0.00
Patient Safety & Quality	3.20	0.00	0.00	2.20	0.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00
Social Inclusion	7.10	0.00	1.00	2.60	2.50	0.00	1.00	0.00	0.00	0.00	0.00	0.00
CMO's Office	**30.83**	**1.00**	**2.00**	**7.80**	**6.30**	**0.00**	**2.80**	**0.73**	**3.60**	**0.00**	**0.00**	**6.60**
Private Health Insurance	9.50	0.00	1.00	2.80	1.00	0.80	2.10	0.00	1.80	0.00	0.00	0.00
Health Insurance	**9.50**	**0.00**	**1.00**	**2.80**	**1.00**	**0.80**	**2.10**	**0.00**	**1.80**	**0.00**	**0.00**	**0.00**
Capital, EU/International & Research Policy	6.00	0.00	1.00	2.00	2.00	0.00	0.00	1.00	0.00	0.00	0.00	0.00
Finance I	24.10	1.00	1.00	3.00	3.50	0.00	6.80	0.00	7.80	0.00	0.00	1.00
ICT (Internal & External)	8.50	0.00	1.00	1.00	3.50	0.00	2.00	0.00	1.00	0.00	0.00	0.00
Information Unit	5.00	0.00	0.00	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	2.00
Performance Evaluation	6.20	0.00	1.00	1.80	1.40	1.00	0.00	0.00	1.00	0.00	0.00	0.00
Research Unit	5.60	0.00	0.00	1.00	0.60	0.00	1.00	0.00	0.00	0.00	0.00	3.00
Resource Allocation	2.00	0.00	1.00	0.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00
Finance, Performance Evaluation, Information & Research	**57.40**	**1.00**	**5.00**	**9.80**	**12.00**	**2.00**	**10.80**	**1.00**	**9.80**	**0.00**	**0.00**	**6.00**
National HR Unit	11.00	1.00	1.00	4.00	2.00	0.00	1.50	0.00	1.50	0.00	0.00	0.00
Professional Regulation Unit	9.40	0.00	0 80	2.60	1.40	1.00	1.00	0.00	1.60	0.00	0.00	1.00
Workforce Planning/Education & Training/Medical Indemnity & Agency Governance U	14.10	0.00	1.00	3.60	4.40	0.00	2.60	0 50	2.00	0.00	0.00	0.00
National HR & Workforce Planning Unit III	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
National HR & Workforce Planning	**34.50**	**1.00**	**2.80**	**10.20**	**7.80**	**1.00**	**5.10**	**0.50**	**5.10**	**0.00**	**0.00**	**1.00**
Citizen Participation Unit	4.60	0.00	0.00	0.00	0.00	1.00	1.00	0.00	0.60	0.00	0.00	2.00
Disability	13.60	1.00	1.00	4.00	4.00	1.00	1.00	0.00	1.60	0.00	0.00	0.00
Mental Health	7.60	0.00	1.00	2.00	1.60	0.00	2.00	0.00	1.00	0.00	0.00	0.00
Office for Disability & Mental Health	**25.80**	**1.00**	**2.00**	**6.00**	**5.60**	**2.00**	**4.00**	**0.00**	**3.20**	**0.00**	**0.00**	**2.00**
Disability Litigation	1.80	0.00	0.00	1.00	0.00	0.00	0.80	0.00	0.00	0.00	0.00	0.00
Long Stay Charges Unit	6.50	0.00	1.00	2.00	2.50	0.00	0.00	1.00	0.00	0.00	0.00	0.00
Services for Older People	12.23	1.00	1.00	2.00	3.00	1.00	1.00	0.00	3.23	0.00	0.00	0.00
Strategy for Older People	6.30	0.00	0 50	1.00	3.80	0.00	0.00	1.00	0.00	0.00	0.00	0.00
Office for Older People	**26.83**	**1.00**	**2.50**	**6.00**	**9.30**	**1.00**	**1.80**	**2.00**	**3.23**	**0.00**	**0.00**	**0.00**
Childcare Directorate	25.43	1.00	1.00	1.80	4.73	1.00	7.00	1 80	7.10	0.00	0.00	0.00
Children's Legilsation Unit	3.00	0.00	1.00	2.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Children & Youth Services Development Unit	20.80	0.00	1.00	4.60	3.60	1.00	3.50	0.00	6.10	0.00	0.00	1.00
Child Welfare & Protection Policy Unit 1	6.60	0.00	1.00	1.00	0.60	0.00	2.00	1.00	1.00	0.00	0.00	0.00
Child Welfare & Protection Policy Unit 2	3.50	0.00	1.00	1.50	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Child Welfare & Protection Policy Unit 3	4.30	0.00	0.00	1.50	0.80	0.00	1.00	0.00	0.00	0.00	0.00	1.00
Office of the Minister for Children & Youth Affairs	**63.63**	**1.00**	**5.00**	**12.40**	**10.73**	**2.00**	**13.50**	**2.80**	**14.20**	**0.00**	**0.00**	**2.00**
Communications & Press Office	6.80	0.00	0.00	1.00	2.00	0.00	2.80	0.00	1.00	0.00	0.00	0.00
Corporate Legislation Unit	5.20	0.00	1.00	2.80	0.00	1.00	0.40	0.00	0.00	0.00	0.00	0.00
Corporate Development - Records Management	5.30	0.00	0.00	0.00	1.00	0.00	1.00	0.00	3.30	0.00	0.00	0.00
Corporate Development - Support Services	15.00	0.00	0.00	1.00	1.00	0.00	2.00	0.00	1.00	10.00	0.00	0.00
Corporate Development - Training & ORP	4.50	0.00	0.00	1.00	1.00	0.00	0.00	0.00	2.50	0.00	0.00	0.00
Human Resources	14.60	0.00	1.00	2.80	2.00	0.00	3.80	1.00	4.00	0.00	0.00	0.00
Internal Audit	3.00	0.00	0.00	1.00	1.00	0.00	0.00	0.00	1.00	0.00	0.00	0.00
Legal Section	4.73	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.00	0.00	0.00	2.73
Parliamentary Affairs Unit	9.00	1.00	1.00	2.00	2.00	0.00	2.00	0.00	1.00	0.00	0.00	0.00
Parliamentary Affairs Unit - FOI	2.80	0.00	0.00	0.00	0.00	0.00	0.80	0.00	2.00	0.00	0.00	0.00
Unassigned Staff (On Loan etc.)	4.20	0.00	0.00	0.40	0.00	2.00	0.80	0.00	1.00	0.00	0.00	0.00
Parliamentary & Corporate Affairs	**75.13**	**1.00**	**3.00**	**12.00**	**10.00**	**3.00**	**13.60**	**1.00**	**18.80**	**10.00**	**0.00**	**2.73**
Controlled Drugs & Pharmacy Unit	4.60	0.00	0.00	0.80	2.00	0.00	0.00	0.00	0.00	0.00	0.00	1.80
Eligibility Unit	4.80	0.00	1.00	3.00	0.00	0.00	0.80	0.00	0.00	0.00	0.00	0.00
Food Safety, Medicines & Tobacco Control	18.73	0.00	1.00	3.73	4.80	0.00	3.30	0 80	4.10	0.00	0.00	1.00
Primary Care	14.00	1.00	1.00	3.00	3.00	1.00	2.00	1.00	2.00	0.00	0.00	0.00
Food, Primary Care & Eligibility	**42.13**	**1.00**	**3.00**	**10.53**	**9.80**	**1.00**	**6.10**	**1.80**	**6.10**	**0.00**	**0.00**	**2.80**

BRIEFING FOR MINISTER
HEALTH SECTOR DISABILITY SERVICES

1. KEY STATISTICS

Specialist disability services are provided in a variety of community and residential settings. The integral role of the non-statutory, voluntary and community groups is of particular relevance to the provision of health and personal social services to people with a disability. These agencies provide a very significant and broad range of services in partnership with and on behalf of the Health Service Executive (HSE).

Expenditure on health services for people with a disability in 2011 will be around €1.5 billion with an overall staffing level of 15,800wte. The majority of that funding is used by the non-statutory agencies providing services. Specialist services include assessment and early childhood/family support services, community-based medical, nursing and therapy services, aids and appliances, financial allowances, specialist day services including sheltered work and rehabilitation training, home support and personal assistance, respite care and residential services.

The National Service Plan 2011 includes the following

- Core Disability Service levels will be maintained.
    - 9,200 people in residential places
    - 20,000 day service places
    - 7,500 people receiving respite residential support
    - 3.34 million hours of Personal Assistant/Home Support Hours

2. CURRENT MAJOR ISSUES

2.1 Value for Money and Policy Review of Disability Services

A Value for Money and Policy Review of the Efficiency and Effectiveness of Disability Services is being undertaken. This in-depth review of Disability Services will assess how well current services meet their objectives and will support the future planning and development of services. A Steering Group chaired by Laurence Crowley is overseeing the Review, which it is planned to complete during 2011

A Project Team, reporting to the Steering Group, is making progress on the data collection stage of the Review, which involves gathering data from multiple sources on the various service types, organisation types and client groups which are encompassed by the disability programme. A Policy Expert Reference Group has completed its work on future policy proposals. The proposals envisage a reframing of disability services towards a model of individualised supports and individualised budgeting, based on assessed need and underpinned by mainstreaming of all public services.

On 3rd December 2010, the Department published on its website:

- the findings of a public consultation process undertaken by the Project Team as part of the Review, and
- a summary of the key policy proposals drafted by the Expert Reference Group.

Circulation of the draft policy proposals to other Departments is planned.

2.2 Funding of Disability Services

In 2011 the Minister instructed the HSE to

- give favourable treatment to disability services in the budget setting process with a maximum 1.8% decrease in funding to disability service providers
- protect the funding and levels of respite care services in 2011

The HSE was provided with an extra €10m for disability services to provide for a growth in demand for residential, day places and additional hours of personal assistant/home supports.

Innovation funding is provided in 2011 to support the transition from institutions to person-centred models of care in disability and mental health and the provision of potential innovative respite services.

2.3 National Quality Standards – Residential Services for People with Disabilities

Adults

National Quality Standards: Residential Services for People with Disabilities were formally submitted for approval to the Minister for Health and Children by HIQA in 2009. The Department of Health and Children, the HSE and HIQA agreed that progressive implementation of the standards would commence on an administrative basis and that they would become the benchmark against which the HSE assesses both its own directly operated facilities and those that it funds. The possibility of full statutory implementation of the standards is under ongoing consideration, having regard to the resources available.

Children

Draft National Quality Standards for Care Services for Children and Young People: Foster Care; Children's Residential Centres; Special Care Units; Children's Detention Schools; Residential Centres for Children and Young People with Disabilities have been prepared by HIQA. The standards are currently under consideration by the Board of the Authority and will be submitted for approval to the Minister for Children and Youth Affairs in the near future.

2.4 Thalidomide

The Government's proposals for additional service and financial supports for Irish survivors of thalidomide were rejected by the Irish Thalidomide Association. The Department has made a voluntary disclosure of files relating to the circumstances surrounding thalidomide in the 1950s/1960s and the arrangements made in the 1970s. The Association's legal adviser has indicated that legal proceedings will follow consideration of the documentation. A claim for damages has been received in respect of one survivor.

3. INTERSECTORAL WORKING

3.1 National Disability Strategy

The National Disability Strategy comprised of five elements:

1. Disability Act 2005;

2. Education for Persons with Special Educational Needs Act 2004;
3. Sectoral Plans published by six Government Departments;
4. Citizen's Information Act 2007;
5. A Multi-Annual Investment Programme for disability support services.

The Department of Community Equality and Gaeltacht Affairs has lead responsibility for the coordination of the National Disability Strategy, the National Disability Authority and the UN Convention on the Rights of Persons with Disabilities.

3.2 The Office for Disability and Mental Health
The Office for Disability and Mental Health was established in January 2008 to support the Minister for Disability & Mental Health, in exercising his responsibilities across four Government Departments: Health & Children, Education & Skills, Enterprise, Trade & Innovation and Community, Equality & Gaeltacht Affairs.

There is a need to improve co-ordination and communication across different Government Departments and agencies both in the delivery of services to people with a disability and in the framing of policy initiatives. This is the main focus for the Office. The Office brings together responsibility for a range of different policy areas and State services which directly impact on the lives of people with a disability and people with mental health issues.

The key disability priorities for the Office for Disability and Mental Health are:

- the delivery of integrated health and education support services for children with special needs
- to support the development and implementation of appropriate health related and employment supports for people with disabilities and people with mental health concerns.

<u>Current Inter-Sectoral Issues</u>

3.3 Department of Education and Skills
Disability Act 2005 and the Education for Persons with Special Educational Needs (EPSEN) Act 2004 –
Part 2 of the Disability Act 2005, which provides, *inter alia*, for an individual assessment of need, was commenced for children under the age of 5 on 1 June 2007. Implementation has posed significant challenges, as reflected in ongoing difficulties in meeting statutory deadlines for processes under the Act (assessments, service statements and reviews). For example, in 2010, only 30% of assessments were completed within specified timelines. While the HSE has developed regional action plans to tackle the backlog of overdue assessments specifically, there is a need for the Department and the Executive to work together to develop more sustainable approaches within existing resources. These will need to address the administration associated with the processes under the Act; in particular, the diversion of clinical resources from intervention to administration. Current work to reconfigure children's disability therapy services across the 0-18 age span will inform the development of these approaches.

It had been intended to have the Disability Act 2005 and the EPSEN Act 2004 fully implemented during 2010 in respect of children/young people between 5 and 18 years

of age, and for adults thereafter. In the light of financial circumstances, further implementation of the two Acts has been deferred.

In order to provide for a joined-up approach to the planned implementation of the Disability Act 2005 and the EPSEN Act 2004, the Department of Health and Children and the Department of Education and Skills had established a Cross Sectoral Team in 2006. The Team included senior officials from both Departments, as well as representatives from the Health Service Executive (HSE) and the National Council for Special Education (NCSE). Notwithstanding the deferred implementation of both Acts, the Cross Sectoral Team continues to meet to address issues of mutual concern, including the issues regarding assessments for children under 5 referred to above.

Integrating Children with Disabilities into Mainstream Pre-School Settings -
Work is underway to develop and agree a framework for the integration of young children with disabilities in mainstream pre-school settings. The group includes representation from the Department, the Department of Education and Skills, the Office of the Minister for Children and Youth Affairs, and the HSE.

3.4 Department of Enterprise Trade and Innovation and Department of Social Protection

In 2009 this Department established a Cross Sectoral Group (CSG) on Employment of People with Disabilities, with the (former) Departments of Enterprise, Trade & Innovation and Social Protection. The Health Service Executive and FÁS are also members of the Group. The purpose of the CSG is to progress the mainstreaming of employment services for people with disabilities, and:

- To develop a strategic framework to facilitate and promote access to employment for persons with a disability, based on the commitments in the Sectoral Plans.
- To formulate a comprehensive employment strategy as part of the strategic framework.
- To develop an appropriate continuum of training and employment support services and improve and develope the employment opportunities for people with a disability.

The composition of the Cross Sectoral Group is currently being reviewed following the recent changes in Departmental responsibilities for training and employment.

3.5 Department of Environment, Heritage and Local Government

The Department of Health and Children (DOHC) is working with the Department of the Environment, Heritage and Local Government (DOELG) in relation to the housing arrangements for people with disabilities through:

Inter Agency Protocols – Housing Needs of People with a Disability
The joint aim of DOHC and DOELG in relation to Inter Agency Protocols is to develop formal mechanisms between the HSE and housing authorities for the sharing of information relating to the housing needs of people with disabilities on (a) housing needs identified under the assessment of need process for under fives in line with the commencement of Part 2 of the Disability Act (b) support costs for social housing projects grant aided by DOELG for people with disabilities and

(c) governing the strategic assessment of the nature and extent of local housing needs of people with a disability

Housing Strategy for People with Disabilities
DOHC is inputting into the Draft Housing Strategy for People with Disabilities being developed by DOELG. Our aim is to ensure that at a strategic level people with disabilities are eligible to be assessed for access to appropriate housing. This includes the 4,000 people with disabilities who are currently living in institutional or congregated settings (defined as settings with 10 or more residents.)

3.6 Department of Social Protection
A decision was taken to transfer appropriate functions including income support schemes to the Department of Social Protection. An implementation group representative of the Departments of Health and Children and Social Protection and the Health Service Executive has successfully transferred responsibility for the Domiciliary Care Allowance (including the Respite Care Grant) to Social Protection since 2009.

The small number of people (less than 20) who were receiving the Infectious Disease Maintenance Allowance were transferred to an appropriate Social Protection allowance in 2009 and the Department repealed the legislation in 2010.

While it has been agreed that the Supplementary Blind Welfare Allowance should be transferred the Department of Social Protection are not in a position to progress the transfer at present given other priorities and current resource constraints.

Policy and operational issues relating to the Mobility Allowance and Motorised Transport Grant are under review in the Department and a separate detailed submission will be made to the Minister.

Disability Unit
March 2011

Drugs

1. DOHC Drug Treatment

1.1 Policy

The National Drugs Strategy (interim) 2009-2016 sets out the policy framework in relation to problem drug use. The Strategy outlines a series of 63 individual actions based on 5 pillars of: supply reduction; prevention; treatment; rehabilitation; and research. Impelementation of the Strategy is co-ordinated by the Department of Community, Equality & Gaeltacht Affairs (DCEGA) through the Office of the Minister for Drugs (OMD). A partnership approach between statutory, voluntary and community sectors in addressing drug issues is an important dimension to the Strategy.

1.2 OMD/DoHC role

The OMD has 2 groups in place to oversee the implementation of the Strategy as follows:

(i) The Oversight Forum on Drugs (OFD) is chaired by the Minister for CEGA, and senior officials from all sectors, Government Departments (at PO level) and agencies are representated on the Forum. The Forums's primary role is the high level monitoring of progress being achieved across the Strategy.

(ii) The Drugs Advisory Group (DAG) is also chaired by the Minister for CEGA, and is representative of all sectors, Government Departments (at AP level) and agencies. It's primary role is to advise the Minister on operational and policy matters, support and drive the implementation of the Strategy at local and regional level, ensure effective co-ordination between Departments and Agencies, oversee and support the work of the Local and Regional Drugs Task Forces. In this regard each Department/Agency has made a time commitment to the OMD. In addition each member of the DAG acts as liaison to 1 Regional and 1 Local Drugs Task Force, attends each meeting of the Task Force and reports back to the DAG.

The DoHC is the lead agency in relation to 9 actions while the HSE is the lead agency in relation to 17 actions. In addition the HSE is named as a contributor in a considerable number of additional actions.

1.3 National Drug Treatment Reporting System

The Health Research Board maintains the National Drug Treatment Reporting System which is a database on treated drug and alcohol misuse in Ireland. It records the numbers of individuals entering treatment nationally for addiction problems associated with drugs or alcohol. The HRB also maintains the National Drug-Related Deaths Index (NDRDI) which is a census of drug-related deaths (such as those due to accidental or intentional overdose) and deaths among drug users in Ireland. Officials from the Social Inclusion Unit co-chairs meetings of the NDRDI with the Department of Justice and Law Reform.

In Dec 2010, the HRB published its trends paper in relation to "Problem Benzodiazepine use in Ireland – treatment (2003 to 2008) and deaths (1998 to 2007)".

The main findings in the period 2003 – 2008 are as follows:

(i) The annual number of treated cases reporting Benzodiazepine as a problem substance increased by over 63%, from 1,054 in 2003 to 1,719 in 2008;

(ii) The number of cases that reported Benzodiazepine as their **main** problem substance increased by 120%, from 76 in 2003 to 167 in 2008;

(iii) The number of cases that reported Benzodiazepine as an **additional** problem substance increased by 59%, from 982 in 2003 to 1,562 in 2008.

In addition, the HRB published data from the NDRDI in June 2010 on "Drug-related deaths and deaths among drug users in Ireland, 1998 to 2007". The main findings from this data are as follows:

(i) Between 1998 and 2007 benzodiazepines were implicated in nearly one third (31%) of all deaths by poisoning, with the annual number increasing from 65 (out of a total of 178) deaths in 1998 to 88 (out of a total of 274) deaths in 2007;

(ii) The total number of deaths by poisoning in the 1998 – 2007 period was 2,120 of which 649 had benzodiazepines implicated (31%).

The Department of Health & Children and the HSE are currently actively engaged in the development of policy and the consideration of measures to improve practices regarding the use of benzodiazepines within the health system.

Good Practice Guidelines for Clinicians on benzodiazepines were issued by the Department of Health and Children at the end of 2002. Work is ongoing regarding the appropriate process for the update and reissue of these Guidelines to prescribers, pharmacists and all relevant health professionals.

1.4 EU

The Social Inclusion Unit participates in providing information to, and attending meetings of, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), the Pompidou Group and the Drug Prevention and Information Programme.

2. HSE Drug Treatment Services

2.1 Services

The HSE provides a range of addiction services incorporating education & prevention, harm reduction, treatment, stabilisation, rehabilitation and aftercare support.

Based on a capture recapture study by the National Advisory Committee on Drugs (NACD) there were an estimated 20,000 opiate users in Ireland in 2006. The following table sets out the number of clients recorded on the Central Treatment List as receiving methadone maintenance treatment in selected years:

Year (end December)	No. of clients receiving methadone maintenance treatment
2003	6,883
2007	8,523
2008	8,718
2009	9,047
2010	9,266

At the end of December 2009, 5,382 of the 9,047 clients had their methadone dispensed by pharmacists in the community rather than in specialist addiction clinics.

At the end of December 2010, 5,598 of the 9,266 clients had their methadone dispensed by pharmacists in the community rather than in specialist addiction clinics.

The following table sets out the number of GPs and pharmacies involved in providing methadone maintenance treatment in selected years:

Year (end December)	No. of GPs	No. of Pharmacies
2003	205	295
2007	247	427
2008	259	466
2009	277	480
2010	284	500

The following table summarises HSE spending on addiction services in recent years:

Year	HSE Spend (€ million)
2006	€96.7
2007	€101.9
2008	€101.9
2009	€104.9
2010 Est. *	€107.36

* Includes €3 million once off from HSE South / Excludes HSE cuts.

Out of its total allocation from the Department of Health and Children, the **Health Research Board** provided the following breakdown of funding for its work in relation to alcohol and drugs.

Year	HRB Spend (€ million)
2007	€0.984
2008	€1.033
2009	€0.949170
2010 Estimate *	€0.896924

* Subject to change with respect to staff costs and retention and Government directives.

2.2 Current Issues and Developments

The Review of the Methadone Treatment Protocol (The Introduction of the Opioid Treatment Protocol) was completed in November 2010 and launched on 20th December 2010 by Minister Carey. The review addressed a range of issues such

as GP Contracts, audits, integration with the Rehabilitation Framework, clinical governance and others.

2.3 National Addiction Training Programme

The National Addiction Training Programme (NATP) under the HSE demographic funding has been given an annual funding budget to carryout Cognitive Behaviour Coping Skills (CBCS) training, rehabilitation training and brief interventions particularly in regard to overdose and alcohol screening. The brief intervention model has been piloted in 3 hospitals in 2010 and it is intended to develop this further in 2011 with training supported via the NATP. In this expansion the key objective of providing a joint drug/alcohol brief intervention will be explored. This will support the need to analytically examine those attending Emergency Departments with addiction issues via the HIPE data base. The initial meeting of the reconstituted Steering Group took place on 7th February with the next meeting scheduled for the 14th March.

2.4 Reducing Waiting Times for Methadone Treatment

Notwithstanding the provision of an additional 3,686 methadone treatment places between 2001 and 2008, there are still unacceptable waiting times in some locations, mainly in the Midlands, East and South as well as in a small number of treatment centres in Dublin. To address this issue the HSE, with the assistance of DCEGA minor capital grants (€1.1 million), were provided in 2010 towards developing additional methadone clinics in Limerick city, Cork city, Tralee, Wexford, Gorey, Carlow/Kilkenny, Waterford, Drogheda and Dundalk. The development of these services is progressing and all 13 planned methadone facilities will be in operation in 2011. The Irish Prison Service (IPS) clinics for Cork, Limerick and Castlerea are planned for 2011.

The recruitment of additional Level 1 and 2 GPs and pharmacies participating in the methadone programme is essential to reducing waiting times for treatment. An online Level 1 GP training module is available through the ICGP to assist with the recruitment/retention of GPs at community level to facilitate transfer of clients from HSE clinics to community based provision. To facilitate the provision of the new methadone clinics the ICGP on behalf of the HSE has trained additional Level 2 GPs.

2.5 Services to Under 18s

Under 18 year olds are prioritised for methadone maintenance treatment and there is no waiting list for this cohort. The allocation of €2.46m was drawn down by the four regions of the HSE late in 2010. This has allowed for the ongoing development of additional frontline addiction services including additional psychology services, counselling and outreach services and family therapy in each RDTF area for under 18s in partnership with the voluntary sector.

2.6 Needle Exchange Services

Following on from the recommendations of the joint National Advisory Committee on Drugs / National Drugs Strategy Team report on needle exchange, the HSE has prioritised the provision of needle exchange services in areas outside Dublin where no services currently exist. The HSE and the Irish Pharmacy Union (IPU) have agreed a plan, supported by the Elton John AIDS Foundation, to roll out needle exchange services through Community Pharmacies in 65 new locations.

The recruitment of the National Liaison Pharmacist post is completed and a panel has been formed. The Irish Centre for Continuing Pharmaceutical Education (ICCPE) training module for participating Pharmacists was completed at the end of 2010. It was successfully attended by pharmacists in six regional locations outside of Dublin. Negotiations are ongoing with the IPU regarding the fee per item for needle exchange services.

2.7 Rehabilitation

The HSE as the lead agency has commenced the implementation of the Report of the Working Group on Drugs Rehabilitation (May 2007) by establishing the National Drug Rehabilitation Implementation Committee (NDRIC) and employing a National Senior Rehabilitation Coordinator. The NDRIC has developed a rehabilitation framework which has been approved by the OMD. The HSE are piloting this framework in the 4 HSE areas with targeted frontline pilot sites.

The NDRIC has adopted a phased approach to selecting pilot sites. To this end three pilot sites (Blanchardstown, North Inner City Dublin and Dundalk have been selected for the first stage). A further nine sites have made submissions for the 2nd stage and the NDRIC will consider these submissions at its 23rd February and 30th March meetings. Funding for the pilot sites will be made available via the the HSE.

Work is ongoing to develop best practise models for integrating Addiction Services with Primary Care Networks. The HSE/Residential Rehabilitation Group have devoted considerable time in examining how to improve integration of Tier 4 services and has commissioned research on this issue.

The HSE Social Inclusion Office in partnership with **drugs.ie** is currently developing an interactive online care pathway planning tool encompassing a searchable services directory that gives extensive information on each listed drug and alcohol service provider. It is envisaged that this will be an online starting point for persons wishing to access treatment and rehabilitation (and harm reduction) and an online reference point for professionals wishing to locate complementary and follow-on services for existing clients to facilitate a continuum of care approach.

Social Inclusion
24th February 2011

The Childcare Directorate of the OMCYA implements three major early childhood care and education programmes, including the free Pre-School Year in Early Childhood Care and Education (ECCE) programme.

The Early Childhood Care and Education (ECCE) programme was introduced in January 2010 and provides for a free Pre-School Year for all eligible children in the year before commencing primary school. In 2010, the ECCE scheme cost approximately €155 million. Children are eligible when they are aged between 3 years 3 months and 4 years 6 months in the September of the relevant year. In January 2010 53,000 children (83% of the eligible cohort for that year) availed of the free Pre-School Year. In September 2010, the first full year of the scheme, the participation rate increased to 63,000 children (94% of the eligible cohort for that year). The ECCE programme is delivered through participating pre-school services, including daycare services, and some 4,300 (95% of pre-school services) have entered, ensuring wide availability of the pre-school year. Services are required to adhere to the principles of Siolta, the National Quality Framework for Early Learning and Pre-School Leaders must hold minimum qualifications in a relevant field. It is a fundamental principle of the scheme that it is delivered free of charge to parents. As a result, all children have equal access to an appropriate early learning setting at a key developmental stage.

The Childcare Directorate also implements the Community Childcare Subvention (CCS) programme, which was introduced in September 2010. This programme supports disadvantaged and low income parents to access affordable childcare by providing support funding to community childcare services. Almost 1,000 community childcare services are participating in the CCS and charge reduced fees to qualifying parents in respect of 25,000 children at a cost of approximately €50 million per annum.. The subvention rates result in reductions of up to €100 per week for each full daycare place, with proportionate reductions where children attend for shorter hours.

A third programme, the Childcare Education and Training Support (CETS) programme, was introduced by the Childcare Directorate in September 2010. This is a labour activation measure to support parents attending training and educational programmes, provided by the Department of Education and Skills through FAS and the Vocational Education Committees (VECs). Over 700 childcare services are participating in the CETS programme, providing approximately 4,000 free childcare places to qualifying parents in locations across the State at a cost of approximately €25 million per annum. As the places are available to parents for the duration of their course, the number of parents benefiting from the programme in any one year is significantly higher than the total number of places available.

City and County Childcare Committees

The Childcare Directorate of the OMCYA provides funding to thirty three City and County Childcare Committees (CCCs), to provide a local network of administrative support for the three major early years programmes.. This support is provided to more than 4,500 services participating in the ECCE, CCS and CETS programmes. In addition, the CCCs promote quality improvement through a range of activities including training and other supports for childminders, parent and toddler groups, and pre-school service personnel. The CCCs also collaborate with the eight national voluntary childcare organisations which are funded by the Childcare Directorate in implementing Siolta, the National Framework for Early Learning. In December 2010, the Childcare Directorate launched a new National Strategic Plan 2011-2013, for the CCCs and VCOs, to provide a clear framework for their roles in supporting the three early childhood care and education programmes during 2011-2013.

Child Care Regulations

The Childcare Directorate of the OMCYA is responsible for the Child Care (Pre-School Services) (No. 2) Regulations 2006 which are implemented by the Health Service Executive (HSE). In December 2010, the Childcare Directorate launched National Quality Standards for Pre-School Services which are based on the Child Care Regulations. These are intended to guide and assist service users and providers in working toward high standards based on the statutory requirements.

National Childcare Co-ordinating Committee

The National Childcare Co-ordinating Committee (NCCC) is chaired by the OMCYA and provides a national forum for representatives of the early childhood care and education sector. The NCCC continues to advise and assist the OMCYA in promoting a co-ordinated national approach to early childhood care and education policy and provision.

FEMALE GENITAL MUTILATION

Current Situation

The Criminal Justice (Female Genital Mutilation) Bill 2011 was published on 20th January 2011. However, due to the general election, this Bill has now fallen. It is very important that this Bill is included into the next legislative programme as it provides essential protection to children against an internationally recognised human right abuse. Ireland will be questioned on this issue in this year's review by UN Committee on the Rights of the Child. The Bill enjoys cross-party support and the research and legislative background work has been completed.

Background

On the 18th of May last, the Government approved the request of the Minister for Health and Children to draft the Heads of a Bill to prohibit female genital mutilation. The decision arose as a result of a Private Member's Bill on this matter tabled earlier on the 21st of April 2010 in the Seanad by Senator Ivana Bacik.

Main Provisions of the Bill

The main purpose of the Bill is to prohibit female genital mutilation (FGM); along with providing for related offences – some of which apply to certain extra-territorial jurisdictions.

The Bill creates an offence of doing or attempting to do female genital mutilation. There are exemptions from the offence for doctors and midwives. For example, a midwife does not commit an offence of FGM when doing a surgical operation on a woman when she is in labour or has just given birth, if the purpose of the operation is connected with the labour or birth. In addition, a woman who self-mutilates is not guilty of an offence; nor is a person who does an act on a woman who is over 18 years and there is no permanent bodily harm from that act – such as certain types of body piercing.

A defence of custom or ritual in proceedings is not permitted; neither is a defence that the girl/woman or her parents/guardian consented to the act of FGM being done to her.

The Bill also provides for the offences of removing a girl or woman from the State where one of the purposes is to have FGM done to her, and doing or attempting to do an act of FGM outside the State in three specific extra-territorial circumstances – such as an act attempted or done by an Irish citizen or a person ordinarily resident in the State in a place where FGM is an offence. (Exemptions similar to some of those summarised above are also prescribed for these offences.)

Punishment is up to 14 years imprisonment or a fine or both; for a summary conviction, the penalty is a fine of up to €5,000 and/or imprisonment for up to 12 months.

Information on FGM

Female genital mutilation is defined as the partial or total removal of the external female genitalia, or any practice which purposely alters or injures the female genital organs for non-medical reasons. The type of FGM performed varies with ethnicity and region.

WHO estimates that between 100 and 140 million women and girls worldwide have undergone FGM. Most of these women and girls are resident in one of 28 countries, almost all in Africa, although there are reported cases of FGM in some countries in the Middle East and Asia. Practising countries include: Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Cote d'Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Ghana, Guinea-Bissau, Guinea, Kenya, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Somalia, Sudan, Uganda, United Republic of Tanzania, Togo and Yemen.

In Ireland, relevant population data from the 2006 Irish Census was used by AkiDwA (an Irish organisation for the support of African and migrant women) to collate an estimate of 3,170 women (calculated by country of origin and age group) who are resident in Ireland and living with FGM.

FGM is an internationally recognised human rights violation of women and girls. The practice has been strongly denounced by the World Health Organization (WHO), the United Nations Population Fund (UNFPA), and other international medical and health organisations as a violation of numerous human rights treaties and contrary to medical ethics. FGM is a serious child protection and women's health issue that has real implications for children and women in Ireland.

The age at which girls undergo FGM varies by community and region. The most common age when FGM is performed is between four and ten years, though this can vary from birth until first pregnancy.

FGM has no health benefits and involves removing and/or damaging healthy and normal body tissue. Its short-term consequences can include: death; haemorrhage; shock from severe pain and bleeding; transmission of HIV and other viruses. In the long-term, complications can include gynaecological problems, obstetrical complications, increased maternal or neo natal mortality and psychological trauma.

Social Inclusion
24th February 2011

Briefing for Minister

Food Safety

Department's role

This Department's role is to ensure that an appropriate legal framework, policies and structures are in place to achieve the highest standards of **food safety**. To achieve this objective, the Department

- represents Ireland at EU Food Safety Working Group meetings;
- transposes EU food safety into Irish law;
- prepares national food safety legislation; and
- monitors the work of both the Food Safety Authority of Ireland (FSAI) and the Food Safety Promotion Board (Safefood).

Recent Achievements

During 2010, the Department produced 9 Statutory Instruments which gave effect to 41 pieces of legislation (39 EU and 2 national). This work included:

- the transposition into Irish law of EU legislation on official control of foods and imports of foods of non animal origin; and
- the introduction of national regulations relating to the food hygiene requirements for butcher shops.

Food Safety Authority of Ireland (FSAI)

The FSAI is an independent and science-based agency, dedicated to protecting public health and consumer interests in the area of food safety and hygiene. It has a staff of 86. It is responsible for enforcing food safety legislation across the 47,500 food businesses and it oversees the work of over 2,500 persons involved in food control, in a number of official agencies with which it has service contracts. These agencies include the HSE, the Department of Agriculture, Fisheries and Food, the Sea Fisheries Protection Authority, the Marine Institute and the Local Authorities.

A total of 54 Enforcement Orders (34 Closure Orders, 7 Improvement Orders and 13 Prohibition Orders) were served for breaches in food safety legislation in 2009 compared with 46 in 2008 (34 Closure Orders, 6 Improvement Orders and 6 Prohibition Orders), an increase of 17%.

A sum of **€16.556m** is being allocated to the FSAI for 2011, a reduction of 5% on 2010.

Food Safety Promotion Board / *safe*food
The Food Safety Promotion Board (or '*safe*food') is one of six North/South Implementation Bodies established under the Good Friday Agreement in 1999.
S*afe*food is principally charged with raising food safety awareness- through public campaigns, conferences, training and advising professionals and the general public. It is also involved in supporting North/South scientific co-operation, and links between institutions working in the field of food safety - laboratories, statutory food safety enforcement agencies, and international and domestic research bodies. It has a staffing complement of 30.

S*afe*food is jointly funded by this Department and the Department of Health, Social Services and Public Safety in Northern Ireland. The agreed contribution level is 30:70 North/South. A sum of **€8.5m** (**€5.95m** from this Department) is being allocated to Safefood for 2011, a reduction of approx 10.7% on 2010.

Current Issues

Transfer of Feed Functions to FSAI
The Report of the Inter-Agency Dioxin Review Group, 2010, recommended that the remit of the FSAI should be extended to include animal feed (currently with the Dept of Agriculture, Food & Fisheries). This recommendation was never formally adopted by Government. It is for the Department of Agriculture, Food & Fisheries to progress this. Assuming Government approval, it will be necessary to introduce legislation to amend the FSAI Act 1999.

Raw Milk
The Department has agreed to introduce new regulations, on behalf of Dept of Agriculture, Food & Fisheries, to ban the sale of raw milk for direct human consumption. It is hoped to introduce this during 2011.

Labelling
In January 2008, the European Commission proposed a Regulation aimed at updating and harmonising existing labelling legislation. The proposal is primarily about providing consumers with the improved information on such areas as Country of Origin, Allergens and Nutrition Labelling.

This Department submitted a position paper to the Commission in 2008 and, since then, has contributed to EU Working Group meetings, ensuring that the Irish position is taken into account. The European Parliament and the Council completed their first readings during 2010. As the Council's proposal does not accord with the Parliament's first reading, negotiations between Parliament and Council will take place and this will lead to a second reading this year.

GMOs

While Ireland is opposed to the use of GM crops in Ireland, we have a "positive but precautionary" stance on the introduction of GMO food and feed. The Department liaises with Dept of Agriculture, Fisheries & Food (regarding feed) and Dept of Environment (regarding crops) on this issue. Until recently, Ireland remained neutral on EU proposals relating to GMO food/food products. In February 2011, however, the Government agreed to change its voting position and gave its support to a number of proposals from the EU Commission aimed at authorising the placing on the market of food, food ingredients and feed containing, consisting of, or produced from genetically modified maize and cotton.

Novel Foods

In January 2010, the European Commission stated it would go to the European Parliament within a year with a report on the use of cloned animals in food and feed. (Some MEPs have been demanding a ban on food from clones and their offspring). It is hoped that a trialogue process between Council, Commission and EU Presidency will result in a compromise proposal that will give further protection to the consumer in relation to new foods.

Food Supplements

The Food Supplements Directive requires the setting of maximum levels for vitamins and minerals in food supplements and fortified foods based on scientific risk assessment, while also taking due account of what is considered an adequate vitamin and mineral intake for an average person. An increasing range of foods fortified through the addition of vitamins and minerals are on the market. Certain groups within the food industry are opposed to the setting of maximum limits at levels below those currently in use.

Discussions at European level on the development of a methodology under which maximum safe levels for vitamins and minerals in food supplements would be set have not yet reached conclusion.

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Health and Nutrition Claims

A 2006 Regulation specifies the conditions for the use of nutrition and health claims. A nutrition claim implies that a food has particular nutrition properties while a health claim implies a health benefit to the consumer.

As of the end of October 2010 some 1,745 claims from a total of 4,637 had been assessed by the European Food Safety Authority (EFSA) with some 80% of the claims receiving a negative opinion. EFSA has confirmed that it will finalise the evaluations of all health claims by the end of June 2011.

Brief for new Minister on Governance of HSE and other agencies

HSE Accountability

- Central elements of current accountability framework within which the HSE operates are: the Code of Governance, the three year Corporate Plan, the annual National Service Plan, and the Annual Report and Financial Statements. The Code of Governance and Service and Corporate Plans are subject to approval by the Minister. In addition, the HSE is required to obtain the Minister's prior written permission for major capital spending.

- The improved focus on accountability brought about by the current framework, better use of information and more effective performance management has probably been one of the most important drivers of change in health in recent years and there has been substantial progress in that regard notwithstanding the ongoing difficulties caused by the absence of single national financial, employment and service activity systems.

HSE Board and Chief Executive Officer

Board:

- The board of the HSE is the governing body of the Executive as set out in Section 12 of the Health Act 2004. The Board may delegate to the CEO any of the executive's functions.
- The Board of the HSE is made up of 11 members (including the Chairperson and 10 ordinary members) appointed by the Minister for Health and Children in accordance with Section 11 of the 2004 Health Act. The CEO is also a member of the Board.
- The HSE Board meets on a monthly basis. Its functions include: the adoption of the HSE Corporate Plan, Service Plan and Capital Plan; adoption of a Code of Governance; monitoring progress against the Corporate, Service and Capital Plans; adoption of the Annual Financial Statements and Annual Report.

CEO:

- The Board delegates operational responsibility for the day-to-day running of the HSE to the CEO. The CEO is accountable to the Board. The CEO is also the Accounting Officer under Section 20 of the Health Act 2004 and has specific responsibilities in relation to the Appropriation Accounts of the HSE Vote.

HSE Code of Governance

- The HSE Code of Governance was approved by the Minister in March 2008, under Section 35 of the Health Act 2004. The HSE is currently revising the code, for submission to the Minister in Q2 2011. The Code covers the conduct of the Board and staff of the Executive.

HSE Annual Report & Financial Statements

- Under Section 37 of the Health Act 2004, the HSE must submit an Annual Report to the Minister. The 2009 Report was laid before the Houses of the Oireachtas in June 2010 and the 2010 Report must be submitted no later that 21 May 2011.

HSE Annual National Service Plan

- The HSE is obliged to submit a National Service Plan to the Minister each year for approval under Section 31 of the Health Act 2004. The HSE National Service Plan 2011 was approved by the Minister on 22 December 2010. The Plan outlines how the HSE plans to deliver health and personal social services within its 2011 current budget of €13.456bn, a net reduction of €638m on the original 2010 provision. The Plan is based on service activity levels for 2011 which are broadly in line with 2010 levels. The Plan also reflects the Minister's guidance to the HSE that there should be a particular focus on protecting services to vulnerable groups.

- The Minister set out the Government's **overall requirements for the HSE** when requesting the preparation of the Plan. In particular, the Minister advised that the budgetary adjustments should take account of relative priorities and that services delivered to the most vulnerable members of the community should be protected to the greatest extent possible. Accordingly, the Minister requested a differential approach to the achievement of the service expenditure reduction of €290m, with a relatively lower target for mental health and disability and a somewhat greater reduction for acute hospitals. In line with this principle, the Minister instructed the HSE to implement reductions in the Service Plan allocations as follows:
  - (i) a maximum budget reduction of 1.8% for disability & mental health services or about €40m of the required saving;
  - (ii) a minimum reduction of 3.2% for acute hospitals or about €150m of the required saving; and
  - (iii) a balancing reduction of about 2.3% in other areas or about €100m of the required saving (with a greater reduction within this for non-frontline areas such as corporate).

  The Service Plan submitted by the HSE and approved by the Minister reflects this approach to the achievement of the necessary savings.

- In line with the Minister's requirements, the Plan identifies the **key risks** to be managed in delivering the planned service levels outlined while continuing to operate within its Vote. The key risk identified by the HSE is the organisation's capacity to realise the necessary savings during 2011 while maintaining services at or close to current levels. Other significant risks identified include:
  - (i) Deviation from the projection in the Service Plan of the likely number of staff employed due to the impact of the recruitment moratorium, Voluntary Redundancy Scheme, Voluntary Early Retirement Scheme and natural attrition;
  - (ii) Unanticipated costs associated with the Clinical Indemnity Scheme;
  - (iii) Savings associated with the Primary Care Reimbursement Scheme(PCRS) not materialising due to unanticipated additional demand for medical cards and other demand led schemes.

- The Minister asked the Board to ensure there are arrangements in place to manage and mitigate these risks in a manner which takes account of overall Government policy in the relevant areas, in particular the imperative to control public spending, and which is underpinned by robust operational management and control systems and processes.

- **Human Resources:** The HSE will be required to reduce employment levels by approximately 1,520 by end 2011 in line with the Government's National Recovery Plan to reduce staffing levels in order to achieve substantial savings in the public service pay bill. This reduction is over and above the reduced numbers on foot of the voluntary exit scheme.

- The annual service planning process has been improved and refined each year. The HSE National Service Plan is probably the most important single and detailed accountability instrument in use by the Department at present. It captures in a clear and quantified way the wide range of services provided by the HSE. It establishes more explicit links between funding, staffing and services. It includes commencement targets for the operation of new capital infrastructure. It incorporates an improved set of activity measures, outcome based performance indicators and deliverables in key service areas, which are matched with targets and timescales that are capable of being benchmarked internationally. As a result the Department has a better understanding of the type, volume and impact of services delivered by the HSE for the monies allocated under its Vote.

Department Statement of Strategy and HSE Corporate Plan

- Under Section 29 of the Health Act 2004, the HSE must submit a three year Corporate Plan to the Minister for approval. The high-level objectives in the Department's Statement of Strategy are used to inform the HSE Corporate Plan (as well as similar plans by other health agencies) and the HSE Corporate Plan in turn sets out the desired medium and longer term objectives which are implemented annually through the HSE National Service Plan.

- The existing Corporate Plan covers the period 2008-2011. The Department and the HSE are currently working collaboratively on the development of the HSE Corporate Plan 2011-2013, which is due for completion in the coming months.

Annual Output Statement for Health Group of Votes

- The outputs and impact indicators for the various care group/service programmes are incorporated in the Annual Output Statements covering the entire Health Vote Group which are submitted to the Oireachtas each year. The Institute of Public Administration, in a recently published report on public sector trends, identified the Health AOS 2010 as having the best-defined output targets, with most being clear, well-defined and challenging.

HSE Operational Performance Management

- Within the HSE, the National Service Plan is underpinned by a range of business plans at various operational levels. The HSE has also developed its own system of operational performance management - HealthStat – which generates comparative performance information at the level of hospital/hospital network and local health office. This information is used at monthly HealthStat forum meetings chaired by the CEO to focus on the performance of individual hospitals and local health offices.

Ongoing Monitoring of Performance

- The above performance management architecture builds upon a consistent information governance framework which has been developed by the Department

- The HSE reports monthly to the Department on the performance of the health system against the agreed targets set out in the National Service Plan and biannually against the agreed targets set out in the Corporate Plan.

- Quarterly 'high level' meetings take place between the Secretary General and the Chief Executive Officer of the HSE, and their respective management teams, to discuss issues arising in relation to implementation and progression of the National Service Plan. 'Triangular' monthly meetings are held between the Department of Finance, Department of Health and Children and the HSE. Individual Policy Units in the Department continue to engage on an ongoing basis with their HSE counterparts in relation to service issues.

- The quality and timeliness of financial reporting, including the link between Vote and I&E accounting, has improved considerably. Among other things, this has helped the Department and the HSE to identify and focus on particular cost reduction initiatives in recent years, most notably in relation to drug/pharmacy costs, insurance, procurement and agency nursing. Measures like these, coupled with reductions in salary rates, professional fees, employment numbers and other policy changes have allowed for a cash reduction of €1.3 billion or 9% in health spending between 2008 and 2011. The underlying cost reduction has been even greater because of the need to meet unavoidable cost increases and demographic pressures which would normally have required funding increases. These cost reductions have been achieved while maintaining service levels, as set out in the annual service plan, and in some cases growing activity in priority areas.

- The arrangements for managing employment levels have also been improving and the "employment control framework" concept was developed and applied first in health before being extended to other sectors. It has helped to secure a steady reduction since March 2009 in overall numbers employed in the public health service while also protecting and increasing employment numbers in key areas such as medical consultants, social workers and certain therapist grades. Further details are set out in the Employment Control Framework note in the brief.

Estimates and Expenditure Management

Funding the Health Services

The public health and personal social services are funded through 3 Votes. Vote 39 is the Vote for the Office of the Minister for Health and Children which covers the Department, a range of health agencies and payments in respect of Hepatitis C Special accounts and the National Lottery Discretionary Fund. Vote 40 provides funding for the Health Service Executive. Vote 41 provides for the Office of the Minister for Children and Youth Affairs which funds a range of child care and youth programmes.

The gross current expenditure provision for the Health Group of Votes in 2011 is €14.051 billion, a nominal reduction of €782m on the 2010 Vote. The underlying savings figure is greater because of the need to provide, within the overall allocation,

for increased superannuation costs, an increase in the number of medical cards and extra funding to support a number of key policy priorities.

The main areas of savings are as follows:

	€m
▪ Demand Led Schemes (drug costs & professional fees)	449
▪ Moratorium Savings	93
▪ Other procurement and non-core pay cost savings	221
▪ Administrative & other savings in Votes 39 & Vote 41	38
▪ Exit Package	123
▪ Other technical adjustments	111
	1,035

Within the overall expenditure reduction, some additional funding is being provided to address unavoidable cost pressures and key policy objectives. The main cost pressures are €115m for an estimated 120,000 additional medical cards, €57m for additional superannuation costs and €36m for the State Claims Agency. It also provides some additional funding for the following key priority services:

	€m
▪ Older People - Fair Deal (€6m) - Home care packages (€8m)	14
▪ Disability	10
▪ Cancer	10
▪ Child Protection/Ryan Report	9
▪ Suicide	1
▪ Total	44

The above savings and additional allocations have been incorporated in the HSE Service Plan which was approved on 21st December 2010 and the Revised Estimates published on 15th February this year.

Vote 40 Health Service Executive
Outturn 2010
The HSE following the Supplementary Estimate had approved expenditure of €14,791 in 2010. The HSE reported a surplus on its Vote of €155m.

Included in the approved expenditure figure was €250m for the Voluntary Early Retirement and Voluntary Redundancy Schemes (exit package). The Department of Finance sanction stipulated that funding provided for the schemes could only be used for that purpose and that any of the €250m allocation unspent must be surrendered to the Exchequer. The HSE has indicated that the cost of the exit package was approximately €100m, a saving of €150m. This reduces the underlying surplus to just about breakeven.

There was a surplus on the Demand-Led schemes of €71m. The main source of expenditure pressure throughout last year was excess spending in acute hospitals. While there was some improvement in hospitals over the course of the last year, the overall breakeven position achieved by the HSE was only possible through savings in demand-led schemes and other areas offsetting excess expenditure in acute hospitals. Such savings cannot be relied upon in 2011 to compensate for budgetary excess in

hospitals. There was also a substantial shortfall on receipts collected by the HSE, of approximately €65m.

When account is taken of the surplus on the exit scheme there was a net surplus on the Vote, including capital of €4.677m.

Estimates 2011

The HSE's gross estimate for 2011 is €13.795b. This includes €392m for the capital programme. This represents a 5% reduction on the 2010 Outturn. As indicated above the estimate provides that the HSE will achieve savings on drug costs and community schemes, procurement savings, savings arising from the moratorium and the implementation of the Croke Park agreement as well as savings arising from the exit package.

In December the Department and the HSE reached agreement with the Irish Pharmaceutical Healthcare Association on further price reductions and other measures to achieve full year savings of €200 million in the cost of drugs. The HSE is also in the process of negotiating significantly improved procurement terms with a wide range of its suppliers. In addition, further reductions have been achieved in GP fees under the Financial Emergency Measures in the Public Interest Act and a review of the fees paid to community pharmacists under the same Act has just been finalised.

The numbers employed in the publicly funded health service have already fallen and will be reduced further this year through the ongoing impact of the moratorium/employment control framework. Further savings in payroll costs will be achieved through reductions in the volume of overtime and agency staff. The challenge to management and staff alike will be to make maximum use of the Croke Park Agreement to ensure services can continue to be provided with less staff and lower payroll costs.

It is estimated that moving to the full recovery of costs for private treatment in public hospitals would contribute additional income of about €93 million. The 2011 increase will recover an additional €75 million and the balance, approximately €18 million, is due to be obtained in the context of the 2012 Budget. This represents an overall 21% increase charges in 2011. There have been no increases in the A&E charge, the statutory day and inpatient charges, or the monthly threshold for the Drug Payment Scheme.

Another factor in the HSE's finances will be the possible impact of current discussions with the UK regarding payments for the health care, under EU regulations, of UK pensioners resident in Ireland. The UK has been arguing for some time that the level of payments should be substantially decreased. Discussions are ongoing with the UK Department of Health at present regarding payments for this year and future arrangements under the agreement between the two countries.

Vote 39 Office of the Minister for Health and Children

The Health and Children gross Vote in 2011 is €342m a decrease of 10% over the Budget for 2010. However the Vote has shown an increase on the actual outturn for 2010 due to a number of exceptional once-off savings in 2010. These relate to exceeding the target reductions in staff in the Department, savings in legal costs, payments to the Hepatitis C special accounts, dissemination of information and in some of the health agencies such as the Health Information and Quality Authority, where anticipated developments did not materialise. Another reason that the Budget for 2011 shows an increase in health agencies over the actual 2010 expenditure is that additional provision has had to be made for the further roll out of HIQA's statutory responsibilities, the development of the Health and Social Care Professional Council and the establishment of the Adoption Authority.

Vote 41 Office of the Minister for Children

The 2011 Gross Estimate for Vote 41 (Office of the Minister for Children and Youth Affairs) amounts to €333 million comprising €322m current and €11m capital. The allocation represents a decrease of €27 million or 8% on the 2010 Vote of €360 million. This reduction comprises €7m current expenditure and €20m capital expenditure.

The allocation includes provision for a range of services in respect of children and young people including:

- **€167 million** for the free Pre-School Year in Early Childhood Care and Education which was introduced in January 2010 and is currently benefiting approximately 63,000 children.
- **€86 million** in capital and current funds under the National Childcare Investment Programme.
- **€4 million** to support targeted measures for children and young people, including those in disadvantaged areas.
- **€27 million** towards *Growing Up in Ireland* - the National Longitudinal Study of Children in Ireland, the Young People's Facilities and Services Fund and a range of other programmes.
- **€45 million** to support the delivery of a range of youth work programmes and services for young people, including those in disadvantaged communities, by the voluntary youth work sector.
- **€3 million** to support costs which may arise in connection with the holding of a Constitutional Referendum on Children.

Conclusion

Due to the situation regarding the public finances and the requirement to reduce public expenditure, it has been necessary to reduce health expenditure in recent years. Since 2008 overall cash savings of about €1.4 billion or 9% have been achieved on current expenditure. Over and above this further internal savings have been made to fund unavoidable additional costs and policy priorities. The budgetary savings required from the HSE and other health providers this year will continue to be very challenging. There are a range of initiatives and policies at national level, such as procurement negotiations, nationally developed care pathways and the Croke Park framework, which will support the achievement of savings and the delivery of the

national service plan. However realising the savings and the successful implementation of the plan will also require intensive management at local level. The expenditure trends in the acute hospitals last year and in previous years suggest that this will continue to be the area of greatest challenge. Expenditure on demand-led schemes is also subject to variation and it has been agreed with the Department of Finance that the trends on these schemes need careful ongoing monitoring. The HSE was allocated €6m additional funding for the Fair Deal Programme. It has now indicated that the additional funding has been fully utilised to deal with new applicants under the scheme, but that it is now at the point where it cannot accept any new applicants unless existing capacity becomes available.

Capital

Capital investment in health services takes the form of investment in acute hospital infrastructure, primary community and continuing care, childcare facilities and the use of medical technology to enhance the care of patients. It is designed to complement the overall effort to maximise the effectiveness and efficiency of the health services.

The total exchequer health capital provision for 2011 is **€403.5m**, comprising

1 ***The Department's Vote*** (Vote 39), allocation **€15.45m**
- €0.45m is allocated in respect of the administration of the Department's internal ICT infrastructure
- €15m to support capital grants to agencies under the aegis of the Department

2 ***The HSE Vote*** (Vote 40), allocation **€377.25m**
- €334.71m in respect of building, equipping and furnishing health facilities
- €40m ICT allocation
- €2.539m in national lottery funding

An additional €15m has been allocated based on planned disposal of surplus assets by the HSE and reinvestment of the proceeds.

3 ***Office of the Minister for Children and Youth Affairs*** (Vote 41), allocation **€10.8m**
€10m relates to capital infrastructure development in the National Childcare Investment Programme with the remaining €0.8m for the Young Peoples Facilities and Services Fund.

1 Department Vote (Vote 39)
This vote supports the following directly funded agencies:-

- Health Research Board (HRB)
- Health Information & Quality Authority (HIQA)
- Health and Social Care Professional Council
- National Cancer Registry Ireland
- Office of the Ombudsman for Children

The HRB has capital commitments amounting to [redacted] in 2011 which includes clinical scientist awards, translational research awards, PhD Scholars Programme and co-funding for the construction of a Clinical Research Facility (sanction for a Clinical Research Facility at University College Hospital Galway was approved in 2010, however construction is delayed as the preferred contracting company went into receivership in 2010).

The remaining agencies require capital for ICT, office equipment, some refurbishment and furniture.

2 HSE Capital Allocation (Vote 40)

The 2011 capital allocation for the HSE is €392.25m.

The capital programme has undergone significant downward adjustment in previous years. The following table shows HSE allocations and expenditure since 2005:-

HSE Vote 40	2005 €m	2006 €m	2007 €m	2008 €m	2009 €m	2010 €m	2011 €m	Total €m
Capital Allocation	564.063	574.556	524.951	593.720	442.763	367.370	392.250	3,459.673

HSE Capital Plan 2011 – 2015

The HSE develops a Capital Plan which sets out proposed capital expenditure on areas other the ICT. (Department of Finance procedures require individual approvals of ICT projects.) A detailed HSE capital plan is being finalised and preliminary discussions are planed prior to formal submission to the Minister (the Plan requires the Minister's approval with the consent of the Minister for Finance).

Funding for the period 2011 to 2015 is €1,661.35 [1]. Exchequer funding of €337.25m is available in 2011 together with expected sale proceeds of €15m to support capital construction and equipping projects. The next table shows funding for the period 2011 to 2015 together with HSE commitments, additional projects to commence in 2011 (and subsequent years), and as of yet unallocated funding which it is proposed will be allocated closer to the time.

[1] an allocation of €334.25m is assumed for 2015. The 2011-2015 figures refer to construction and equipping only (i.e. they exclude ICT)

Available Funding	2011 €m	2012 €m	2013 €m	2014 €m	2015 €m	Totals €m
Capital Allocation	337.25	321.85	333.75	334.25	334.25	1,661.35
HSE Contractual Commitments	[redacted]					
Capital required to complete	[redacted]					
Minor Capital, Contingency, Project Management	[redacted]					
Projects in Planning						
Additional projects to commence in 2011	[redacted]					
Additional projects to commence in 2012/2013		[redacted]				
Unallocated funding		[redacted]				

It is expected that [redacted] will be held in reserve in 2011 as a contingency and when the HSE is certain that expenditure will remain within profile and the planned receipts realised from disposals the [redacted] will be released [redacted]

New Projects in 2011
Taking into account existing contractual commitments, minor capital, contingency, and project management allocations, there is very limited scope for new approvals in 2011 (in the region of [redacted]. The HSE is finalising proposals in this regard.

Revenue Implications (of projects to be completed in 2011)
According to the HSE no additional revenue or whole time equivalents (WTEs) over and above those detailed in its National Service Plan 2011 are required for projects to be completed in 2011.

Further information on investment programmes and projects underway/planned is available from the Capital Section. In any event further briefing will be provided in the context of the Minister's consideration of the HSE's proposed Capital Plan.

Reduction in Pay of Public Servants

- 10% reduction in pay rates and fixed term allowances for anyone being recruited into certain entry grades to the civil service with effect from 1 January 2011

- Serving public servants salaries were reduced with effect from 1 January 2010 as follows:-
    - 5% on the first €30,000 of salary
    - 7.5% on the next €40,000 of salary
    - 10% on the next €55,000 of salary

[redacted]

This produced overall reductions in salaries ranging from 5% to just under 8% in the case of salaries up to €125,000.

Higher earners were cut as follows:

- 8% reduction on all salary greater than €125,000 and less than €165,000
- 12% reduction on salaries greater than €165,000 and less than €200,000
- 15% reduction on salaries greater than €200,000

- As a result, Salaries of Deputy Secretaries and Assistant Secretaries were cut by 14% and 11.8% respectively (taking account of the termination of the Scheme of Performance Related Awards previously payable to grade of Deputy Secretary and Assistant Secretaries which entailed an average payment of 10% of salary)

Pension Related Deduction

A new Pension Related Deduction was introduced with effect from 1 March 2009. It is charged an all pay as follows:

- First €15,000 of earnings exempt
- 5% on all earnings between €15,000 and €20,000
- 10% on all earnings between €20,000 and €60,000
- 10.5% on earnings greater than €60,000

Reduction in Travel & Subsistence

- All travel and subsistence rates were reduced by 25% with effect from 5 March 2009

Public Service Pensions

CURRENT ARRANGEMENTS
Staff recruited prior to the enactment of Public Service Superannuation (Miscellaneous Provisions) Act 2004

- Minimum Retirement Age of 60
- Maximum Retirement Age of 65

Staff recruited since the enactment of Public Service Superannuation (Miscellaneous Provisions) Act 2004

- Minimum Retirement Age of 65
- No Maximum Retirement Age

NEW PROPOSALS

A new single scheme for all new entrants to the public service from 2011 onwards will be introduced – (legislation currently being drafted) with the main provisions as follows:

- Minimum Retirement Age 66 to bring it into line and link it henceforth with the State Pension age
- Maximum Retirement Age of 70 years
- pensions to be based on "career average" earnings rather than final salary as currently applies. A specific "pension accrual rate" will be applied to pensionable pay so that each year public servants will earn or accrue a certain amount of pension payable on retirement. This is a fairer, more equitable and progressive system: it lowers the pensions of persons with high earnings especially in late career with less impact on the pensions of lower paid public servants with relatively "flat" career earnings such as nurses and manual workers.

Brief on the Employment Control Framework February 2011

1. The Department's role in employment control

Public sector em ployment levels are a key element in dec isions taken by Governm ent on achieving reductions in public sector expenditure. Health sector em ployment levels have been subject to monitoring for many years and in recen t years Em ployment Contro l Fram eworks govern overall policy on health employment numbers. The Fram ework also provides the tools for the HSE, the Dep artment of Health and Children and the Departm ent of Finance to implement Government policy on numbers employed.

The current Employment Control Framework 2011 – 2014 (ECF) is built on the targets set out in the Natio nal Recover y Plan. It includes the moratorium but this is tailo red f or the health sector – see below. The policy objectives of the ECF and moratorium are ensh rined in th e Public Sector Agreement.

Separate ECFs are in place for staff in the Department and staff in non-comm ercial state agencies under the Department (regulatory bodies, etc.).

Employment levels in the HSE and voluntary bodies are monitored by the Department of Health & Children in conjunction with the Department of Finance, and in the context of both Department's membership of the Joint Employment Control Monitoring Committee (which also includes officials from the HSE). This committee also reviews the implementation of the Framework.

2. Employment Control Framework 2011-2014/Moratorium on recruitment

The Employment Control Framework for 2011-2014 gives effect to the Government decision on employment policy in the public sector and provides that there will be a net reduction in employment to 2014. This includes a target reduction in numbers in 2010 to achieve the overall reduction of 9,135 from end 2010 to end 2014 and consequential pay roll savings (reduction from 2011 onwards is approx. 6,000 excluding transfers of staff to other Departments and the impact of recent voluntary early retirement scheme).

There are a number of grades exempted from the moratorium (see below), under the ECF 2011-2014, to maintain key front line services and to support the development of policies in relation to disability, mental health, cancer, and child care. These exemptions are subject to certain conditions being met by the HSE and employers concerned.

a. **Medical Consultants**
b. **Speech and Language Therapist, Occupational Therapist, Physiotherapist**
c. **Clinical Psychologist, Behavioural Therapist**, **Counsellor**
d. **Social Worker** (incl. Posts for implementation of Ryan Report)
e. **Emergency Medical Technicians**
f. **Psychiatric Nurses** — up to 100 posts to support the implementation of *A Vision for Change*.
g. **Public Health Nurses** — up to 70 posts to facilitate the recruitment of student public health nurses.
h. **Nurse Sponsorship Scheme** — up to 30 posts to facilitate the appointment successful students from this sponsorship scheme.
i. **Advanced Nurse Practitioner/Clinical Nurse Specialist** — 50 posts to allow for improved skill mix and better utilisation of the nursing resource in priority areas (acute/chronic illnesses).
j. **Additional Intern Places** — 40 additional training places
k. **National Cancer Control Programme posts** —
    - Clinical engineering technician
    - Dosimetrist
    - Physicist
    - Radiation Therapist

Targets in the Employment Control Framework

The HSE's December census data show the progress made on the targets in the framework:

	Dec-09	Dec-10	Difference	2012 Target	Posts in addition to Dec 09 outturn (which constitute target)	Variance
NCHDs	4,803	4,714	-89	Not applicable	Not applicable	Not applicable
Hosp. Conslts.	2,317	2,412	95	Not defined	1 new post = 2 suppressed NCHD posts	Not applicable
S&L Ther., OTs & Physios.	3,348	3,581	233	3,728	380	-147
Clin. Psychol., Behav. Ther., & Counsellors	954	969	15	1,184	230	-215
Social Workers	2,189	2,432	243	2,489	300	-57
Notes: (i) The target increases for the above grades were to take place over 3 years under the 2010-2012 Employment Control Framework*. Data above for Dec 2010. (ii) The above grades have been grouped together in accordance with the targets set out in the ECF. (iii) The 95 WTE increase in Hospital Consultants, includes 29 WTE from the National Cancer Screening Service (NCSS) - included for the first time in the census in September. (iv) Since December 09, there has been progress on recruiting Physios (+70 WTE), S&LTs (+62 WTE), OTs (+100 WTE). (v) The number of Social Workers is higher than that of December 08. The above Social Worker data differ from the HSE's December PR data because the HSE data exclude non-professionally qualified Social Workers (46 WTE in December).						

* Note: revised timeframes in place for Employment Control Framework 2011-2014

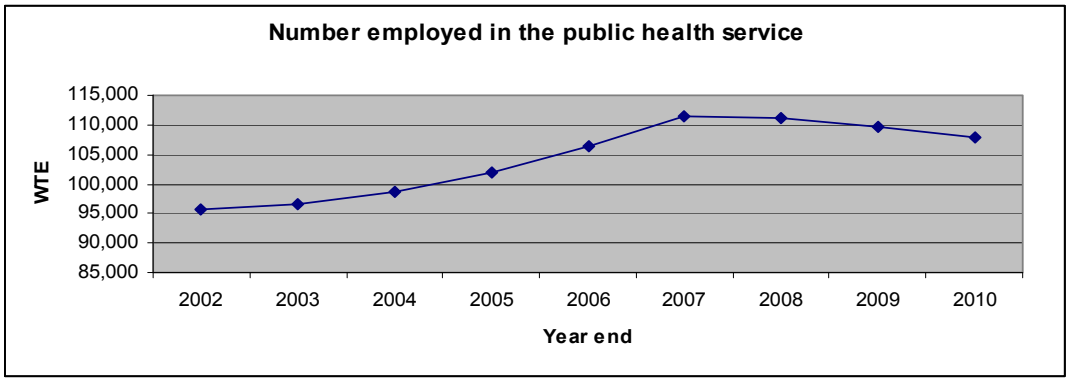
Overall there has been a significant increase in those areas targeted for growth with some remaining expansion planned over the next two years.

3. Health Employment Trends

The graph below shows the trend in health employment from 95,679 WTE at December 2002 to 107,972 WTE at December 2010. This increase arose from an increased demand for services and additional funding invested in such services. Some of the increase also arose from changes in the grades and agencies that are now counted in the Health Service Personnel Census (e.g. subsumed agencies and posts not previously counted). This change in methodology took place in the March 2007 census[2].

There was a 13% (12,293 WTEs) increase in the numbers employed in the public health service between December 2002 and December 2010.

[2] The HSE has estimated that the net effect of the change is approximately 3,000 WTE. These changes comprise the inclusion of student nurses and chaplains together with the addition of subsumed agencies into the HSE, together with many other posts in projects or categories previously excluded.



Breakdown by grade category

The numbers employed in the public health service, by grade category, are as follows:

Numbers (WTE excld. career break) employed in the public health service							
	Dec 04	**Dec 05**	**Dec 06**	**Dec 07 ***	**Dec 08**	**Dec 09**	**Dec 10**
Medical/ Dental	7,013	7,266	7,712	8,005	8,109	8,083	8,096
Nursing	34,313	35,248	36,737	39,006	38,108	37,466	36,503
Health & Social Care Professionals	12,830	13,952	14,913	15,705	15,980	15,973	16,355
Management/ Admin	16,157	16,699	17,262	18,043	17,967	17,611	17,301
General Support Staff	13,771	13,227	12,910	12,900	12,631	11,906	11,421
Other Patient & Client Care	14,640	15,586	16,739	17,846	18,230	18,714	18,295
Total	**98,723**	**101,978**	**106,273**	**111,505**	**111,025**	**109,753**	**107,972**

Notes: (1) Excludes Home Helps. (2) Student nurses are included in the 2007 and 2008 employment ceilings on the basis of 3.5 students equating to 1 wholetime equivalent. The employment levels adjusted for student nurses on the above basis are 110,664 WTEs (Dec 07) and 111,001 WTEs (Dec 08). (3) Student nurses are included in the 2009 and 2010 figures on the basis of 2 students equating to 1 wholetime equivalent — the figures above are already adjusted. (iv) The data for Other Patient and Client Care and General Support Staff may have been affected by reclassification between grade categories.

**** The Dec 07 figures above include the effect of the change in methodology in the census in March 07. The HSE has estimated that the net effect of the change is approx. 3,000 WTEs resulting from the inclusion, for the first time, of various grades and posts in the Management/Admin group, student nurses and other grades/posts in subsumed agencies.***

Breakdown by care group/programme

The following table sets out the numbers employed in the public health service, by care group/programme, as at December 2009 and December 2010. While information by grade in the health sector has been readily available for some years, data by care group/programme has not been available until recently. Further progress in reporting by care group/programme is expected during 2011.

Care Group	31/12/2009	30/11/2010	Change in 2010
Acute Hospitals	50,402	49,119	-1,283
Ambulance Services	1,465	1,494	29
Cancer Services	604	909	305
Children & Families	2,470	3,159	689
Corporate Functions	3,118	3,028	-90
Disabilities	16,011	15,705	-306
Mental Health	9,778	9,429	-349
Older People	11,154	10,674	-480
Palliative Care	626	651	25
Population Health Services	1,123	1,100	-23
Primary Care	12,437	12,015	-422
Social Inclusion	565	689	124
Total	**109,753**	**107,972**	**-1,781**

Notes: (1) Excludes Home Helps; (2) the HSE has advised that categorisation by programme/function to be a work-in-progress and remapping of care staff to the care programmes/functions continues to be carried out at the service delivery end. There are ongoing significant challenges in that some staff work across care programmes/functions and HR and finance systems are not integrated; and (3) source: Health Service Staff Census.

Issues and risks

- The HSE has made good progress in 2010 in keeping employment numbers below the employment ceiling. The challenge is to ensure that this progress can be continued up to 2014 in order for numbers employed to reduce in line with the targets set out in the National Recovery Plan.
- The principal effect of the moratorium is that posts that fall vacant due to resignation, retirement or termination of contract are not filled. In the main, the HSE has little control on the grade or location of these posts. The Framework provides for redeployment to fill essential vacancies and this is provided for in the Public Service Agreement. However, the HSE must manage its staffing resources so as to minimise the impact of the moratorium on front line services.
- A key consideration for HSE is to stay within budget. Given that staff account for 70% of the cost of many services provided, it is essential that the HSE stay with the employment ceiling.
- The HSE has recently advised that in some hospitals (mainly the large Dublin acutes), numbers employed in Nurse Banks have not been reported in the census. A detailed report is awaited from the HSE. Nurse Banks were established some years ago in some hospitals to provide a flexible and more effective solution to sourcing agency nurses.
- The HSE is allowed to decide a limited (but unspecified) number of exceptions to the moratorium without recourse to the Department. Partial details on the exceptions granted have been supplied by the HSE, but a full report is awaited. This facility is subject to overall compliance with the framework.

Brief on Pensions
February 2011

- All public health sector pension schemes are defined benefit schemes with pension based on final salary (maximum of 40 years service). They operate on a pay-as-you-go basis – that is they are funded from annual revenue funding. There are four main schemes and a number of smaller schemes. The four main schemes, as follows, have a total membership of approximately 140,000 members. The HSE scheme accounts for over 65% of the total.

Scheme
Voluntary Hospital Superannuation Scheme
Nominated Health Agencies Superannuation Scheme
Local Government Superannuation Scheme
Health Service Employee Superannuation Scheme

The current issues include:

Targeted Voluntary Early Retirement (VER) and Voluntary Redundancy (VR) Schemes.

In early November 2010 the Government decided to make funding available for a voluntary early retirement scheme and a voluntary redundancy scheme for certain categories of staff in the public health service. The purpose of these two schemes was to achieve a permanent reduction in the numbers employed in the public health sector from 2011 onwards and to facilitate public health reform. The VER and VR schemes were open to employees in the 'Management and Administration' and the 'General Support Staff' categories within the public health sector.

Uptake
The HSE have advised that final uptake is in the region of 2,006 individuals (1,742.82 WTE) however this is subject to minor adjustment as queries are finalised etc. In addition there are 19 individuals (17.88 WTE) currently on maternity leave who have the option to avail of the scheme on their return.

The most recent detailed information in respect of the 2,006 individuals who have departed from the health service is as follows; 640 departed under the voluntary early retirement scheme and 1,366 availed of the voluntary redundancy scheme.

Of the total; 1,334 have exited from Management / Administration grades while the remainder (672) is from General Support Staff grades.

1,409 were HSE employees while the balance (597) was employed in voluntary hospitals, disability organisations etc.

Costs / Savings
The most recent information available from the HSE indicates that the cost of the schemes in 2010 is approx. €100.4m, subject to some minor adjustment as cross checks are completed.

Gross salary savings in 2011 are estimated to be €74m approximately (of which €32.5m VER and €41.5m VR) while 2011 pension costs under the VER scheme are expected to be approximately €14m.

Incentivised Scheme of Early Retirement (ISER)

In October 2010 the HSE and other health service employers undertook a review of eligible ISER applications which were originally refused / refused on appeal for stated business reasons. The reviews had to be completed and all decisions communicated no later than 31 December 2010. Applicants approved under this process must retire no later than 31 January 2011. In total approximately 370 health sector applications were reviewed by the relevant employers. The HSE will shortly confirm the number of applications approved under this review process.

ISER - Historical

In February 2010, approval was given to the HSE to lift the suspension on the Incentivised Scheme of Early Retirement (ISER) in the public health sector, on a restricted basis.

The ISER did not apply to grades exempted from the moratorium on recruitment and promotions under the 2009 Employment Control Framework for the Public Health Sector in order to meet the requirements of integrated health care delivery and, in particular, to address needs in the community in respect of care of the elderly and people with disabilities. Members of all other grades who met the eligibility criteria and were approved by the closing date for the scheme were facilitated to exit the system up to 31 March 2010. This sanction was subject to the following conditions:

- that the employees concerned retire not later than 31 March 2010;
- that the posts concerned will be suppressed and that the HSE will monitor the situation to ensure that they remain unfilled;
- that the conditions of the scheme in relation to future re-employment (set out in this Department's Circular No. 8/2009 dated 15 May 2009) are strictly adhered to.

260 employees had their application to leave under this scheme approved.

Number of retirees

Data in relation to retirements across all pension schemes is not available but figures in respect of the HSE (largest employer) are representative. The number of persons who retired in 2009 in the public health sector rose considerably over previous years.

2007	1,393
2008	1,787
2009	2,609

The HSE provisional estimate for 2010 is in the region of 2,600 retirements.

In his December 2009 budget, the Minister for Finance announced that public sector employees who retired on or before 31 December 2010 would have their pension benefits calculated by reference to the scales applying on 31 December 2009, with

incremental credit on th ose scales if appr opriate. The Public Se rvice Pension Rights Order (SI 302 of 2010) extende d by one year the period in which the superannuation benefits of retiring public servants will be unaffected by the pay reductions set out in the Financial Em ergency Measures in the Public Interest (no 2) Act, 2009. This deadline was further extended to February 2012 in the December 2010 budget so as to prevent a log jam of public service retirements in 2011 and to spread the extra pension lump sum costs over a more manageable period in both 2011 and 2012.

[redacted]

The above italic ised and bolded material should not be released and is exempt under Sections 20 (1) and 21 (1)(c) of the FoI Act

Rationalisation of HSE subsidiary Companies

Update on Progress

The former health board s established companies some years ago to pro vide for the delivery of a variety of health and personal social services. In 2007, the Departments of Health and Children (DoHC) and Finan ce (DoF) made a policy decision that the companies should no longer be used to provide ancillary health services outside of the HSE structure. It w as proposed that those companies be wound up. A total of nine com panies with 1,351 (W TE 527.52) empl oyees have been identified by the HSE (December, 2010).

While there are a num ber of complex legal and HR issues to be addressed as part of this process, significant progress has been made in 2010. The Department is working closely with the HSE, in conjunction with the DoF and other stakeholders, towards resolution of the issues. DoF sanction was received in the third quarter of 2010 i n relation to the subsum ing of one of the companies (Eastern Community W orks Ltd) into the HSE. [redacted] The latter equates to a total of 491.64 (WTE) posts transferring into the HSE. Work is ongoing in relation to the remaining companies and the project overall.

The above italic ised and bolded mate rial should not be released and is exempt under Section 20 (1) of the FoI Act

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The above italic ised and bolded material should not be released and is exempt under Section 20 (1) of the FoI Act

Health Agencies (other than HSE)

1 Agency allocations and staffing

There are currently 24 health agencies under the aegis of this Department. Of these, 21 agencies employing some 1500 whole time equivalents currently report to this Department for the purposes of the Employment Control Framework (ECF)**.** The table below outlines the staffing levels and funding arrangements for these bodies. The Minister appoints Board members to each of these agencies.

Agency	Allocation € (m)	Staffing (WTE)
Adoption Authority	3.5	28
An Bord Altranais	Self funding	41
Dental Council	Self funding	5
Food Safety Authority of Ireland	16.6	80
Food Safety Promotions Board	6.0	33
Health and Social Care Professional Council	1.4	5
Health Information Quality Authority	11.7	152
Health Insurance Authority	Self funding	9
Health Research Board	32.3	72
Irish Blood Transfusion Service	Self funding	553
Irish Medicines Board	3.3	256
Medical Council	Self funding	50
Mental Health Commission	15.0	39
National Cancer Registry Board	2.8	49
National Council for the Professional Development of Nursing & Midwifery	1.7	12
National Social Work Qualifications Board	0.5	7
National Treatment Purchase Fund	85.6	47
Office of the Ombudsman for Children*	2.1	10
Opticians Board	Self funding	2
Pharmaceutical Society of Ireland	Self funding	24
Pre-Hospital Emergency Care Council	3.0	16
Institute of Public Health*	1.2	
Children's Acts Advisory Board+	0.5	

Drug Treatment Centre Board+	HSE funded	

*The Minister does not appoint members to the Boards of these agencies.
+These bodies are due to be subsumed in early 2011.

2. Employment Control Framework

Background
The ECF for the health sector NCSAs envisages an overall net reduction in the numbers employed in these bodies of at least 128 in the period 2011-2014, or an annual average of 32. This reduction is being achieved through the application of the moratorium on the filling of public service posts by recruitment, promotion and acting appointments.

The allocations for pay in the grant to each of the NCSAs will be adjusted in each financial year to reflect the savings (current year and full year) which will flow from the application of the framework in each body.

Implementation
Within the overall employment ceilings for health sector NCSAs, the Department may, on foot of a written application from the body concerned, exempt the following grades from the moratorium on recruitment:

- Chief executive officer posts and other posts specified in statute to carry out an essential statutory function; and
- Professional and technical grades involved in essential frontline inspection and welfare services.

There is also a mechanism in place where proposals for the filling of a post on exceptional grounds will be considered through the redeployment of a member of staff of the same or equivalent grade from another post, or the simultaneous suppression of another or a number of other posts of equivalent salary value to the post being proposed for filling.

Progress to date
- Nine of the bodies reported a reduction in staff over the course of 2010.
- Certain other bodies (Health Information and Quality Authority, the Pharmaceutical Society of Ireland and the Health and Social care Professionals Council) are increasing their staffing numbers in order to undertake additional statutory responsibilities.
- While some approved vacancies remain to be filled, the 2010 target reduction of 20 WTE was met.

Policy Issues
A survey of agency staff carried out in 2010 for the first iteration of the Employment Control Framework which covered the period 2010-2012 indicated that the then target of 60 could be met or exceeded. A further survey will be required to determine if the revised ECF target of 128 can be achieved over the period 2011-2014 based on the moratorium alone.

3. Implementation of the Croke Park Agreement

Background

In October 2010 the Department invited each agency to consider the Public Service (Croke Park) Agreement and to complete an Action Plan outlining their response. Details of the most significant actions / savings were then submitted to the Department of Finance. The second iteration of the agency Action Plans have now been received and forwarded to the Implementation Body.

Proposed actions

Several actions were commonly proposed across the agencies in response to the Agreement: commitment to fair and open competitions for recruitment / promotion, enhanced monitoring and management of sick leave, expansion of Electronic Funds Transfer for payments to suppliers, tighter controls on procurement / renewal of service contracts, greater use of websites etc.

A number of agencies have expressed an interest in exploring options for shared services and procurement with other agencies. Existing examples of this include the Mental Health Commission which currently provides a shared accounting service with the Office of the Disability Appeals Officer. Other innovative proposals include the outsourcing of particular functions and the wider sharing of audit information. The Forum of Chief Executives of Health Regulatory Bodies might provide an opportunity to consider this type of inter-agency working. The Forum, which was established in 2008, aims to provide a mechanism for exploring opportunities to harmonise certain business processes, share best practice and facilitate coordination where appropriate between member organisations.

4. Agency Rationalisation

Background

Arising from the Government decision of 8 July 2008 on expenditure measures, a comprehensive programme of agency rationalisation is being implemented across the public service.

This Department's measures for the rationalisation of agencies within the health sector have been prepared primarily in the context of the OECD's recommendations for a more integrated public service. The measures reflect and build upon the progress to date with agency rationalisation within the sector under the overall health reform programme, and take account of experience to date with the practicalities of rationalisation.

The implementation of the rationalisation programme will mean that, the number of health agencies will decline from 34 to 19 agencies. The Department's main focus to date has been and continues to be the progressing of a significant legislative programme required to facilitate the roll out of this rationalisation programme. Each agency must be dissolved and rationalised by way of Primary Legislation.

It had been originally planned to merge the FSAI and IMB but following a Memo to Government in 2010 it was agreed that both should remain stand alone agencies.
Six bodies have been dissolved to date as follows:

Agency	*Dissolved\Merged*	*Date*
National Council on Ageing & Older People	Dissolved and subsumed into DoH&C	1 September 2009
Women's Health Council	Dissolved and subsumed into the Department of Health and Children	1 October 2009
Postgraduate Medical and Dental Board	dissolved and subsumed into HSE	1 January 2009
Crisis Pregnancy Agency	Dissolved and subsumed into HSE	1 January 2010
National Cancer Screening Services Board	Dissolved and subsumed into HSE	1 April 2010
Office of Tobacco Control	dissolved and functions transferred to the HSE	1st January 2011

Plans are underway to rationalise a further seven bodies as follows:

Agency	*Current Position*	*Due Date*	*Next Steps*
Drug Treatment Centre	Currently being dissolved and subsumed into HSE	1st April 2011 (Provisionally)	
National Council for the Professional Dev. of Nursing and Midwifery	To be dissolved and subsumed into An Bord Altranais.	During 2011	Enactment of the Nurses and Midwives Bill 2010 lapsed with the dissolution of the Dail
National Cancer Registry Board	To be dissolved and subsumed into HSE	1 January 2012 (Provisionally)	Awaiting enactment of the Health Information Bill
National Social Work Qualification Board	To be dissolved and subsumed into Health & Social Care Professionals	1st Quarter 2011	Expected Q1 2011
Pre-Hospital Emergency Care Council	To be subsumed into the Health and Social Care Professionals Council	Provisionally 2011	Health Miscellaneous Provisions Bill to be drafted
Opticians Board	To be subsumed into the Health and Social Care Professionals Council	To be confirmed (Provisionally 2011)	Health Miscellaneous Provisions Bill to be drafted
Children Acts Advisory Board	Subsumed into the Office of the Minister for Children and Youth Affairs on an administrative basis	May 2011 (Provisionally)	Enactment of Child Care (Amendment) Bill 2009 lapsed with dissolution of the Dail

The implementation of the rationalisation programme will mean that, including the HSE and two North/South bodies, **there will ultimately be 19 agencies in the health sector:**

- HSE, Adoption Board, Office of th e Om budsman for Children, N ational Treatment Purchase F und, Health Res earch Board, Irish Blood Transfusion Service and the National Haemophilia Council;
- Food Safety Prom otion Board and the Ins titute of Public Health (both North/South bodies);
- Five professional regulators : the Medical and D ental Councils, Bord Altranais, Health & So cial Care P rofessionals Council, Ph armaceutical Society of Ireland, and
- Five other regulators: HIQA, Mental Health Commission, Food Safety Authority of Ireland, Irish Medicines Board and Health Insurance Authority.

Brief for new Minister

Head Shops and Misuse of Drugs legislation

1 Control of 'legal highs' on sale in 'head shops'

The Government made an Order under the Misuse of Drugs Act in May 2010 declaring over 200 substances which had been on sale in 'head shops' to be controlled drugs for the purposes of the Misuse of Drugs Acts, 1977 and 1984.

The substances concerned included:

- synthetic cannabinoids (SPICE products)
- benzylpiperazine (BZP) derivatives
- mephedrone, methylone and related cathinones
- GBL and 1,4 BD.

The Criminal Justice (Psychoactive Substances) Act 2010 came into force in August 2010. It is now a criminal offence to sell or supply substances which may not be controlled under the Misuse of Drugs Acts but which have psychoactive effects.

Since these measures were taken, the number of head shops selling 'legal highs' has reduced from over 100 to around 20.

New psychoactive substances have emerged such as 'Whack' and 'Amplified'. The Department has been working closely with the Department of Justice and Law Reform, the Gardaí, the Customs Service, the Forensic Science Laboratory, the IMB and others with a view to bringing these substances under control. The Department will seek Government approval shortly to ban additional substances under the Misuse of Drugs Act 1977.

2 Suboxone Feasibility Study

A feasibility study on the use of Suboxone as an alternative to methadone for the treatment of opiate dependency has been completed. The prescribing/dispensing at the study sites is being evaluated with a final report due shortly. On completion of the evaluation, an Expert Group is expected to make recommendations regarding the circumstances and patient cohorts in which Suboxone would be most appropriate and the regulatory and operational framework that should apply.

3 Cannabis-based medicinal products

A cannabis-based medicinal product (Sativex®) was recently authorised in the UK and Spain as an add-on treatment for symptoms of spasticity due to multiple sclerosis. No product has sought authorisation as yet in Ireland.

Currently, the use of cannabis or cannabis extracts is prohibited under the Misuse of Drugs Act 1977, except for the purposes of research. Expert clinical advice is being sought by the Department on the use of cannabis-based medicinal products. Initial contacts indicate that the evidence base for the authorisation of cannabis-based medicinal products has not been demonstrated as yet.

4 Article 75 of Schengen Agreement

Article 75 of the Schengen Agreement allows persons travelling within the EU to carry their legally prescribed narcotic or psychotropic drugs for medical use. Ireland is not at this time a full party to the Schengen Agreement but intends to participate in certain provisions of the Agreement, including Art 75, subject to a range of appropriate procedures and arrangements being implemented. The Department of Justice and Law Reform has informed this Department that we should take the necessary measures to give effect to Article 75.

The most significant issue in order to implement Art 75 relates to persons travelling within the EU carrying cannabis products for medical use which have been legally prescribed in other Member States. Under Irish law currently, it is not permissible to import cannabis into Ireland. To give full effect to Article 75 it would be necessary to put in place a legal mechanism to retain the prohibition on the importation of cannabis while permitting EU travellers to import legally prescribed cannabis products. This will be examined by the Department during the current year.

5 Additional Controls on Benzodiazepines

There is a requirement on Ireland arising from a United Nations resolution to introduce import/export controls on benzodiazepines. This requires an amendment to the Misuse of Drugs Regulations and it is intended to do so in 2011. It will also be necessary to create an offence of unauthorised possession of a benzodiazepine.

In addition, the Department is receiving increasing evidence of the inappropriate use of benzodiazepines in Ireland. This may necessitate the introduction of additional legislative controls on the prescribing of benzodiazepines.

6 Various amendments to the Misuse of Drugs legislation

Various amendments are planned to be made to the Misuse of Drugs legislation in 2011 as follows:

- Introduce controls on the use of Anabolic Steroids
- Introduce an exemption for methadone prescriptions from certain hand-writing requirements
- Technical amendments relating to nurse prescribing of certain controlled drugs.

Briefing for New Minister on Health Behaviours

Department's Role

The Department's role on Health Promotion is to develop policies and to support efforts to create greater awareness of the positive impact healthy lifestyles can have and to identify measures that could be put in place to make it easier for people to adopt healthy lifestyles. In practical terms this means seeking to reduce smoking and alcohol consumption levels, encouraging people to maintain a healthy weight by eating a healthy diet and by being physically active.

The Importance of Health Behaviours

For many years, the health of Irish people has improved and mortality from the major diseases has reduced due to better treatment and prevention. This window is, however, slowly closing. In Ireland, as in other countries, chronic health conditions such as diabetes and high blood pressure are on the rise. Our ageing population, together with adverse trends in obesity, diet, exercise and other risk factors mean that the level of chronic health conditions will certainly increase. If the experience of other countries is replicated, more than one third of our youth and adult population will have one or more chronic health conditions within the next 10 years. Within the next decade, the burden of chronic disease will be significantly more pronounced and the capacity of the health system will be severely stretched.

Health promotion is the process of enabling people to increase control over and to improve their health. Health promotion activities are targeted for specific populations or health issues and can work in different settings. In recent years, the health system has focused more on treatment and care as a result of the need for greater efficiencies in the acute services sector.

It is acknowledged that more needs to be done on the upstream determinants of health and to emphasise prevention as a means to reducing chronic diseases and emerging health inequalities.

The Health Promotion Policy Unit will play a key role in the **Public Health Review** to be conducted in 2011. This will address the broad determinants of health and health inequalities through our health services, community and education settings. It is anticipated that the review will identify a number of key lifestyle policy issues such as smoking, alcohol and obesity wherer further action is required. The review will describe the approaches and priority objectives and actions under key lifestyle headings so as to improve health, reduce inequalities, disease and costs on the health system.

Smoking

Smoking is the leading cause of preventable mortality, causing 6,500 deaths every year. Advances have been made with regard to smoking and smoking control in Ireland in recent years. In March, 2004 the workplace ban on smoking was introduced in all places of work, including licensed premises. The continued prevalence of smoking in the population and the negative impact on health continues

to be a major cause of concern, particularly in relation to young people. The Department is currently undertaking a review of tobacco policy and has established a small group comprising of the Department, the Health Service Executive and the Office of Tobacco Control to develop proposals on what further measures might be taken to reduce initiation and prevalence of smoking in Ireland.

Measures to be considered by the Review Group include the need for enhanced tobacco control measures, improved cessation services, price increases and educational and awareness programmes. International evidence consistently highlights price increases as the most effective way to reduce smoking rates. The report of the Review Group will be submitted to the Minister upon completion later this year.

Alcohol Policy

The level of alcohol consumption in the population and the particular pattern of drinking (binge drinking) continue to be a public health concern. In March 2009 the Government agreed to include alcohol in a ***National Substance Misuse Strategy***. A Steering Group has been established to develop proposals for an overall National Substance Misuse Strategy that will incorporate the already agreed drugs policy element. The Steering Group is being jointly chaired by the Department of Health and Children and the Department of Community, Equality and Gaeltacht Affairs. The Group is examining a wide range of issues in relation to alcohol policy such as pricing (including below-cost selling and minimum pricing), supply and availability treatment, prevention, marketing and sponsorship. The Steering Group is working towards completing its work in the first half of 2011.

Obesity

The National Taskforce on Obesity Report 2005 recognised that a multi-sectoral approach is necessary, to implement all of the Report's recommendations. While the report of the Intersectoral Group on the Implementation of the Recommendations of the National Taskforce on Obesity found significant progress, at both national and local level had been made in implementing the NTFO's recommendations, it also recognised the need for continued and concerted action to halt the rise in the levels of overweight and obesity. The Group gave some consideration to key priority areas for action in the short to medium term and considered that measures to increase physical activity among children was of fundamental importance as was the need for continued awareness programmes about the dangers of excessive consumption of foods high in fat, sugar and salt and of the benefits of regular exercise.

The food pyramid and national healthy eating guidelines are currently being reviewed and a revised version is to be issued by the Department in the coming months.

The Department is also working with other departments on the National Sustainable Development Strategy which is bringing together policies on the environment, transport, education and health.

It is anticipated that the **Public Health Review** will identify a number of priority areas for action in the coming months.

Health Promotion Policy Unit

February 2011

Briefing for new Minister - Health Protection

The overall objective of the Health Protection Unit is to develop policy and suitable legislative framework to support public health protection through: control of infectious diseases; national immunisation and vaccination programmes; appropriate national public health emergency planning (including pandemic influenza); contributing to EU and WHO health protection policy development; and monitoring the implementation by the HSE of all such policy and legislation.

Notifiable Infectious Diseases

The 1947 Health Act entitles the Minister for Health and Children to specify by regulation the diseases that are infectious diseases and covered by legislation. The current regulations are contained in the 1981 Infectious Diseases Regulations, which were revised on nine occasions between 1985 and 2007.

On 1st July 2000, the Infectious Diseases (Amendment) Regulations, 2000 (S.I. No 151 of 2000) came into force. Under these regulations, as amended by S.I. No. 865 of 2004, the Health Protection Surveillance Centre was assigned responsibility for the collation and analysis of weekly notifications of infectious diseases, taking over from the Department of Health and Children.

On 1st January 2004 a major revision to the regulations came into operation. S.I. No. 707 of 2003 established a revised list of notifiable diseases and introduced a requirement for laboratory directors to report infectious diseases. As soon as a medical practitioner becomes aware of or suspects that a person on whom he/she is in professional attendance is suffering from or is the carrier of an infectious disease, or a clinical director of a diagnostic laboratory as soon as an infectious disease is identified in that laboratory, he/she is required to transmit a written or electronic notification to a Medical Officer of Health.

The Scientific Advisory Committee (SAC) of the Health Protection Surveillance Centre (HPSC) is currently reviewing the list of notifiable diseases with a view to bringing forward proposals for an updated list. When this exercise is completed it is proposed to revise the list and consolidate the Infectious Diseases Regulations.

An expert group is currently being established to review Part IV of the 1947 Health Act in relation to infectious diseases, including Section 38 which provides for the detention and isolation of persons who may be a source of infection.

H1N1 Pandemic

A public health alert was received from the World Health Organisation on 24 April 2009 indicating that human cases of Pandemic (H1N1) 2009 virus infection had been identified in the US and in Mexico. The WHO pandemic alert level was raised to phase 6 on 11 June, i.e. in effect the WHO declared a pandemic. Once the Pandemic was declared the Department of Health and Children and the Health Service Executive implemented plans to deal with the pandemic.

A national review of the response to the pandemic here in Ireland has been commenced jointly by the HSE and the Department of Health and Children and it is planned to have an Outbreak Report and an evaluation of the pandemic response completed by mid 2011. At European level the Commission and the EU Member States have set up a number of evaluation processes on the national and EU response

to the H1N1 Pandemic. The WHO has also initiated a review process. It is expected that these EU/WHO Reviews/evaluations will also be completed in the first half of 2011.

2010/2011 Seasonal Flu

The Swine Flu virus that spread around the world during 2009 and 2010 is now part of the winter flu that we are seeing in 2011. Based on advice from the World Health Organisation (WHO), this year the seasonal flu vaccine contains three common flu virus strains, including the Pandemic H1N1 (swine flu) strain. Unlike last year, because the swine flu virus strain is included in the seasonal flu vaccine only one flu vaccination is required this year. Current developments are as we expected.

Influenza activity in Ireland peaked for the 2010/2011 season during week 1 of 2011 and is now declining slowly and it is expected that it will continue to decline. To date (23rd February 2011) this season 905 confirmed influenza cases (596 were A H1N1) have been hospitalised and 120 cases have been admitted to ICU. There have been 23 influenza associated deaths reported to date this season of which 14 were influenza A (H1N1). Eighteen deaths occurred in patients with underlying medical conditions.

The number of mortalities in the weekly report is compiled from deaths where influenza is listed as a contributory cause of death on the death certificate. It is expected that some additional deaths, which have not yet been formally notified as influenza associated deaths, pending the issuing of death certificates by coroners, may be reported in the coming weeks.

HPV Vaccination

Infection with Human Papillomavirus (HPV) is the main cause of cervical cancer. HPV is transmitted mainly through sexual contact. A national HPV vaccination programme commenced in May 2010 in secondary schools for girls in first year. During 2010 all girls in second year and those who entered first year in September were offered vaccination. The programme will continue with the vaccine being offered to all girls in first year in secondary school each year.

Primary Childhood Immunisation Programme

The objective of the Primary Childhood Immunisation Programme is to achieve an uptake level of 95%, which is the rate, required to provide population immunity and to protect children and the population generally from the potentially serious diseases concerned. Ireland's recommended immunisation programme is based on policy advice from the National Immunisation Advisory Committee (NIAC) of the Royal College of Physicians of Ireland. NIAC guidance is published and distributed to all general practitioners and physicians involved in immunisation.

The HSE has initiated and continues to implement measures to address areas where uptake is low which include an information campaign to remind Allied Health Professionals and parents of the vaccination schedule and increase awareness of the availability of the vaccine.

The Department has got agreement from the Department of Finance to undertake a Value For Money assessment of Immunisation Programmes to be completed by end 2011. The main objective of this review is to carry out a systematic analysis of the national immunisation programmes currently funded through the Exchequer and secure improved efficiency and effectiveness in this regard. In order to achieve these objectives it is intended to examine Government policy on immunisation as well as implementation of the immunisation programmes.

The scope of the project is confined to the major national immunisation programmes as opposed to other programmes such as occupational immunisation programmes. The programmes to be examined are:

(a) the Childhood immunisations (e.g. MMR, BCG);
(b) the Seasonal Flu vaccine; and
(c) the HPV vaccine.

International Health Regulations

The International Health Regulations (IHR), 2005 were formally adopted at the 58th World Health Assembly in 2005. The purpose and scope of the Regulations are to 'prevent, protect against, control and provide a public health response to the international spread of disease in ways commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade'. The IHR refer to among other issues global public health response to natural occurrence, accidental release or deliberate use of biological and chemical agents or radionuclear material that affect health with a view to responding to the need to ensure global public health.

The Regulations came into force in June 2007 and place certain legal requirements on all States. In particular, the Regulations provide that –

"Each State Party shall assess, within two years following the entry into force of these Regulations for that State Party, the ability of existing national structures and resources to meet the minimum requirements described in this Annex. As a result of such assessment, States Parties shall develop and implement plans of action to ensure that these core capacities are present and functioning throughout their territories"

The Department of Health & Children as the lead organisation responsible for the implementation of the IHR has identified both the strengths and weaknesses of our current structure and capacity to respond to a public health emergency of international concern. In particular the Department has identified the need for more formal structures between the key agencies responsible for threats of a chemical, biological and radiation nature, and the health service. The Department is also recommending that gaps in legislation are both adequately identified and addressed so that it is clear who takes overall lead in the preparation for, the identification and response to, public health emergencies of international concern and how different agencies will work together during a public health emergency of international concern (PHEIC).

The Department has established an IHR Implementation Group to ensure that Ireland has the core capacity to meet fully its obligations under the Regulations.

Non-Cancer Screening

A policy framework in relation to non-cancer screening is being developed. This will include governance arrangements with the HSE for neo-natal screening and cystic fibrosis screening.

Health Research

Health research is a key factor in promoting the health of the population, combating disease, reducing disability and improving the quality of care. It is fundamental to the effective and efficient delivery of health services bringing to bear learning from international best practice and appropriate evaluation techniques and application.

It also plays an important role in the knowledge economy, contributing to Ireland's international competitiveness and economic growth. '***Building Ireland's Smart Economy – A Framework for Sustainable Economic Renewal***', outlined a programme for medium-term economic recovery based around the concept of the Smart Economy. One of the commitments therein was that "*an Action Plan for Health Research would be developed in order to exploit the opportunities for stronger linkages between our health sciences and related Foreign Direct Investment and indigenous sectors such as medical devices and bio-pharma*".

The ***Health Research Group*** (HRG) was established by the Minister for Health & Children and the Minister for Enterprise, Trade & Employment in 2007 under the auspices of the Inter-Departmental Committee for the Strategy for Science, Technology and Innovation (SSTI) [1]. Its main purpose was to ensure that health research in Ireland was coordinated, prioritised and focussed and that national policies and strategies for health research were framed strategically in the context of the wider science, technology and innovation agenda. The HRG is chaired by the Department of Health & Children.

In 2009 the ***Action Plan for Health Research 2009-2013***, prepared by the Health Research Group, was launched. The Plan provides the lead on national priorities and resources allocation in health research.

Current Position
The Plan is in implementation phase and Subgroups/Work Streams have been established under the Health Research Group to ensure that actions planned for implementation over the lifetime of the Plan 2010-2013 are carried out on time.

Significant progress was made in 2010 in implementing the most immediate actions.

The first Action Plan Annual Report (2009-2010) is being finalised. It is intended that a seminar will be held by mid 2011 to which all relevant stakeholders (academia, industry, health sector etc.) will be introduced to, and updated on, the work of the HRG and health research in Ireland.

It is hoped that the Minister might launch the report and address the seminar.

Health Research Board
The Health Research Board (HRB) is a statutory body under the aegis of the Department of Health & Children with a mission to improve health through research and information. Its functions include promoting, assisting, commissioning or

[1] key statutory stakeholders in health research in Ireland are represented on the Group

conducting medical, health, epidemiological and health services research. The Board co-operates with other research bodies in Ireland and elsewhere in promoting, commissioning or conducting relevant research. It is also important that the HRB has a close working relationship with the HSE in order that research is aligned with the priority health needs of the population.

The HRB is the lead agency in Ireland supporting and funding health research. It provides funding, maintains health information systems and conducts research linked to national health priorities. The aim is to improve people's health, build health research capacity and make a significant contribution to Ireland's knowledge economy.

[redacted]

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[redacted]

Human Tissue and Organ Donation

Key Points

Hospitals have considerably improved their practices in relation to the post mortems and retention/disposal of human tissue. This follows publicity some ten years ago where hospitals were found to have retained the organs of children following post mortem examinations.

There has also been increased emphasis on promoting donation of organs for the purposes of transplantation.

The Heads and General Scheme of a Human Tissue Bill to deal with these areas have been prepared. The Bill is designed to regulate the removal, retention, storage, use and disposal of human tissue from deceased persons and consent for the use of donated tissue from living persons for the purpose of transplantation and research.

Post-Mortem Practice and Procedures

Reports on the best practice in relation to post mortems and organ retention were prepared by Dr. Deirdre Madden in 2002, and progress in implementation was reviewed by Michaela Willis in 2009. The Willis report showed very good progress made by the HSE in implementing national guidelines in hospitals across the country. The Department will continue to liaise with the Executive to evaluate progress in this regard.

EU Directives on Quality and Safety of Tissues & Cells

EU Directives on Quality and Safety of Tissues and Cells lay down standards of quality and safety for human tissues and cells which are intended for human applications. They apply to the donation, procurement, testing, processing, preservation, storage and distribution of human tissues and cells when intended for human applications. They also apply to manufactured products derived from human tissues and cells intended for human applications.

The Irish Medicines Board is the competent authority under the Regulations which transposed the Directives. All tissue establishments require authorisation by the IMB to carry out their activities and are subject to regular inspections.

Organ Donation & Organ Transplantation in Ireland

Ireland has an above average rate of organ donation relative to other EU countries. In 2009, the rate was 20 organ donors per million population. There were a total of 90 donors in 2009 and this led to a total of 261 organs being transplanted. The total number of donors and transplants since 2003 were:

	2003	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**
Total Number of Donors	86	89	76	91	88	81	90
Total Number of Transplants	187	206	205	234	223	224	261

Efforts to improve organ transplantation from deceased persons generally centre on trying to increase donation rates. There is much debate, for example, on whether consent to organ donation should be expressly required ('opt-in') or assumed unless specifically refused ('opt out'), or some variation of this. While this issue is important, evidence from other countries indicates that good co-ordination at hospital level and counselling arrangements for relatives are the key to high donation rates, irrespective of the system of consent. The Human Tissue Bill will deal with this issue.

EU Directive on Standards of Quality and Safety of Human Organs intended for Transplantation

An EU Directive on standards of quality and safety of human organs intended for transplantation is due to be transposed by August 2012. The Directive seeks to ensure that a set of minimum health and safety standards for human organs intended for transplantation is in place in all Member States and aims to reduce the risk of infectious diseases being transmitted to the organ recipient and to enhance the efficiency of exchanging organs between Member States.

Strategic Issues

The Department would suggest that preparation of a Human Tissue Bill and transposition of the EU Directive above should be the key priorities in this area.

March 2011

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Briefing Note for Minister
Medicines

Department's role

This Department is responsible for the development of policy with regard to medicinal products, cosmetics and poisons. This is a highly regulated area and the preparation of legislation, both primary and secondary, is an ongoing task. The Department works in close cooperation with the Irish Medicines Board.

Irish Medicines Board

The IMB is the statutory agency responsible for the regulation of human and veterinary medicines, cosmetics and clinical trials in Ireland. It is also the Competent Authority for the implementation of EU and national legislation relating to blood and blood components, tissues & cells and medical devices.

The IMB assesses applications to market medicines in Ireland and also participates in the assessment of applications made under the pan- EU system. The Board monitors the quality of medicines by conducting inspections at sites of manufacture and distribution of medicines and by random sampling of products both pre and post authorisation. It also monitors the type and frequency of any reported side-effects.

The IMB obtains most of its income through fees collected from industry. In 2010, total estimated expenditure was €25.5 million of which estimated €22 million was collected in fee income. The IMB is moving towards becoming a fully funded by industry. In 2010 enforcement activities became fully funded by industry. By end of 2011 controlled drugs and tissue monitoring activities will be similarly funded. By end of 2012 when medical device activities become funded by industry, the IMB will have achieved full self financing.

Transposition of EU Directives

In 2010, the Department transposed eight EU Directives relating to cosmetics. The majority of the amendments were technical in nature.
One EU Directive relating to medicinal products was also transposed. It concerned the control of advanced therapy medicinal products based on genes (gene therapy), cells (cell therapy) and tissues (tissue engineering). These advanced therapies herald revolutionary treatments of a number of diseases or injuries, such as burns, Alzheimer's disease, cancer or muscular dystrophy

Cosmetics

The cosmetics industry in Ireland is a large employer with a number of leading international companies based here. Responsibility for cosmetics safety transferred from this Department to the Irish Medicines Board on 1st October 2010. As well as improving levels of safety for the public, a strong Competent Authority will enhance the attractiveness for industry in locating in the State.

Recast of Cosmetic Regulations
This Regulation entered into force in January 2010 and the majority of its provisions will be enacted in July 2013. The aim is to codify, simplify and update existing provisions and to provide for harmonised notification of cosmetic products placed on the EU market. Another key goal is to ensure a higher level of consumer protection.

Current Issues

Pharmaceutical Package
In December 2008, the EU Commission published 3 legislative proposals (referred to as the Pharmaceutical Package). The three proposals are:

(a) The 'Pharmacovigilance' Proposal
Pharmacovigilence relates to the detection, assessment, understanding and prevention of adverse effects of medicinal products. An EU Directive and Regulation was published in December 2010. Transposition of the Directive into national law must be completed by July 2012. The overall aim is to update and streamline current practices and procedures in order to improve overall patient safety.

(b) The 'Falsified Medicines' Proposal
This was approved by the EU Parliament in February 2009 with an 18 month transposition period. It aims to better protect EU citizens from the serious threats posed by falsified medicines.

(c) The 'Information to Patients' Proposal
The overall principle of the proposal is to lay down clear rules on how information on prescription only medicines may be provided to patients by pharmaceutical companies. [A **detailed note on this is in Appendix below]**

Ireland's Presidency of the EU, 2013

It is expected that negotiation of the following new Directives will be ongoing during the Irish Presidency of the EU –

(i) New Clinical Trials Directive
The EU Commission is currently engaged in a consultation regarding a review of the EU Directive dealing with the conduct of clinical trials on medicinal products for human use.

(ii) New Medical Devices Directives
The EU Commission is reviewing the medical devices directives. Proposals are likely to focus on market surveillance (safety/performance monitoring), vigilance (adverse incident management), notified body monitoring (certification activities), clinical evaluation and transparency.

Claim for damages in respect of the arthritis drug Aulin
Personal injury actions have been commenced by three individuals against a number of parties including the Minister and the IMB claiming, inter alia, that the Minister and the IMB failed to use due care in authorising the arthritis drug Aulin (Nimesulide). The plaintiffs suffered liver damage and claim that this was due to taking the drug.

Aulin was initially authorised for the Irish market in 1995 by the Minister on the advice of the IMB's predecessor, the National Drugs Advisory Board. The IMB assumed the competent authority function in respect of medicines in January 1996. The IMB suspended the drug from the market in May 2007. One of the cases is at an advanced stage and a draft defence is currently being prepared by Counsel acting on behalf of the Minister.

Labelling – language requirements
An Coimisinéir Teanga has raised the issue of whether labels and package leaflets accompanying medicinal products should be provided in both English and Irish. Legal advice received by the Department indicates that the relevant EU Directive requires labelling and packaging in Irish **and** English. The Department has concerns that the additional costs involved for manufacturers and/or retailers may results in some products being withdrawn from the Irish market. The Department is trying to assess this risk in consultation with the IMB.

Appendix

EU proposals on the provision of information to patients regarding prescription-only medicines

1. Key provisions of the "Information to Patients" Proposal

The Commission has stated that the Information to Patient Proposal aims to ensure that EU citizens have access to reliable information on prescription medicines. The overall principle is to lay down clear rules on how information may be provided directly to patients by pharmaceutical companies. The key provisions are as follows:

(i) Industry to be permitted to provide information "in a different way"

It is proposed that industry would be permitted to provide information on prescription medicines "in a different way" i.e. other than through labelling and patient information leaflets. Member States have argued that this could be used to permit the advertisement of prescribed medicines. Member States are also concerned that, as currently drafted, it may be possible for industry to omit negative information regarding the product.

(ii) Industry to be permitted to "push" information via certain types of media and the internet

The original Proposal also envisages that industry would be permitted to provide information on prescription medicines to patients through the media (except TV and radio), health-related publications and on the internet.

(iii) Member States to "pre-vett" the information to be published by industry

It is proposed that information on prescription medicines would have to be submitted in advance for prior approval to a designated body - in Ireland, this would most likely be the Irish Medicines Board.

2. Position of the Council of Ministers

During discussions in 2009, a large majority of Member States stated that they did not support the Proposal because it did not provide an appropriate mechanism to make objective and unbiased information regarding prescription-only medicinal products available to patients. Some Member States were not prepared to enter into an examination of the Proposal and would not participate in any discussions. Only the UK and Lithuania gave positive views on the Proposal.

The core issues raised by the Member States were that:

(i) There was a lack of distinction between "information" and "advertising. As a consequence Member States were concerned that the Proposal would not be sufficient to prohibit advertising of prescription-only medicinal products to the general public

(ii) The monitoring by national medicines agencies and European Medicines Agency of "information" to be provided by industry was likely to have significant cost and administrative implications,

(iii) Member States are concerned that allowing information on prescription medicines to be provided directly to members of the public would promote brand loyalties and

(iv) Member States expressed concern that information would not be proactively provided regarding older, low-cost medicines which may be as effective as newer more costly treatments.

(v) Member States were concerned that patients should have access to information on prescription medicines that is objective, relevant and evidence-based. Member States considered that EU competent authorities, national health authorities and healthcare professionals are more appropriate as channels for the supply of information on prescription medicines to patients.

3. Position of Parliament

In Sept 2010 the European Parliament Committee adopted its Report on the Proposal. Its main points on the Proposal were as follows:

(i) Change of Emphasis
The Parliament wishes to change the emphasis of the proposal to focus on the rights of patients to have access to information rather than on meeting the pharmaceutical industry's desire to be permitted to provide information. The Parliament is advocating a "pull" principle whereby the public can seek information, but information would not be actively disseminated by industry. The Parliament also proposes a greater emphasis on the role of patient organisations and on healthcare professional's in providing information to patients.

(iii) Limits on advertising
The Parliament is opposed to permitting the industry to make information on prescription medicines available via television, radio or newspapers, magazines and similar publications. The Commission proposal only prohibited information being provided by television and radio.

4. Current Status of the Proposal

The Commission is currently working on a redraft of the Proposal taking into account the Parliament's views. It is expected that a new version of the Proposal will be ready for negotiation at the Council during Spring 2011.

5. Ireland's Position to date

In common with many other Member States, we have concerns regarding many of the proposals in the current text. It is recognised that there is a public desire and need for access to reliable and high quality unbiased information about medicines. The Irish Medicines Board has been progressively working to make patient information leaflets and Summaries of Product Characteristics (prescribing information) publicly available on its website (this is not the case in all Member States). Many patients resort to unregulated sources on the Internet to gain access to information about their medication.

We have indicated that we are open to examine the Proposal and Parliament's amendments to ascertain whether, by amendment of the Proposal or redraft by the Commission, an appropriate legal basis can be achieved for providing the public with better information on prescription medicinal products.

BRIEF FOR NEW MINISTER - MENTAL HEALTH

Key Statistics and Trends

- Over the last decade the number of patients resident in Irish psychiatric facilities has reduced by 33.5%, with numbers falling from 4,230 in 2000 to 2,812 in March 2010.
- Shorter episodes of in-patient care have been achieved and in 2009, 49% of all discharges occurred within two weeks of admission.
- The number of admissions to psychiatric facilities has decreased by 19% during the 10 year period 1999 to 2009.
- Involuntary admissions have reduced by 31%, from 2,830 in 2005 to 1,952 in 2010.
- The number of patients readmitted to hospital has shown a year on year reduction since 2001, from 17,146 in 2001 to 14,223 in 2009. The reduction in readmission levels points to an improvement in community based services.

The above developments are in line with mental health policy outlined in *'A Vision for Change'* (2006) which proposes a new model of service delivery which is patient-centred, flexible, community based and where the need for hospital admission is greatly reduced. An Independent Monitoring Group was appointed to monitor and assess progress on the implementation of '*A Vision for Change'.* The Group is expected to publish its 2010 Annual Report in April/May of this year.

Legislation

The *Mental Health Act 2001* provides a modern legislative framework for the admission, detention and treatment of persons with a mental disorder in compliance with international standards and obligations. The Act provided for the establishment of the Mental Health Commission, the appointment of the Inspector of Mental Health Services and the establishment of Mental Health Tribunals which review, reaffirm or revoke patient detention orders. A fundamental review of the operation of the Act is proposed for 2011.

Funding

Total funding available for mental health in 2010 was c. €970m. Budget 2011 provided special consideration for the mental health and disability sectors, which will ensure a maximum reduction of 1.8% in 2011 for those sectors. The relatively lower reduction, compared to other health sectors, recognises that these services are provided to vulnerable groups.

Innovation funding of €3m was allocated to the *Genio Trust* in 2010*,* through a service level agreement with the HSE, to support the transition from institutional to person-centred models of care for people with mental health difficulties and people with disabilities. A further €2m will be provided to *Genio* in 2011 to further this work. The focus this year will be on the closure of one institution/hospital and increasing the provision of cost effective, family and community based respite care, as an alternative to traditional institutional models.

A further €1m from the Innovation Fund will be provided to fund the expansion of *Jigsaw*, currently in 5 counties, to a further 10 counties. *Jigsaw* is an innovative community based support service for young people, which has been developed by Headstrong and is designed to promote systems of care that are accessible, youth-friendly, integrated, and engaging for young people.

Service User Participation

A key recommendation of '*A Vision for Change'* is the involvement of service users in all aspects of mental health policy, service planning and delivery. The National Service Users Executive (NSUE) was established in 2007 and has developed into a vibrant, independent force in the mental health arena. NSUE recently published its *Second Opinions Report*, a report of a survey of NSUE members. The overall national results were encouraging and the results in respect of some local services indicated extremely high satisfaction levels with the services provided. Awards were presented to the best Community Mental Heath Team - Loughrea/Athenry (85% satisfaction rate), Best Day Facility - Tara Suite, Dunshaughlin (82% satisfaction rate), and most improved service - West Cork Mental Health Services (73% satisfaction rate).

Child and Adolescent Services

The development of child and adolescent services is a priority for the HSE and ongoing improvement in service delivery is reflected in the HSE December Performance Monitoring Report which indicates that

- no. of children seen by the mental health service is up by almost 5%.
- 78% were seen within 3 months of referral - exceeding target by 8%.
- the waiting list has decreased by 3.8%.
- no. of children waiting longer than 12 months has reduced by almost 38%.

There are currently 55 multidisciplinary Child and Adolescent Mental Health teams nationally and further 5 teams will be developed in 2011. Bed capacity for children and adolescents has increased from 12 beds in 2007 to 52 at present. Work is due to commence this year on the second phase of the child and adolescent unit at St. Vincent's Hospital, Fairview which will increase capacity from 6 to 12 beds, providing 58 beds nationally by 2012. Work has commenced on the Linn Dara Child and Adolescent Mental Health Day Facility in Cherry Orchard, Dublin and is expected to be completed by September 2011.

The provision of further child and adolescent beds in the Dublin Mid Leinster region is currently under consideration by the HSE, as is the provision of psychiatric beds in the new Paediatric Hospital. However a recent independent report commissioned by the Mental Health Commission, following a high level of under age admissions to adult facilities in Limerick and Waterford, has suggested that the recommendation in a *Vision for Change* for 108 beds nationally is generous by international standards, particularly in light of the increasing emphasis on the delivery of community based care. In the circumstances questions remain regarding the need for the provision of further child and adolescent beds by the HSE. It is also prudent to consider whether the immediate needs of the Dublin Mid Leinster region could be provided by the independent sector; in this regard initial discussions have taken place between the Department, the HSE and the independent sector.

Hospital Closure Programme

Central to a *Vision for Change* is the closure of the old psychiatric hospitals and the transfer of patients to more appropriate community based settings.

- Acute admissions to St. Brendan's, Grangegorman have ceased and enabling works are underway on the development of a 54-bedded replacement long stay facility as part of the Grangegorman Redevelopment Project.

- Acute admissions to St Senan's Hospital, Enniscorthy have ceased and closure of the long stay accommodation will be completed during 2011/2012, with the implementation of €16m capital investment programme.
- Construction works are due to commence shortly on an acute in-patient psychiatric unit at Beaumont Hospital to replace the unit at St. Ita's, Portrane.
- A residential unit is under construction in Clonmel; community services are being developed which will provide alternatives to in-patient admissions and enable the mental health service in South Tipperary to be remodelled.
- The Community Nursing Unit, Ballinasloe was recently commissioned; no patients remain in the main campus of St Brigid's Hospital.

Forensic Service

The HSE is progressing the development of the national forensic mental health service. A Cost Benefit Analysis, Project Brief and Business Case for the development of a new Central Mental Hospital (CMH), an Intellectual Disability Forensic Mental Health Unit, a Child and Adolescent Forensic Mental Health Unit and 4 Intensive Care Rehabilitation Units is being prepared. In the current economic climate, the challenge here will be to agree the appropriate funding mechanism to fund these developments.

Agreement has been reached with the HSE in relation to the provision of Consultant psychiatric support to the Gardai in emergency incidents.

Following the enactment of the Criminal Law (Insanity) Act 2010 and the introduction of conditional discharge for CMH patients, it is necessary for the HSE to provide, as a priority, step down facilities for persons so discharged. The Executive is in negotiations with Dublin City Council regarding the provision of a 10 – 12 bed High Support Hostel in the north city.

Suicide Prevention

'Reach Out' (2005) – is the National Strategy for Action on Suicide Prevention (2005 -2014). Four levels of action comprise the main body of the Strategy i.e. general population approach; targeted approach; responding to suicide; and information and research. The HSE established the National Office for Suicide Prevention in 2005 to oversee the implementation of the Strategy.

Suicide statistics by year and gender are shown in the following table.

Year	Male	Female	Total
2007	362	96	458
2008	386	120	506
2009*	422	105	527
2010* (Quarters 1&2)	185	46	231

**Provisional figures*

The number of deaths by suicide had been decreasing year on year, falling from 497 in 2003 to 458 in 2007. However, the CSO Report on Vital Statistics for 2008 which was published on 25 February last, revised the provisional figures for 2008 (424) upwards to 506. This represents an increase of 10.5% on 2007. The provisional figures available for 2009 indicate a further increase of 4% to 527, the highest level of suicide deaths ever recorded in this country. (The actual figure for 2009 could be higher as some undetermined deaths may be recorded as suicide following a coroner's inquest).

However, suicide is not just a mental health issue - many factors contribute to the rise in suicides e.g. economic downturn, unemployment, alcohol, financial difficulties, breakdown of relationships, etc. International evidence indicates that during an economic downturn suicide numbers increase. One study indicates that a 1% increase in unemployment leads to a 0.79% increase in suicides. In particular, unemployment is a stronger risk factor in the 35 to 54 age groups of men. The international research also shows that higher social spending on active labour market programmes aimed at keeping and reintegrating workers in jobs, reduces the effect of unemployment on suicide.

The total annual funding available to support suicide prevention initiatives is in the region of €8m which includes the annual budget of €3.7m for the National Office for Suicide Prevention (NOSP). The balance (€4.3 m) is used to fund Resource Officers for Suicide Prevention, self harm nurses in hospital emergency departments, and the development of local suicide prevention initiatives.

In an effort to counteract the impact of the current economic climate on mental health, additional funding of €1m was allocated in Budget 2011 to the NOSP to build on initiatives to date and bring added momentum and new impetus to its activities to address the increasing incidence of suicide and self-harm.

See Change

A National Stigma Reduction Campaign, *See Change* was launched in April 2010 with the aim to positively change social attitudes and behaviour, to inspire people to challenge their beliefs about mental illness, to be more open in their attitudes and behaviour and to encourage people in distress to seek help. This campaign will continue in 2011.

Cross-Sectoral Working

In January 2008, the Office for Disability and Mental Health (ODMH) was established as a cross-cutting Office with a remit across four Government Departments: Health and Children, Education and Skills, Enterprise and Innovation and Justice and Law Reform. The Director of the ODMH is also a member of the Senior Officials Group on Social Inclusion, which monitors progress on the Government's commitments in relation to social policy. One of the key priorities of the ODMH is to bring a new impetus to the implementation of *'A Vision for Change'* working in partnership with the HSE and other stakeholders.

A Cross-Sectoral Team has been established under the auspices of the ODMH to bring about improvements in services for people with mental health difficulties who come into contact with the criminal justice system. The team includes senior officials from the Departments of Health and Children, Justice and Law Reform, the Irish Prison Service, An Garda Siochana, the HSE and the Central Mental Hospital. Achievements to date include the agreement in relation to the provision of Consultant

psychiatric support by the HSE to the Gardai in emergency incidents and extensive consultation on the drafting and implementation of the Criminal Law (Insanity) Act 2010. (See above under Forensic Service).

BRIEFING FOR INCOMING MINISTER – PALLIATIVE CARE

Palliative Care

Palliative Care is primarily concerned with **quality of life**. It is dedicated to a form of active treatment that is destined to ensure that patients are enabled and encouraged to live their lives to the greatest possible extent, in the manner and in the setting of their choice (*National Advisory Committee on Palliative Care, 2001*).

A *Palliative Care Services Medium Term Development Framework* was published by the HSE in July 2009. This framework sets national priorities which have been agreed by all stakeholders based on solid needs analysis to ensure that services do not develop in an ad-hoc fashion and that any developments proposed in future reflect areas of greatest need.

'Palliative care for children with life-limiting conditions – A National Policy' was launched in 2010. It is estimated that approximately **1,400** children are living with life-limiting conditions in Ireland and that there are approximately **490** childhood deaths per year. Of these, it is estimated that **350** are from life-limiting conditions. Ultimately, this policy aims to ensure that all children with life-limiting conditions will have the choice and opportunity to be cared for at home.

The Irish Hospice Foundation has agreed a funding commitment of **€2.25 million** over five years to fund, up front, the key Paediatric Palliative Care Consultant post and fully fund, for three years (and partial fund for a further three years), **5** outreach nursing posts. In addition, the HSE will fund **3** outreach nursing posts for placement in 2011.

'*The Quality Standards for End-of Life-Care'*- Hospice Friendly Hospitals programme, launched in 2010, sets out best practice in relation to end of life care provision. HIQA will consider these in the context of developing its own *National Standards for Safer Better Healthcare* (draft published by HIQA on 23/09/10).

***National Specialist Palliative Care*-** the main elements relating to service provision in this area are;

- **8** dedicated specialist **in-patient units**
- **6** specialist **day care centres**.
- Almost all LHO areas have access to **Specialist Palliative Care/Home Care Teams** in the community. Many of these services are a consultant-led multidisciplinary service. However, in some areas there continues to be a number of nurse-led services.
- **Approx 38** of all acute general hospitals have varying degrees of access to dedicated specialist Palliative Care teams.

Briefing for new Minister

High level policy issues relating to Patient Safety and Quality

An Overview

Introduction

Improving the quality of care provided to service-users including the safety, effectiveness, appropriateness, access, efficiency and acceptability of that care has been identified as a policy imperative in recent years.
There is a wide range of initiatives that are now underway at a policy and an operational level, including:

- strengthening and reform of regulatory frameworks for providers and professionals,
- structural reforms including the establishment of HIQA and organisational reforms within the HSE and the Department
- a range of other policy initiatives (many arising from the Report of the Commission on Patient Safety and Quality Assurance)

Taken together, these initiatives have the potential to radically transform the direction and delivery of health and personal social services. Some of these are at earlier stages of development than others. Furthermore, some of these issues might appear to be distinct but are in fact highly related or inter-dependent.

The Chief Medical Officer has overall policy responsibility for quality and safety of health services. This includes:

1. Leading implementation of the report of the Commission on Patient Safety and Quality Assurance (Madden Commission)
2. Oversight of effective response and learning systems to patient safety incidents within the public and private sectors.
3. The establishment and operational management of the patient safety protocol within the Department.
4. Leading policy development in relation to clinical leadership and clinical governance
5. Legislative proposals for quality and safety (particularly licensing)
6. The corporate relationship between HIQA and the Department of Health and Children
7. Professional regulation and clinical indemnity in conjunction with HR directorate
8. The Patient Safety First initiative which communicates to the health system and the public on patient safety
9. The National Framework for clinical effectiveness which will lead to mandating of clinical guidelines and audit by the Minister for Health and Children.
10. Policy and oversight in managing health care associated infections.

1. Leading implementation of the report of the Madden Commission

The evolution of patient safety as a health policy issue arose from the release of a number of seminal reports internationally. Similarly, in Ireland there have been several high-profile inquiries and reports on health care failures which underlined the need for an increased focus on patient safety and quality. Arising from the report of the Lourdes Inquiry, the Commission on Patient Safety and Quality Assurance was established (Madden Commission) in January 2007.

The report of the Madden Commission was entitled Building a Culture of Patient Safety and was published in August 2008. Its title speaks directly to the challenge that must be overcome in relation to patient safety and quality.

The Report referred to the challenges of dealing with "unsafe practices, incompetent health care professionals, and poor governance of health care service delivery, errors in diagnosis and treatment and non-compliance with standards". The report was agreed by Government on 27 January 2009 with approval to progress the legislation and establish a Steering Group to drive implementation of all the134 recommendations. The report's recommendations include proposals that constitute the mutually reinforcing framework including:

- Leadership and accountability throughout the service through new governance, management and reporting structures with legal duty for patient safety on CEOs and Boards of Management
- legislation on licensing of all public and private healthcare providers
- mandatory adverse event reporting
- open disclosure on patient safety incidents and all clinicians to participate in national programme of clinical audit
- improved research, education and training on patient safety
- patient involvement in service review and planning

An Implementation Steering Group (ISG) was established in May 2009 for a period of 18 months. Chaired by Dr. Tony Holohan, the Department's Chief Medical Officer, the Group has met twelve times. This implementation phase came to an end at the end of 2010. A Final Report to the Minister is being finalised, and will be submitted to the Minister with a proposal which will provide for continuity of high level engagement of the stakeholders that worked together on the implementation.

Significant progress has been made in several of the areas covered by the Commission's recommendations. Ongoing development of policy responses is still underway in a number of areas including adverse event reporting, credentialing and privileging and professional regulatory frameworks.

Work to implement the joint HSE/Department National Strategy for Service User Involvement in the Irish Health Service is continuing under the umbrella of the Commission report implementation. The HSE and the Department has completed consultation on a patient information piece entitled "You and your health services". This document was launched at the Patient Safety Initiative launch in September 2010. A number of patient leaflets that will prompt patients to assertively engage in their own health care and to ask questions designed to ensure their care is safe is in preparation.

The HSE is currently looking for service user volunteers to participate in a new pilot investigation process for investigating incidents and complaints in the HSE.

A Patients Safety Champion Network is being brought together by the HSE and DoHC that will be a further patient force for improvement in the quality and safety of services that are delivered.

2. Oversight of patient safety incidents

A major policy focus in recent years has been on ensuring a robust and consistent approach to risk management and incident management within the public health system.

The HSE's response capacity to patient safety incidents and the governance and management implications of this were criticised directly in the reports that were conducted into a number of patient safety incidents mostly related to the management of symptomatic breast disease during 2007 and 2008. Since that time, there has been a significant enhancement of the HSEs capacity to manage patient safety incidents. These incidents also provided a very significant driver for the reform of cancer services.

This is not to in any way take from the fact that further progress is required to allow us to assure the Minister that the risks of incidents occurring is minimised, that the detection of them when they do occur is maximised and that lessons are fully learned from their occurrence and any investigations they may give rise to.

One of the most significant contributions to this patient safety agenda was the establishment of the Quality, Risk and Patient Safety Directorate in the HSE, which is designed to drive clinical governance, quality and risk national standards and protocols and to provide clinical leadership within the healthcare system. Initially, this was under the direction of Dr Barry White. It is now headed by Dr Philip Crowley who was formerly Deputy Chief Medical Officer in the Department of Health and Head of the Patient Safety and Quality Unit.

The HSE has prepared a 'Risk and Incident Escalation Procedure' which outlines the steps that must be taken by each manager to escalate risks and incidents, as appropriate, that occur with their own service. This procedure is not intended to replace routine local incident management reporting, rather it is there to be used in circumstances where a National or integrated response is required to manage the issue.

The HSE's National Incident Management Team (NIMT) and Serious Incident Management Team (SIMT) is part of this streamlined structure. The patient safety unit of the CMOs Office meets on a regular basis with the HSE's Director of Quality and Safety to liaise on the Department's protocol and its links with the HSE's National and Serious Incident Management Teams, and to review patient safety issues arising. This is working very well as a process to support the accountability and stewardship role of the Department as it relates to the public health care system.

- *Clinical Indemnity Scheme*

The Clinical Indemnity Scheme (CIS) provides cover in respect of clinical negligence claims occurring in public hospitals and HSE facilities. The total cost of the Scheme in 2010 was €77.2 million. Payments in respect of compensation and costs made by the SCA are reimbursed to it by the HSE.

The CIS also has statutory responsibility to provide risk advisory services to State authorities with the aim of reducing the frequency and severity of claims over time and enterprises have a statutory obligation to report adverse clinical incidents and near- misses to the CIS.

A Working Group on Medical Negligence chaired by Mr Justice Quirke made a number of key recommendations in November 2010 regarding the use of Periodic

Payment Orders and the Minister for Justice has indicated his intention to progress proposals for amending legislation as soon as possible.

[redacted]

3. Patient Safety Protocol

The Department introduced an internal Patient Safety Protocol in 2008 for dealing with correspondence received by the Minister or the Department relating to patient safety concerns. The aim of this process is to clarify and strengthen arrangements for managing such communications and to ensure an appropriate strategy for the management of patient safety issues.

In recent months it was considered timely to revise the Protocol within the Department, covering both the HSE and the Private Hospitals sector. This revision coincides with the HSE's new National Structures to manage National and Serious Incidents (see Oversight of patient safety incidents below).

The Department's revised Protocol builds on the previous protocol and ensures that the Minister, MAC and HIQA are kept informed on a regular basis of patient safety issues notified to the Department, covering both the public and private sectors.

The HSE's comprehensive National and Serious Incident Management Policies and Procedures for application at local and national levels are in place to ensure an immediate, appropriate and consistent response to all notified incidents and the dissemination of learning from such events.

Although the Minister for Health does not currently have a legal remit covering the private healthcare sector, the CMO's Office considers it appropriate that concerns raised with the Department relating to the private hospital sector are communicated to that sector in a supportive and suitable manner and that sharing of learning from such experiences be encouraged. The Patient Safety Protocol includes procedures for addressing individual complaints raised about service received in private hospitals. To this end, the CMO's Office is preparing to develop the establishment of a general mechanism for supporting sharing and learning from such events, with the involvement of the private hospitals and Independent Hospitals Association of Ireland (IHAI).

4. Clinical leadership and clinical governance

- *Clinical Governance*

A number of key recommendations of the Commission related to the development of clinical governance processes. Clinical governance means corporate accountability for clinical performance and must be fully integrated with corporate and financial governance. In practice, this will see boards and management teams putting in place a range of processes and information flows that relate to service quality (including access, efficiency and effectiveness) and patient safety.

The implementation steering group for the Madden Commission has overseen the development by the HSE of a paper entitled "Achieving Excellence in Clinical Governance". This paper sets out requirements of and guidance for managers in relation to clinical governance. These encompass the various structures and processes

that must be in place to ensure that responsibility is taken at appropriate levels in the system and that there is a balanced authority and accountability relating to it.

The standards under development by HIQA will set out clear requirements in relation to such governance arrangements and will therefore act as a significant lever for their implementation. In addition, it should be expected that the HSE would reflect such arrangements in any service level agreement they put in place with any third party for the procurement of services.

- *Clinical Leadership*

The effective, efficient and safe delivery of high quality health services depends very significantly on effective managerial and clinical leadership in the context of a strong and well governed and managed health system.

There are a number of current examples of emerging clinical leadership. These include the development of clinical directors, the emergence of the Forum of Postgraduate Training Bodies, the establishment and development of structured relationships between the Department and the Faculties/Colleges and the establishment and development of clinical programmes within the HSE.

In order to consolidate the benefits that flow from having effective engagement and leadership from the clinical community in policy development and implementation, it is essential that good quality in structures and processes underpin this clinical leadership. National Clinical Programmes and the proposed Framework for Clinical Effectiveness will provide a significant means through which a constructive clinical leadership role can be transacted to the benefit for the entire system.

- *The Clinical Director Role*

A more specific implementation process is being developed in the HSE, through the quality and clinical care directorate, which will see the development of a much more consistent and clear role for clinical directors. Their role to date has developed differently in different settings. It is fair to say, however, that the developments to date have helped improve the culture in relation to quality and safety and the performance monitoring of consultant practice. However, there is a significant need for that to be consolidated into an operational management role in relation to clinical matters with the appointment of the next wave of clinical directors, which is due in the early part of 2011. In particular, it is necessary that the authority and accountability attaching to the role, its inter-relationship with that of the CEO and Director of Nursing and others be clarified. A specific requirement exists to ensure that clinical directors execute the clear role that was defined from them in the consultant contract in terms of monitoring activity in accordance with the public/private mix.

5. Legislative proposals for quality and safety

- *Health Information Bill*

Provision for the reporting of serious adverse events/incidents will be made in the Health Information Bill which is currently being drafted with a view to publication in the first half of 2011. Open communication with patients following an adverse event is key to good governance and to encourage this, the Bill will give legal protections to the disclosure to patients of adverse events. This Bill will also provide for legal

protections for adverse event/incident reports and clinical audit. Appropriate exemptions from FOI will be provided for.

- *Licensing*

Legislative proposals for the licensing of public and private healthcare providers are being prepared in line with recommendations made by the Commission on Patient Safety and Quality Assurance. The Commission envisaged that HIQA would be the licensing authority. Licensing is one of a number of levers which can improve patient safety. The overall impact will be to ensure that the healthcare providers:

- maximise the quality of care people can receive within available resources
- minimise risk of poor outcomes for patients
- monitor, audit and proactively survey quality and risk
- ensure that risks are appropriately mitigated and managed
- apply learning from monitoring, audit and incident management

The intention is to have a proportionate system which has the confidence of the public. The legislation will be designed to improve patient safety by ensuring that healthcare providers do not operate below core standards which are applied in a consistent and systematic way. Providers will (in time) also have to adhere to national clinical guidelines. Standards and other requirements will be enforceable through inspection and imposition of sanctions if necessary. Governance and accountability issues for licensees will be central to the legislation.

Licensing will be targeted at areas which are not currently subject to regulation. Proposals on services to require a licence will be based on the level of risk associated with a service after taking into account any other protections offered by other regulatory or management and governance systems, and what contribution licensing can make to ensure those risks are managed.

The legislative framework will allow HIQA to take a targeted and proportionate approach to the monitoring of licensed providers and will be enabling rather than prescriptive, so that HIQA can adapt processes as necessary while maintaining transparency and consistency in implementation and enforcement matters.

The intention is that the licensing system will be self financing from HIQA's perspective, with licence fees covering HIQA's administrative and inspection costs. Other potential costs for providers include compliance costs in meeting standards and their own administrative costs. In the case of public providers, the costs will ultimately fall on the exchequer.

The immediate effects of licensing are:

1. Mandatory standards and a legal structure through which HIQA can work with providers to ensure that standards are met.
2. Private providers will be included in the regulatory system.
3. New services will be required to be licensed before they are established and
4. A licence can be cancelled and an unsafe service discontinued.

Subject to the Minister's approval of the approach overall, detailed proposals will be prepared for submission to the Minister with the aim of seeking Government approval to carry-out a public consultation process on the draft Heads of Bill.

- *Medical Practitioners (Professional Indemnity)(Amendment) Bill 2009*

Following on from a Private Members Bill (July 2009) to amend the Medical Practitioners Act 2007 to provide for mandatory professional insurance for certain medical practitioners and related matters, a Memorandum for Government has been drafted requesting the Government's approval to draft Heads of Amendments to the Bill. The memorandum was not finalised due to the dissolution of the Dáil. The draft Memorandum can be adapted should the Government decide to introduce a Bill in the new Dáil in relation to this issue.

6. Health Information and Quality Authority (HIQA)

HIQA was established in May 2007 as part of the Government's overall Health Service Reform Programme. HIQA's Healthcare Quality function includes the setting and monitoring of standards and the conduct of investigations. HIQA incorporates the office of the Chief Inspector of Social Services (SSI). HIQA also has functions in relation to Health Technology Assessment and Health Information.

Since its establishment, HIQA has been actively driving the patient safety agenda through, for example, setting standards for infection prevention and control and has published a number of reports of compliance with these standards in the form of Hygiene Audits of each acute hospital. This has clearly contributed to the recent welcome reduction in major forms of healthcare associated infections.

In July 2009, the Chief Inspectorate arm of HIQA commenced the registration and inspection of public and private nursing homes. HIQA registration is granted following an inspection visit to confirm that the nursing home complies with HIQA standards.

Other main achievements to date include National Hygiene Service Quality Review of acute hospitals, development of a number of standards (e.g. Symptomatic Breast Disease Standards), conduct of a number of Health Technology Assessments and Investigations (e.g. Rebecca O'Malley). Inspection of certain childcare facilities continue.

During 2009 the Minister commenced the provisions of the Health Act 2007 which facilitate employees to disclose matters of concern to them about safety or certain other aspects of publicly provided health and personal social services to an authorised person. This is known as 'protected disclosure' and provides the individual making the disclosure with statutory protection against penalisation in their employment and against civil liability. This procedure applies to all employees of the HSE and agencies funded by the HSE as well as bodies established under the Health (Corporate Bodies) Act 1961, e.g. the Crisis Pregnancy Agency, National Treatment Purchase Fund and others.

Returns for the period Mar 2009 to Dec 2010 indicate that there were 24 protected disclosures, all from HSE.

7. Professional regulation

Reform of professional regulatory structures, to reflect the changing nature of healthcare and professional responsibilities, evolving societal expectations of professional accountability and drawing on lessons from regulation in other sectors and internationally, is required. Significant initiatives in this area include the enactment of the Medical Practitioners Act 2007, work that has been done on the

development of a Nursing and Midwifery Bill and the establishment of the Health and Social Care Professionals Council.

Ongoing work in this area is necessary to ensure harmonisation of approach between the different regulators in line with the recommendations of the Commission on Patient Safety, to ensure that there is appropriate transparency and accountability in the regulatory processes and to address the interface between the responsibility of regulators to ensure that professionals are competent and the responsibility of employers to ensure that they are performing to the required standard.

The totality of the regulatory regime contributing to the patient safety agenda includes the regulation of the service providers by HIQA and the Mental Health Commission in their respective areas. It also includes the professional regulatory bodies, namely the Medical Council, An Bord Altranais, the Dental Council, the Pharmaceutical Society of Ireland, the Health and Social Care Professionals Council and the Irish Medicines Board.

Professional bodies, such as the RCSI, RCPI and the education section continue to promote patient safety through their education, professional development and other agendas. Greater input from patients at all levels in the healthcare system through the Commission's report is also becoming a reality.

Specifically in relation to medical practitioners, the provisions of the Medical Practitioners Act relating to competence assurance were commenced in May of 2010. This will require that all doctors who are not in approved training posts participate in on-going processes that enable them to maintain skills, knowledge and competence such as continuing medical education and continuous professional development. The actual establishment of these programmes will be a matter for the individual training bodies in the various medical specialties. This mandatory requirement will commence as and from 1st May 2011. The requirement for competence assurance may provide a means through which adherence to clinical guidelines and participation in clinical audit can be mandated.

8. The Patient Safety First initiative

On 23rd September, 2010 the Minister for Health and Children along with other key participants launched the 'Patient Safety First' declaration of commitment. 'Patient Safety First' is an awareness raising initiative through which healthcare organisations declare their ongoing commitment to patient safety. Through participation in this initiative, those involved commit to play their part in improving the safety and quality of healthcare services. This commitment is intended to create the momentum for positive change towards patient safety.

The Patient Safety First event also included the launch of a new Patients' Charter "You and Your Health Service" as well as an online patient safety course for doctors which has been developed jointly by the Royal College of Physicians of Ireland and the Royal College of Surgeons in Ireland, with financial assistance from the Health Service Executive.

The overall branding was supported by a new 'Patient Safety First' logo and the launch of a new website (www.patientsafetyfirst.ie).

9. The National Framework for clinical effectiveness

The Minister established a National Clinical Effectiveness Committee in late 2010. The aim of the Committee is to strengthen the evidence base for the most effective delivery of clinical care, resulting in improved outcomes for patients and greater reassurance for them about the quality of their care. It will achieve this by providing a national mandate to quality assured health guidelines (systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances) and healthcare audit. In order to do this it will support and guide the work of guideline developers (doctors, nurses and other health and social care professionals) across the Irish healthcare system. It will assess guidelines developed in priority areas to ensure that they provide statements of best practice and will disseminate these throughout the Irish healthcare system, both public and private. The Committee is chaired by Prof. Hilary Humphreys and held its 3rd meeting in February.

10. Healthcare Associated Infections

Complex medical care (organ transplantation, cancer chemotherapy) has resulted in an older patient population, many of whom live with multiple medical illnesses and who are more susceptible to infection. Antimicrobial resistance has potential to become one of the greatest threats to public health in Ireland unless the principles of prudent antimicrobial use become deeply embedded in medical and veterinary practice.

As a result, healthcare-associated infection (HCAI) has been a policy priority for the Department and despite recent improvements, MRSA figures remains an ongoing challenge for the health services in Ireland. Internationally, it is accepted that HCAI and the prevention of HCAI should be at the core of the delivery of a quality health service.

National Standards for the Prevention and Control of Healthcare Associated Infection were published by HIQA in May 2009 and the process of implementation is underway. HIQA is expected to begin monitoring compliance against these standards during 2011.

Antimicrobial consumption, both in the community and healthcare setting had been increasing annually up to 2009, when a reduction in consumption was recorded. Initiatives such as European Antibiotic Awareness Day and the publication of Irish national guidelines on antimicrobial stewardship in hospitals in 2009 have raised awareness of this key topic.

The HSE produced its National Infection Control Action Plan – Say No to Infection in 2007. Its aim is to reduce HCAIs by 20%, MRSA infection by 30% and antibiotic consumption by 20% over the period of the Plan. It also provides for A National Surveillance System to collect data and provide information on a quarterly basis to monitor HCAIs. This shows a decrease of 40% in the number of MRSA cases reported between 2006 and 2009. Antimicrobial stewardship teams within several acute hospitals has had significant impact on antimicrobial consumption and expenditure. However, the speed with which antibiotic resistance has developed has now outstripped the availability of novel treatments. Severe infections due to methicillin resistant Staphylococcus aureus (MRSA) have been declining. However, Ireland has the highest proportion of vancomycin resistant enterococcus (VRE) in

Europe and the emergence of multi-drug resistant Gram-negative bacteria, such as carbapenem-resistant enterobacteriaceae (CRE) has already been reported in Ireland.

Patient Safety and Quality Unit,
CMOs Office,
Department of Health & Children
February 2011

Private Health Insurance
Detailed Briefing

Summary

Key Statistics

- Almost 50% of the population (2.228 million people) have private health insurance.
- Overall VHI has a 64% share of the open private health insurance market but it has 82% of the 60 yrs + age group and 92% of the 80 yrs + age group.

Recent Developments

- A degree of support for the cost of health insurance claims by older people is provided for through the Interim Scheme of Age-Related Tax Credits and Community Rating Levy which has been in place since 2009. A higher level of support for older people has been put in place for 2011, with tax credits set to compensate for 65% (up from 50% in 2010) of the extra cost of insuring older people.

- The HIA has submitted recommendations in relation to Risk Equalisation and also Minimum Benefit Regulations.

Current Issues

Creating a Sustainable VHI

- The VHI has the great majority of older health insurance customers, creating a very uneven distribution of risk in the Irish market. In addition, the VHI is under considerable challenge from the EU Commission because of its position as a State-owned company with a derogation from the rules applying to other health insurers.

(The information highlighted below(strikethrough) should not be released by virtue of Section 22(a) of the Freedom of Information Act 1997 as amended, as the information would be exempt from production in proceedings in a court on the ground of legal professional privilege).

FOR MINISTER'S INFORMATION ONLY
NOT FOR GENERAL RELEASE

European Court of Justice case in relation to VHI derogation from the terms of the 3rd Non-Life Directive.

- An oral hearing has been granted before the European Court of Justice in Luxembourg on **10 March 2011.**
- The Court's decision on the case is expected within 3-6 months, [redacted]

Market issues

- Segmentation in the market is prevalent, i.e. plans are being designed, marketed and priced to attract certain categories of customers, in particular vocational groups and corporate business. Competition is for younger, healthier customers only.
- Cover for orthopaedic and ophthalmic treatments reduced for most VHI Healthcare plans (apart from Plans A – E and Options) from 1 February or 9 February. These benefits generally appeal to older customers.

Price increases

- VHI Healthcare increases from 1 Feb 2011 - 15% for more than half of its customers; higher increases for other plans - 21% for plans D and E through to 35% for Plan B and 45% for Plan B Options (29% of their membership have Plan B or Plan B Options).
- Aviva have increased prices by 14% with effect from 1 March 2011.
- Quinn Healthcare increased prices on its "individual" plans from 1 January 2011 by between 8% and 24%. "Individual" plans with cover for a semi-private room in private hospitals increased by c. 16%. Quinn "corporate" plans increased with effect from 1 February 2011 from between 3% and 15%. Corporate plans with semi-private room in private hospitals increased by 3%.
- Quinn Healthcare has announced that it proposes to further increase the cost of health insurance policies by an average of 6% from 1 April 2011. The Essential Plus Plan will increase by 3.19% with the Essential Plus (excess) Plan increasing by 8.17%.

BUPA Damages Case

- Following on from the Supreme Court decision in July 2008 to strike down the previous Risk Equalisation (RE) Scheme, BUPA initiated proceedings in the courts seeking damages from the State. The case is ongoing and the Department has recently completed a significant piece of work on discovery of relevant records. It is likely that a date for hearing the case will be set shortly.

Planned Developments

The following were the developments planned prior to the appointment of the Government on 9 March 2011. The Department will shortly make a submission to the Minister on the issues below:

- To progress a sustainable policy in relation to the future of the VHI
- To implement a new transitional arrangements from 2012 that closely approximate the effect of a full RE Scheme (following the ending of the Interim Scheme in 2011).
- To develop a full, robust new RE scheme to start in 2013.
- The revise minimum benefit regulations to reflect current developments in the market, in particular, to deal with challenges to community rating.
- To introduce lifetime community rating that encourages people to take out health insurance earlier in their adult life rather than later.

In view of developments in the PHI market, it may now be necessary to review the timetable for and the approach to introducing a full RE scheme.

Key Statistics

- As of 1 December 2010, 49.8% of the Irish population are estimated to have private health insurance compared to 50.6% on 1 December 2009.

- **Market Share**

Insurer Market Share	End December 2010 Members '000s	Market Share	End December 2009 Members '000s	Market Share
Aviva	**305**	**14.2%**	**233**	**10.6%**
Quinn Healthcare	**463**	**21.6%**	**516**	**23.6%**
VHI Healthcare	**1,373**	**64.1%***	**1,442**	**65.8%**
TOTAL	**2,141**	**100%**	**2,191**	**100%**

*When Restricted Membership Undertakings (about 87,000 members) are taken into account, the VHI's share of the total market drops to 62%.

- **Age Profile of Health Insurance Market**

– VHI has 36,000 of the total of 39,000 customers over 80 years of age – 92% of the market among that age group.

– The average cost of a health insurance claim for a person in the 80 years and over age group is 8 times that of a person in the 30 to 39 years age group.

– More than four out of five people (82%) over the age of 60 who have private health insurance are customers of VHI.

Company	Customers over 60 Yrs	% share of over 60 age group
VHI	**278,000**	**82%**
Quinn	**45,000**	**13%**
Aviva	**15,000**	**4%**
Total	**338,000**	**100% (rounded)**

– An age distribution (average for the period July to De c 2010) of each insurer's membership is set out in the following ta ble, with the corresponding averages for the period Jan to June 2010 in brackets.

This information contain in the following table details of market share within health insurance broken down by company and age and was provided by health insurers to the Health Insurance Authority in compliance with Section 7 of the Health Insurance Acts 1994 to 2009. This information was provided in confidence and its disclosure would constitute a breach of a duty of confidence provided for under Section 12A of the Health Insurance (Amendment) Act 2001. For this reason access to the record must be refused under Section 32(1)(a) of the FOI Acts 1997 and 2003 -Enactments Relating to Non-Disclosure of Records.
In addition this information has significant financial and commercial value. Having considered the matter I am satisfied that its disclosure is very likely to result in a material financial loss or gain to individual health insurers. In addition, it could be used by competing companies in conjunction with what is already known to advance their position in the market and therefore prejudice the competitive position of individual companies in the conduct of their business. For these reasons I have decided that the

record is exempt under Section 27 (1) (b) of the FOI Acts, 1997 and 2003 and should not be disclosed.

As required by the FOI Act I have also considered the public interest factors favouring both the release and the withholding of the record

<u>Factors in favour of release in the public interest:</u>

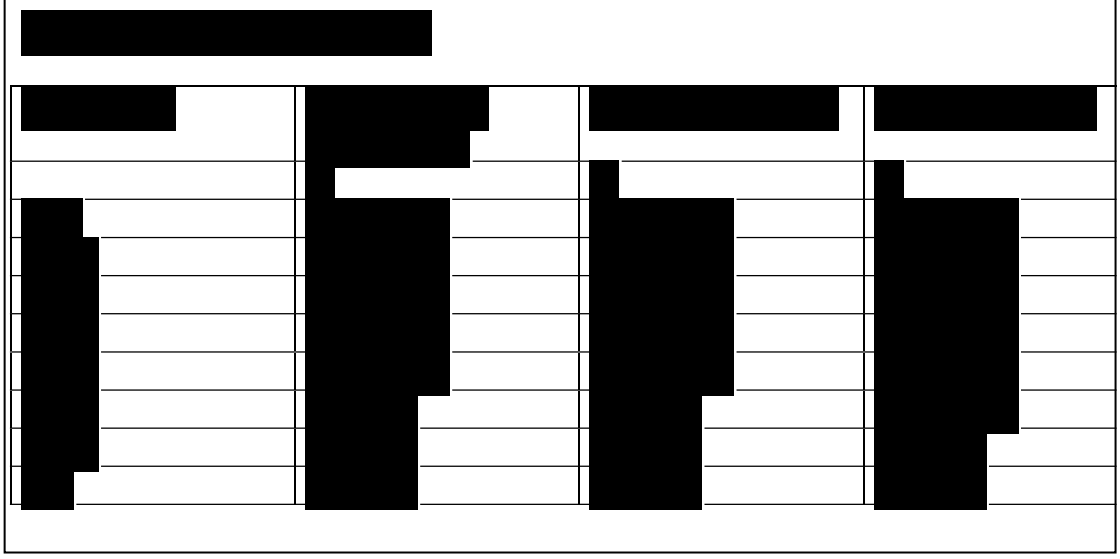
- there is a public interest in the operations of a public body being transparent

<u>Factors in favour of withholding the record in the public interest</u>

- there is a public interest that a company not be unduly impeded in carrying out its business
there is a public interest in a public body being able to make informed decisions in the course of carrying out its functions and, as part of this , in being able to maintain the confidentiality, in certain circumstances, of sensitive information received from commercial entities

Having considered the matter I am satisfied that the public interest would <u>not</u>,on balance, be better served by granting access to this record).

TABLE FOR MINISTERS INFORMATION ONLY
NOT FOR GENERAL RELEASE



- **Product Developments**

	Aviva Health	Quinn Healthcare	VHI Healthcare	Totals
Number of inpatient products at end June 2009	106	21	32	**159**
New products notified to HIA Since June 2009	16	10	26	**52**
Total number of inpatient products at 23 February, 2011	122	31	58	**211**

– The table shows the number of new plans being developed and marketed by undertakings. On 23 February, 2011 there were a total of 211 private health insurance plans on offer from the three open market insurers.

– A continuing feature is the marketing of plans to particular groups (e.g. corporate schemes or professions). These plans are often at significantly lower prices than older plans and plans marketed to individuals.

- **Product Price Comparison with effect from 1 February 2011**

Standard Cover Plans		
Insurer	**Individual Plan**	**Alternative Plan**
VHI Healthcare	€1224 "Plan B"	€772 Teachers Plan
Quinn Insurance Ltd	€995 "Essential Plus"	€644 "Company Health Plus with Excess"
Aviva Health	€848 "We Level 2"	€661 "Business Plan Hospital"

The above table compares the prices of individual plans with the prices of alternative plans. Many of these alternative plans are targeted at professionals or the corporate sector. These alternative plans, however, are available to the entire population without restriction.

All plans were correctly priced as of 03 March, 2011 from the HIA website.

(Further plan details on page 20)

<u>Recent Developments</u>

- Risk Equalisation and Minimum Benefits

– The HIA has completed its consultation in relation to Risk Equalisation and also Minimum Benefit Regulations and submitted its analysis and recommendations to the Minister on 23 December 2010. Work is ongoing in the Department and with the HIA to progress these matters.

- Temporary Community Rating support measures

– A degree of support for the cost of health insurance claims by older people is provided for through **the Interim Scheme of Age-Related Tax Credits and Community Rating Levy** which has been in place since 2009. A higher level of support has been put in place with effect from 1 January, 2011 with tax credits set to compensate for 65% (up from 50%) of the extra cost of insuring older people.

– For policies commencing in the period 2009 to end 2011 the scheme will provide for a net benefit to VHI of an estimated €159m. This comprises €41m in 2009, an estimated €48m in 2010, and some €70m in the current year.

– The HIA have estimated the net cost, in 2011, to Aviva and Quinn will be in the region of €33m and €37m, respectively.

(Further details of the Interim Scheme are on page 18)

Current Issues

- **VHI**

ECJ Case – VHI Derogation

(The information highlighted below (strikethrough) should not be released by virtue of Section 22(a) of the Freedom of Information Act 1997 as amended, as the information would be exempt from production in proceedings in a court on the ground of legal professional privilege).

FOR THE MINISTER'S INFORMATION ONLY
NOT FOR GENERAL RELEASE

European Court of Justice case in relation to VHI derogation from terms of the 3rd Non-Life Directive, including in relation to solvency requirements

- Infringement proceedings initiated by the EU Commission have been commenced in the European Court of Justice in relation to the VHI derogation from the terms of the 3rd Non –Life Directive. i.e. VHI is not currently subject to regulation by the Central Bank.
- Written pleadings on this case have been completed and part of the State's defence includes reference to the previous Government's decision on the future strategy for the private health insurance market, including regulatory change and the capitalisation, authorisation and sale of VHI.
- An oral hearing will take place before the European Court of Justice in Luxembourg on 10 March 2011.
- The Court's decision on the case is expected within 3-6 months.
- [redacted]
- Officials from the Department are maintaining regular contact with DG Internal Market in Brussels to update them on progress regarding the implementation of plans for the insurance market and VHI. The most recent meeting with Commission officials took place on 9 February 2011.

VHI Financial Position

- VHI is continuing to lose market share and its financial position is becoming more acute as it loses members in the younger age cohorts and as its insured population ages, thereby increasing claim costs significantly. After tax results showed a net deficit of €42m for 2009. The outturn for 2010 is not yet known but should show a reduction in the deficit.

– VHI has stated that in 2009 it lost over €170m in meeting the healthcare needs of its 280,000 customers over the age of sixty and is forecasting a 2011 loss of €147m on its older customers before the implementation of the 1 February, 2011 price increase.

Creating a Sustainable VHI

– The VHI has the great majority of older health insurance customers, creating a very uneven distribution of risk in the Irish market. In addition, the VHI is under considerable challenge from the EU Commission because of its position as a State-owned company with a derogation from the rules applying to other health insurers.

– The company is not required to maintain the level of reserves required by other insurers and is not currently authorised by the Central Bank. The EU also considers that the VHI effectively enjoys an unlimited guarantee of solvency from the State, a claim rejected by Ireland.

– In order to achieve authorisation, the VHI will require capitalisation and a sustainable business plan, which in turn depends critically on a properly functioning RE scheme.

  - The previous Government decided to sell the VHI because it believed that it would be harder to achieve EU approval to a new RE scheme, and more difficult to get EU agreement to capitalisation, if the State continued to own the VHI. In addition, it concluded that the State should not be both regulator of the health insurance market and owner of one of the insurers.

– With these factors in mind, the Department has recently undertaken an EU procurement competition for financial, legal and other advice on the disposal of the VHI. The tender was requested on the basis of:

(1) A report on the options for rebalancing the risk across the private health insurance market in the context of the (then) proposed sale of the VHI
(2) A report on the options available for authorisation and disposal of VHI, including the advantages, disadvantages and estimated costs of each option and
(3) Lead the process of authorisation and execution of the sale of VHI as well as implementing strategies for a rebalancing of the market if appropriate.

(The information highlighted below currently forms part of the Department's deliberative processes for the future of the VHI.
For these reasons I have decided that the record is exempt under Section 20 (1) of the FOI Acts, 1997 and 2003 and should not be disclosed.
As required by the FOI Act I have also considered the public interest factors favouring both the release and the withholding of the record

Factors in favour of release in the public interest:

- there is a public interest in the public being better informed and more competent to comment on public affairs
- the right of the public to have access to information

Factors in favour of withholding the record in the public interest

- there is a public interest in avoiding a premature release of the record which could contaminate the decision making process
- release of the record at this time would impair the integrity and viability of the decision making process to a significant degree without countervailing benefit to the public

Having considered the matter I am satisfied that the public interest would <u>not</u>,on balance, be better served by granting access to this record.)

[redacted]

- The European Commission has a particular interest in this area, from competition, State Aid and single market perspectives. Any capitalisation by the State will have to meet the Commission's prudent investor standard.

<u>VHI Claims Cost Review</u>

- The Minister for Health and Children, having responsibility for governance matters relating to the VHI, as well as overall responsibility for the market, asked the Department's actuarial advisors Milliman, to carry out a detailed examination of the VHI claims costs for 2009 to review the way in which the costs of claims it received were managed. With the co-operation of the VHI, Milliman conducted a detailed assessment of the situation. The report was completed in September 2010.
- Following the completion of this review of VHI's claims costs a presentation on the final report was made to the Minister on 22 September. The report was sent to the Board of VHI and to the HIA for their consideration and response and the Minister raised the matter with the Chair and CEO at a subsequent meeting. In addition, officials have raised the various issues involved with the VHI on a number of occasions.
- Details of the main findings are provided. VHI have rejected the contents and recommendations of the report. Following discussions with the VHI and Milliman, a redacted version of the report was published on the website of the Department (25 February, 2011).

  *Key findings from the report include**:***

  - *Material increases in utilisation in high-tech hospitals, which have higher unit costs than other acute private hospitals. (Largely attributable to two particular unnamed high-tech hospitals).*
  - *High trend rates for day case utilisation at acute private hospitals, combined with substantial increases in average costs for inpatient procedures. One or two unnamed hospitals have driven the increase in average costs for inpatients, where inpatient unit costs have increased by 10%.*
  - *Claims costs per person over the period 2008 to 2009 rose by 19%, while premiums per person rose only 13%. Premium increases have inevitably been constrained by the competitive landscape in which VHI operates.*
  - *VHI has given limited focus to utilisation management and investing in ways to manage claims that can yield savings regardless of the risk profile of the insured population. Report finds that there are potential savings of a minimum of 5%-10% in this area.*
  - *VHI has concentrated on the issue of risk equalisation to the exclusion of claims management techniques.*
  - *There may be consequences for some financially precarious private hospitals and cash strained public hospitals as a consequence of VHI concentrating more on claims management.*

- *As VHI's standard benefit plans do not include cover for prescription drugs, it is feasible that it could design and implement chronic disease management programmes that improve clinical quality of care without increasing its costs.*
- *A move to more effective management will require an investment by VHI in staff and other resources, which could be more than offset by claims costs savings.*
- *There is evidence that "patients" may be substituting stays in high-tech hospitals for standard acute private hospitals. There is also evidence that standard acute private hospitals are more adept at shifting utilisation from inpatient to day case than high-tech hospitals.*

<u>VHI Travel Insurance</u>

- This product is currently only available to VHI members who hold valid health insurance policies on the basis that the standard VHI healthcare policy is integral to and provides the foundation for the added on benefits available with this travel insurance product. The Minister announced in May 2010 that she considered VHI's current travel insurance to be anti-competitive and requested VHI to open travel insurance products to everybody and not restrict it to VHI healthcare policy members. Competitors had argued that the travel insurance product discouraged VHI members from switching to other providers. Legal advice has been sought from the Office of the Attorney General and this advice is awaited.

- **Price increases for 2011**

- VHI Healthcare announced on 6 January that it would increase prices for its non-corporate health insurance plans from 1 February 2011 with increases of 15% for more than half of its customers. Higher increases apply for other plans - ranging from 21% for plans D and E through to 35% for Plan B and 45% for Plan B Options. (Further details on page 21)
- Aviva increased prices by 14% with effect from 1 March 2011. These increases will apply across the range of health insurance products.
- Quinn Healthcare increased prices on its "individual" plans from 1 January 2011. These increases were between 8% and 24%, with the products providing cover for a semi-private room in private hospitals increasing by c. 16%.
- Quinn Healthcare increased prices by between 3% and 15% on its "corporate" plans from 1 February 2011. A plan with benefits at the most popular level (i.e. semi-private room in private hospitals) increased by 3%).
- Quinn Healthcare has announced that it proposes to further increase the cost of health insurance policies by an average of 6% from 1 April 2011. The Essential Plus Plan will increase by 3.19% with the Essential Plus (excess) Plan increasing by 8.17%.

<u>Factors cited by Insurers as reasons for price increases</u>

- the increase in daily bed charges for public hospitals
  - accounting for 5-6 % of increases
- increase in the Community Rating levy on health insurance policies
  - accounting for 5-6 % of increases

- medical inflation
- an ageing of its customer profile base
- the impact of customers seeking better value in the market.

(Further details of annual increases in premium prices are on page 24)

- **Market Issues**

- VHI have reduced benefit for orthopaedic and ophthalmic treatments on all of their plans commencing or renewing after 9 February, except for Plans A-E (including "options"). As these benefits are most appropriate to older customers, older customers must opt for these more expensive plans in order to obtain or retain these benefits.
- Health insurance plans are being designed, marketed and priced by insurers to attract certain categories of customers, in particular vocational groups and corporate business. Competition is for younger, healthier customers only.

- The effect has been to segment the market into older less profitable lives and younger more profitable lives. As a result of these strategies health insurance is currently being provided to different market segments at significantly different prices.

BUPA Court Cases

- **Costs in respect of legal proceedings between BUPA Ireland Ltd and the State regarding the introduction of the 2003 Risk Equalisation Scheme.**

- The Minister approved payment of the costs arising from High Court and Supreme Court proceedings arising from two judicial reviews initiated by BUPA following the introduction of the 2003 RE Scheme and the decision to introduce risk equalisation payments from 1 January, 2006. The payment, in the amount of €3,975,806.20 was made in October, 2010.

- **BUPA Damages case against the State arising from its exit from the market**

(The information highlighted in the following box (strikethrough) should not be released by virtue of Section 22(a) of the Freedom of Information Act 1997 as amended, as the information would be exempt from production in proceedings in a court on the ground of legal professional privilege).

NOTE FOR MINISTER'S INFORMATION ONLY
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Following on from the Supreme Court decision to strike down the previous Risk Equalisation Scheme BUPA initiated proceedings in the courts seeking damages from the State. The case is ongoing and the Department has recently completed a significant piece of work on discovery of relevant records.

[redacted]

[redacted]

Planned Developments

- The previous Government announced a set of actions in May 2010 for the health insurance market. These comprised:

  - The development of a full, robust new risk equalisation (RE) scheme to start in 2013;
  - For 2010 and 2011, to continue the temporary interim tax relief/levy system, with payment rates to be considered in context of the annual recommendation of the HIA;
  - the implementation of new transitional arrangements from 2012 that closely approximate the effect of the full RE scheme;
  - making a substantial capital investment in VHI in order to achieve its authorisation with urgency; with the actual amount to be determined between the Minister for Finance and the Minister for Health and Children in light of appropriate advices;
  - the investigation of measures to achieve a more even balance of customers among companies in the market;
  - the organisation of the sale of VHI, with the appointment of financial advisors to advise on structuring and sequencing;
  - steps toward the introduction of primary care cover on chronic disease management into required minimum benefits for health insurance policies; and
  - other actions to increase competition and choice in the market;

Risk Equalisation

- The implementation of new **transitional arrangements from 2012** that closely approximate the effect of the full RE Scheme (following the ending of the interim scheme in 2011)

    - As part of its consultation pro cess on Risk Equalisation the HIA, forwarded its advic es to the Min ister in r elation to the T ransitional Scheme

(The following information contains advice and recommendations and currently form part of the Department's deliberative processes in the area of risk equalisation.
For these reasons I have decided that the record is exempt under Section 20 (1) of the FOI Acts, 1997 and 2003 and should not be disclosed.
As required by the FOI Act I have also considered the public interest factors favouring both the release and the withholding of the record

<u>Factors in favour of release in the public interest:</u>

- there is a public interest in the public being better informed and more competent to comment on public affairs
- the right of the public to have access to information

<u>Factors in favour of withholding the record in the public interest</u>

- there is a public interest in avoiding a premature release of the record which could contaminate the decision making process
- release of the record at this time would impair the integrity and viability of the decision making process to a significant degree without countervailing benefit to the public

Having considered the matter I am satisfied that the public interest would <u>not</u>,on balance, be better served by granting access to this record).

NOTE FOR MINISTER'S INFORMATION ONLY
NOT FOR GENERAL RELEASE

[redacted]

- The developm ent of a full, robust new risk equalisation (R E) schem e to start in 2013.

However, it m ay now be necessary to re view the tim etable for and approach to achieving a full RE scheme.

<u>Background</u>

- In May, 2003 the EU Comm ission aut horised the 2003 Risk Equalisation Scheme (RES) and this decision was uphe ld by the Court of First Instance in February 2008 following a challenge by BUPA.

- BUPA also challenged the scheme under Irish Law and, having been approved by the High Court in 2006, the Suprem e Court, in July 2008, struck down the RES on dom estic law grounds, holding th at the Regulations introducing the scheme were *ultra vires* the 1994 Health Insurance Act.

- The McKechnie High Court judgement (paragraph 293) stated:

Therefore the creation of a risk equalisation scheme, pursuant to s. 12, is in my view a pressing and substantial need in a free and democratic society. I believe that the provision of such a scheme, (in a regulated market) and its impact on the property rights of BUPA is a regulation of the exercise of those rights in accordance with the principles of social justice and that the limitations placed on such rights are essential in the common good. Such rights are not absolute and their exercise may be curtailed when balanced with the common good.

(The information highlighted below (strikethrough) should not be released by virtue of Section 22(a) of the Freedom of Information Act 1997 as amended, as the information would be exempt from production in proceedings in a court on the ground of legal professional privilege).

NOTE FOR THE MINISTER'S INFORMATION ONLY
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[redacted]

- The Interim Scheme is the first scheme which has actually transferred funds from insurers with lower risks to an insurer with higher risks. It has not been challenged in the courts.

Current position

- The HIA issued its Consultation Paper to the market in July 2010 and received submissions and also met with interested stakeholders including the three commercial insurers. The Authority completed its analysis, including of the proposed Transitional Scheme and Minimum Benefit Regulations, and forwarded its advices to the Minister on 23 December 2010.

(The following information contains advice and recommendations and currently form part of the Department's deliberative processes in the area of risk equalisation.
For these reasons I have decided that the record is exempt under Section 20 (1) of the FOI Acts, 1997 and 2003 and should not be disclosed.
As required by the FOI Act I have also considered the public interest factors favouring both the release and the withholding of the record

Factors in favour of release in the public interest:

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Factors in favour of withholding the record in the public interest

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- release of the record at this time would impair the integrity and viability of the decision making process to a significant degree without countervailing benefit to the public

Having considered the matter I am satisfied that the public interest would not,on balance, be better served by granting access to this record).

NOTE FOR THE MINISTER'S INFORMATION ONLY
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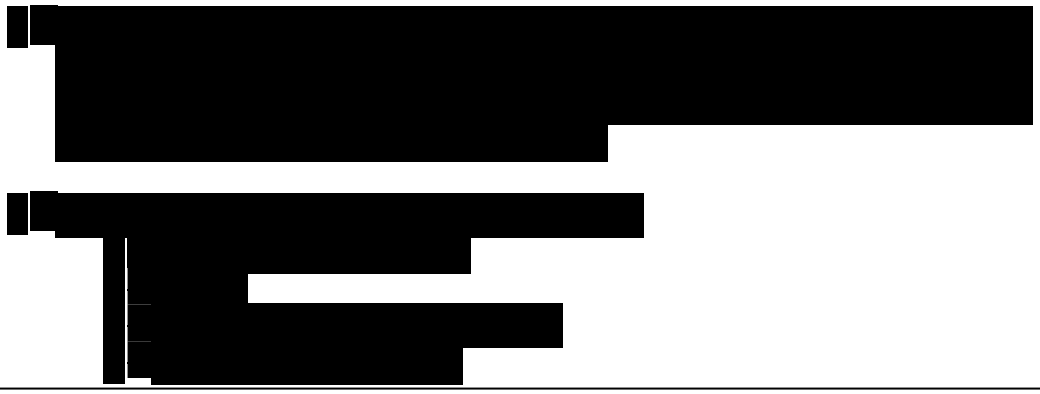


- The envisag ed tim eframe for the Risk Equalis ation Bill to be published is quarter 3, 2011, with an enactm ent da te during quarter 4, 2011 and full implementation by 1 January, 2013.

- A key part of the process in implementing a risk equalisation scheme or any Transitional Scheme is the requirement to consult and negotiate with the EU Commission. Legal advice is that this should be ongoing and regular. The Unit had useful meetings with Commission officials (separate meetings with DG Competition and DG Internal Market) in September 2010 and February 2011. The purpose of the meetings was to appraise the Commission of the Government's decisions on the future strategy for the private health insurance market including regulatory change and the capitalisation, authorisation and sale of VHI.

- **Minimum Benefit Regulations:**

  - The Minimum Benefit Regulations made under the Health Insurance Acts require insurers to offer a minimum level of cover to every insured person. At present, the benefits cover access to a semi-private room in a public hospital, including in-patient consultant fees and cover a wide range of acute treatments. However, as the Regulations were published in 1996, they have very much been overtaken by developments in the private health insurance market and healthcare provision. Provision for a review of these regulations was part of the comprehensive strategy adopted for the health insurance market in May 2010.

  - The current regulations are almost entirely focused on hospital benefits and changes will be considered which will reflect developments in the market, in particular, to deal with challenges to community rating.

    Consultation Process and Recommendations

  - The Health Insurance Authority (HIA) conducted a consultation process in relation to minimum benefits to be provided by insurers last summer, with a closing date of 13 September 2010. The HIA submitted its report to the Minister on 23 December and the main recommendations in the report include the following:

(The following information contains advice and recommendations and currently form part of the Department's deliberative processes in the area of minimum benefit regulations.
For these reasons I have decided that the record is exempt under Section 20 (1) of the FOI Acts, 1997 and 2003 and should not be disclosed.
As required by the FOI Act I have also considered the public interest factors favouring both the release and the withholding of the record

Factors in favour of release in the public interest:

- there is a public interest in the public being better informed and more competent to comment on public affairs
- the right of the public to have access to information

Factors in favour of withholding the record in the public interest

- there is a public interest in avoiding a premature release of the record which could contaminate the decision making process
- release of the record at this time would impair the integrity and viability of the decision making process to a significant degree without countervailing benefit to the public

Having considered the matter I am satisfied that the public interest would not,on balance, be better served by granting access to this record).

– The Department has considered the contents of the HIA report and has also held discussions with the HIA. A further submission will be made to the Minister shortly.

- **Lifetime Community Rating**
  – The current system in Ireland is called single rate community rating, where a person's age at entry does not determine the level of premium that they pay. Under Lifetime Community rating the premium that a person pays rises with the age at which they enter the private health insurance market. New rules will be brought forward to encourage people to take out health insurance earlier in their adult life rather than later. This will involve gradually higher costs to be applied to customers the longer they wait to take out private health insurance for the first time. Discussions on initial draft regulations have been ongoing and have included input from the HIA, Milliman (Actuarial Advisors) and the Office of the Attorney General.

- Ministerial approval will be sought to consult further with insurers in advance of formal legal drafting by parliamentary counsel of proposed regulations. It is envisaged that legal drafting will be completed by the second quarter of 2011 or as soon as possible thereafter.

Additional Information

- **The Health Insurance Authority (HIA)**

  - The HIA is the statutory regulator of the private health insurance market (non-prudential) and was established in 2001 under the Health Insurance Acts.
  - The HIA is independent in the exercise of its functions. The principal functions of the HIA as provided for in the Health Insurance Acts include the following:
    - To monitor the health insurance market and to advise the Minister (either at his or her request or on its own initiative) on matters relating to health insurance;
    - To monitor the operation of the Health Insurance Acts and, where appropriate, to issue enforcement notices to enforce compliance with the Acts;
    - To carry out certain functions in relation to health insurance stamp duty and age related tax credits and in relation to any risk equalisation scheme that may be introduced;
    - To take such action as it considers appropriate to increase the awareness of members of the public of their rights as consumers of health insurance and of health insurance services available to them; and
    - To maintain "The Register of Health Benefits Undertakings" and "The Register of Health Insurance Contracts".
  - The HIA shall exercise such powers as are necessary for the performance of its functions. The Minister for Health and Children ("the Minister") may assign further responsibilities to the Authority as provided for in the Acts.
  - The HIA has a staffing complement of nine and its income for 2010 was €3,048,861. The costs and expenses of the HIA are funded by a levy paid by all health insurers on the Register of Health Benefit Undertakings. The amount of the levy was reduced from 0.14% to 0.12% of the premiums paid to apply from 1st January 2011
  - The Chair and Members of the Authority are appointed by the Minister.

- **Restricted Membership Undertakings (RMUs)**

  - Restricted Membership Undertakings provide health insurance schemes for in-patient health insurance cover, the membership of which is restricted to employees and pensioners of particular organisations. They do not participate on the open market and have a total membership of about 87,000 people. The RMUs are registered with the HIA which maintains the Register of Health Benefit Undertakings in accordance with the Health Insurance Acts. The following RMUs are on the Register of Health Benefit Undertakings:
  - ESB Staff Medical Provident Fund
    Irish Life Assurance Plc Outdoor Staff Benevolent Fund
    Irish Life Medical Aid Society
    New Ireland/Irish National Staff Benevolent Fund

Prison Officers Medical Aid Society
St Paul's Garda Medical Aid Society
The Goulding Voluntary Medical Scheme.

- **Interim Scheme of Age-Related Tax Credits and Community Rating Levy**

1) The scheme, which is administered by the three open membership private health insurers, has been in existence since 2009. It is Exchequer neutral and ensures that every customer has the benefit of a community rated health insurance premium. Community rating in principle means that each insurance policy, containing specified benefits, is priced the same to everyone, irrespective of their age or medical condition. The purpose of the scheme is to support community rating where everybody pays the same amount for their health insurance.

2) Restricted membership undertakings are excluded from the scheme as their insurance products are not available to the general public.

3) The scheme allows insurers with additional costs arising from insuring older people (who have a preponderance of claims) to be compensated for up to, but no more than, 65% of these additional costs. It works by allocating Tax Credits to insurers for persons in three age bands and funding this by the payment of a Levy by all insured persons in the market.

4) The amounts of the levy and the tax credits by age group have been chosen such that where an age group gives rise to claims losses, the system should reduce those claims losses by 65% for older age groups compared with the average claims for all age groups.

5) The choice of a 65% reduction in average claims costs at older ages is designed to strike a balance between reducing the incentive that exists for insurers to avoid older customers, while also allowing for a competitive market in which individual insurers are not required to share efficiencies in their own claims management with their competitors.

6) The HIA report recommended increasing the tax credits applying for policies commencing in 2011 to equate to 65% (up from 50%) of the higher levels of prescribed benefit for older people and combined this with a proposal to remove tax credit in respect of those in the 50-59 age group.

7) The HIA determined that there was no overcompensation in respect of 2009 and concluded that the net impact of the tax credits and levy proposed for 2011 is significantly less than the estimate of the extra cost of providing cover to older people, calculated using market data.

8) Having discussed the changes with the European Commission, the Department notified health insurers in December 2010 of the revised rates which would apply for policies commencing or being renewed from 1 January 2011.

9) The HIA has estimated that the net benefit of the tax credits/levy to VHI in 2011 will be in the region of €70m and the corresponding cost to Aviva and Quinn will be in the region of €33m and €37m, respectively.

The rates for 2011 and 2010 are set out below.

Age-Related Tax Credits 2011 (Additional tax relief, for the benefit of health insurance companies, starting for people aged 60 and over and increasing for higher age groups)		
Age Band	**2011 Rates**	**2010 Rates**
50-59	Nil	€200
60-69	€625	€525
70-79	€1,275	€975
80+	€1,725	€1,250

Stamp Duty 2011

The rates for 2011 are set out below with 2010 rates in brackets.

€205 in respect of each insured person aged 18 or over (*2010 rate €185*)
€66 in respect of each insured person aged less than 18 (*2010 rate €55)*

- **VHI Price Increases from 1 February 2011.**

  - The increases announced by VHI will amount to 15% for more than half of its customers, with higher increases up to a maximum of 45% for those on other plans.

  - Family Plans
    Families on the Parents & Kids plan, VHI's most popular family plan, will see their premiums increase by 15% in February 2011 or approximately €331 per year. Over the past two years families have seen prices increase by 13% in total as VHI decreased the child rate on their most popular family plans in 2009. Family customers of one of VHI's competitors have seen their premiums increase by 33% in the same timeframe.

Premiums for a family of two adults and two children on VHI's Parents & Kids after 1 February 2011:

Date	Adult Premium	Child Premiums	2 adults & 2 children
February 2011	€1,043.04	€226.75	€2,539.58
February 2010	€906.99	€197.18	€2,208.34
February 2009	€828	€300	€2,256

Premiums for a family of two adults and two children on VHI's One+ Plan after 1 February 2011:

Date	Adult Premium	Child Premiums	2 adults & 2 children
February 2011	€828	€218.50	€2,093
March 2010	€720	€190	€1,820

Plan B and Plan B Options

VHI Healthcare has increased the premium for one adult on Plan B by €317 to €1,224 and Plan B Options by €444 to €1,430 from February 1, 2011. 29% of VHI Healthcare's customers currently have Plan B or Plan B Options.

2011 Price increase by plan

60% of VHI customers will see the cost of their premium increase by 15% when their policy falls due for renewal. The 15% increase will apply to VHI's Plan A, Parents & Kids, Life Stage Choices and One Plans. The remaining plans will see premium increases as follows:

Plan B /Plan B Excess	35%
Plan B Options	45%
Plan C	25%
Plan D	21%
Plan E	21%

Annual increases in premium rates

Year	BUPA / Quinn Increases	Vhi Increases	VIVAS / AVIVA Increases
1990 / 1991	n.a.	4.0%	n.a.
1991 / 1992	n.a.	5.1%	n.a.
1992 / 1993	n.a.	4.1%	n.a.
1993 / 1994	n.a.	6.0%	n.a.
1994 / 1995	n.a.	8.5%	n.a.
1995 / 1996	n.a.	6.0%	n.a.
1996 / 1997	n.a.	6.0%	n.a.
1997 / 1998	9.0%	9.0%	n.a.
1998 / 1999	9.0%	9.0%	n.a.
1999 / 2000	9.4%	9.4%	n.a.
2000 / 2001	6.25%	6.5%	n.a.
2001 / 2002	9.4%	9.0%	n.a.
2002 / 2003	14.4%	18.0%	n.a.
2003 / 2004	8.25%	8.00%	n.a.
2004 / 2005	6.0%	3.0%	n.a.
2005 / 2006	9.0%	12.5%	7.5%
2006 / 2007	0.0%	12.5%	6.7%
2007 / 2008	8.2%	8.5%	10.2%
2008 / 2009	16.0%	23.0%	6% - Oct 2008 €128 per adult (net of trs) – Jan 2009
2009 / 2010	15.0%	8.0%	12%

Notes:

1. In each row increases took effect between September of the first year and March of the second year.
2. Increases are those announced by the insurers as "average increases" except for the Quinn increase in 2007 /2008 (see note 3). Percentage increases vary significantly by products.
3. Quinn did not announce an average increase in 2007 / 2008. Quinn had a range of different increases / reductions in the core price for different plans, removed the group discount for most people and introduced a charge for monthly premiums. The figure included here is the increase in average premium paid per person, which will include the effect of upgrading / downgrading.

Brief for Minister for Health and Children

March 2011

From Chief Medical Officer

On the state of public health

Introduction

Ireland has made very significant strides in relation to the health of its people in recent decades. People now live longer and with a greater quality of life than ever before. We have seen improvements in standards of living, education, health behaviours, access to and quality of health services, health technologies and a range of other important trends. This has led to gains in important measures of public health that have improved Ireland's health not only in absolute terms but also relative to other countries in the EU and the OECD.

Much of this success has been achieved through the pursuit of public health policies over many decades. The success of public health policies in reducing the mortality and morbidity from communicable disease, providing clean water and air, providing safer food, promoting health behaviours and tackling other health determinants has been overshadowed in more recent years by the necessary focus on health system performance.

The cost and long-term sustainability of our health system is a major challenge. For many years, the health of Irish people has improved due to better treatment and prevention from the major diseases. This window is, however, slowly closing. Our ageing population, together with adverse trends in obesity, diet, exercise and other risk factors means that the level of chronic health conditions will certainly increase. There is much which can be done because approximately two thirds of the predicted disease burden is caused by risk factors which can be prevented.

Strategic context

Strategically, there are two major priorities for the health system. The first is **maximising health system performance** relative to available funding. This encompasses policy issues such as effectiveness, efficiency, VFM etc. The second is **maximising health** which encompasses health promotion, health improvement, health protection and health inequalities. The former is inward looking in terms of the health system whereas the latter needs to be more outward and medium term looking in terms of influences on health, health determinants etc.

The focus, quite reasonably, of the HSE, the Department and many key wider stakeholders, the media etc. has been very much more around health system performance agenda. Given its importance, that is something we all understand and support.

As with other countries, we are increasingly challenged by non-communicable disease- a range of largely preventable conditions which are shaping and challenging the provision

of health services, not just from a financial point of view but also from an organisational point of view. By this I mean the fact that the health system is well structured to deliver episodic care but, as with all other developed health care systems, struggles with the challenges posed by chronic disease which require a greater focus on prevention, co-ordination, continuity, integration and information flows which follow the patient.

Public health protection is an essential goal for society in delivering wellbeing and quality of life. Based on our growing body of knowledge of the determinants of health and of the distribution of diseases and conditions within the population, it is possible to protect the health of the population through the identification of possible threats and through putting in place measures to prevent or reduce their impact on health.

Health trends

Demography

The rise in life expectancy in Ireland during the past decade has been unmatched by any other country in Europe. Ireland has gone from a position of nearly 1 year below average EU life expectancy to almost 1 year above in the space of 10 years during which time average EU life expectancy has also been increasing (see Figures 2 and 3). The greatest gains have been achieved in the older age groups reflecting decreasing mortality rates from major diseases.

During the past decade the single most dramatic demographic feature has been the unprecedented rise in population by more than 16% to a figure of 4.4 million. It is worth noting that older cohorts of individuals are living longer than ever before in human history. At the same time, younger cohorts are having fewer children.

Key Facts- Demography

- Total population of Ireland 2006 census is 4,234,925. This is over 72,000 more than the projected figure from the 2002 census and the majority of the population live in or close to major urban centres
- The total fertility rate has fallen from over 3 in 1980 to approximately 2 in recent years
- Immigration has been mainly in the 25-44 age group and so has added to the labour force and decreased the dependency ratio
- The total dependency ratio will increase in the future due to increased life expectancy and declining fertility rates
- The number of older people is expected to rise by 230% to 1.5 million in 2036. The number of older people will rise by approximately 168% to 1.243 in 2036. (CSO: Population & Labour Force Projections 2011-2041)
- By 2021, 30% of those aged 65 years and over will live alone
- The Race and ethnicity structure of the population of Ireland is changing and the health inequalities experienced by ethnic minorities in other countries is well recognised
- People over 65yrs contribute significantly to the percentage of acute hospital bed days used
- Changing demographics will significantly increase the demand for health and social care and new methods of reducing demand for healthcare and health system funding is urgently required
- As many of these issues are cross cutting, real and defined intersectoral working is required.

When these two effects interact with roughly constant retirement ages, the aged dependency ratio increases. It is important to distinguish between increasing longevity and an increasing age dependency ratio. The first gives a sense of the increase in aggregate size of the retired population; the second gives a sense of fiscal capacity to support the retired population.

CSO projections indicate that the number of people over the age of 65 is projected to increase from over 500,000 now to over 1,300,000 in the next 30 years with the greatest proportional increases occurring in the 85+ age group (Appendix 1).

Rising levels of population health does not mean that all people benefit equally. All the evidence we have points to widening gaps in health experiences. Data from the recent All Ireland Traveller Health Study, for example, show traveller life expectancy remains at levels last experienced by the general population 60 years ago. Traveller men have a life expectancy 15 years less than the general population, and 10 years less for Traveller women.

Life style related risk factors

Many factors influence and determine health, whether at an individual or population level. A range of factors has been identified as social determinants of health and these generally include: the wider socio-economic context; inequality; poverty; social exclusion; socio-economic position; income; public policies; health services; employment; education; housing; transport; the built environment; health behaviours or lifestyles; social and community support networks and stress. At an individual level, factors such as age, sex, hereditary factors and lifestyle choices are important health determinants.

Key Facts- Lifestyle related health facts

- Approximately 60% of the predicted disease burden is accounted for by seven preventable and leading risk factors including high blood pressure, tobacco, alcohol, high cholesterol, overweight and obesity, poor diet and physical inactivity.
- The burden of lifestyle risk factors that contribute to chronic diseases rests more heavily in the lower socio-economic groups arising from underlying social, economic and environmental determinants of health, particularly during childhood.
- Smoking – smoking is the leading cause of preventable mortality accounting for over 6,000 deaths every year.
- Smoking prevalence declined up to 2005 but has remained static ever since. There has been a sharp increase in smoking prevalence in children between the ages of 15-18 since 2006. Recent EU data shows that Ireland is one of the few countries in the EU with a rising prevalence of smoking
- Alcohol – Irish adults drink in a more dangerous way than nearly any other country. Irish children drink from a younger age and are drinking more than ever before. Alcohol is a contributory factor in half of all suicides and accounts for up to 10% of bed days in hospitals. Alcohol related road accidents cost an estimated €530million in 2007
- Obesity – in Ireland, overall 36% of adults are overweight and 15% are obese. This trend is increasing
- The environment in which we live is obesogenic, favouring a sedentary existence with increasing urbanisation, television, computers, DVDs and use of cars combined with increasing use of convenience or processed calorie-dense foods.
- There is a trend of decreasing physical activity among Irish adults, particularly for women.
- A little more than half of children exercise at least four times a week and, in adults, more than one in four have little or no physical activity.
- Illicit drug use is another significant risk factor for morbidity and mortality and a variety of studies show increasing use. For example, the percentage of 10-17 year old school aged children increased from 12% in 2002 to 16% in 2006 reporting lifetime use of cannabis.

People who are less well off or who belong to socially excluded groups tend to fare badly in relation to these social determinants. For example they may have lower incomes, poorer education, fewer or more precarious employment opportunities and/or more dangerous working conditions or they may live in poorer housing or less healthy environments with access to poorer services or amenities than those who are better off – all of which are linked to poorer health.

In order to translate high-level policies into measurable achievements and to embed the principles of sustainable development in all policy areas we need to increase our reach outside the traditional health service silos, across government, into local government, the voluntary sector, and communities themselves. This requires a partnership approach and a commitment to maximising the contribution of existing opportunities.

Efforts to address inequalities in health must address the way in which the social determinants of health are distributed unfairly. Addressing the social determinants of health suggests 'going beyond the immediate causes of disease' and placing a stronger focus on upstream factors, or the fundamental 'causes of causes'.

Chronic disease

In overall population health terms, the past decade presents a clear picture of rapid decreases in mortality rates from chronic diseases accompanied by a rapid rise in life expectancy. Mortality from circulatory system diseases fell by almost 40% between 2000 and 2009 and cancer death rates reduced by 11%.

Ireland remains somewhat (5.5%) above the EU mortality rate for cancer and for deaths from smoking-related diseases, many of which will, of course, be cancers. Survival rates from cancer continue to improve and the gains are leading to a reduction in the gap between survival rates in Ireland and other developed countries.

Key facts- Chronic disease

- Heart disease, stroke, cancer and other chronic diseases will account for the greatest burden in deaths and disability for the foreseeable future
- Approximately 80% of GP consultations and 60% of hospital bed days are related to chronic diseases and their complications
- Approximately 60% of the disease burden in Europe is accounted for by 7 leading risk factors including high blood pressure, tobacco, alcohol, high cholesterol, overweight and obesity, poor diet and physical inactivity
- There is a projected increase in health service demand of 60% by 2020 that will continue to rise thereafter
- Health inequalities in chronic illness rates are mirrored by higher rates of risk behaviours in lower socio-economic groups
- The prevalence of diabetes is predicted to increase significantly. This represents a challenge to primary care and hospital management. Most of this demand should be managed in the community, based around the primary care team. Demand will arise from the diagnosis and management of diabetes and more importantly from the associated vascular, skin, kidney and eye complications.
- There has been a very significant increase in the incidence of suicide in the last two years.
- About 1 in 4 people will experience some mental health problems in their lifetime
- The estimated cost of mental health problems to the economy was outlined at €3 billion in the Mental Health Commission's report "The Economics of Mental Health Care in Ireland" published in September 2008
- By 2020 it has been estimated that depression will be the leading cause of morbidity in Europe. Such disorders can lead to suicides.

The challenge of an aging population together with unhealthy lifestyles is steadily increasing the level of chronic diseases in this country and this will continue for the foreseeable future. Future projections indicate a doubling of some chronic diseases over a 15 to 20 year period. Ill health related to lifestyle factors such as tobacco, alcohol, diet and a lack of physical activity are key in preventing chronic diseases reaching unsustainable levels. The burden of lifestyle risk factors that contribute to chronic diseases rests more heavily in the lower socio-economic groups.

Effective interventions are known and it is estimated that 80% of cardiovascular disease and type 2 diabetes as well as 40% of cancer could be avoided if major risk factors were eliminated. The model of chronic disease care required to meet this challenge will need to involve more proactive care which is structured and integrated and which focuses on the prevention of the condition and its complications. Prevention will need to be focused not only on those at high risk but also the entire population to reduce risk factors for chronic diseases. Population based preventative strategies share a common approach that combines elements of wider public policy which address the core determinants of health such as poverty, education, food production and marketing, environment and transport policies.

The primary healthcare sector will also play a central role in the overall care that is required. One important challenge is to continue the development of models of shared care within disease management programmes that describe the nature of preventative care, treatment and rehabilitation between primary care and specialist services. This will require patients to actively participate in the management of their condition and self-care programmes should play a key role in the management of chronic conditions.

Health Protection

Control of communicable diseases continues to be one of the major public health successes in Ireland. Despite this, challenges remain. In the global context, there is a growing risk of transmission of communicable disease, ensuing from ever-increasing global travel and trade. Recent decades have seen the emergence of new, previously unrecognised threats such as:

- Pandemic Influenza (H1N1) 2009
- Severe Acute Respiratory Syndrome (SARS)
- Acquired Immune Deficiency Syndrome (AIDS)
- Transmissible Spongiform Encephalopathies (TSEs)
- Ebola haemorrhagic fever (EHF)
- Anti-microbial resistance.
- Avian Influenza H5NI

The following outline some of the principal challenges which we will continue to address.

Antimicrobial Resistance (AMR): Complex medical care (organ transplantation, cancer chemotherapy) has resulted in an older patient population, many of whom live with multiple medical illnesses and who are more susceptible to infection. While we have seen significant improvements, the speed with which antibiotic resistance has developed has now outstripped the availability of novel treatments. Antimicrobial resistance has the potential to become a significant threat public health in Ireland unless the principles of prudent antimicrobial use become deeply embedded in medical and veterinary practice.

Healthcare-Associated Infection (HCAI): Infections occurring during a patient's hospital stay remain an important cause of harm and death. Key interventions which protect patients include; hand hygiene, sensible use of antimicrobials and ensuring that invasive medical devices (e.g. IV lines/drips, urinary catheters) are managed properly and removed promptly. National standards and guidelines have been published regarding key

HCAI issues and are being implemented. The number of new C. difficile infections and invasive MRSA infections has been declining and alcohol hand gel use has been increasing.

Vaccine Preventable Diseases (VPD): Vaccine preventable diseases are one of the great public health successes. Many children survive and many more people live free of disability because of the power of vaccination. That said, our levels of coverage are not as high as many other EU Member States. Information systems are not sufficiently robust to identify those children which remain unprotected by a second dose of certain vaccinations.

HIV/AIDS: HIV/AIDS remains a substantial threat to the Irish population. In recent years the number of cases acquired in the risk group men having sex with men (MSM) has increased considerably. With HIV to be included on the list of notifiable diseases shortly, the challenge of this disease should become more manageable.

Sexually Transmitted Infections (STI): Sexually transmitted infections have increased dramatically over the last 10 years almost doubling between 2000 and 2008 to 11,294 cases. These figures highlight the importance of early treatment and effective preventive strategies to minimise the health effects of these infections.

Hepatitis and gastroenteric infections: Hepatitis C is a significant problem in Ireland, with an estimated 20-50,000 people in Ireland chronically infected with hepatitis C. While there is no vaccine, effective treatment is now available with a sustained response in around 50% of cases. Demand for health care relating to serious liver complications in those chronically infected with hepatitis C is expected to increase significantly in the next decade. Despite the low prevalence of hepatitis B in the Irish population, the risk of transmission is rising. The introduction of a Hepatitis B vaccine into the primary childhood vaccination schedule will ensure that future generations are protected against this preventable disease. Reported verotoxigenic E.coli (VTEC) infection and cryptosporidiosis rates are one of the highest in Europe. Improvements to public water supplies will help reduce one of the common exposure routes.

Respiratory Disease: Tuberculosis remains one of the most important communicable diseases globally and in Ireland over the last decade an increasing proportion of cases have been diagnosed in those born outside the country (approximately 40% in recent years). With reduced immigration into Ireland this increase is expected to decline. New guidelines on the prevention and management of Tuberculosis were published in 2010. The seasonal influenza wave for the 2010/2011 season started in mid-December. GP out of hours services were particularly impacted over the Christmas and new year holiday period. Children were relatively less affected than during the pandemic wave, probably related to the pandemic vaccination programme undertaken during late 2009 and the early part of 2010. Ninety of the 120 ICU cases admitted this flu season (75.0%) had underlying medical conditions. Many of those in the risk categories had not received the recommended dose of seasonal flu vaccine with 2/3 of the fatal cases known not to have received seasonal flu vaccine and only 10% known to have received it.

Public health preparedness: Public health threats such as the recent swine flu pandemic illustrate the need for health emergency preparedness as these threats span the spectrum

of health services and often require an intersectoral response. Similar responses may be required for threats relating to environmental factors. Measures to enhance air quality, limit public exposure to pollution, hazardous chemicals and noise are key priorities in reducing the impact of environmental factors on health.

Climate change poses a major challenge to the health of the world's population in the future. Health consequences include increased heat related mortality and morbidity, decreased cold related mortality in temperate countries, greater frequency of infectious disease epidemics following floods and storms and substantial health effects following population displacement from sea level rise and increased storm activity.

Environmental changes arising from global travel and trade, increasing industrialisation and technology, changes in human behaviours and changes in land and environment use all present an ongoing threat to food, air and water supplies

Conclusion

Ireland is facing a period of major challenge in relation to its health system. The population is growing and ageing. Its composition is also changing in a way which will define our future health needs. A higher proportion of the population will be dependent on those in work, which will impact our ability to care for the growing number of, particularly elderly, people with health and social needs.

In parallel with the ageing of the population there will be a very significant increase in the prevalence of chronic diseases such as cancer, diabetes, cardiovascular disease, mental illness, dementia and locomotor disabilities. This is due to a combination of an increase in the incidence of these conditions, related largely to underlying lifestyle related health risks, as well as falling disease specific mortality for cancer and cardiovascular disease meaning that many people are now living with, rather than dying from, chronic disease.

A small number of avoidable risk factors cause most of the burden of chronic disease. Tobacco consumption, alcohol, diet and physical activity are key lifestyle issues where even modest changes among the population will bring about important improvements in people's health. This would benefit significantly from a high level co-ordinated intersectoral approach that addresses the determinants of health and which is lead by Government through the Minister of Health and Children. Public policies and health care programmes which promote healthier lifestyles as well as improving the environments where we live and work, will prevent the emergence of risk factors and reduce chronic diseases and their burden to families and society. The policy approaches share common elements such as health education and awareness programmes, initiatives to limit the availability of products such as tobacco and alcohol which impact on health and the capability to monitor and evaluate health improvement actions. The Department has prioritised a number of health improvement actions on diet, physical activity, tobacco and alcohol consumption. It is important that there is consistency in these approaches and that actions are sustained.

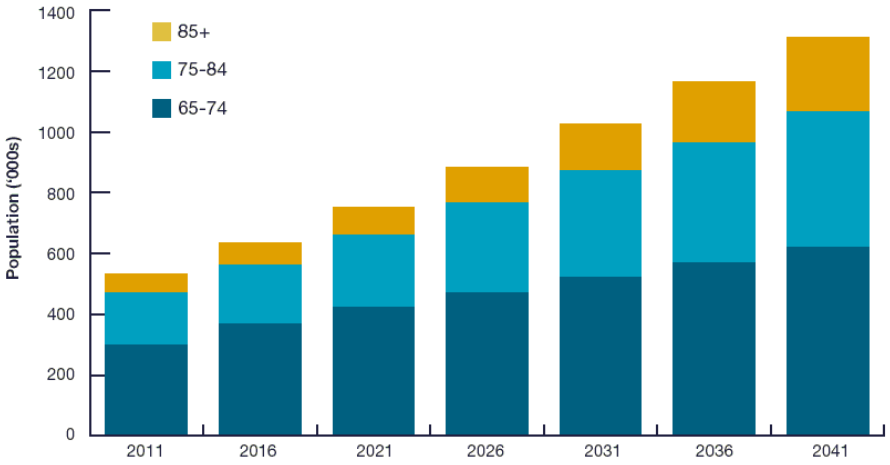
In recent years, the health system has undergone significant changes. For now and future years, a key element is that the health of the population is at the centre of public policy and that there is an appropriate public health function to support this. In the course of

2011, the Department of Health and Children will evaluate the role of public health in this new environment.

Dr Tony Holohan
Chief Medical Officer
February 2011

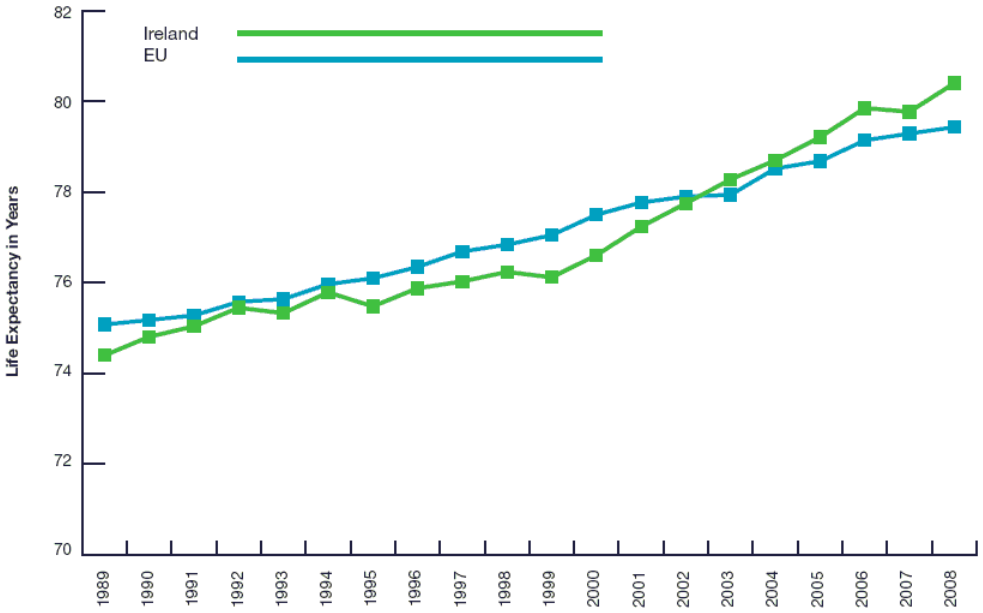
Appendix 1 Population and health information for Ireland

Figure 1 Projected Population for Older Age Groups, 2011 to 2041



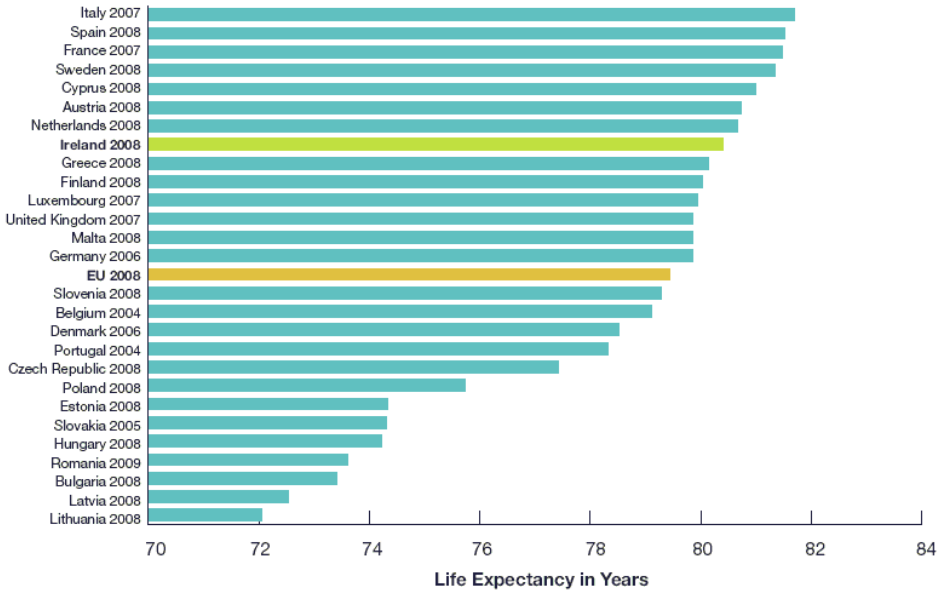
Source: Central Statistics Office - Population and Labour Force Projections 2011-41.Note: M0F1 assumption used

Figure 2 Life Expectancy at Birth for Ireland and EU-27, 1989-2008



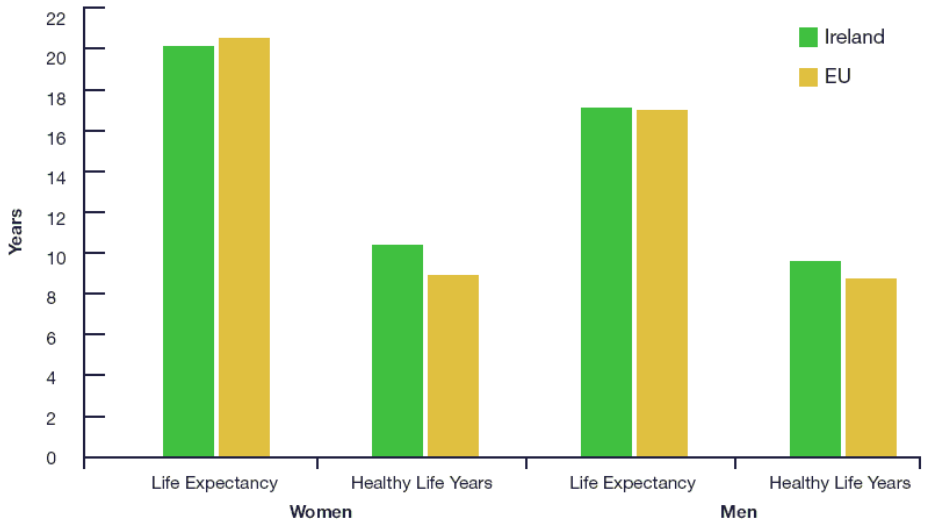
Source: European Health For All Database, WHO Regional Office, Copenhagen, Denmark

Figure 3 Life Expectancy at Birth for EU Countries, 2008 or Latest Available Year



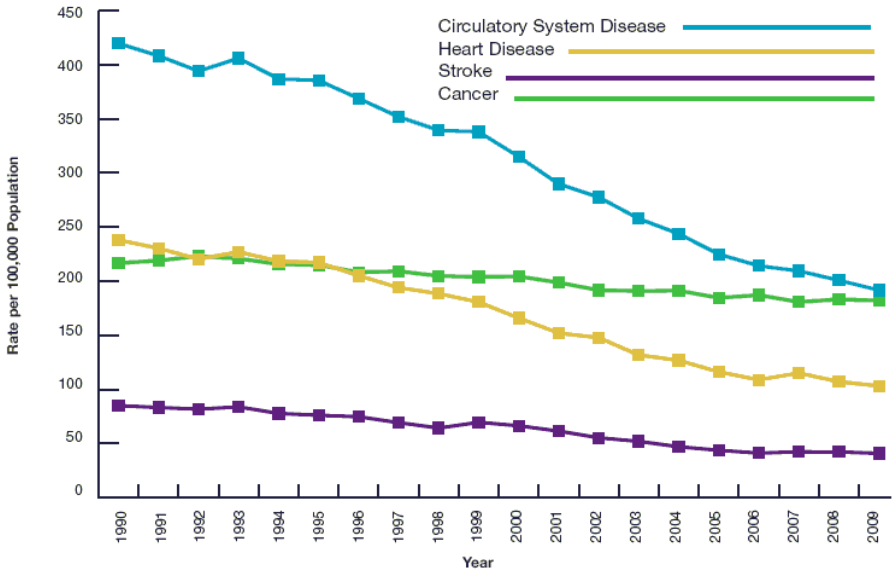
Source: European Health For All Database, WHO Regional Office, Copenhagen, Denmark

Figure 4 Life Expectancy and Healthy Life Years at Age 65 Male and Female, Ireland and EU-27 2007



Source: Eurostat

Figure 5 Age Standardised Death Rates for Selected Causes, 1990-2009



Source: Public Health Information System (PHIS), Department of Health and Children

Briefing for New Minister on Rare Diseases

Department's Role

The Department's role is to deliver on the EU Council of Minister's agreement for Governments to develop national policies on rare disease by 2013. Ireland also participates in a number of European Commission Committees which supports work on rare diseases at EU level.

The Rare Diseases Policy

The proposed national rare disease policy will involve a number of elements:

- The development of an over arching plan for rare diseases to focus and orient action
- The development of national/regional centres for expertise for the diagnosis and management of rare diseases and to link with established EU reference networks
- The development of policy on access to orphan drugs and their reimbursement for patients
- The fostering of research on rare diseases
- The establishment of adequate mechanisms for the definition, classification and codification of rare diseases. This will include consideration of patient registries for epidemiological and planning purposes.

The Department is establishing a National Steering Group to oversee the development of a national plan for rare diseases. The Institute of Public health In Ireland will assist the Department throughout the process. Membership of the Steering Group is to be drawn from representative stakeholders including the Department, the Health Service Executive, the Health Information and Quality Authority, the Health Research Board, the Irish Medicines Board and patient organisations. It is proposed that work commence in Q2 2011 and that the strategy be completed midyear 2012.

Health Promotion Policy Unit

February 2011

Briefing for new Minister

Acute Hospital Services

Key Issues

Introduction

This note provides information and an overview of the key issues faced by the acute hospital system. More detailed information is of course available on each area. The issues discussed are:

National Issues

1. Acute hospital activity
2. Acute hospital capacity
3. Reconfiguration of acute services
4. Emergency Departments
5. Waiting times for elective services
6. Ambulance and patient transport services
7. Maternity services

Other Service Issues

8. Children's Hospital of Ireland
9. Lourdes Hospital Redress Scheme
10. Symphysiotomy
11. Drogheda Review
12. Cystic Fibrosis

1. Acute Hospitals: Activity

There are some 50 acute hospitals in Ireland, which in 2010 treated 586,000 in-patients 733,000 day cases, 3.6m out-patients, 1.2m attendances at emergency departments and assisted over 74,000 births.

Activity: The level of service provided

In order to maximise efficiency, the focus has been on increasing day case activity while reducing reliance on inpatient treatment. As illustrated below, day cases now substantially outstrip in-patient work in Irish hospitals. Since 2005, inpatient discharges have remained more or less the same (a 1% increase) while daycases have risen by 43%. Significant increases in births (27%) and outpatient attendances (37%) have also been managed. Emergency department attendances rose by 9% over the same period.

Key Acute Hospital Data 2005-2010	2005 2	006	2007	2008	2009	2010 (provisional outturn data)	% change 2005-2010
Inpatient discharges	575,476	588,875 61	2,346 59	9,910	593,359	586,102	1%
Day cases	512,034	558,813 58	3,369 64	1,974	669,955	733,131	43%
OPD attendances	2.6m 2.	8m	3.1m	3,275m	3.35m	3.58m	37%
ED attendances	1.1m 1.	245m	1.3m	1.15m	1.12m	1.2m	9%
Births	58,489	62,740 6	9,998 7	4,000	74,602	74,280	27%

These increases in activity have been achieved against a backdrop of an ageing population, increased incidence of chronic disease and curtailment of the number of acute beds available, primarily for reasons of cost control.

Other Key Hospital Data, 2010

Average Length of Stay	6.1 days
Emergency Admissions	369,000
Delayed discharges	601 (Dec 2010)
Bed days used	3.6m
Occupancy rates	90.1%
Elective in-patient procedures on day of admission	50%
ED waiting times - Patients admitted within 6 hours of registration - Patients admitted or discharged within 6 hours - Patients not needing admission discharged within 6 hours	 56.2% 62.7% 93.3%
OPD - New:Return Ratio - Did not attend (DNA) rate	 1:2.6 14.3%
Births by Caesarean Section	26.0%

Source: HSE Performance Report, December 2010

HSE 2011 National Service Plan
The HSE's Service Plan for 2011 concentrates again on achieving increased efficiency, committing to broadly the same level of overall hospital activity as in 2010. Main features include:

- a 2 % reduction in in-patients, offset by a 3% increase in day cases
- achieving targets on selected procedures, 75% of which should be done on a day basis
- improving the ratio of new to return patients in OPD, with a 1:2 target (some hospitals have an excessive number of return patients)
- a 30% increase in new OPD attendances in two target specialties - dermatology and neurology
- performance improvements in areas such as same-day admission for surgery and minimising length of stay.
- reduce the significant variations in length of stay for similar treatments between different hospitals.

The HSE's commitment to implementation of a number of national programmes, such as the acute medicine and elective surgery programmes, will support the achievement of these targets in 2011.

Potential for further efficiency
In 2010 the Department analysed data from the HIPE (Hospital Inpatient Enquiry) system to see what potential there might be for more efficient practices across the hospital system.

Some of the findings were:

- Big variations in the extent to which elective patients are admitted on the day of surgery. St. James's does so in 65% of cases while St. Vincent's and Tallaght are at just 17% and 15% respectively.

- Significant differences in Average Length of Stay (ALOS) for elective patients, depending on the day of admission. In the Mater, ALOS is 6.76 days for those admitted on a Monday but 13.5 days for those admitted on a Saturday. CUH's figures are 5.09 and 11.15, and Connolly 5.07 and 16.18.

- Big variations in ALOS when the top 100 Diagnosis Related Groups (DRGs) by volume are analysed. We could save many thousands of bed days if hospitals achieved, or even moved towards, the average for the best three hospitals in each DRG.

This information has been shared with the HSE. Developmental work already under way, such as the Elective Surgery Programme and the Acute Medicine Programme, is aimed at delivering more clinically appropriate and more cost-effective care. The Department has also strongly encouraged the Executive to continue to develop its capacity to analyse and use the data available to it to inform the management and delivery of acute hospital and other services. services. The HSE and Royal College of

Surgeons (RCSI) are working on standardised length of stays for a set of key procedures with a view to achieving these in co-operation with clinicians.

Challenges to achieving efficient hospital activity
Significant changes in working practices and procedures in hospitals will be needed to achieve continued improvements in efficiency. The need to live within budgets may lead to the implementation of relatively crude measures in the short-term, such as further bed closures, before the necessary service improvements are brought to fruition.

In the coming years, unless appropriate new service delivery arrangements are developed which move as much non-acute activity as possible into primary care, the acute hospital system will still be stretched to cope with the demographic and other pressures.

2. Acute Hospitals: Capacity

Bed Numbers
The total complement of public hospital beds is currently 13,400 (11,600 in patient and 1,800 day beds). This excludes acute psychiatric beds.

The exact number of beds available at any one time fluctuates, depending on such factors as planned activity levels, maintenance, refurbishment and staff leave arrangements. Beds may also be closed from time to time in order to control expenditure, given the need for every hospital to operate within its allotted budget for the year.

Bed numbers are not a meaningful currency for measurement of hospital system performance. Beds represent an input rather than an output. The real issue is the number of patients treated rather than the number of beds at any one time.

The focus is increasingly on greater efficiency and more appropriate models of patient care, treating more/same numbers in same/fewer beds through such measures as shifting patients to lower levels of complexity (day surgery, community-based services, etc). The service has been treating a greater number of patients from year to year, through more efficient and clinically more appropriate processes, as illustrated earlier in the table on hospital activity from 2005 – 2010.

Beds closed
Latest HSE data shows that 886 in patient beds and 9 day beds were closed in the week ending 27 February 2011.

It is important to note that at any one time there are usually several hundred beds declared as “closed” and in recent years this number has not fallen below 400-500. It is doubtful that many of these beds will be brought back into commission in the foreseeable future because of the financial implications, particularly in respect of costs such as nursing, pharmacy, catering and cleaning, as well as theatre and diagnostic costs where these arise.

The overriding requirement on hospitals to manage within budget could result in additional bed closures during 2011. This could result in longer waiting times and cancellation of elective admissions if the type of efficiencies discussed above (section 1) are not delivered.

Progress has been made in recent years in developing primary care and community based services. It will however take time to put in place the kind of integrated community-based service (like those in Denmark or Canada) envisaged by the PA Consulting Report. Significant service demands will therefore continue to be placed on the acute hospital system, particularly in terms of inpatient beds.

The goal of maximising hospitals' efficiency cannot be achieved overnight. Improving efficiency will take sustained efforts over a number of years.

Increasing Bed capacity: Co-Location

The intended purpose of the co-location policy was to provide extra bed capacity. It was seen as the most cost effective way to deliver up to 1,000 extra beds while minimising the capital costs to the State. This was to be done through the development by the private sector of private hospitals on the sites of public hospitals and the transfer of private activity on these sites from the public to the private hospitals. In July 2005 the then Minister issued a formal direction to the HSE under section 10 of the Health Act 2004 to implement the policy, setting out an assessment framework. This set out requirements concerning value for money, governance and other criteria.

There are legal agreements in place governing the development of a number of co-located hospitals, but the current economic environment has made it extremely difficult for the projects to secure financing from international or Irish banks.

A separate note on co-location is attached.

3. Acute Hospital Reconfiguration

National Issues

Ireland's acute hospital system developed in a piecemeal fashion over many years. It was originally organised around individual county hospitals, an arrangement which served the country well in the 1930s – 1950s, but it is not the basis for a safe, high quality service in modern times.

Successive reports have raised concerns about the low volumes of complex activity carried out in some hospitals, and have pointed to the difficulty of safely maintaining these services in all acute hospitals. However, the reports have also stressed that smaller hospitals have a very important role in providing services to their local communities, including day surgery, diagnostics and OPD. Properly organised, these facilities can and should meet a very high proportion of the hospital related needs of local population.

The reconfiguration of hospital services currently underway is intended to deliver a health system that is in line with the model of care emerging internationally, particularly in terms of quality and patient safety. It also aims to improve efficiency and to ensure the sustainability of services.

The HSE's clinician-led National Clinical Care Programmes have many of the same strategic aims, especially in terms of providing care in the most efficient and effective manner and in the most appropriate clinical setting.

The future configuration of acute services must also take account of the outcome of HIQA's reports on services at Ennis (2009), Mallow (review underway) and other engagements between HIQA and the HSE in relation to certain risk issues in both the Mid-West and the North-East. The Ennis review noted that the likely approach for surgery was clear, but that more work needed to be done in relation to the best provision of acute medical services.
This has since been assisted by the HSE's Acute Medicine Programme Report, published in December 2010, which sets out four generic hospital models aimed at providing safe and sustainable care within the constraints of each hospital's staffing, facilities and resources.

There has been a focus on developing integrated networks of hospitals in each region, with local agreement as to which hospital provides what service.

Background

The HSE has been proceeding on a phased basis to reorganise acute hospital services. Some regions are at an advanced stage, while others are at an early stage of planning. The HSE has put in place national and regional governance structures to ensure consistency and an integrated approach. At regional level, the process has typically involved a project steering group and a designated local clinical lead. Consultation with stakeholders as proposals are developed is also of critical importance. The process of consultation has greatly improved in recent projects.

Quality, patient safety, service sustainability (particularly with regard to the problems being faced in recruiting NCHDs for smaller hospitals) and the need to maximise efficiency underpin the rationale for reorganising services. The reconfiguration process aims to ensure that:

- Complex care is provided in hospitals with a sufficient case volume to achieve best outcomes for patients;
- Smaller hospitals concentrate on day surgery and diagnostic activity such as imaging and outpatient services;
- There is improved integration with primary care/GP services;
- Hospitals will be able to comply with the introduction of hospital licensing when introduced;
- Best value for money is achieved and duplicated services or low-volume activities are not maintained at too many locations.

The Department has been working with the HSE at a national level in relation to reconfiguration. We participate in quarterly workshops organised by the HSE that bring together all of the key personnel involved in reconfiguration in each region.

Known risks

Local opposition to reconfiguration, often led by local staff, is understandable but risks hampering the implementation of changes needed to maximise the safety of services and hence patient outcomes.

The HSE, while clear about what services should move into the larger central hospitals, needs also to demonstrate in practical ways how less complex activity can shift from the centre to the smaller hospitals. Moving services in both directions is key to an effective service. A good recent example is the colorectal screening programme, which has recently announced the location of candidate hospitals for colonoscopy units under the programme. A number of smaller local hospitals are included, emphasising the argument that they have a genuine role to play in the future.

There is a risk, particularly if it does not prove possible to recruit sufficient NCHDs to smaller hospitals, that changes to services such as 24-hour ED may in some cases have to be brought forward in advance of structured reconfiguration plans being developed. Good planning can help avoid this situation.

Failure to reorganise hospital services safely will prompt requirements for change from other sources. For example, the colleges set minimum standards, including a sufficient volume of cases in each unit, for the purposes of recognising training programmes for NCHDs.

Reconfiguration has to be handled sensitively, based on genuine consultation and good communication. Properly implemented, the process will bring real improvements in outcomes and a more cost effective service.

Progress in Reconfiguration by Region

Reconfiguration is at different stages depending on when the process commenced. It is most advanced in the Mid West and North East. The South West has recently completed an extensive planning exercise, while other regions are at much earlier stages.

Mid West (Clare/Limerick/North Tipperary)
Dr Paul Burke is the clinical lead. The HSE has made significant progress in reorganising acute hospital and related services in the mid-west region since April 2009. This has involved the relocation of some more complex services to Limerick Regional.

A single region-wide department of emergency medicine was set up and 24-hour Accident and Emergency services centralised in Limerick. Staffing of the ambulance services in Clare and North Tipperary has been enhanced and an advanced 24-hour paramedic service is in operation. Ennis and Nenagh now provide an urgent care/minor injuries service for 12 hours a day.

Acute and complex surgery (including all cancer surgery) is now being carried out in Limerick Regional. Five day elective surgery is carried out in St. John's Hospital. Day surgery is undertaken at Ennis and Nenagh and St. John's Hospitals.

A regional department of Anaesthesia/Critical Care has been established and all critical care services are now provided in Limerick Regional. Four additional ICU/HDU beds have been constructed and are expected to be available from the end of the first quarter of 2011 as an interim measure, to facilitate the change in management of critically ill patients in the region. Construction of a new critical care block in Limerick Regional Hospital is proceeding and this project is expected to be completed in the latter half of 2012.

North East (Cavan/Monaghan, Louth/Meath)
The North East transformation programme involves reconfiguring acute and complex care from five to two hospital sites (Drogheda for Drogheda/Dundalk/Navan and Cavan for Cavan/Monaghan).

Dr. Dominic O'Brannigan is the clinical director for Louth Meath and Dr. James Hayes is the clinical director for Cavan Monaghan.

In July 2009, all acute care transferred from Monaghan Hospital to Cavan Hospital, where a Medical Assessment Unit (MAU) is located to assist the Cavan Emergency Department (ED).

In June 2010, all acute and emergency care transferred from Dundalk to Drogheda Hospital. An interim MAU, which complements the new significantly larger ED, is located in Drogheda, where a permanent MAU is due to open shortly. In addition coronary, critical and intensive care beds and two inpatient wards were provided to Drogheda in 2010.

[redacted] but due to safety issues, acute / emergency surgery ceased earlier than originally planned in September 2010 at Navan. Patients currently presenting to Navan are admitted, stabilised and then transferred to hospitals on the Dublin North East rota.

Day medical services, minor elective surgery (i.e. requiring local anaesthetic only) and endoscopy remains in Navan. Orthopaedic Services including elective orthopaedic surgery also continue as normal. [redacted] An MAU is also located in Navan.

Elective day case surgery and diagnostic work continues to take place in Dundalk and Monaghan. MIUs are also located in these hospitals.

The HSE has commenced an assessment in Louth Meath to (a) explore how, in the context of the reconfiguration programme, additional capacity at Drogheda can be determined, with a provisional timeframe for completion of any capital works by mid 2012 and (b) take account of the National Acute Medicine Programme in the delivery of services, including the provision in the programme that MAUs will continue to be

located in local hospitals and receive GP referrals of low risk medical patients that do not require resuscitation.

Separately, the HSE has commenced an assessment to consider which expanded services can be delivered at Monaghan in line with the National Acute Medicine Programme.

South West Reconfiguration (Cork/Kerry)
The clinical lead is Professor John Higgins. The HSE's Report on Reconfiguration of South-West Acute Hospital Services was published in November 2010. It is intended to have a single hospital system for all six acute hospital campuses in the region, with a single regional department in each specialty across the six hospitals, including acute medicine, emergency medicine, general surgery, anaesthetics and maternity, and a single clinical governance structure.

Most complex acute care will be delivered in one regional centre, with most non-complex care delivered in other hospitals. 24/7 ED services will eventually be provided only at CUH and Kerry General, with Urgent Care Centres providing 8am to 8pm services elsewhere. Maternity services will be maintained at Kerry also.

The HSE is commencing detailed implementation planning and the moving of certain services is advanced. For example, rectal cancer services are moving to the Regional Cancer Centre, CUH, in the first quarter 2011. Orthopaedic services are expected to move from St Mary's Orthopaedic Hospital to South Infirmary/Victoria in summer 2011.

South-East Reconfiguration (Kilkenny/ South Tipperary/Waterford/Wexford)
The HSE is in the process of reviewing the organisation of hospital services in the South-East. All South-Eastern Hospitals Group acute hospitals - Wexford, Waterford, South Tipperary (Clonmel) and St Luke's Kilkenny - will continue to be involved in the delivery of services. No decisions on the future arrangements have yet been made. The future arrangements for emergency departments and obstetric services have been particularly contentious issues in the discussions to date.

West/North West
Re-organisation processes are at initial stages in the West /North West.

So far, a Reorganisation Project Group has been established to develop a plan for acute services in Roscommon and Galway. Following consultations with key stakeholders including clinicians, senior managers and directors of nursing across the three hospitals, a reorganisation plan will be developed by the Group.

A Clinical lead will be identified in the near future and a Project Manager will be appointed to co-ordinate and drive planning and implementation. It is expected that an agreed detailed implementation plan will be available in the course of 2011.

Dublin Mid-Leinster
A project team has being formed and initial planning towards the development of a full project plan is underway in the region.

4. Emergency Departments

Waiting times in Emergency Departments (EDs) are unacceptable and a major source of concern. The problem is generally confined to those awaiting admission, but where it occurs patients are severely affected.

The HSE's target is to assess, treat and discharge or admit every ED patient within a maximum of 6 hours from the time of registration. The data available at present indicates that about 94% of ED patients *who do not require admission* are treated and discharged within 6 hours, but that only 55% of patients *who need admission* are treated within this time.

The problems cannot be addressed solely within EDs themselves. They must be dealt with throughout the whole hospital (e.g. through support from medical and surgical teams) and the rest of the health system (including action to address delayed discharges).

Data: Waiting Time Performance

Ireland has 50 acute hospitals, of which 33 have Emergency Departments. The EDs handle around 1.1 million emergency presentations each year and about one-third of these require admission to hospital.

For many years the HSE has been counting waiting times in EDs by recording the numbers assessed as in need of admission at 2 pm each day. This is a poor indicator of the true extent of waiting times since it records only those who need to be admitted (ignoring those who do not) and counts their time spent waiting only from the point of decision to admit. This '2 pm trolley count' understates actual waiting times considerably.

The Irish Nurses and Midwives Organisation publishes an 8 am trolley count, which shows even poorer performance because it is taken before morning ward rounds that lead to discharge or admission of many patients. It is also a poor indicator of waiting times and is not necessarily validated in the same way as HSE data.

The HSE is now implementing a project to collect data on the full patient waiting time experience in EDs. This 'time in/time out' data will show the actual time waited by all patients, whether admitted or not, and it will be a much more meaningful indicator than either 8am or 2pm trolley counts.

The new data set cover 17 hospitals so far. The HSE aims to cover 21 hospitals by the end of March, accounting for 71% of all ED attendances, rising to 28 hospitals and 90% of all attendances by the end of 2011. The data indicate that we are well short of achieving a 6-hour target for all patients. Latest data (mid February) shows:

- 62.8% seen and admitted or discharged within 6 hours
- 84.8% seen and admitted or discharged within 12 hours; and
- 97.6% seen and admitted or discharged within 24 hours.

Addressing the ED Problem

The HSE has argued that its escalation policy, which implements specific sequential steps to address overcrowded EDs, is and has been effective. However, it needs the co-operation of all staff throughout the hospital. The final element of the escalation policy is a Full Capacity Protocol, which involves moving patients on trolleys from ED to an in-patient ward once a specified tipping point has been reached. There is strong international evidence that this approach is highly effective in relieving pressure throughout the hospital (it prompts earlier discharges of those who can safely go home, for example) and it is clinically safer than leaving patients in overcrowded EDs.

Consultants in Emergency Medicine have argued that implementation of the escalation policy, including the Full Capacity Protocol, would be the single most effective means of quickly reducing waiting times in EDs. However, this view is strongly opposed by the Irish Nurses and Midwives Organisation, which has consistently refused to implement it.

Difficulties in EDs have to be addressed throughout the hospital and the wider health system. The HSE is currently working on:

- delayed discharges, reduction of average length of stay, day of admission procedures, improved ward rounds, availability of senior clinical decision makers with timely access to diagnostics, measures to address NCHD shortages, continued roll-out of measures in the primary care area;
- continued implementation of the Emergency Medicine Programme and related clinical programme and roll-out of Acute Medicine Units;
- implementation of the full capacity protocol and other measures to address surge in the Emergency Departments;
- implementation of measures to address difficulties in specific hospitals and measures to monitor progress on implementation;
- 24/7 availability of diagnostics and better, faster results reporting in hospitals; and
- planning for seasonal increases in demand.

The Department is supporting and monitoring the HSE's actions in relation to EDs to ensure the best possible outcomes for patients. The main areas being monitored and prioritised are:

- Implementation of action plans in Emergency Departments and monitored regularly on the ground.
- Enhanced management structures linking ED with rest of the hospital.
- Clear management responsibilities assigned and demonstrably carried through (including by professional and support staff).
- Implementation by HSE of the system of recording the total wait time for patients in Emergency Departments.
- Continued development of system wide response to Emergency Department difficulties (as above);
- Continued implementation of the Emergency Medicine Programme and roll-out of Acute Medicine Units.

- Implementation of the full capacity protocol and other measures to address surge in the Emergency Departments.
- Implementation of early discharge planning protocols including communication with step down and primary care facilities.
- Implementation of measures to address difficulties in specific hospitals and measures to monitor progress on implementation.
- More robust planning for seasonal increases in demand.
- All the above encompassed in a publicly available Emergency Departments programme and integrated as part of the Clinical Programmes currently being developed.

Other Initiatives

The HSE is looking beyond EDs alone to address waiting times. Its has undertaken a number of initiatives including:

- Winter Initiative Programme to reduce waiting times at times of peak demand.
- Code of Practice for Integrated Discharge Planning and actions to reduce the number of delayed discharges (including the introduction of the "Fair Deal" and improvements in long stay capacity)
- Establishment of the Accident and Emergency Forum (A&E Forum)
- Actions aimed at improving Clinical Leadership and Access to Senior Decision Makers
- Development of Clinical Programmes and related programmes such as the Emergency Medicine Programme and National Acute Medicine Programme
- ED Patient Experience Time Project (PET)

Information on each of these elements is available in more detailed notes should the Minister require them.

Challenges

The main challenge in this area is a continuation of unacceptable waiting times in some EDs. The HSE has worked intensively on this area for some time and has made progress, but there is no doubt that it will be very challenging to achieve a six hour maximum waiting time target for all patients in the short term.

5. Waiting Times for Elective Services

Waiting times for some elective services continues to be a significant problem, particularly in the area of GP referrals for out-patient appointments. Better progress has been made in relation to elective surgical lists, where average waiting times have improved significantly in recent years.

Elective In Patient and Day Cases

In 2002, average waiting times in major elective specialties were reported as being between two and five years. These figures pre-date the standardised national arrangements for the reporting and analysis of waiting list data developed by the

National Treatment Purchase Fund. However they are indicative of the excessive waiting-times experienced in previous decades, despite the injection of targeted "Waiting List Initiative" funding.

The NTPF reports that the median waiting-time for surgical intervention is now 2.4 months. This takes into account those patients who have to wait for only a short period before being treated.

NTPF data indicates that at the end of 2010 there were 781 persons waiting for over 12 months for surgery. A substantial reduction has been achieved in this area, the equivalent figure for 2007 being 4,637. Most of these long-waiting patients have been deemed by their hospital as unsuitable for treatment under the NTPF.

NTPF and Waiting Times

The NTPF was established in 2002 to purchase treatment (primarily surgery but also some diagnostic services) for patients whom the public hospital system has been unable to treat in a timely manner.

The Fund sources and negotiates prices for treatment for these patients, primarily in the private hospital sector. As a matter of policy, services may be purchased from public hospitals only where they are not available in the private system. Some 200,000 patients have received treatment through the NTPF since 2002. In 2010, the Fund facilitated over 32,000 public patients, comprising 20,600 inpatient treatments, approximately 8,000 outpatient consultations and 3,500 MRI scans.

The NTPF has also instituted standard national arrangements for the collection and reporting of waiting-lists across 44 hospitals, through the Patient Treatment Register (PTR).

It is important to note that while it accounts for only about 1% of overall public hospital activity, the NTPF accounts for some 10% of surgical activity involving public patients.

In terms of value for money, the Fund has achieved a 15% average reduction in treatment prices since 2006 and is being pressed to continue to achieve improved value for money. The Comptroller & Auditor General's 2008 report concluded that, relative to the casemix benchmark, procedures purchased from private hospitals by the NTPF generally cost less than those carried out in the publicly-funded hospital system. The C&AG reached a similar conclusion in a further analysis in his report for 2009, which was considered by the PAC on 27 January last.

It is important to note that the NTPF purchases services only from hospitals considered suitable by its medical and nursing advisors.

Future role of NTPF

The long-term future of the NTPF will need to be considered in the context of more systematic approaches to managing the provision of surgical and diagnostic services in acute hospitals. It has taken on other functions also. For example it negotiates rates

on behalf of the HSE under the Nursing Homes Support Scheme (Fair Deal) with 450 homes for residential care, in a market of approximately €850m in 2010.

In the context of the HSE's 2011 National Service Plan, the NTPF has been asked to work with the HSE in developing a new initiative to set distinct budgets and to "purchase" elective orthopaedic activity in public hospitals.

The Fund is also being asked to undertake a study of the cost of providing respite care for persons with a disability, in two pilot areas, including possible options for the development of alternative delivery models.

Outpatient Waiting Times

Improving patient access to outpatient services is a key priority. It involves over 3.5 million attendances annually, and is the gateway to accessing many hospital-based elective services. The true extent of the problem is poorly quantified at present, because unlike inpatient/day cases, there is no nationally validated, comparable data base.

Historically, there was no common national standard for hospitals for the management and reporting of outpatient referrals. The numbers referred and waiting-periods could not be assessed uniformly. Claims of waiting lists of thousands, and stretching to several years, could neither be verified nor validated because there was no reliable, uniformly collected data set. This has limited the ability to manage and improve these services.

In 2010 the HSE used a National OPD Data Quality Programme to develop standard national rules for the recording, management and reporting of GP referrals.

As a result, from the beginning of 2011 standardised national OPD data arrangements are being put in place in all acute hospitals. These will apply to all referrals received from January of this year. As the databases are built up, this will enable measurement of such parameters as the number of referrals received, the average time to triage of referrals by the consultant, numbers of new attendances, non-attendances and cancellations by patients and how long people have been waiting.

This information will allow for better planning and management of outpatient appointments and for comparisons between the performance of different clinics and hospitals for equivalent services.

When the information is well established, the HSE will publish it as part of its normal monthly data on performance.

Validation of existing Outpatient waiting-lists

The Department has asked the HSE to develop arrangements for the validation of existing outpatient waiting-lists. While there may be many referrals on file and apparently long waiting-times for a consultation, quite a number of patients may no longer need an appointment. The NTPF's experience in this area in the last five years is that of all patients contacted on an OPD waiting list, only half accept an offer of an

appointment. One-quarter were found not to need an appointment, and a further 13% did not respond to an offer.

The 2011 Service Plan commits to validation of lists in the 15 hospitals with the longest waiting times. However the HSE indicates that it is working to establish a standardised, valid, national method of reporting on the lists of 'patients believed to be waiting' prior to 1 January 2011.

Further discussions are planned in order to establish more clearly how the HSE proposes to approach this task. There must be a consistent national approach so that information can then be compiled into a clear national picture, ideally by specialty as well as by hospital.

Improving OPD Access

The HSE is taking a number of steps to improve access to OPD services and reduce waiting times:

- A 30% increase in new OPD attendances in 2011 in dermatology and neurology;

- Twelve musculo-skeletal physiotherapy-led clinics are being established in 2011 to assess patents referred for rheumatology and orthopaedic consultations. (Experience has shown that a sizeable proportion of these patients can be managed in this way);

- The national target ratio of new to return patients is 1:2. (As noted earlier, some hospitals were seeing excessive number of return patients);

- Efficiency is being improved by reducing levels of non-attendance (DNAs).

6. Ambulance and Patient Transport Services

Before the HSE was established, each health board had its own ambulance service. There was little co-ordination of activities across these boundaries and no clear national leadership on pre-hospital care within the health service. Supported by the Department and HIQA, the HSE National Ambulance Service is working to improve the management and integration of ambulance services.

In particular, the following are being addressed:

- Reduction to just two ambulance control centres from the current nine
- Appointment of clinical lead for pre-hospital care
- Improved integration of emergency ambulance services in Dublin
- Development and implementation of new performance indicators for pre-hospital care.

Background
The National Ambulance Service provides pre-hospital emergency care and emergency and some non-emergency patient transport. The Service is undergoing significant change in order to ensure quality, safety and value for money.

Pre-hospital care includes advanced paramedics, who can provide more complex life-saving care on-site; in this way, patients can be stabilised before being brought to the most appropriate Emergency Department.

There are currently 171 officers trained to Advanced Paramedic (AP) level in the HSE National Ambulance Service with an additional 31 due to commence their 1 year internship during 2011. There are 25 Dublin Fire Brigade personnel trained to AP level.

Improvement measures
The HSE is reducing its ambulance control centres on a phased basis, from the current nine to two (Ballyshannon and greater Dublin area) with a target date of the end of 2011. This will have essential patient safety and cost benefits.

All current control rooms are now equipped with Advanced Medical Priority Dispatch System (AMPDS), which allows the most appropriate deployment of pre-hospital services – in particular advanced paramedics. Staff have been trained in the use of this software and its use nationally commenced in late 2010.

In December 2010 HIQA completed a report, "*Pre-Hospital Emergency Care: Key Performance Indicators for Emergency Response Times"*. This recommends response times for first responders and for ambulances. The HSE's National Service Plan 2011 commits to measuring current response time performance, in order to inform the setting of performance targets for the service.

The HSE has recently appointed Mr Cathal O'Donnell, Consultant in Emergency Medicine, as clinical lead for pre-hospital care.

Dublin Emergency Ambulance Services
Dublin Fire Brigade (DFB) provides emergency ambulance services in the Dublin area, with provision for the HSE to act in a back-up role where required.

Historically, there has been limited effective co-operation between the two services. While both have control facilities located in Tara Street, these function separately and only interact by way of formal communications.

HIQA has identified the separation of the operation of the two ambulance services as unsatisfactory and the HSE is working with the DFB on achieving more integrated arrangements.

There have also been issues between the two organisations in relation to the provision of ambulance services in Swords and the overall amount that should be payable by the HSE to Dublin City Council in respect of emergency ambulance services.

Discussions are taking place between the HSE and Dublin City Council on service co-ordination and financial issues, to ensure that the necessary service quality and value for money are achieved. These include the replacement of the HSE and DFB Dublin call centres by the new Eastern national control centre and integrating the day-to-day operation of the two organisations' ambulance resources. There will be important IR issues to address as these changes are implemented.

Irish Coast Guard
The HSE and the Irish Coast Guard have agreed to develop a pilot project for the ICG to provide aeromedical support to the HSE ambulance service. This would involve the Shannon-based helicopter, when available, responding to requests for assistance to take high-acuity patients by air to a hospital appropriate to their clinical needs. The project will assess what patient benefit, if any, results from the use of air over road transport for defined high-acuity patients.

Non-Emergency Transport
Non-emergency transport comprises inter-hospital transfers, patient transport from home to health facility and from health facility to home. It includes both HSE and private transport providers. The HSE has no statutory obligations in this area.

In 2009, the Department asked the HSE to develop a clear national approach to non-emergency transport. We said that transport, where provided, should be in the most cost-effective way, with clear conditions - primarily clinical - for the HSE to provide transport to health facilities. The HSE has been working to develop standard criteria on who qualifies for transport.

The HSE's total patient transport costs were some €52.5m in 2009. This includes the cost of emergency ambulance provision (HSE and DFB) amounting to about €23m.

In terms of non-emergency patient transport, the HSE pays in the region of €29m for taxi services and other non-acute transport such as minibuses and a small amount of contracted-in ambulance service. These are non-pay costs and do not include costs of any directly-provided patient/client transport.

The approximate breakdown of the €29m by service was:

Hospitals	€10m	(e.g. cancer, dialysis, outpatient clients)
Disability	€7.7m	
Mental health	€3.5m	
Older persons	€2.7m	
Multicare (community)	€2.1m	
Children and families	€1.3m	
Primary care	€1.3m	

HSE spending under all patient transport headings was reduced from €56.8m in 2008 to €52.6m in 2009. A further reduction to €47.5m was targeted in 2010. The Department had sought a €10m reduction in transport costs overall in 2010, with a further €5m reduction to follow in 2011.

Such reductions are challenging to achieve without reducing the level of transport support. Efficiencies have been achieved through new procurement arrangements and a tighter focus on when such support is actually required by clients.

Challenges
There is potential for industrial action in relation to the re-organisation of the national command and control structure and the replacement of the HSE and DFB control centres in Dublin.

There are still significant funding and management issues outstanding between the HSE and Dublin City Council over the DFB's provision of emergency and pre-hospital services in the Dublin area.

Further reductions in HSE spending on non-emergency transport may lead to criticism on grounds that this is limiting people's ability to access necessary services.

7. Maternity Services

There are some 74,500 births in Ireland projected for 2011. This may decrease somewhat in future given the economic circumstances and emigration. Nineteen public hospitals provide maternity services as well as one private hospital.

A key policy concern is to ensure that we organise maternity services in line with best practice, taking account of womens' preference for a broader choice of services, including the potential for midwives to play a more prominent role in obstetrics. The aim is also to enhance primary and community maternity and gynaecology services as a preferred approach for women with uncomplicated pregnancies. This allows mothers greater choice and better access to services closer to home where it is safe to do so.

There are quality and safety implications where the number of births in a unit falls below a minimum volume. The configuration and size of some of the smaller maternity facilities in Ireland will be taken into account as part of the reconfiguration process.

The current model of stand-alone maternity hospitals in Dublin in not the norm internationally. A major independent review of maternity services in the Dublin area (KPMG/HSE)[1] recommended that the three Dublin maternity hospitals should be located alongside adult acute services. Under these proposals, the Coombe would transfer to Tallaght, Holles Street to St. Vincent's and Rotunda to the Mater site.

The HSE is seeking to progress these developments, as well as moving the maternity hospital in Limerick to the regional hospital site.

Background
There are 19 public hospitals providing maternity services in Ireland listed below.

Rotunda Hospital

[1] Independent Review of Maternity Services in the Greater Dublin Area (KPMG/HSE 2009)

Coombe Hospital	Letterkenny General Hospital
National Maternity Hospital	Mayo General Hospital
Cork University Hospital	Portunicula Hospital
Kerry General Hospital	Sligo General Hospital
South Tipp General Hospital	Midland Regional Hospital Mullingar
St. Luke's General Hospital	Mid-West Regional Hospital Ennis
Waterford Regional Hospital	Cavan General Hospital
Wexford General Hospital	Our Lady of Lourdes Drogheda
University Hospital Galway	Midland Regional Hospital Portlaoise

Mount Carmel Hospital in Dublin is the only private hospital currently providing maternity services in Ireland.

Key Data
The number of births nationally for 2010 was 74,418, a decrease of 0.3% on the number for 2009. The number of births to the end of November 2010 was 68,072, down 0.24% on the figure of 68,235 for the same period in 2009.

The December Performance Reports indicate increases in the number of births in Coombe Hospital, Mullingar, Holles Street, Portlaoise and Cavan.

The rate of caesarean section delivery for 2010 was 26%, up from 25.8% in 2009 and remains substantially higher than the target of 20%, which in turn, is significantly above the international targets (WHO target is between 10% and 15%). The Department has asked the HSE to address the issue of reaching the 20% rate as a priority.

Obstetrics and Gynaecology
A HSE clinical programme for obstetric and Gynaecology has been established with the appointment of two clinical leads for midwifery and obstetric/gynaecology. The roles of the clinical leads are to develop and implement a maternity and gynaecology clinical programme in accordance with the HSE Service Plan incorporating the recommendations of reports such as the KPMG/HSE report.

The maternity hospitals are progressing approaches for the models of care that will operate on the sites of adult hospitals. These models will be developed in partnership with the HSE Obstetrics Clinical Programme to ensure that maternity services are reconfigured to achieve consistent best practice models of care to support integrated primary, community and hospital maternity services.

Other Issues: Misdiagnosis of Miscarriage
In June 2010, alleged cases of misdiagnosis of miscarriage were reported in the media where drug or surgical treatment was recommended to women where a misdiagnosis of miscarriage had been made in error and subsequent information demonstrated that the pregnancy was viable. The HSE set up a Miscarriage Misdiagnosis Incident Management Team to manage the incidents and lead an immediate National Review of Miscarriage Misdiagnosis to examine possible cases over the last five years. It is expected that the Review process will be completed before the end of the 1st quarter of 2011. A Review Procedure Document issued to all hospital sites in June 2010,

setting out the steps required to refer cases to this review including governance issues, verification of cases and procedures.

The HSE set up a Miscarriage Misdiagnosis Incident Management Team to manage the incidents and lead an immediate National Review of Miscarriage Misdiagnosis to examine possible cases over the last five years. In all, 32 cases were forwarded by hospitals to the National Miscarriage Misdiagnosis Review, and on examination, 24 cases were deemed to meet the inclusion criteria and included in the review. It is expected that the Review process will be completed before the end of the 1st quarter of 2011.

Other Service Issues

8. Children's Hospital of Ireland

The new Children's Hospital of Ireland (CHoI) will replace the three children's hospitals at Crumlin, Temple Street and Tallaght. Planning is at an advanced stage. Preparatory site work could commence by the end of this year with full construction starting in early 2012. Building is scheduled to finish by the end of 2014, with the hospital opening, following commissioning, in late 2015.

There has been considerable debate about the appropriate location for the hospital. Detailed expert analysis concluded that it was best for clinical reasons to build it alongside an adult acute site, and the Mater campus was chosen in 2006.

The National Paediatric Hospital Development Board is a statutory body charged with planning, designing, building equipping and furnishing the new hospital. The Department supports and monitors the work of the Board and the HSE on the development of this project, and participates on the HSE Steering Group overseeing the work.

It will be very important to ensure that there is an agreed governance structure in operation for the new CHoI well in advance of its opening. The Department is working with the HSE and the three paediatric hospitals to agree a suitable governance structure.

Background: Decision to build a new, tertiary level, children's hospital

The 2006 McKinsey Report to the HSE, *Children's Health First***,** recommended that:

- The population and projected demands in this country can support only one world class tertiary paediatric hospital;
- Such a hospital should be located in Dublin; it should ideally be located alongside a leading adult academic hospital; and it should accommodate the secondary care needs of children in the greater Dublin area; and
- The hospital should be a central component of an integrated national paediatric service, incorporating outreach capabilities at key non-Dublin hospitals and an adequate geographic spread of emergency-type facilities in Dublin.

Following the McKinsey report, a Joint HSE/DoHC/OPW Task Group was established in 2006 to advise on the optimum location of the proposed new hospital in line with the McKinsey recommendations. Each of the six major adult academic hospitals in Dublin made a detailed submission to the Task Group.

The decision essentially came down to a choice between the Mater and St. James's Hospitals. On balance, the Group considered the Mater to be in the best geographical position to facilitate a clinical network of critical adult and paediatric specialties. It also noted that, due to the significant enabling and decanting works already carried out on the Mater campus, the project could be delivered more quickly on that site.

Subsequently, the review of maternity services in Dublin (HSE/KPMG) recommended that services at the Rotunda Hospital should transfer to the Mater campus. This would lead to a network of adult, children and maternity services on the one campus, which would bring further advantages to patients.

The RKW Report (2007) included a detailed assessment of capacity at the Mater site and concluded that all of the requirements for a tertiary children's hospital can be accommodated there and still allow room for expansion beyond 2021. The report was informed by clinical and architectural experts from major children's hospitals in Toronto, Philadelphia and Manchester and by international architectural advice.

Since then, the work done by the Development Board, including the Project Brief approved in August 2010, has confirmed the suitability of the Mater site from an operational point of view.

The merging of the three Dublin children's hospitals into a single hospital structure alongside the Mater Hospital will ensure a critical mass of specialised skills to provide highly complex treatment and care to sick children. It will also provide additional benefits for sub-specialisation and the development of campus-wide support services. The Faculty of Paediatrics has also endorsed the approach.

Capital Cost – Funding

The current estimate of total project capital costs is €650m, including an Ambulatory/Urgent Care Centre at Tallaght which will be built separately by the HSE in advance of the CHoI opening. This figure, which is inclusive of VAT, includes core building costs, equipment, architect/design fees, and all contingencies included as standard in major projects such as construction, inflation, and planning and execution.

The €650m estimate also includes the cost of a car park, commercial units, hospital school, education and research facilities, but these are funded through a range of other funding sources as set out below. It also includes project and business team costs. In accordance with the Department of Finance guidelines for capital projects, contingencies and VAT (estimated at €150m) are also included in the project costs. The figure excludes ICT costs (estimated at €60m) which will need to be addressed separately under the HSE's ICT budget for these services.

The capital costs for the CHOI have been extensively benchmarked and are comparable with other hospital capital costs. This benchmarking has been undertaken separately by independent quantity surveyors and by the HSE quantity surveyor team using established costing metrics.

Earlier estimates of costs of the CHoI were considerably higher but have fallen due to reductions in building costs and other savings identified. The figures will be reviewed further at the detailed design stage and on receipt of the construction tender bids.

Proposed Sources of Funding

HSE capital allocation	€400m
Car Park, Research, Education, Retail Units, Private Clinics, Hospital School	€90m
Philanthropy	€60m
Fundraising/Financing Options	€50m
Tallaght A/UCC (from HSE capital allocation)	€50m
Total	**€650m**

While originally included in the planning process for the CHoI, the Tallaght A/UCC is now being progressed separately by the HSE.

The Development Board has recently submitted proposals for raising money through philanthropic means. The proposal is currently being considered by the HSE.

Cost of Building on a Greenfield site

Every site has site specific costs. Irrespective of the exact cost differences between the Mater campus site and a notional Greenfield site, the substantial clinical benefits of locating the children's hospital alongside a major academic teaching hospital, and a maternity hospital in the future, were the primary factors that influenced the original decision in favour of the Mater site.

The HSE has estimated that the cost of building the CHoI to the same specification on a greenfield site would be in the region of €50m less than building on an existing site such as the Mater. However, this is an indicative figure only, and will vary depending critically on the nature of the individual greenfield site, including the cost of additional elements such as the extent of connecting roads required, provision of utilities such as gas, water and drainage, land acquisition and increased need for car parking. Any projected capital saving from this option would be once-off, and would ultimately be offset by savings every year in running costs on an integrated child/adult campus.

Planning, construction and completion

The Development Board is in formal discussion with An Bord Pleanála and is ready to submit its formal planning application very shortly. In parallel with this, the initial advertisement for invitations to tender for the design/build could commence. Subject to planning permission being granted, building work can commence in early 2012. Preparatory work on site would be possible before this, including diversion of

services on site and preparatory building work. The hospital would be commissioned in 2015.

The HSE has committed to construction and opening of the A/UCC in Tallaght one year in advance of the completion of the NPH.

Possible Challenges to Project

The project management and design work was procured on a specific schedule for the delivery of project milestones. The hospital design has advanced to support the planning application and the procurement of the contractor, both of which would be ready for issue in March. There is a monthly run rate of €550,000 to €650,000 on the project; this needs to be considered if the progression of these two project milestones is delayed beyond March 2011.

Conditions on the granting of planning permission can be expected. Planning permission could of course be refused (as in the case of any application) but the fact that the Local Area Plan and the City Development Plan both locate the national children's hospital at the Mater campus could be expected to strengthen the case. Limits could also be set on the hospital which could adversely affect the development of a tertiary level hospital.

The concerns raised in public about the location (access/traffic, future expansion capability) are addressed in the planning application documentation and hospital design.

A decision to move the location would result in considerable delay to the project.

[redacted]

9. Lourdes Hospital Redress Scheme

Patient Focus represent women who were treated by Michael Neary, a former Consultant at Our Lady of Lourdes Hospital Drogheda who was found guilty by the Medical Council of professional misconduct in relation to the unnecessary removal of wombs from 10 patients between 1986 and 1996. His name was removed from the Medical Register.

Following an Inquiry, a compensation scheme was established in 2007. A total of 119 women were given compensation by the Lourdes Hospital Redress Board. The total cost of the scheme was €20.6m.

The previous Minister sought advice from the Chair of the Board, Judge Maureen Harding Clarke, on whether the scheme should be extended to a number of additional cases. The Chair advised against an extension and the then Minister accepted this

recommendation. In January 2011, there was a renewed call by *Patient Focus* for the Lourdes Hospital Redress Scheme to be extended.

Inquiry and Compensation

In 2004 the Government established an Inquiry into peripartum hysterectomy at Our Lady of Lourdes Hospital, Drogheda chaired by Judge Maureen Harding Clark. Judge Clark subsequently advised on an appropriate scheme of redress arising from the findings of the Inquiry. Arising from this, the Government established a non-statutory ex gratia scheme of redress.

The Redress Scheme was specifically for former patients of Mr. Neary who underwent at Our Lady of Lourdes Hospital, Drogheda:

- an unplanned obstetric hysterectomy[2] which in the opinion of a consultant obstetrician was medically unwarranted or
- an unplanned bilateral oophorectomy[3] which in the opinion of a consultant obstetrician was medically unwarranted.

The Scheme did not include former patients of Mr. Neary who had already been compensated, those whose operations were medically warranted, or those who agreed in advance to any of the outlined procedures performed on an elective basis. Also excluded were patients who were aged 40 and over and underwent an unnecessary bilateral oophorectomy or removal of a remaining single functioning ovary, patients who were deceased or their next of kin.

Extension of Scheme

The Lourdes Hospital Inquiry did not extend to a wider examination of Dr. Neary's general practice or of the clinical practice of his colleagues. However, Judge Clark became aware during the course of the Inquiry that some patients of Dr. Neary had undergone a bilateral oophorectomy that may not have been clinically warranted. The Inquiry also received medical reports from women who had undergone bilateral oophorectomy with relatively little evidence that the procedures were warranted. Not only did these women lose the ability to reproduce but they also suffered immediate surgical menopause.

Judge Clark took medical advice on a selection of oophorectomy cases involving younger women treated by Dr. Neary. She was advised that while it is sometimes necessary to remove both ovaries in the presence of serious disease, the occasions of such radical procedures are not common. This led her to conclude, also on medical advice, that unwarranted oophorectomies performed by Dr. Neary on women aged under 40 be included within the scope of the redress Scheme.

[2] Obstetric hysterectomy means a hysterectomy carried out in association with pregnancy, either in the peripartum period (within 6 weeks of delivery) or following from a miscarriage or incomplete abortion

[3] Bilateral oophorectomy means the removal of both ovaries or a remaining single functioning ovary at the time of obstetric hysterectomy or as a gynaecological procedure.

The Lourdes Hospital Redress Board subsequently determined that awards were payable in 119 cases. All awards determined were notified to successful applicants. The total cost of the Scheme was **€20.6m.**

Requests for Further Extension of Scheme

The then Minister was asked to consider an extension of the scope of the Scheme to include former patients outside of the terms of the Scheme. This included a number of women aged over 40 – in one case just over that age. The then Minister consulted with Judge Clark in the matter, who advised against an extension. Acting on this advice, the then Minister decided against an extension of the Scheme and this was publicly communicated in November 2008.

10. Symphysiotomy

A support group *Survivors of Symphysiotomy* (SOS) has been calling for a public inquiry into the practice of symphysiotomy for some time.

The procedure was employed in Ireland from about 1920 until the early 1980s and was used to effect an immediate dramatic increase in the size of the pelvic outlet to allow delivery of a baby. It was gradually replaced by Caesarean section as the preferred method of delivery where required.

It appears that the procedure continued to be used in Ireland for some time after it had been all but discontinued in other developed countries, and that within Ireland it continued to be used for a longer period in the north eastern area, most notably in Our Lady of Lourdes Hospital, Drogheda.

The procedure has been associated with serious side effects including pain and incontinence. Its specific impact has been more difficult to assess because some of its side effects are also found in women who have given birth without the procedure.

Review of Procedures

Little if any new learning would be gained from a full-scale inquiry into a procedure which has been discontinued many years ago. Those who practised it are either long retired or deceased.

Rather than setting up a full review, the then Minister for Health and Children asked the Institute of Obstetricians and Gynaecologists last February to prepare a report for her concerning the practice of Symphysiotomy in Ireland. She asked for an assessment of the circumstances in which the procedure was carried out, what protocols or guidance existed at the time to guide professional practice, and details of when the practice changed and why.

The Institute sought to make arrangements for the review to be carried out by an external team. Unfortunately, it was not possible to progress this in the way originally proposed. The Institute is now making alternative arrangements with the assistance of a university school of public health.

Support Services for Symphysiotomy Patients

Supports and services continue to be provided by the HSE to women who suffer effects of having undergone this procedure. These include:

- the provision of medical cards to symphysiotomy patients who requested them;
- the nomination of a Liaison Officer for a patients' group for SOS;
- the availability of independent clinical advice by Liaison Officers who assist in co-ordinating the provision of services to patients,
- the organisation of individual pathways of care and the arrangement of appropriate follow-up, including medical assessment, gynaecology assessment, orthopaedic assessment, counselling, physiotherapy, reflexology, home help, acupuncture, osteopathy and fast tracked hospital appointments;
- the refund of medical expenses related to symphysiotomy in respect of medication/private treatments, and
- the establishment of a triple assessment service for patients at Cappagh Hospital, Dublin.

The HSE has remained proactive in seeking out and offering help to women who had symphysiotomies and who may wish to avail of the services offered by the HSE.

11. Drogheda Review: Michael Shine Case

Two patient support groups, *Dignity 4 Patients* and *Patient Focus*, have called for an independent review in relation to the case of a former consultant, Michael Shine in Our Lady of Lourdes Hospital Drogheda, who was accused of sexual abuse and has been struck off the medical register.

The former surgeon worked in Drogheda from 1964 until 1995. The issues arising from the case has been the subject of an independent review commissioned by the then North Eastern Health Board and chaired by Dr. Miriam Hederman O'Brien, which reported in 1995.

The patient support groups have sought a further inquiry in more recent times. In October 2009, the then Minister announced the establishment of an independent review, the "Drogheda Review", to advise her on whether any additional information or insights were likely to be achieved from a further full investigation.

On the advice of the Attorney General, the then Minister appointed the former High Court Judge, Mr. TC Smyth, to undertake this initial investigation. Judge Smyth interviewed those wishing to be heard and reviewed documentation submitted to him.

He submitted his written report to the Minister on 15 September 2010. The report recommended that a further investigation should not be held. It also recommended that, in order to avoid prejudicing any civil or criminal cases, the report should not be published.

The Attorney General concurred with this advice but agreed that a short summary of the report could be prepared and published. Accordingly the then Minister, in

consultation with the Department's legal advisor, the Attorney General and Judge Smyth prepared a summary for publication, which was sent for information to both patient support groups in January 2011.

12. Cystic Fibrosis Services

Ireland has one of the highest reported *incidence* of CF in the world, with 1:1353 live births. This is almost four times the average rate in other EU countries and the United States.

In terms of *prevalence* there are 1,043 individuals registered with CF in Ireland - 552 are adults and 491 children (under18). The prevalence is comparable with other countries. The number of children born with CF each year is projected to remain stable, but the number of adults with CF is increasing, resulting in increased healthcare needs each year.

The Cystic Fibrosis Registry of Ireland (CFRI) receives support funding from the HSE. Ireland is the only European country to commit public funding to a cystic fibrosis registry. The CFRI produces relevant data on 90% of people with cystic fibrosis.

Construction of the biggest single capital development for CF patients, a ward block with isolation facilities, is underway in St. Vincent's Hospital. It will be opened next year.

Background

The Pollock Report (2005, commissioned by the CFAI) assessed the need for current and future cystic fibrosis patients. The HSE then established a Working Group to undertake a detailed review of CF services, and the development of CF services was set as a policy priority.

In 2006/7 extra funding was provided to employ some 48 additional specialist staff , including consultants, nurses and allied healthcare professionals. Significant developments for people with CF have been made in:

- St. Vincent's University Hospital, Dublin: Construction of facilities underway, to be opened in Q2 of 2012.
- Beaumont: A new ambulatory care facility opened on 26 October 2010.
- Crumlin: Clinics and inpatient services for children and young people
- Temple Street: a dedicated respiratory unit will open later this year, including a new respiratory lab, treatment room, consulting rooms and walk in access to clinical nurse specialists.

There are regional services at CUH, Waterford, Limerick, Galway and Drogheda. More detailed information is available on all of the services above.

Newborn Screening for Cystic Fibrosis
The National Newborn Bloodspot Screening Programme (NNBSP) is a critical component of the HSE's overall child health priorities. The recent publication *Review*

of the NNBS Programme - 2010 highlighted the urgency of implementing a governance and management structure for the NNBSP including the integration of cystic fibrosis screening into this programme in the immediate future. The HSE is currently developing governance and management structures for the introduction of screening for CF into the NNBSP.

Under the HSE National Service Plan, newborn screening for cystic fibrosis will be integrated into the existing National Newborn Bloodspot Screening Programme in Q2 2011.

Challenges
As it is estimated that the number of adults with cystic fibrosis will continue to grow treatment and support services will need to be planned effectively.

Early diagnosis and treatment of cystic fibrosis has been shown to provide better outcomes for patients. The Department has requested the HSE to ensure roll-out of the newborn screening for cystic fibrosis as soon as possible and once robust governance is in place.

Briefing Note for Minister for Health and Children
Child Welfare and Protection Policy Unit
March 2011

1. Child Welfare and Protection Policy Unit Overview

The primary objective of Child Welfare and Protection Policy Unit is to develop a policy and legislative framework which supports the delivery of a modern and integrated child welfare and protection service. The Unit also has a strong oversight function monitoring and evaluating the implementation of policy, particularly by the HSE, which has statutory responsibility in this area.

In recent years there has been a particular focus on overseeing the implementation of the findings and recommendations of the Report of the Commission to Inquire into Child Abuse (Implementation Plan) and the recommendations from other investigations, inquiries and reviews into child welfare and protection services. The Unit also promotes and oversees the development of a modern framework for adoption services in line with the Adoption Act, 2010, including the ongoing development of the Adoption Authority of Ireland

2. Children in Care

The primary legislation governing services is the ***Child Care Act 1991***. Under this Act the Health Service Executive (HSE) has a statutory duty to promote the welfare of children who are not receiving adequate care and protection. The definition of a child is a person under 18 years of age who is not or has not been married.

2.1 Types of Care

If a child is in need of care and protection and is unlikely to receive it at home, then the HSE has a duty to ensure they receive appropriate care. In cases where parents are unable to cope due to illness or other problems they may agree to their children being taken into the care of the HSE on a voluntary basis. In these cases while the HSE has care of the children it must consider the parents' wishes as to how the care is provided. The HSE is obliged to provide care for these children for as long as their welfare requires it.

In cases where the HSE has concerns for the care and wellbeing of a child it may apply to the courts for a care order. These orders give the HSE a range of powers regarding care planning and care placements. Children in the care of the HSE may be accommodated in a range of settings as detailed in the following table.

Children in Care as at December 2010	
Care Setting	**No. of Children**
Foster Care	3447
Foster Care with relatives	1674
Residential Care	437
Other Residential Care Placements	169
TOTAL 5,727	

The following sections provide further detail on the range of care options available.

Fostering
The HSE where possible will place a child in foster care. Many children living in foster care have been living with their foster families for most of their lives. Others have shorter placements. The majority of separated children seeking asylum are now placed in foster care.

Relative Foster Care
Relative carers go through an assessment and approval, in a similar way to general foster carers. The child is allocated a social worker who visits regularly and a Care Plan is developed and reviewed regularly.

Residential Care
For young people that are unable to live at home or in an alternative family environment residential care may be considered suitable. Residential care can be in a home run by the HSE or by a voluntary or private company. It is the policy and practice of the HSE not to place children aged twelve years and under in residential care unless for exceptional reasons.

Special Care/High Support
Special Care involves the detention on an exceptional basis of a non-offending child for his or her own welfare and protection in a special care unit with educational and therapeutic supports. The child's behaviour, and the risk of harm it poses to his or her life, health, safety, development or welfare is addressed in the care setting. Future care requirements are also explored.

2.2 Health Information and Quality Authority / Inspection of Foster Care
Standards for children in residential are governed by the National Standards for Residential Care (DoHC 2001) . The HSE centres are currently subject to inspection by the Health Information and Quality Authority,(HIQA) and the non-statutory centres are currently registered and inspected by the HSE. The HIQA also inspects the HSE's provision of foster care services.

Pursuant to a Government decision of July 2010, discussions are underway with a view to expanding the functions of HIQA to inspect the area of health funded child protection services.

2.3 Allocated Social Workers
This table details the allocation of social workers to children in care and existence of care plans at end Q3 2010:

Percentage of \Children in Care with allocated social worker	**92%**
Target for 2011 for allocated social worker	**100%**
Percentage of children in care with Care Plan	**88%**
Target for 2011 for Care Plan	**100%**

3. Children's Referendum

The Minister for Children and Youth Affairs presented a copy of the third and final report of the Joint Committee on the Constitutional Amendment on Children to Cabinet in early March 2010. The Cabinet decided that, in view of the complex nature of the issues involved, all Ministers and Government Departments as well as the Attorney General should consider the report and examine the implications of the proposed wording for their individual areas of responsibility. A range of unintended policy and resource implications were identified, including concerns that the concept of continuity of care might lead to children being left in inappropriate care situations. There were also concerns about implications for immigration policy as someone due to be deported could claim it is in their child's interests that they remain in the country and about the way in which the voice of the child provisions could lead to unwieldy and inappropriate arrangements; for example, where a child is being suspended from school it could result in legal representation being on both sides.

In view of these difficulties, the Minister for Children and Youth Affairs presented to Government the policy objectives for the Referendum and was granted Government approval to develop revised wording for an amendment, in co-operation with the Office of the Attorney General. New wording, which takes into account the proposals put forward by the Committee, has been drafted by the Attorney General's Office with policy support provided by the Office of the Minister for Children and Youth Affairs.

On January 12th the Government approved

- the policy objectives now proposed for the amendment of the Constitution in relation to children's rights
- the wording for the referendum
- the drafting of a Referendum Bill

The Office of the Minister for Children and Youth Affairs is giving consideration to the following tasks in preparation for the holding of a Referendum;

- Drafting of a Referendum Bill
- Preparation of a policy paper on the adoption legislation proposals
- Undertaking research into public awareness and understanding of the issues involved.

4. Children First

Children First, the National Guidelines for the Protection and Welfare of Children were first published in 1999. Over the last eleven years they have operated as the over-arching national Guidelines for individuals and agencies that come into contact with children. The aim of Children First is to direct the identification, investigation, assessment, reporting, treatment and management of child abuse.

The Children First Guidelines are being updated and revised in light of a detailed review and to reflect policy and legislative changes since 1999. The OMCYA is also engaging with other Government Departments on the development of a supporting implementation framework to ensure more consistent application of the revised Guidelines, once launched.

The HSE, in parallel, is reviewing its existing arrangements to support the implementation of the revised Children First. The HSE has a key role to play in terms of providing training and advice to organisations working with children and to the general public. The Ryan Commission Implementation Plan also committed to the drafting of legislation to provide that all bodies in receipt of exchequer funding would have a duty to comply with Children First, the policy position in this regard is currently being considered by OMCYA.

5. Ryan Report Implementation

The Report of the Commission to Inquire into Child Abuse (the Ryan Report) was published in May 2009. The then Minister for Children and Youth Affairs was tasked with producing an Implementation Plan for the Report's recommendations. The Implementation Plan was accepted by Government and was published in July, 2009. In drawing up this Implementation Plan, key stakeholders with particular knowledge and expertise in the area of child welfare and protection were consulted.

The Implementation Plan sets out 99 proposals to address each of the 20 recommendation in the Ryan Report, and includes proposals considered essential to further improve services to children in care, in detention and at risk. An amount of €15m was allocated by Government in 2010 to progress the implementation of Ryan actions. A further €9m is being provided in the current year.

The Minister for Children and Youth Affairs is required to chair a high level group to monitor the implementation of the actions specified in this Plan. The group includes representatives from the Office of the Minister for Children and Youth Affairs (OMCYA), the HSE, HIQA, the Irish Youth Justice Service (IYJS), the Department of Education and Science and An Garda Síochána. The group meets twice a year and a progress report is presented to Government each year. The first progress report was laid before both Houses of the Oireachtas in July 2010.

6. HSE Service Plan 2011

The annual HSE Service Plan is the annual contract for services between the State and the HSE. The 2011 Service Plan was agreed by the Minister for Health & Children in late 2010. The Plan contains a number of commitments in the area of children and family services under three broad headings as follows:

1. Delivery of statutory services
2. Implementing strategies to support service delivery
3. Ryan Report Implementation Plan

Among the specific areas highlighted under the three headings are:

- Aftercare services
- Allocation of social workers to children in care
- Capacity review of Special Care and High Support
- Review progress on Strategy for Youth Homelessness
- Management of Children First implementation plan
- Implementing provisions of the new Adoption legislation
- Development of the National Child Care Information System

- Implementing restructuring of children and family services

7. Special Care - Child Care (Amendment) Bill, 2009

The primary objective of the Child Care (Amendment) Bill, 2009 is to create a statutory framework for the High Court to deal with Special Care cases, instead of the High Court employing its inherent jurisdiction. The feasibility of a single district judge hearing these cases was examined, but due to various difficulties with this approach the current approach was deemed the most effective.

The Bill allows Special Care Units to be registered and inspected by HIQA. It also provides for the dissolution of the Childrens Acts Advisory Board. The Bill had completed Report Stage prior to the dissolution of the Dáil.

8. Supreme Court Case **(NB: NOT FOR RELEASE UNDER FOI)**

A Supreme Court appeal is due to be held shortly challenging the HSE's powers to assess and respond to allegations of third-party abuse under Section 3 of the Child Care Act, 1991, while a criminal prosecution is ongoing. The appeal had been due to be heard in the Supreme Court on 18 October, 2010 but was deferred following a request for a short adjournment by the State's solicitors.

The case could give rise to a requirement for emergency legislation to amend Section 3 of the Child Care Act, 1991.

9. Commission of Investigation into the Diocese of Cloyne **(NB: NOT FOR RELEASE UNDER FOI)**

The redacted material below is exempt under Section 11(1)(b) of the Freedom of Information Acts on the basis that the content is confidential until such time as the Minister for Justice, Law Reform and Defence publishes the report.

[redacted]

10. HSE Audit of Catholic Church Dioceses and Religious Orders

The HSE is due to report shortly to the Minister setting out the findings of a national audit of child protection practices in each Catholic Church Diocese.

It is expected that the Commission of Investigation's report into the diocese of Cloyne may be published before the Minister receives the HSE's Audit report.

A separate audit of **Religious Ord ers** is also being undertaken. It is not at as advanced a stage as the audit of the Catholic Church dioceses.

11. Youth Homelessness

A Strategy for Youth Homelessness was developed in 2001. A review of progress in 2008 by the HSE in conjunction with other agencies found much progress had been made, especially in interagency cooperation, early prevention and an out of hours service. There are information deficits on numbers of children using the service. Incorrect information has been published in the media. Work is in progress to improve information on the number of young people under 18 years who are homeless, and to establish what areas of the service are working well and where improvements are needed.

12. Aftercare

The provision of an appropriate aftercare service has been highlighted as a key element to achieving positive outcomes for young people leaving care. Aftercare services assist young people leaving care to achieve a successful transition from the care environment to independent adult life in the community. In response to calls that the provision of Aftercare Services be put on a statutory basis, legal advise was sought and the Attorney General's Office confirmed that the obligation contained in Section 45(4) of the Child Care Act 1991 is in substance mandatory. Accordingly, the Act creates a statutory power and the HSE, as recipient of this power, must put itself in a position where it can exercise the power should the need arise. The HSE is finalising its Aftercare Policy and Implementation Plan.

13. Out of Hours Service

The HSE has put in place a standardised national system whereby Gardai can access an appropriate place of safety for children found to be at risk out of hours under Section 12 of the Child Care Act 1991. This service conforms with Child Care Regulations and with the National Foster Care Standards. The provision of this service aims to ensure that children presenting as 'at risk' outside of normal working hours are provided with an appropriate emergency place of safety thereby reducing or eliminating social admissions of children in an acute hospital setting.

In addition, the HSE is undertaking a pilot out-of-hours social work service in two locations as provided for in the Government's Implementation Plan for the findings of the Report of the Commission to Inquire into Child Abuse.

14. Review into Deaths of Children in Care / Serious Incidents

In view of concerns in relation to the processes surrounding the review of child deaths by the HSE, the Minister for Children and Youth Affairs has taken a number of steps to address the issue:

14.1 Independent Review Group on Child Deaths

- The Minister established the Independent Review Group on Child Deaths on March 8th 2010. The Group is composed of Ms. Norah Gibbons and Mr. Geoffrey Shannon.
- The Independent Review Group on Child Deaths is examining existing information in respect of deaths of children over the period of 1 January 2000 to 30 April 2010 who were:

    a) in care within the meaning of the Child Care Act, 1991 at the time of their death

b) in receipt of aftercare within the meaning of Section 45 of the Child Care Act, 1991 at the time of their death

c) known to the child protection services within the meaning of the HIQA guidance to the HSE of 20 January, 2010 at the time of their death.

- The Review Group has completed a preliminary examination of all files received from the HSE and is now compiling learning and recommendations.
- The Review Group intends to interview families of the deceased who may wish to have the opportunity to air their views.
- It is expected that the Group will report to the Minister shortly.

14.2 HIQA Guidance for Review of Serious Incidents/ HSE Review Panels

- In January 2010 the HIQA published "Guidance for the Health Service Executive for the Review of Serious Incidents including Deaths of Children in Care".
- The Guidance describes a standard, unified, independent and transparent system for the review of serious incidents including deaths of children in care in Ireland. The guidance outlines the purpose of national review, the national review panel and team and the review process. The guidance also addresses the timing of review, benchmarks for individual reviews, publication and external reporting and monitoring of the review process.
- The HSE has established the Review Panels envisaged in the HIQA Guidance document under the chairmanship of Dr Helen Buckley. The HSE has reported incidents of a serious nature to the HIQA as required under the Guidance procedures.

15. Adoption

The Adoption Act, 2010, commenced on 1 November 2010. The new legislation, which incorporates the provisions of the Hague Convention, is designed to provide a framework to ensure that appropriate procedures have been followed and that all adoptions are effected in the best interests of the child. . It gives force of law to the Hague Convention on the Protection of Children and Co-operation in Respect of Inter-country Adoption, which entered into force for Ireland on1 November 2010.

The Adoption Authority was also established on 1 November 2010. The Board of the Authority meets fortnightly and is currently dealing with a range of practical issues following its establishment. However, the new framework of adoption will mean that major change is required, and it will be some time before all aspects of the new system are in place. This is causing some concern in the adoption community. The OMCYA is working very closely with the Adoption Authority to ensure that change happens as quickly as possible.

The Adoption Act 2010 limits adoptions into Ireland to countries who are signatories to the Hague Convention on Inter Country Adoption or with which Ireland has a bilateral agreement. There are currently no bilateral agreements in place. Hague officials take the view that countries should be encouraged to achieve a Hague standard and adopt the Hague Convention. They would see bilateral agreements as a watering down of this approach.

Office of the Minister for Children and Youth Affairs
Intersectoral Agenda

The Office of the Minister for Children and Youth Affairs (OMCYA) focuses on harmonising policy issues that affect children in areas such as early childhood care and education, youth justice, child welfare and protection, children and young people's participation, research on children and young people, youth work and cross-cutting initiatives for children.

The Children and Youth Services' Development Unit of the Office has a key role in supporting Goal 3 of the National Children's Strategy as regards

1. Harmonisation of policy issues across sectors;
2. Harmonisation of policy and consolidation of funding for services which have cross-sectoral aspects to them;
3. Supporting the development of service delivery and local implementation mechanisms which align with national policy and, in particular, the intersectoral/inter-agency aspects of local services.

1. Harmonisation of Children's Policy

National Children's Strategy

The National Children's Strategy, *Our Children — Their Lives,* published in November 2000, was a 10-year plan with a vision of:

'An Ireland where children are respected as young citizens with a valued contribution to make and a voice of their own; where all children are cherished and supported by family and the wider society; where they enjoy a fulfilling childhood and realise their potential.'

The Strategy was a ground breaking document for its time and facilitated a paradigm shift in how policy and operational matters relating to children and young people were examined and delivered upon. Ireland received many plaudits (UN, UNICEF etc.) for its inception in the early part of this century. As a consequence of the strategy, in real terms, there have been significant improvements in service provision and policy across many child related areas.

With the completion of this initial stage, a framework for the further strategic and considered development of areas focusing on children and young people is required – not only to map a vision for future policy direction but to embed the effectiveness and efficiencies presented by the utilisation of an outcomes focus, evidence based decision making and integrated working practices. The production of a new Strategy, the preparatory work for which is being advanced by the OMCYA, would be invaluable in this regard and would draw strong parallels with key elements of Transforming Public Service, which also focuses on these areas.

In the creation of the new strategy, it is proposed to draw on the framework of the current NCS and its 3 goal structure –

Goal 1: Voice of the Child
Goal 2: Understanding Children's Lives
Goal 3: Supports and Services

coupled with the outcome based themes cited in the Agenda for Children's Services that include –

> Healthy both physically and mentally
> Supported in active learning
> Safe from accidental and intentional harm and secure in the immediate and wider physical environment
> Economically secure
> Part of positive networks of family, friends, neighbours and community, and included and participating in society

Work on the new Strategy has commenced. An initial request for inputs issued to Departments in December and first inputs have been received. The National Children's Advisory Council has been re-established and has had an initial meeting and a workshop day around the new NCS. A full public consultation process is envisaged for the April-end May period – preparations are underway in relation to that process. A separate consultation process with children and young people is also planned, preparations are at an advanced stage and the consultation process is scheduled for 28th March to the 1st April, 2011.

An initial indicative time-line of end September for a first draft of the new Strategy has been set. Adherence to this time-line is predicated on successful completion of the consultation process before the summer period.

International Children's Rights

The Children and Youth Service Development Unit currently has some responsibilities for International Affairs for children and young people. Active engagement with our European and International colleagues has allowed the OMCYA to keep abreast of international perspectives and developments as well as contributing with our EU partners to the shaping of policy relating to children and young people.

The key international commitment regarding the children's field is the **United Nations Convention on the Rights of the Child.** Ireland ratified the UNCRC without reservation on 21 September 1992. The Convention entered into force for Ireland on 21 October 1992. Ireland signed the European Convention on the Exercise of Children's Rights in 1996 and arrangements to ratify the Convention will be made when certain provisions of the Children Act 1997 are brought into force. Similar to other common law countries, Ireland has a 'dualist' system under which international agreements, to which Ireland becomes a party, are not automatically incorporated into domestic law.

In line with the requirements of the Convention, Ireland has already reported twice to the UN Committee on the Rights of the Child. Ireland's 3rd and 4th Reports (combined) were due in April, 2010. Considerable preparatory work has been undertaken, however, the changing economic situation has meant that the achievements and future plans being cited have been changing rapidly. It is hoped to bring this work to a conclusion in the first half of 2011 for formal report to the Committee. Examinations of the Committee are running behind, this is one of the reasons Ireland has been asked for a combined 3rd and 4th report. It is anticipated that

the examination will take place as much as a year after the actual submission of a report.

The European Commission issued a communication in relation to the rights of the child in February 2011. This communication outlined the European Union's priorities such as child friendly justice, parental responsibility, participation and child protection in the broadest sense focusing in the dangers associated with the internet as well as more obvious dangers such as sexual abuse/exploitation and child abduction. It also outlined the desire of the Commission that the broad principles of the EU Charter of Fundamental Rights as ratified by Lisbon 2 be put into practice. The question of the competence of individual member states in relation to these issues is generally acknowledged and appreciated at EC/EU level (guarantees obtained by Ireland before Lisbon 2 referendum refer). It is clear however that the EC/EU intends to maintain a keen and increasing interest in this area given the potentially wider impact of provisions contained in the EU Charter of Fundamental Rights in terms of Human Rights generally.

Ireland participates in a number of key European fora (see below) where the main issues/priorities at EU level are discussed and explored. It will be necessary for the State to carefully monitor developments at EU level in the coming years in terms of how the various provisions of the Lisbon treaty are implemented and the possible implications for Ireland. Particular attention will need to be paid to the impact of the provisions of the EU Charter of Fundamental Rights and further exploration of the interaction of this document with the Lisbon 'Guarantees' obtained by Ireland in relation to the rights of the family etc.

The Council of Europe also prioritises children's rights through its programme "Building a Europe for and with Children". The main focus of COE approaches is to guarantee an integrated approach to promoting children's rights. In recent years the Council launched its 3 year programme/strategy 2009-2011 covering the social, legal, educational and health dimensions relevant to protecting children's rights and protect children from various forms of violence. The COE programme comprises two closely related stands: the promotion of children's rights &the protection of children from violence. The COE have recently launched a specific campaign on the protection of children from all forms of violence as well as continuing to develop policies on the wider EC/EU related agenda of protection of children in care, child participation, child friendly justice etc. The campaigns in relation to violence continue to include policy aspects relating to the complete abolition of all forms of coroporal punishment in member states (including in the home setting) such as the COE campaign 'raise your hand against smacking' in 2009.
The Office interacts with a number of European Fora which have been informing both European Commission and Council of Europe deliberations regarding the Children's Rights agenda.

EU Forum on the Rights of the Child is a permanent group promoting children's rights, and meets twice yearly usually in Brussels. They advise and assist the Commission and other European Bodies on matters concerning children. The Forum is chaired by the Commission and draws members from various groups (statutory and NGO) in member states.

Europe de l'Enfance is a permanent intergovernmental group comprised of officials from EU member states. It promotes EU wide comparison of conditions for children and adolescents, to assess policies followed at national level and to encourage cooperation and debate on mainstreaming children's rights in EU policies.

ChildONEurope is the European Network of National Observatories on Childhood stemming from L'Europe de l'Enfance. ChildONEurope aims to create a forum for discussion and exchange of knowledge and best practices on children's policies, mainly through research and study activities.

2. Harmonisation of Policy and Consolidation of Funding

Play, Recreation and Youth-related Services

National Play Policy/National Recreation Policies

The Office has had co-ordinating and oversight responsibility for the development and implementation of the National Play Policy (2004) and the National Recreation Policy (2007). While the implementation of these policies lie largely with the Departments of Environment and Local Government / Arts, Sports and Tourism, there are also actions relevant to the Department of Community, Equality and Gaeltacht Affairs, Department of Education and other agencies.

Ready, Steady, Play! A National P lay Policy in March 2004, was one of the first countries in the world to produce a detailed national policy on play. *Teenspace, National Recreation Policy for Young People* aimed at the 12-18 year olds followed in 2007.

Recent developments co-ordinated and supported by the OMCYA include the provision of grant aid to Local Authorities to promote an official National Play Day on Sunday 4th July and a National Recreation week from 29th Oct – 4th November. These activities aim to raise awareness of play and recreation facilities and opportunities for children and young people and their families. In addition, they have been used to support improved networking for and collaboration between local providers of services including, inter alia, local sports partnerships, arts and heritage officers, youth services and others.

The announcement of a designated €1.5m Youth Cafés funding scheme was a key area of activity in 2010. This nationwide competitive scheme (operated for OMCYA by POBAL) saw a total of 50 existing youth cafés receiving funding supports during the year and a further 16 sites being awarded significant funding for the development of new youth café sites in 2011/12. The launch of the scheme coincided with the formal launch and publication of 2 important OMCYA policy documents; youth cafés a guide and youth cafés toolkit: a practical guide to setting up and running a youth cafés in Ireland, a best practice guide and youth café toolkit.

Youth Services

In January 2009 Youth Affairs Unit and the Young Peoples Facilities and Services Fund moved to the Office of the Minister for Children and Youth Affairs (OMCYA) from their parent Departments. It is hoped this centralised approach will provide a more integrated and cohesive service for children and young people. Current funding streams include the Youth Service Grant Scheme, the Special Projects for Youth

Scheme, the Young Peoples Facilities and Services Fund and certain Local Drugs Task Force projects and certain other provisions including the Local Youth Club Grant Scheme, Youth Information Centres, European Youth in Action Programme (administered by Léargas – The Exchange Bureau) and Gaisce – the President's Award.

The Budget for the youth sector in 2011 is €60.954m which compares to €64.89m in 2010. The youth sector has seen a reduction of 20% in its funding over the past three years and they warn that any further cuts will put jobs and projects in jeopardy. Current numbers of projects direct supported under the various programmes number around 516. In addition, 1,600 youth clubs are aided under the Local Youth Club Grants Scheme.

Recent achievements and developments in the Youth Sector in 2010 include:

- Development and launch of the National Quality Standards Framework in 2010
- Introduction of new standardised reporting and funding application process for youth organisations/projects
- Development of the Code of Good Practice: Child Protection for the Youth Work Sector
- Publication of Homophobic Bullying Guidelines
- The transfer of 21 Local Drug Task Force Projects from Dept of Education and Skills to the OMCYA.

Key next steps for the youth sector include roll out of the NQSF throughout the sector and the development of a new Youth Policy Framework. While recent changes have brought together funding arrangements for the bulk of youth sector provision, it has highlighted the need for a consolidation of Government efforts in relation to youth provision in the informal education sector. A clear need has been identified for an overarching policy framework to accommodate youth work and related areas which fall within/related to the OMCYA's remit. The purpose of the new framework is to articulate clear and measurable policy objectives of the Government in relation to youth:

- to enhance the development, participation and support of young people in the 10 – 21 year age range;
- to provide greater co-ordination and coherence in youth service provision; and
- to ensure such provision is both quality- and outcomes-based.

It is anticipated that the YPF will result in the following outcomes:

- Clearly identified remit and role of the OMCYA in relation to Youth
- Clearly identified common principles underpinning the respective policy areas for Youth
- Stated constituent policy objectives underpinning funding schemes and directing the work of services and supports
- Established outcomes-focused approach in structuring and directing services, programmes, initiatives and interventions
- Defined and efficient structure(s) and systems for the oversight, administration, measurement and assessment of quality youth services and supports for young people

Work on the new framework has commenced. An international expert reference group has been set up to assist in the work. The work is also being supported by the Centre for Effective Services (see below). The National Youth Work Advisory Committee

(established under the Youth Work Act, 2001) will be an integral part of the consultation process on the new framework. A public consultation process and consultation with young people is also envisaged. While the focus will be on the core funding of the OMCYA it is anticipated that a broad framework which accommodates youth services in a broader variety of settings can be developed. For that reason, an interdepartmental group comprising those departments who fund other targeted youth services "adjunct" to those departments remits will also be guiding the process. A target date of end year has been set for the finalisation of a draft framework. It is also envisaged that the policy framework will have implications for the Youth Work Act, 2001 which has, largely, not been commenced.

3. Supporting the Development of Service Delivery And Local Implementation Mechanisms

Working Together for Children Initiative

Towards 2016 makes provision for the establishment of a **National Children's Strategy Implementation Group** (NCSIG), a high-level group chaired by the Office of the Minister for Children and Youth Affairs and linked to the HSE's Expert Advisory Group. The National Children Strategy Group (NCSIC) was established in November 2006. The Functions of the NCSIG are:

- To provide leadership and support to the implementation of integrated services and interventions for children at local level (Towards 2016),
- To support the development and implementation of local Work Plans for Children's Services,
- To support the OMCYA with the development of the National Children's Strategy
- To support the Office of the Minister for Children and Youth Affairs in specific cross-sectoral commitments.

Led by the OMCYA and driven by the NCSIG nationally, the *Working Together for Children* initiative is being developed since 2007. Based on the learning from four pioneer children's services committee sites, a strategic plan for the development of the *Working T ogether fo r Children* has been agreed. Ten **Children's Servic es Committees** (CSCs) have been established and at February 2011 a further 4 applications had been received to establish a CSC locally. The objectives of the CSCs are to develop cross agency working relationships, secure support for the joint implementation of policies/initiatives requiring inter agency action and to maximise integration of service delivery at a local level.

The view of the National Children's Strategy Implementation Group is that the development of local CSCs should be locally determined and led within a flexible framework devised and agreed at national level. The NCSIG and OMCYA have provided a number of supports including, inter alia,

- Technical assistance required by the initial four CSCs to support the change management process involved in the development of a Children's Services Committee.
- A Toolkit to assist with the development of a Children's Services Committee informed by the learning from the initial four sites has been agreed as the broad framework for the development of a work programme for the Phase II CSCs.
- Change management facilitation for the all sites if they require it.

- A standardised Children's and Young People's Workplan template.
- An internal Communications Plan for the *Working Togeth er for Child ren* with local and national actions and supports currently being implemented.

Phase II CSCs are at varying stages of "readiness" it is hoped that at least five of the six them will have Work Plans in place by mid 2011. The initial four sites are implementing their work plans and as issues emerge it is hoped to be able to offer assistance to them through the NCSIG and OMCYA.

Most recent developments include the finalisation of a Governance Framework for the Initiative. It is anticipated that this will be brought to Government for information shortly in order to ensure the highest level mandate is affirmed for the *Working Together fo r Children* initiative – this mandate and leadership is understood to be central to the successful implementation of interagency processes such as this.

Prevention and Early Intervention Programme and other Innovative Projects
Since 2006, the OMCYA has been involved in supporting collaborations between funders to develop a better understanding of "what works?" in complex community interventions for children and their families. The model of approach underpinning this programme is based on evidence of need in the community and an evidence based approach to what works. This approach is gained from professional and personal experience; research literature from successful models tested elsewhere as well as needs assessment on the ground. The approach demands that the underlying set of assumptions are clear, i.e. why the activity or activities proposed are a good solution to the identified problem(s). It is outcome oriented, i.e. it is driven by the benefits or changes for individuals or populations during or after participating in the programme activities. A key element is the ongoing monitoring and evaluation of the outcomes of the activities undertaken and learning from the individual sites. This evaluation is intended to promote a process of continuous improvement and helps to assess what interventions work best and how and where they can be best employed in improving delivery of services or the development of new policy. It should also guide the re-orientation of current services where the evidence indicates that this should happen.

The Prevention and Early Intervention Programme is the flagship fund within the OMCYA. The Programme aimed to examine innovative methods for improving outcomes for children in an integrated way and will run for a five-year period with a fund amounting to €36 million in total. €18 million of this is being provided by the Government and €18 million by Atlantic Philanthropies (AP). The Programme is being managed by the OMCYA and administration of the fund will also be overseen by it. The Government agreed that the best use of this funding would be to focus initially on a small number of projects in severely disadvantaged communities. Three projects submitted proposals to the OMCYA under the Programme as follows:

- *Childhood Development Initiative - A Place for Children in Tallaght West*
- *Preparing for life* (Northside communities of Belcamp, Darndale and Moatview)
- *Youngballymun*

Service Level Agreements were agreed between the OMCYA and the three projects were announced by the then Taoiseach on 23rd February 2007 at Tallaght West CDI.

Since then the Office has also been actively involved in overseeing the administration or co-ordination of funds in respect of a number of projects including inter alia:-

- Barnardo's Brighter Futures Project in Knocknaheeny in Cork – an early years, family support, literacy and pro-social behaviour model for children and families (funded under the Dormant Accounts Flagship Programme with small grant input for evaluation from the OMCYA);
- St. Ultan's School in Cherry Orchard – a "community" school model centred around St. Ultan's Primary School in Cherry Orchard (mainstream and philanthropic funding sources with small grant for strategic planning from OMCYA);
- Longford Westmeath Parenting Partnership – a universally provided parenting support model based on the internationally evaluated Triple P parenting programme (mainstream (HSE) and philanthropic funding with small grant for training and baseline data for evaluation from OMCYA);
- A Barnardo's/One Family Contacts Centres initiative – a child and family contact centre model based in 2 sites to examine and evaluate the potential role of a supported contact for children and parents providing handover or letter box services, supervised or supported contact. These services are aimed at (i) children and their non-resident parents where there are child protection or welfare concerns or relationship difficulties between adults leading to a need for supported contact or (ii) siblings who are in care in separate placements; or (iii) children who are in care. (Once-off funding from mainstream sources including the OMCYA);
- The National Early Years Access Initiative – a new capacity building early years programme aimed at demonstrating inter-agency community based response to the provision of early years education and care. This will target at minimum of 11 sites nationally quality, family support and literacy elements. (Philanthropic funding with small OMCYA and Department of Education and Skills grant funding toward evaluation.)

The Office works collaboratively with a number of philanthropic organisations in both funding and overseeing individual projects and programmes but also in working to develop a clear "what works?" evidence based in the Irish context. See the Centre for Effective Services work referred to below.

Centre for Effective Services

As part of ongoing collaborations with The Atlantic Philanthropies, the OMCYA and the Department of Community, Equality and Gaeltacht Affairs spent some time exploring how Ireland could develop the competencies and capabilities for the design and evaluation of services so as to achieve better outcomes. The Centre for Effective Services which is a North/South project jointly funded by Government and philanthropy was established.

The aim of the Centre for Effective Services (CES) is to provide a means to enable access to the relevant expertise on a timely and supportive basis. This would enable projects/programmes to be focused on tangible outcomes and lend themselves to robust objective evaluation. Support for service design and innovative practice will also be key elements of the Centre's work programme.

It has been agreed that the CES is the way to approach the design and evaluation of children's programmes, essentially to connect the design and implementation of

programmes with scientific and technical knowledge of what actually works. This will enable the OMCYA to develop its own competence for rigorous design and evaluation of programmes based on what actually works.

The CES is assisting the OMCYA with the further roll-out of *Working Together fo r Children* Initiative and the development of a youth policy framework. The is also working with OMCYA and philanthropic partners in assessing the implications for policy and practice arising from the evaluations of the PEIP projects and other innovative children's services projects referred to above. As a co-funder, the OMCYA has a role in agreeing work plans for the CES. The 2011 Work Plan is currently under discussion with the CES and co-funders but will include these elements.

Briefing Note for Minister
Medicines

Department's role

This Department is responsible for the development of policy with regard to medicinal products, cosmetics and poisons. This is a highly regulated area and the preparation of legislation, both primary and secondary, is an ongoing task. The Department works in close cooperation with the Irish Medicines Board.

Irish Medicines Board

The IMB is the statutory agency responsible for the regulation of human and veterinary medicines, cosmetics and clinical trials in Ireland. It is also the Competent Authority for the implementation of EU and national legislation relating to blood and blood components, tissues & cells and medical devices.

The IMB assesses applications to market medicines in Ireland and also participates in the assessment of applications made under the pan- EU system. The Board monitors the quality of medicines by conducting inspections at sites of manufacture and distribution of medicines and by random sampling of products both pre and post authorisation. It also monitors the type and frequency of any reported side-effects.

The IMB obtains most of its income through fees collected from industry. In 2010, total estimated expenditure was €25.5 million of which estimated €22 million was collected in fee income. The IMB is moving towards becoming a fully funded by industry. In 2010 enforcement activities became fully funded by industry. By end of 2011 controlled drugs and tissue monitoring activities will be similarly funded. By end of 2012 when medical device activities become funded by industry, the IMB will have achieved full self financing.

Transposition of EU Directives

In 2010, the Department transposed eight EU Directives relating to cosmetics. The majority of the amendments were technical in nature.
One EU Directive relating to medicinal products was also transposed. It concerned the control of advanced therapy medicinal products based on genes (gene therapy), cells (cell therapy) and tissues (tissue engineering). These advanced therapies herald revolutionary treatments of a number of diseases or injuries, such as burns, Alzheimer's disease, cancer or muscular dystrophy

Cosmetics

The cosmetics industry in Ireland is a large employer with a number of leading international companies based here. Responsibility for cosmetics safety transferred from this Department to the Irish Medicines Board on 1st October 2010. As well as improving levels of safety for the public, a strong Competent Authority will enhance the attractiveness for industry in locating in the State.

Recast of Cosmetic Regulations
This Regulation entered into force in January 2010 and the majority of its provisions will be enacted in July 2013. The aim is to codify, simplify and update existing provisions and to provide for harmonised notification of cosmetic products placed on the EU market. Another key goal is to ensure a higher level of consumer protection.

Current Issues

Pharmaceutical Package
In December 2008, the EU Commission published 3 legislative proposals (referred to as the Pharmaceutical Package). The three proposals are:

(a) The 'Pharmacovigilance' Proposal
Pharmacovigilence relates to the detection, assessment, understanding and prevention of adverse effects of medicinal products. An EU Directive and Regulation was published in December 2010. Transposition of the Directive into national law must be completed by July 2012. The overall aim is to update and streamline current practices and procedures in order to improve overall patient safety.

(b) The 'Falsified Medicines' Proposal
This was approved by the EU Parliament in February 2009 with an 18 month transposition period. It aims to better protect EU citizens from the serious threats posed by falsified medicines.

(c) The 'Information to Patients' Proposal
The overall principle of the proposal is to lay down clear rules on how information on prescription only medicines may be provided to patients by pharmaceutical companies. [A **detailed note on this is in Appendix below]**

Ireland's Presidency of the EU, 2013

It is expected that negotiation of the following new Directives will be ongoing during the Irish Presidency of the EU –

(i) New Clinical Trials Directive
The EU Commission is currently engaged in a consultation regarding a review of the EU Directive dealing with the conduct of clinical trials on medicinal products for human use.

(ii) New Medical Devices Directives
The EU Commission is reviewing the medical devices directives. Proposals are likely to focus on market surveillance (safety/performance monitoring), vigilance (adverse incident management), notified body monitoring (certification activities), clinical evaluation and transparency.

Appendix

EU proposals on the provision of information to patients regarding prescription-only medicines

1. Key provisions of the "Information to Patients" Proposal

The Commission has stated that the Information to Patient Proposal aims to ensure that EU citizens have access to reliable information on prescription medicines. The overall principle is to lay down clear rules on how information may be provided directly to patients by pharmaceutical companies. The key provisions are as follows:

(i) Industry to be permitted to provide information "in a different way"
It is proposed that industry would be permitted to provide information on prescription medicines "in a different way" i.e. other than through labelling and patient information leaflets. Member States have argued that this could be used to permit the advertisement of prescribed medicines. Member States are also concerned that, as currently drafted, it may be possible for industry to omit negative information regarding the product.

(ii) Industry to be permitted to "push" information via certain types of media and the internet
The original Proposal also envisages that industry would be permitted to provide information on prescription medicines to patients through the media (except TV and radio), health-related publications and on the internet.

(iii) Member States to "pre-vett" the information to be published by industry
It is proposed that information on prescription medicines would have to be submitted in advance for prior approval to a designated body - in Ireland, this would most likely be the Irish Medicines Board.

2. Position of the Council of Ministers

During discussions in 2009, a large majority of Member States stated that they did not support the Proposal because it did not provide an appropriate mechanism to make objective and unbiased information regarding prescription-only medicinal products available to patients. Some Member States were not prepared to enter into an examination of the Proposal and would not participate in any discussions. Only the UK and Lithuania gave positive views on the Proposal.

The core issues raised by the Member States were that:

(i) There was a lack of distinction between "information" and "advertising. As a consequence Member States were concerned that the Proposal would not be sufficient to prohibit advertising of prescription-only medicinal products to the general public

(ii) The monitoring by national medicines agencies and European Medicines Agency of "information" to be provided by industry was likely to have significant cost and administrative implications,

(iii) Member States are concerned that allowing information on prescription medicines to be provided directly to members of the public would promote brand loyalties and

would create significant pressure on national health authorities to reimburse particular medicines.

(iv) Member States expressed concern that information would not be proactively provided regarding older, low-cost medicines which may be as effective as newer more costly treatments.

(v) Member States were concerned that patients should have access to information on prescription medicines that is objective, relevant and evidence-based. Member States considered that EU competent authorities, national health authorities and healthcare professionals are more appropriate as channels for the supply of information on prescription medicines to patients.

3. Position of Parliament

In Sept 2010 the European Parliament Committee adopted its Report on the Proposal. Its main points on the Proposal were as follows:

(i) Change of Emphasis
The Parliament wishes to change the emphasis of the proposal to focus on the rights of patients to have access to information rather than on meeting the pharmaceutical industry's desire to be permitted to provide information. The Parliament is advocating a "pull" principle whereby the public can seek information, but information would not be actively disseminated by industry. The Parliament also proposes a greater emphasis on the role of patient organisations and on healthcare professional's in providing information to patients.

(iii) Limits on advertising
The Parliament is opposed to permitting the industry to make information on prescription medicines available via television, radio or newspapers, magazines and similar publications. The Commission proposal only prohibited information being provided by television and radio.

4. Current Status of the Proposal

The Commission is currently working on a redraft of the Proposal taking into account the Parliament's views. It is expected that a new version of the Proposal will be ready for negotiation at the Council during Spring 2011.

5. Ireland's Position to date

In common with many other Member States, we have concerns regarding many of the proposals in the current text. It is recognised that there is a public desire and need for access to reliable and high quality unbiased information about medicines. The Irish Medicines Board has been progressively working to make patient information leaflets and Summaries of Product Characteristics (prescribing information) publicly available on its website (this is not the case in all Member States). Many patients resort to unregulated sources on the Internet to gain access to information about their medication.

We have indicated that we are open to examine the Proposal and Parliament's amendments to ascertain whether, by amendment of the Proposal or redraft by the Commission, an appropriate legal basis can be achieved for providing the public with better information on prescription medicinal products.

BRIEFING FOR INCOMING MINISTER FOR HEALTH AND CHILDREN

OFFICE FOR OLDER PEOPLE

Cross-cutting issues

Background:

The Office for Older People was established in January 2008 within the Department of Health and Children to bring coherence to Government policy, planning and service delivery for older people. The launch of the Office was a further development of the lifecycle approach as set out in the Social Partnership Agreement, *Towards 2016*, which places the person at the centre of social policy development. The establishment of the Office for Older People was another step towards providing older people an opportunity to live a full life and to participate in society.

The arrangements put in place for older people were similar to those operating in the case of the Office of the Minister for Children and Young People. The overall vision is to put in place structures which will provide for a greater cohesion than currently exists in supporting older people structures across the public service.

The Minister for Older People and Health Promotion was a member of the Cabinet Committee for Social Inclusion and had responsibilities in the Departments of Health and Children; Environment, Heritage and Local Government; and Social Protection and was responsible for the Office for Older People in the Department of Health and Children.

The Office is comprised of 3 units: Services for Older People; Strategy Development Unit; and Long-Stay Charges.

The key objectives of the Office are to:

- provide strategic direction and leadership in developing policy and legislation and monitoring and evaluating service delivery and development in relation to services for older people, palliative care services, the health repayments scheme, healthy ageing and litigation, and

- act as an agent for change in driving the development of comprehensive joined-up policy across all Departments in relation to older people.

Cross-Cutting Work Programme:

Cross cutting work to date undertaken by the Office for Older People has included cooperative engagement with the Department of Social Protection on the Carers Strategy and with the Department of the Environment, Heritage and Local Government on sheltered housing.

Key elements of the on-going cross cutting work programme of the Office include (1) the development of a National Positive Ageing Strategy; (2) taking the lead, on behalf of the State, in managing and co-funding The Irish Longitudinal Study on Ageing (TILDA); and (3) responsibility for international issues around ageing and older people.

(1) National Positive Ageing Strategy

A key function of the Office, as set out in the Government decision establishing the Office, is to develop a National Positive Ageing Strategy.

It is envisaged that the National Positive Ageing Strategy will set out a common framework for the development of operational plans by Government Departments clearly setting out their objectives relating to older people, as well as the development of ongoing mechanisms designed to monitor progress and identify challenges facing older people in the future. It is being developed within the constraints posed by the present fiscal situation. It is not the intention that it will propose new service developments; rather it will set the strategic direction for future policies, programmes and services for older people in Ireland.

The Strategy is being developed by a Cross-Departmental Group (CDG), comprised of officials from 11 Government Departments, the Central Statistics Office and An Garda Síochána, and is chaired by the Director of the Office for Older People. An NGO Liaison Group comprising representatives of twelve national-level non-governmental organisations with an interest in older people's issues has been established under an independent chair. An Expert Advisory Group, which is in the process of being established, will also inform the process.

Work to develop the Strategy is being overseen by the Cabinet Committee on Social Inclusion.

A call for submissions on the Strategy was issued in June 2009 and 190 submissions were received from a broad range of stakeholders. The top five priority themes that emerged from the submissions were: health and social care (64%); transport (40%); social inclusion (36%); housing (33%); income and pensions (27%).

In May 2010, the Minister completed a three-month country-wide series of consultation meetings to hear the views of older people, service providers and representative organisations at first hand. These meetings were held in Cork, Sligo, Galway, Kildare, Wexford, Newcastle West, Dundalk, Dublin and Athlone. The Minister also held consultation meetings with a number of NGOs who represent more vulnerable or marginalised older people.

At the public consultation meetings, participants have suggested how services/programmes can be improved and have given views on what works well and on what could be done differently or in a better way (particularly how service delivery could be enhanced in the light of current resource constraints). The themes that arose during the public consultation meetings are broadly consistent with those outlined in the written submissions received.

A report on the consultation process to highlight the issues which older people and service providers raised has been prepared and was published on 22nd November 2010. Work is continuing on developing the Strategy

(2) ***The Irish Longitudinal Study on Ageing (TILDA)***

Given the need to plan for an increasing proportion of the population that will be aged 50 years and over in the years ahead, and the establishment of an Office for Older People in 2008, the Department of Health and Children agreed to fund the Irish Longitudinal Study on Ageing (TILDA), the first of its kind in Ireland. TILDA is also being funded by the Atlantic Philanthropies (AP) and Irish Life and Permanent (IL&P).

TILDA, which aims to produce a significant improvement in the quantity and quality of data, research and information relating to older people and ageing in Ireland, is a 10 year longitudinal study of the health, social and economic circumstances of a large statistically representative sample of 8,000 people aged 50 years and over.

The research is being conducted by a research team of experts from a number of institutes in a variety of fields, led by Principal Investigator, Prof Roseanne Kenny (Prof. of Geriatric Medicine, Trinity College Dublin (TCD) and Project Director, Prof Brendan Whelan (TCD).

The first wave of the research began in late September 2009 and its first outputs are due in Q1-2 of 2011.

Over the course of the Study, Government Departments are being consulted periodically (through the Office for Older People) in relation to the questionnaire content and priority data outputs from each Study wave.

(3) International issues relating to ageing and older people:

The Office for Older People co-ordinates the Department's response to international issues relating to ageing and older people, emerging, in particular, from the EU and from the UN. The EU is in the process of designating 2012 as EU Year for Active Ageing and Intergenerational Solidarity, and the Office will lead on Ireland's contribution to that year. In relation to the UN, the 2007 Madrid Implementation Plan for Active Ageing is currently being reviewed, and a second round of national action plans will be expected in 2012, and the Office will take the lead on this issue also, on behalf of the State.

Services for Older People

Government Policy

Government Policy is to support older people to live in dignity and independence in their own homes and communities for as long as possible and, where this is not possible, to support access to quality long-term residential care.

Changing demographic factors and calls for quality services will place continuing demands on all services. The number of people over age 65 years represented **11%** of the total population in

2010. This number is projected to increase from over 500,000 to 1,300,000 in the next 30 years with the greatest proportional increases occurring in the 85+ age group. At present;

- **Approx 4.5%** living in Long-term Residential Care
- **95.5%** living in Community

1. Overview

MAC Member: **Noel Usher**
Head of Unit: **Geraldine Fitzpatrick**

The Office for Older People comprises three Units –; Strategy Development; Long Stay Charges and Services for Older People (SfOP).

SfOP is responsible for developing policy and overseeing and monitoring the delivery of health and personal social services for older people in both the residential and community sector.

In 2011, the HSE will continue to provide community and home based services. Among the critical challenges will be to ensure that the HSE delivers the outputs promised under its Service Plan, and that the quality of services is ensured.

2. Key Statistics and Finances

Older People	**2011 Budget /NSP Target/Employee Numbers (Public).**
Residential Services	• **€1.011 billion** (includes an additional **€6m** from Budget 2011) - effectively the budget for the Nursing Homes Support Scheme
Community Services	• **€211m** for Home Helps with HSE delivering nearly **12 million** home-help hours, benefiting approximately **54,000** people (same level of service as in 2010). • **€138m** for HCPs (includes additional **€8m** from Budget 2011) to fund the provision of packages this year to around **10,200** older people at any one time, or almost **14,000** clients over the course of the year. • *Day/Respite Care Places* – Around 21,300 places benefiting up to an estimated **80,000 people.**
Palliative Care	• **€74m** for palliative care services in 2011-(almost 3,600 patients received palliative care services in 2010).
HSE -WTE's	• **10,824** wte (Combined -Older People) December 2010
	• **657** wte (Combined -Palliative Care) December 2010

3. Community Services

The Department's aim is to meet people's needs through a variety of supports, which are intended to provide a multi-disciplinary approach to delivering services to people in their own homes. Approximately ***€220m*** additional funding has been provided in recent years for continued development of community services such as Home-Help, Home Care Packages (HCPs), Meals-on-Wheels, and Day/Respite Care.

Home Care Packages, introduced in 2006, was a new initiative designed to provide *Enhanced* supports, over and above *Mainstream* provision.

Arising from an Independent Evaluation of Home Care Packages published in 2009 the Department and HSE accepted that a more standardised approach to provision is required nationally, including the question of access. The Department worked closely in 2010 with the HSE to address the implications and recommendations arising from this Evaluation.

- In December 2010 the HSE commenced new *National Guidelines for Standardised Implementation of Home Care Packages*.
- In 2011 the DoHC and the HSE will work to progress
  - New *National Quality Guidelines for Home Care Support Services*, which set in place minimum standards for the delivery of home based services and
  - *National Guidelines for the Home Help Service* which will provide guidance on access to and allocation of home help hours
- A National Procurement Framework for Home Care Services was tendered in October 2010, and the HSE is progressing this from early 2011.

In 2010 the Department commenced examining the regulation of the domiciliary care sector, and this work will continue in 2011.

4. Residential

The total budget for long-term residential care in 2011 is ***€1.011billion***.

There is a total Public/Private provision of just under **30,000** places (includes long-stay, respite, convalescence and palliative).

- There are approximately **600** residential centres for older people with an estimated **23,700** older people in long term residential care.
- At present there are **8,600** HSE public beds (all bed types).

The Nursing Homes Support Scheme Act 2009 ("A Fair Deal") was signed into law on 1 July, 2009 and related secondary legislation was drafted and brought into force prior to the introduction of the new Scheme. The Scheme commenced in October, 2009.

The scheme is a new system of financial support for individuals who require long-term nursing home care and applies to people entering public and private nursing home care. Under the scheme, individuals make a contribution to the cost of their nursing home care based on their means.

The HSE meets the full balance of cost over and above the individual's contribution in public or private nursing homes approved for the purpose of the scheme.

- Almost **18,000** applications received (by end-December 2010),
- Almost **13,500 -75%** processed.

New Registration and Inspection regime commenced on 1 July, 2009.

The Health Act, 2007 provides for the registration and inspection of nursing homes, both private and public. The Act assigns responsibility for the registration and inspection function to the independent Chief Inspector of Social Services, part of the Health Information and Quality Authority. Standards are a key requirement for registration and inspection of nursing homes.

- HIQA has carried out over **1,000** inspections **to date.**
- All designated centres have been inspected.

- All inspection reports are published.

5. STRATEGIC ISSUES AND PRIORITIES

New Community Legislation – preparation of proposals on access to community services.

Regulation of the Community Care Sector – a position paper on the proposed regulation of this sector is currently being prepared.

Nursing Homes Support Scheme Act, 2009-to oversee and evaluate implementation of the Scheme- include monitoring the number of applicants supported, timeframes for processing applications, costs of public/private beds, subhead B12, phasing out of subvention scheme and contract beds etc.

Care and Welfare Regulations- review of current regulations in the context of issues arising since the introduction of new regime. Issues to be examined include the requirement to have 24 hour nursing in place in residential settings; restraint, information requirements and issues related to short term/respite placements. Review to be completed and revised regulations commenced by mid-year.

Public Residential (Nursing Home) Capacity-review position of all HSE residential facilities (Older People) in terms of meeting the National Standards and Regulations, local demographic pressures and public and private provision, with a view to developing an overall strategy on how it should continue to provide this service in view of current budgetary and other pressures.

Publish **"*Towards a Restraint Free Environment in Nursing Homes*"**-a policy document to promote a culture of non-restraint in nursing homes

National Dementia Strategy-initial research and scoping work to inform the eventual policy has commenced. Formal work will commence on the Strategy during the second half of 2011.

Palliative Care-to monitor and evaluate implementation of policy, including paediatric palliative care policy.

Long Stay Charges

MAC Member: **Noel Usher**
Head of Unit: **Chris Costello**

- **Health Repayment Scheme**

Total cost of the scheme to end 2010 is €471m, including repayments of €442m and overheads of €29.3m. €16.5m has been paid to the Scheme Administrator. 16 claims remain to be concluded.

The 2010 funding provision of €20m (including the additional €3m vired in December) for the scheme was fully drawn down. Funding of €12m has been provided in the REV for 2011.

6,054 appeals were lodged with the health repayment scheme Appeals Office by end January 2011 and 5,027 appeal decisions have issued. 200 appeals remain to be determined. The DoHC received sanction from the DoF to extend the timeframe of the Appeals Office from 31 Dec, 2010 to end Mar, 2011 and options for dealing with any residual appeals post Mar 2011 are currently being considered.

Voluntary Contribution Appeals:
The issue of voluntary contributions being levied from people in community residences has been raised in the context of the Repayments Scheme. A number of such claims submitted to the Repayments Scheme are currently at appeal stage.

[redacted]

Legal Cases
Long Stay Charges Unit is currently managing a number of cases in relation to long stay charges and nursing home fees and also manages litigation in the disability area. This involves close consultation with the Attorney General's Office, the CSSO and the HSE.

There are three appeal cases from individual appellants who are taking action against the Appeals Office in relation to the Repayment Scheme, with the Department and the HSE as notice parties. In another three cases the Department and the HSE are the Appellants.

Discovery:
Motions for Discovery have been set down in a number of cases. The Orders made by the Master in two cases were challenged by the Plaintiffs in the High Court at the end of January. Judgement in these matters should be available by early March.

Briefing for new Minister

Primary Care

Topics

1. **Primary Care Strategy - Primary Care Teams**
2. **General Practitioners**
3. **Pharmacy Issues**
4. **Medical card scheme**
5. **Community Drugs Schemes**
6. **Oral and Dental Health**

Note to Parliamentary Affairs Unit: the highlighted sections in the text should not be released in accordance with Section 20(1) of the FOI Acts. Section 20 (1) applies as the record relates to the deliberative process of the Department.

Section 21 (1) (b) also applies to the highlighted section in the *GP* material as release could have an adverse effect on the performance of the HSE's management functions (including industrial relations matters).

Primary Care Strategy, Primary Care Teams, Etc.

Key Statistics

Primary Care Strategy

- The Primary Care Strategy commenced in 2001. The Strategy is the roadmap for the future development of the primary care service in Ireland over a period of ten to fifteen years.
- The key objective is to develop services in the community which will give people direct access to integrated multi-disciplinary teams of general practitioners, nurses, health care assistants, home helps, occupational therapists and others.
- Each Team will be supported by a wider range of professionals, including pharmacists, dieticians, psychologists and chiropodists who will form a Health and Social Care Network, with each such Network supporting a number of Primary Care Teams.
- Each Team serves a defined population of approximately 7,000 to 10,000 and the Health and Social Care Networks will each cover a population of approximately 30,000.

Primary Care Teams

- The HSE has identified 527 Primary Care Teams (PCTs) and 134 Health and Social Care Networks to be developed by the end of 2011.
- At the end of December 2010, 350 teams were operating (holding clinical team meetings on individual client cases and involving GPs and HSE staff).
- To date, over 3,690 HSE allied health professionals have been assigned to PCTs; 2,615 of these professionals are working in teams which are holding clinical team meetings.
- Some 1,309 GPs are also involved in the development of Teams (Averaging 3.7 per Team).

Primary Care Centres

- The HSE Board has approved the conduct of negotiations with interested parties in respect of 210 locations for Primary Care Centres (PCCs).
- Negotiations are in being in respect of 107 PCCs which will accommodate 137 PCTs.
- 12 centres procured by lease agreement are complete and in operation.
- A further 5 centres are expected to open in the first quarter of 2011.
- The HSE expects at least 115 PCCs to be operational by 2013, supporting 160 Teams.
- The HSE is continuing to develop a number of PCCs funded through its Capital Programme (18 completed to-date).

Community Intervention Teams (CITs)

- CITs are nurse led teams supported by a variety of other health professionals and services which provide a rapid and integrated response to patients with an acute episode of illness. The patient must be medically stable and meet the CIT referral criteria for care in the home/community setting. The purpose of a CIT service is to facilitate the avoidance of hospital admission or attendance.
- The service works in partnership with Primary Care Teams, General Practice, Community Response Beds, Community nursing services, home support services, acute hospitals and other professionals and voluntary services to deliver enhanced services and patient centred care in the most appropriate setting.
- There are currently 6 CITs in place in Dublin North, Dublin South, Cork, Limerick, Clare and North Tipperary.

Progress Achieved & Next Steps

Medicine usage reviews

- It is estimated that 45% of medication is not taken correctly with 20% not taken at all. 15 Primary Care Teams are participating in pilot Medicines Usages Reviews. To-date, 226 reviews have been conducted. This initiative, developed through Primary Care Teams with pharmacist engagement, will help to improve GP/Pharmacist communication.

Falls prevention

- Falls in older people lead to significant morbidity and loss of independence. Over 34,000 people over 65 years old are admitted every year to hospital as a result of falls. A Falls Prevention initiative is currently underway between Primary Care, Services for Older People and Elderly Medicine-Quality and Clinical Care Directorate to prevent falls and fractures in Ireland's ageing population.

Smoking cessation

- A pilot project on smoking cessation is presently being undertaken in PCTs. The objective is to equip PCT personnel to use brief interventions to promote smoking cessation among their patients and/or to refer patients to smoking cessation services. The PCTs involved include those in Arklow, North Clare, Mitchelstown and Tubbercurry.

Mental health

- Community mental health centres are now being developed in tandem with Primary Care Centres, where space allows. 228 such developments have been planned in total. Dublin City University now provides a training course in "Team based approaches to Mental Health in Primary Care" for primary care professionals. 27 staff from 9 PCTs are undertaking this course and participants are drawn from all disciplines working in Primary Care.

IV therapy

- The current process for patients who require IV fluid administration and IV antibiotics is to transfer them to the local A&E Department. The provision of IV therapy in residential facilities could reduce the need for the referral of these patients to Emergency Departments and improve the quality of care to these patients. Work is ongoing in the development of an implementation plan to effect this.

Management of Asthma

- 25 GP practices are participating in a Demonstration Project to support the implementation of the Guidelines launched by the Asthma Society of Ireland.

National Electronic Generic GP Referral System

- HIQA is leading a joint working group tasked with making recommendations on a standardised referral pathway for GP/PCT patients to hospitals. The end of 2011 has been targeted for the roll out of the system in two pilot areas (Tallaght Hospital and the 6 hospitals in the HSE South region). It is envisaged that in due course the generic part of the system can be replaced by specific data sets (when developed) for particular patient groups (e.g. diabetes). The system

will facilitate an appointment being made from the GP practice or PCT, with instant acknowledgement and an appointment allocated within 72 hours.

Management, governance and clinical leadership within PCTs

- These areas will be further developed to enable the development of a sustainable model for managing and governing PCTs as units in the care delivery system. This work is being considered as part of the Integrated Services Programme.

Alignment of the PCT Projects with the Hospital Reconfiguration Projects

- Some planning is required to ensure that the development of PCTs and the reconfiguration of hospital services initially in the North East and Mid West are aligned to deliver a coordinated approach to patient care.
- Integration initiatives such as the Integrated Discharge Planning Project and the Diabetes Integrated Management Programme will be used to establish concrete links between established PCTs and Hospitals in transition. In addition, local integration groups have been established in some areas for discharge planning, Home Care Packages, etc.

Risks / Sensitive Issues

Primary Care Centres - Lease back Arrangements

The HSE has indicated that projections on the number of Primary Care Centres will change each quarter due to various issues, including planning, banking and market difficulties.

General Practitioners

Key Statistics

- GP fees & payments for 2011 are estimated at in excess of €440 million (post reductions).
- Some 2,600 GPs in active practice (full & part time) and some 300 doctors working as locums.
- 2,100 GPs contracted by the HSE to provide services to medical card and GP visit card patients.
- Some 400 GPs will reach the age of 70 in the next 4 to 5 years (current average age is 56/57).

Policy Issues

EU/IMF Programme

The EU/IMF programme provides for the introduction of legislative changes to remove restrictions to trade and competition in sheltered sectors by the end of the 3rd quarter in 2011, including eliminating restrictions on the number of GPs qualifying and removing restrictions on GP's wishing to treat public patients as well as restrictions on advertising.

Restrictions on the number of GPs qualifying

There are 12 GP Specialist Training Programmes with a total of 157 new training places available each year (4 year training programme). Currently 350 applications per year.
GP training programmes are of 4 years duration and trainees are required to complete 2 years in a hospital setting and 2 years in general practice. GP trainees receive remuneration from the HSE during the 4 years of training. No recognition is granted where a trainee has previously obtained equivalent training in a hospital setting.

Restrictions on Access to GMS GP Contracts

The HSE is required, when filling a vacant GP patient panel or creating a new patient panel, to take account of the potential viability of a panel under a range of headings, including: the number of GMS patients on the list; the private practice profile of the area; the number and age profile of the GMS doctors in the area, and the particular public health needs of the area.

At present there are two options for entry into the GMS Scheme for fully trained GPs, after open competition and interview. These are:

- Vacancies arising from the retirement, resignation or death of an existing GMS doctor or where new panel is created in response to an identified need for an additional doctor in an area;
- Recruitment as an assistant with a view to partnership, where an existing GMS contract holder requests approval from the HSE for the creation of a post of assistant with a view to partnership within that practice.

Restrictions on Advertising

Until recently, the Medical Council's *"Guide to Professional Conduct and Ethics for Registered Medical Professionals"* placed advertising restrictions on new GPs. They were only allowed to advertise their arrival in an area by way of newspaper notices. Other methods of advertising, including notification of prices were not allowed. These restrictions have not been included in the Medical Council's 2009 guide.

GMS Contract / Transformation Agenda

- The current GMS GP Capitation Contract was introduced in 1989. Over 99% of GPs contracted to provide services to GMS patients do so under the 1989 contract. The remaining GPs provide services under the 1972 Fee-per-Item contract.
- A review of contractual agreements with GPs commenced in 2005 under the auspices of the Labour Relations Commission (LRC).

- Legal advice received in 2006 and 2007 confirmed that there are legal difficulties arising from EU and national competition law in undertaking negotiations and, in particular, agreeing fee rates relating to the provision of health services by self-employed professionals.
- In October 2008, the former Government announced its intention to amend the Competition Act 2002 to enable the IMO to represent its members in negotiations with the Department and the HSE in respect of the services provided to the public health service in a manner consistent with the public interest.
- Under the Croke Park agreement, discussions are to take place with the IMO regarding the above commitment and a transformation agenda for GPs.

GP Out-of-Hours (OOH)

- About 90% of the population have access to GP out-of-hours (OOH) services.
- In 2011, it will cost the HSE in the region of €90m for the provision of an OOH service to 1.6 million GMS patients approx. Included in this are payments to GP co-ops for cars & drivers.

Progress Achieved & Next Steps

EU/IMF Programme

Fast Track GP Training – the HSE is working with the ICGP to explore a process to fast track GP Training for Doctors who have the relevant hospital training and experience.

[redacted]

[redacted]

GP Out-of-Hours

The HSE carried out a National Review of GP OOH Services in March 2010. This recommended a number of changes to ensure a cost effective & standardised national service including:

- Service to be extended to cover parts of the country where there is currently no OOH provision, such as Dundalk, Limerick, Sligo, Tullamore and Tallaght.
- All GP payments would change to the Special Type Consultation (STC) model as opposed to the grant system which exists in some areas.
- The introduction of a standard national service level agreement template for GP co-ops to facilitate a consistent approach to quality, information requirements, governance, complaints and risk management.
- Nurse telephone triage should only be undertaken on a national basis, quality assured through a clinical decision support system to ensure a standard and cost effective service across the country.

A working group comprising representatives from the HSE, the IMO and the Irish Association of General Practitioner Co-operatives is advancing the implementation of the recommendations.

The HSE and GP members of NEDOC have agreed the implementation of a number of key recommendations with effect from 1st March 2011.

Further analysis on the uptake of the cross border GP OOH service has been requested by the two Health Departments (North & South) as numbers using the service continue to be relatively low (particularly the Donegal-Derry pilot). This will be used to evaluate the sustainability of the service and inform decisions on the future of the pilots or the extension of further pilot areas.

FEMPI

- During 2009 and 2010, the Minister for Health & Children made a number of Regulations under the Financial Emergency Measures in the Public Interest Act 2009 (FEMPI), to reduce the fees payable to certain health professionals.
- S.I. No. 262/2009 came into effect on 7th July 2009. This applied an 8% reduction to a range of GP fees and allowances, which resulted in a full year saving in the region of €34m.
- S.I. 638/2010 came into effect on 22nd December 2010. This applied various reductions to a range of GP fees and allowances, which will result in full year saving in the region of €44m. This is expected to rise to €48m when Regulations relating to immunisation fees are completed.
- The Minister is required to carry out a review of the operation, effectiveness and impact of the amounts and rates fixed under the above regulations before 30th June 2011.

Risks / Sensitive Issues

EU/IMF Programme (Removal of Restrictions on Access to GMS GP Contracts): [redacted]

GMS Contract

[redacted]

Phlebotomy Services - Some GMS contract holding GPs are charging their medical card/GP visit card patients for the provision of a basic phlebotomy service where the samples are taken in the contractor's approved centre(s) of practice for investigative and therapeutic purposes.

The HSE has advised the IMO that it does not agree that a contracted GP is entitled to impose charges on medical card and GP visit card holders for this service and that the routine taking of blood samples from patients cannot be considered anything other than proper and necessary treatment of patients of a kind usually undertaken by a GP and is not something that requires special skill or experience of a degree or kind which GPs cannot reasonably be expected to possess.

Pharmacy Issues

Key Statistics

- Expenditure by the HSE on the GMS and community drug schemes amounted to €2.026 billion in 2009 of which an estimated €396 million was paid to pharmacists in fees and mark-ups. Estimated expenditure in 2010 is €1.971 billion and pharmacists' share is estimated at €384 million.
- In 2010 the HSE paid, in whole or in part, for approximately 70 million items supplied to medical card holders, Drugs Payment Scheme cardholders and Long Term Illness card holders.

Key Achievements

- In February 2010 Irish Pharmaceutical Healthcare Association (IPHA) member companies agreed to a price reduction of 40% for some of the most commonly prescribed off-patent drugs in Ireland. In addition, the rebate paid by IPHA member companies to the HSE in respect of drugs supplied under the GMS scheme has increased. The combination of these measures plus consequent savings in wholesale and retail mark-ups are expected to result in annual savings of approximately €94m.
- Agreement was also reached in September 2010 with the Association of Pharmaceutical Manufacturers in Ireland (APMI) to reduce the prices of their generic medicines in line with the IPHA reductions. The price reductions are expected to deliver annual savings of over €25m for the HSE.
- In December 2010 IPHA member companies committed to providing further savings of €155 million in 2011 through a combination of price reductions and increased rebates to the HSE (including "run through" to wholesale and retail margins). The companies have also committed to working with the Department and the HSE to achieve savings of €35 million through the High Tech Scheme and €10 million on hospital medicines.

Payments to Pharmacists (FEMPI)

In July 2009 the wholesale mark-up paid on medicines was reduced from 17.66% to 10%, a common sliding dispensing fee was introduced across all schemes and the retail mark-up paid on a number of schemes (Drugs Payment Scheme, Long Term Illness scheme, etc) was reduced from 50% to 20%. These changes resulted in annual savings of approximately €120 million in 2010. In June 2010 the Minister reviewed the impact of the revised payments and decided to make no change to the regulations concerning pharmacy fees at that time.

In December 2010 the Minister for Health and Children initiated a further review of payments by the HSE to community pharmacy contractors under the Financial Emergency Measures in the Public Interest Act 2009 (FEMPI). The Department has completed a submission recommending that further reductions be imposed.

[redacted]

Reference Pricing and Generic Substitution

Reference pricing is a scheme employed in many of our EU partners where a group of interchangeable medicines (e.g. generic equivalents) is identified and a maximum reimbursable price set for any medicine from this group. A physician is able to prescribe the brand/drug of choice and the patient is able to have dispensed the brand/drug of choice but the State shall only reimburse the value of the lowest priced medicine in the group.

Generic substitution allows for a pharmacist to substitute interchangeable medicines. Allowing generic substitution is an essential component of a successful reference pricing system. Generic substitution provides the patient with a choice on an interchangeable medicine when a particular brand or none has been prescribed.

The potential short-term savings from increased use of generic medicines has decreased following significant price reductions agreed last year. Savings are now estimated to be in the region of €10 million in a full year. However, it is important that this legislation is enacted in 2011 as a number of high volume medicines are expected to come off patent in the coming years. These reforms will ensure that lower prices are paid for these medicines resulting in significant savings for taxpayers and patients.

A submission on this matter will be made to the Minister shortly.

[redacted]

Medical & GP-Visit Card Schemes

Background Facts & Figures

Medical Cards and GP Visit Cards 2006-2010

Date	National Population	Number of Medical Cards	% of Pop	Number of GP Cards	% of Pop	All Cards as % of Pop
End-2006	4,239,848 1,	221,695	28.8%	51,760	1.2%	30.0%
End-2007	4,339,000 1,	276,178	29.4%	75,589	1.7%	31.2%
End-2008	4,422,100 1,	352,120	30.6%	85,456	1.9%	32.5%
End-2009	4,459,300 1,	478,560	33.2%	98,325	2.2%	35.4%
End-2010	4,470,700 1,	615,809	36.1%	117,423	2.6%	38.8%

- Almost 39% of the population is covered by a medical card or a GP-visit card.
- The cost of the medical/GP card schemes in 2010 is estimated at approximately €1.97 billion. The major cost components are:
  - about one-half of the costs relate to the cost of prescription drugs;
  - about one-quarter of costs relate to payments to GPs; and,
  - about one-seventh of costs relate to fees to pharmacists.
- The HSE has projected further increases in medical/GP cards during 2011:
  - medical cards to increase by about 10% to 1,779,585;
  - GP cards to increase by about 18% to 138,816.
- Based on the HSE's projections for 2011:
  - The medical/GP card schemes will cost about €2.38 billion in 2011.
  - Medical cards will cover 39.8% of the population in 2011.
  - GP cards will cover 3.1% of the population in 2011.
  - Almost 43% of the population will by covered by a medical card or a GP-visit card in 2011.

Main Issues

- **Growth in Medical/GP Card Numbers:** The number of medical/GP cards has increased by 28% in three years between end-2007 and end-2010. This has resulted in a significant increase in the costs of the GMS from about €1.6 billion to about €2 billion.
- **Medical/GP Card Statistics:** Given that the medical/GP card schemes provide services to 1.7 million people and are responsible for about €2 billion of Government expenditure, a *key challenge* is develop business intelligence around the operation of the schemes in terms of key cost drivers, payment streams, applications data, and estimates of potentially qualifying candidates.
- **Centralisation of Medical Card Application Process:** The HSE is in the process of centralising the processing of medical/GP card applications & reviews at the HSE's Primary Care Reimbursement Service (PCRS) in Dublin. The HSE plans to *finalise the centralisation by end-June 2011*.
- **Income Thresholds:** The medical card income thresholds have not been increased since October 2005. However, the percentage of the population covered by a medical/GP card rose from 29.5% in 2005 to 38.8% in 2010.

Community Drugs Schemes

Prescription Charges

A prescription charge of 50 cent for prescribed items dispensed to medical card holders subject to no person or family paying more than €10 per month was introduced from 1st October 2010. The HSE has put in place a refund system in order to refund families who exceed the €10 monthly ceiling. Based on trends in previous years, it is expected that the prescription charges will yield €24 million in a full year.

Prescription charges do not apply to:

- Children in the care of the HSE who have their own medical card;
- Persons who receive services under the Health (Amendment) Act 1996;
- Or to methadone supplied to patients participating in the Methadone Treatment Scheme.

The legislation does not provide for collection of prescription charges where medicines are dispensed by Dispensing GPs. The rural dispensing system is currently under review by the HSE.

Representations have been received seeking exemptions for the following cohorts:

- Patients in nursing homes;
- Patients receiving treatment under the Methadone Treatment Scheme for other medications that may be taken;
- Patients receiving psychiatric medicines;
- Homeless persons;
- Patients who have their medicines changed on a weekly/daily basis including palliative care patients, and
- scope to allow pharmacists exercise discretion to dispense medicines in situation where patients refuse, or cannot afford, to pay.

The legislation allows the Minister to provide for further exemptions subject to certain conditions.

Long Term Illness Scheme and Prescription Charges

It was originally intended that the prescription charge would apply to items dispensed under the Long Term Illness (LTI) Scheme. However the LTI was excluded in response to difficulties flagged by the HSE. There is no link between the LTI and medical card databases which means that it would not be possible to offset charges on one scheme against the other when calculating the monthly ceiling or to link the expenditure of the LTI card holder to that of the family when calculating the monthly ceiling.

The HSE does not provide Long Term Illness cards to people with qualifying illnesses who have a medical card. The HSE also requires that where a person holds both cards, the medical card must be used when the patient gets their medicines at the community pharmacy. This practice has been in place for some time but the effect is that such patients must pay a prescription charge whilst other LTI holders who do not qualify for a medical card are exempt from any charge.

Qualifying conditions for the Long Term Illness Scheme

The Long Term Illness Scheme applies to persons with any of the following conditions : mental handicap, mental illness (for people under 16 only), phenylketonuria, cystic fibrosis, spina bifida, hydrocephalus, diabetes mellitus, diabetes insipidus, haemophilia, cerebral palsy, epilepsy, multiple

sclerosis, muscular dystrophies, parkinsonism, conditions arising from thalidomide and acute leukaemia. The total cost of the LTI scheme in 2010 is estimated at €134m.

The list of qualifying conditions has not been extended since 1975. The Department receives regular correspondence and parliamentary questions seeking inclusion of other illnesses.

The HSE provides medicines and appliances under the LTI which are related to the qualifying illness and this is in line with a 1971 circular from the Department. Other medicines or appliances which are not related to the qualifying illnesses are provided subject to the patient's eligibility under the GMS or DPS. [redacted]

The operation of the LTI Scheme generally is under review by the Department and a detailed submission will be made to the Minister at an early date.

Definition of Dependants for the Drugs Payment Scheme

Under the scheme a Drugs Payment Scheme cardholder pays a maximum of €120 per month on prescribed medicines and non-drug items for themselves and their dependants.

There is no definition of "dependants". The current administrative definition used by the HSE covers an adult, their spouse, and any children under 18 years and any children under 23 years who are in full time education.

The age threshold of 23 for children in full time education is inconsistent with the age threshold applied for the medical card scheme (25).

[redacted]

[redacted]

ORAL AND DENTAL HEALTH

Department's Role

The Department agrees objectives and performance indicators with the HSE for the Public Dental Service and for the Dental Treatment Services Scheme and oversees the development of policy and service delivery in this regard.

Current goals are the provision of a basic level of service within budget to medical card holders under the DTSS and the provision of pain /emergency services for children under 16 and routine care for targeted classes of primary school children under the Public Dental Service together with the provision of advanced, specialist and consultant care in hospital settings.

Discussions are underway with the HSE about the prioritisation of services to be delivered in 2011 and beyond including DTSS services, Public Dental Services, Orthodontics and specialist hospital services including services for care groups such as older people and people with disability.

Activity, outputs, performance

(i) Dental Treatment Services Scheme (DTSS)
The DTSS enables medical card holders (16 years and over) to access basic dental treatment free of charge from contracted dental surgeons in the private sector. The service is delivered by approximately **1,400** dental practitioners. Expenditure was capped at the 2008 level of €63 million as part of the Budget 2010 measures. The HSE introduced measures to achieve this in April 2010. (Nevertheless, over €80 million was spent on the DTSS in 2010, reflecting the legacy from the more comprehensive scheme.) Judgment was delivered on 28th February 2011 in a case taken by two dentists against the changes to the DTSS introduced by the HSE. It was found that the changes introduced by the HSE did not involve a breach of contract.

Treatments available are prioritised in accordance with clinical necessity. Emergency care is provided, with a focus on the relief of pain and sepsis. The remaining care provision is subject to prior approval by a clinician in the HSE, who will prioritise for high risk and exceptional patients; those requiring emergency care, and patients who are considered to have greater clinical urgency and/or necessity in receiving care.

DTSS statistics 2008 – 2010

Year DTSS	*Expenditure*	*Number of Medical Card Holders @ 31st December*	*Number of treatments*
2008	€63.4m 1,	352,120	1,164,007
2009	€87.5m 1,	478,560	1,451,234
2010	€80m	1,615,809	1,466,066

(ii) The Public Dental Service (PDS)
There are **32** Principal Dental Surgeons, each of whom manages the dental services within a Local Health Office (LHO). Around **350** dentists, **400** nurses and **56** hygienists work in the salaried PDS. The PDS budget in 2010 was €60m and remains at €60m for 2011.

PDS services are targeted at:

- Pain-emergency treatment to all children under 16 years of age;
- School children (usually first, fourth and sixth class) for routine care.

A recent review of the HSE Dental Services found that there is a significant variation in the mix of services provided across LHOs and it is difficult to get a clear picture of what is actually being delivered at local level. The future role of the PDS needs to be reviewed by the HSE and the Department.

(iii) Specialist/Hospital Services

(a)Orthodontics: Orthodontic treatment is provided by the HSE free of charge to those with greatest clinical need. Over 17,000 are currently in active treatment. Waiting lists for assessment and treatment are variable and up to 4 years in some areas.

Main activity statistics 2010

No. on assessment waiting list by grade	**Grade 5 - 2,101**
	Grade 4 - 5,900
No. on treatment waiting list by grade	**Grade 5 – 2,478**
	Grade 4 - 9,126
No. of assessments completed/carried out during 2010 by grade	**Grade 5 – 1,449**
	Grade 4 – 10,775
No. of patients placed on treatment waiting list in 2010	**Grade 5 - 1,551**
	Grade 4 - 4,393
No. in active treatment by grade	**Grade 5 - 2,737**
	Grade 4 – 14,512
No. completed active treatment in 2010	**5,326**

(Grade 4 and 5 refers to need for treatment with Grade 5 being the greater need)

(b) Paediatric dentistry: Consultant paediatric dentists are located in the Dental School and Hospital, TCD. They provide care to medically or otherwise compromised children in Our Lady's Children's Hospital, Crumlin and to oncology patients in St James's Hospital, Dublin and the National Children's Hospital, Tallaght. Consultant and specialist paediatric dentists in the Cork Dental Hospital provide care for paediatric patients in the Southern Region.

(c) Other dental services provided in hospitals: The two dental hospitals provide advanced, specialist and consultant care in a broad range of areas to patients referred from general practice. This includes support to patients undergoing medical procedures, consultant care to special-needs patients and an on-call and a prison service for the Dublin region.

(iv) Dental Treatment Benefit Service
The Department of Social Protection's Treatment Benefit Scheme currently covers approximately 2 million insured persons for a free examination.

Progress achieved and next steps

The HSE appointed Dr Dympna Kavanagh as National Oral Health Lead (Interim)/Clinical Director in mid 2010 on a one year contract. Her key objectives are:

Stage 1 - Establish an Inspectorate for the salaried and contractor services.

Stage 2 - Key strategic posts to be developed in a National Office, linked to the National Oral Health Lead, to support implementation of National HSE Dental Policy.

Stage 3 - Change from a management system based in 32 LHO areas to a delivery system at an operational Integrated Services Area (ISA) level (estimated 16 areas).

DTSS/Public Dental Services
A list of high risk conditions for which primary dental care is essential has been developed. Standards for service development for older people have been developed and standards for Disability, Mental Health and Social Inclusion will follow.

Orthodontics
A pilot study is underway in the Mid West. It involves a review of records of 1,632 patients on the assessment waiting list, prioritisation of patients with special needs and clinical assessments by a Senior Dental Surgeon and a Specialist Orthodontist using the Index of Orthodontic Treatment Need (IOTN). The pilot is also focussing on upskilling primary care practitioners in assessment, examining an alternative service delivery approach e.g. nurses, orthodontic therapists and oral hygiene advice for adolescents.

Dublin and Cork Dental Schools and Hospitals
Realignment of services, under new service level agreements, will involve tertiary and complex dental surgery cases being carried out in national and regional centres with less complex procedures being carried out in community and primary care settings.

Dental services for people with intellectual disabilities
A pilot project in the South is looking at alternative techniques to General Anaesthesia such as Relative Anaesthesia and IV Sedation so as to reduce waiting lists for such patients.

Other issues

(i) Irish Expert Body on Fluorides and Health
The Irish Expert Body on Fluorides and Health was set up in 2004 to oversee the implementation of the recommendations of the Forum on Fluoridation regarding the fluoridation of the public piped water supplies in Ireland. The future role of the Expert Body is currently under consideration.

(ii) Bio Monitoring Programme

There was a commitment in the Renewed Programme for Government 2009 to carry out a national study of total fluoride intake in the population. This will be achieved through a bio-monitoring programme, which will be carried out by the HSE.

Social Inclusion Unit

Briefing for New Minister

Social Inclusion Unit has responsibility for policy relating to a range of excluded population groups that are subject to various risks of inequalities in health. These include Travellers, people living with HIV, Lesbian, Gay, Bisexual and Transgender (LGBT) people, ethnic minorities, refugees and asylum seekers, prisoners, victims of gender-based violence and homeless adults. Taking into account that policy development and implementation for some of these population groups are the remit of other Department's (e.gRefugee and Asylum Policy) and the overall volume of work within the Social Inclusion unit, we intend to carry out a review of this policy area to ensure effective allocation of our resources and relevant contribution.

Health Inequalities

Heath Inequalities are differences in health outcomes between and within population groups. These differences are shaped by a wide variety of factors (known as social determinants), including employment, housing, health services, education, transport, community and social experiences, and the environment. These factors are inter-related and their effect can be influenced by personal factors such as lifestyle, socio-economic group, gender, ethnic group, geographic location, age, sexual orientation, disability etc. A clear example of health inequality is the direct relationship between low income, poor housing, and long-term illness, or death at a younger age than average.

The Health Service Executive (HSE) is committed to addressing health inequalities through a population health approach and, in partnership with the Institute of Public Health and the Department of Health & Children has developed the "Health Inequalities Framework 2010 – 2012". This Framework emphasises key policy areas, which will ensure that HSE services are as equitable as possible for all service users.

The CMO's office is preparing a new policy framework for public health that will focus on the principles of health protection and promotion and on reducing health inequalities. In this regard, one of the areas the Social Inclusion Unit will examine is the issue of volunteering and its impact on improving the health of the community.

Traveller Health

The poor health status of Travellers has long been a cause for concern; however progress continues to be made in this area. The Traveller Health Advisory Committee (THAC) was established in 1998. It consists of Department of Health and Children staff, members of the HSE and representatives of Traveller organisations. The THAC advises the Minister for Health and Children on policy in relation to health services for Travellers. The work of THAC was crucial to the preparation of "Traveller Health - A National Strategy 2002-2005". This Strategy continues to provide the basis for current policy.

Funding

Annual funding in the order of €12m is allocated through Traveller Health Units which have been set up in each HSE area. Travellers and Traveller organisations are involved in partnership with HSE personnel through each Traveller Health Unit in the development of Traveller health services and in the allocation of resources.

All-Ireland Traveller Health Study

The findings of the All-Ireland Traveller Health Study were launched on 2nd September, 2010. It was the first such study of the health status of Travellers since 1987 and the first that involved Travellers from both the North and South. The Study was carried out on behalf of Travellers, for and by Travellers, in order that the results would be more robust and more useful to policy makers and service providers. It was jointly funded by the Department of Health and Children and the Department of Health, Social Services and Public Safety in Northern Ireland and supported by the Health Service Executive. The Study cost **€1,394,887** with additional fieldwork costs of **€302,609** being covered by the HSE and the DHSSPS. The Study included a census of the Traveller Population and an examination of their health status and utilisation of health services in order to identify the factors which influence mortality and health status. The Study will inform future policy development and practice in relation to Travellers.

One of the key findings from the study is that Travellers of all ages continue to have much higher mortality rates than people in the general population, with Traveller men now living on average 15 years less than men in the general population and Traveller women living on average 11.5 years less than women in the general population. Deaths from respiratory diseases, cardiovascular diseases and suicides were found to be more markedly increased in Travellers compared to the general population. Among the positive results from the study were evidence of good access to health services and improvements in Traveller women's health.

The findings of the Study have been presented to the High Level Officials Group on Traveller Issues and to the National Traveller Monitoring and Advisory Committee; both of these committees come under the Department of Community, Equality & Gaeltacht Affairs. In addition, a working group has been set up by the Traveller Health Advisory Committee to draw up a priority action plan.

HIV

The National AIDS Strategy Committee

The National AIDS Strategy Committee (NASC) is an advisory group to the Minister set up in 1991 to address the emerging AIDS crisis. Membership of the committee includes officials from the Department of Health and Children, the Health Service Executive, other Government Departments, representatives of NGOs and people living with HIV. The committee has 3 sub-committees at present: Care and Management; Surveillance; Education

and Prevention. In addition to HIV, the committee has also taken on an advisory role with regard to STIs. NASC published its first report in 1992, and followed up in 2000 with the production of *AIDS Strategy 2000* which is the policy from which Ireland deals with HIV/AIDS and other STIs.

Prevalence

A total of 168 new HIV diagnoses were reported to the Health Protection Surveillance Centre **(**HPSC) during the first half of 2010. This is a decrease when compared to 209 new diagnoses in the first half of 2009. Of the 127 cases where route of transmission was reported it was indicated that 44.9% were MSM; 40.2% were heterosexual and 11.8% were IDU. The cumulative total number of HIV infections reported up to the end of June 2010 is 5,805.

The total number of AIDS diagnoses reported to the end of December 2009 was 1,066 with reports of 18 new AIDS diagnoses in the first half of 2010. The total number of deaths among AIDS cases reported to the end of December 2009 was 414 with reports of two deaths among AIDS cases in 2009.

Funding

There are currently ten genito-urinary medicine/infectious diseases consultants based in Dublin, located in St. James's, The Mater, Beaumont, Temple Street and Our Lady's Children's Hospital, and one each in Cork and Galway University Hospitals. Irish policy is that appropriate treatment is made available free of charge to all who test positive for HIV.

Regulation

On 19th October 2010 NASC approved a proposal that HIV be added to the schedule of notifiable diseases. This issue will be dealt with in the context of a review of the Notifiable Diseases being undertaken by the Health Protection Unit of the DoHC.

Prevention

NASC's Education and Prevention sub-committee launched its *Education and Prevention Plan 2008 – 2012* to provide a roadmap for HIV and AIDS Education and Prevention in Ireland. It presents six key areas for action among seven population groups at particular risk of HIV infection. The Plan was informed by research conducted by NUI Galway and by the findings of the Irish Study of Sexual Health and Relationships.

Although the rate of new cases of HIV decreased in 2009, increases in the rates of diagnosis among some groups which previously responded well to health protection messages indicate that preventing HIV and AIDS and promoting safer sexual practices must continue to be priorities for the health and education sectors into the future.

Gender-based Violence

Gender-based violence is the responsibility of Cosc - the National Office for the Prevention of Domestic, Sexual and Gender-based Violence. Cosc is based in the Department of Justice and Law Reform. The Social Inclusion Unit feeds into the work of Cosc in this area through its representation of the Department on the National Steering Committee on Violence Against Women.

HSE Policy

In 2009, the HSE published its Policy on Domestic, Sexual and Gender-based Violence. The HSE Policy dovetails into Cosc's National Strategy on Domestic, Sexual and Gender-based Violence (2010-2014), which was launched in March 2010. This Strategy is about delivering 8 key high-level Goals and actions including standardisation of service provision across the country, training for all HSE Staff and Voluntary/Community Sector providers and a strong focus on hearing the voice of service users in all aspects of service planning, design, development, delivery and evaluation.

Sexual Assault Treatment Units

The implementation of the National Review of Sexual Assault Treatment Services is complete, with 6 Sexual Assault Treatment Units (SATUs) now operating nationally. These units strive to provide a 24-hour a day service, 7 days a week for men and women who have experienced incidences of rape or sexual assault. The units are located at The Rotunda Hospital (Dublin), South Infirmary Victoria University Hospital (Cork), Waterford Regional Hospital, Midlands Hospital (Mullingar – opened in February 2009), Galway (opened in August 2009) and Letterkenny. As well as undertaking clinical and forensic examination of men and women who are engaging with the criminal justice system, these units also provide care for people who choose not to report an incident to An Garda Síochána.

Services for Homeless Adults

The Department of the Environment, Heritage and Local Government holds lead responsibility for the provision of accommodation to homeless persons and a New Integrated Homeless Strategy was published in 2008. The Social Inclusion Unit feeds into this policy area through its representation of the Department on the High Level Liaison on Dublin Homeless Services.

The provision of health services to this group is primarily a matter for the Health Service Executive. The HSE funds the in-care costs of over 2,000 individual beds and 180 family units in 145 NGO projects. It also funds primary care outreach services to homeless hostels and day centres and specialist multi-disciplinary mental health teams. All monies allocated in respect of Adult Homeless Services have been allocated to the relevant non-governmental and Voluntary Organisations and other related services. In the Dublin area for 2010 a reduction amounting to approx 5.5% was made to HSE funding for homelessness services which will reduce overall expenditure in this area from €19.3m in 2009 to approximately €18m this year.

Social Inclusion Unit

February 2011

Briefing Material for Minister

Sunbed Legislation

Policy context and objectives

Skin cancer is the most common type of cancer in Ireland and is a particular problem for Irish people because of their fair skin. In June 2006, *A Strategy for Cancer Control in Ireland* was published by the National Cancer Forum, which recommended the regulation of sunbeds including restricting their use to adults only. This was adopted as Government policy.

The proposed legislation seeks to protect children and young persons under 18 years of age from the risk of skin damage, and the increased risk of developing skin cancer; and to promote a greater public awareness of the dangers of developing skin cancer, premature ageing and eye damage from exposure to ultraviolet radiation (UVR).

Progress to date

A public consultation was conducted in May 2008 and a number of meetings were held with key stakeholders. An initial Regulatory Impact Analysis (RIA) was completed which takes account of the research in the area, the recommendation made by national and international organisations and the approaches taken in different jurisdictions (including Scotland, Northern Ireland and Australia).

In June 2010, the Government approved the drafting of a Bill to regulate the use of sunbeds. The main provisions for inclusion in the Bill are as follows:-

(i) to prohibit the sale or hire of sunbeds to anyone under 18 years of age;
(ii) to prohibit the use of sunbeds in an unsupervised premises;
(iii) to require the placing of warning signs in sunbed premises;
(iv) to require the placing of warning labels on sunbeds;
(v) to provide an exemption for sunbed use for medical purposes;
(vi) to require the completion of informed consent forms by persons using sunbeds in commercial premises;
(vii) to require sunbed operators to supply protective eyewear;
(viii) to prohibit those with skin type 1 (very fair skin) from using sunbeds;
(ix) to require sunbed operators to provide staff training;

(x) to control the remote sale or hire of sunbeds for those under 18 years of age;

(xi) to prohibit claims attributing health benefits to sunbed use;

(xii) to prohibit promotional marketing practices;

(xiii) to provide for enforcement to be undertaken by the Health Service Executive;

(xiv) to provide for a fee to be prescribed for the registration of sunbed premises.

Next Steps

- A revised RIA will be submitted to the Minister for approval of the policy proposals;
- Subject to Ministerial approval, a Government decision will be sought to have a Bill drafted by Parliamentary Counsel.

Briefing Note on Tobacco Control
February 2011

Background

- Tobacco use is the leading cause of preventable death in Ireland. Each year over 6,500 people die prematurely from the effects of tobacco and thousands of others become ill because of tobacco-related diseases.
- In November 1999, the Oireachtas Joint Committee on Health and Children published ***"A National Anti-Smoking Strategy - A Report on Health and Smoking"*** which recommended that a national anti-tobacco strategy be adopted.
- The report of the Tobacco Free Policy Review Group entitled ***"Towards a Tobacco Free Society"*** was published in 2000 and adopted as Government policy.

Progress achieved

- The Public Health (Tobacco) Acts 2002 and 2004 provided for a number of significant tobacco control measures, including the ***Smoke Free at Work*** initiative.

- Implementation of the Acts was disrupted due to a legal challenge by PJ Carroll & Others. However, in 2007 the plaintiffs discontinued their challenge.

- Key provisions of the Acts were commenced with effect from 1 July 2009 including:

    - Ban on in-store advertising of tobacco products
    - Ban on display of tobacco products
    - Requirement for all tobacco products to be out of view and stored within a closed container only accessible by the retailer
    - Prohibition on self-service vending machines **except** in licensed premises or registered clubs.
    - Requirement for all retailers of tobacco products to register with the Office of Tobacco Control.

- The aim of these provisions is to further de-normalise tobacco and to protect children from the dangers of tobacco consumption. Research shows that tobacco advertising at the point of sale is a key factor in a young person starting and continuing to smoke. If young people can be prevented from purchasing tobacco products there is less chance they will become addicted and suffer a smoking related illness. Restricting advertising will also support adults who are trying to quit.

- Price has also been identified as an effective tobacco control measure, particularly in preventing young people's initiation and subsequent addiction to tobacco. Cigarette prices in Ireland are the highest in the world (WHO MPOWER Report on the Global Tobacco Epidemic 2009). Our tax take alone of €6.71 per packet, is higher than the retail price of cigarettes in all but one other EU Member state.

- Repeated surveys over the last ten years show a slow but definite decline in the number of people smoking. Since the late 1980s the prevalence rate has reduced from just under 50% to 29% as indicated in the 2007 Slán survey.

- As part of the programme of rationalisation of State agencies, the Office of Tobacco Control was dissolved and its staff and functions were transferred to the HSE with effect from 1 January 2011.

- The Office of Tobacco Control received funding from the Department and the allocation for 2010 was €1.726 million. Funding of €1.5m was transferred to the HSE Vote for 2011.

Next Steps

- The Office of the Parliamentary Counsel has been requested to draft Regulations to facilitate the introduction of combined text and photo warnings on tobacco products. The date for the introduction of the new warnings will be a matter for the Minister to decide, once the regulations are finalised.

- In October 2009, Philip Morris Products SA and Others commenced litigation against the Minister and the Attorney General in relation to the measures commenced in 2009. The Department is liaising with the CSSO and AGO on the preparation of our defence.

- A strategic review of tobacco policy is ongoing to identify what further policy proposals might be available to reduce the health and social burden of tobacco consumption in Ireland.

Briefing material for new Minister
Enablers

Overview
This section outlined a number of essential "enablers" to improving the quality and efficiency of our health services in the future. They are grouped into three categories as follows

1. Change enablers
2. Corporate/functional enablers
3. Policy enablers

Change Enablers

(a) Croke Park

The Public Service Agreement (commonly referred to as Croke Park Agreement) is the overarching framework for major changes in work practice in the coming years. The health service section of the Croke Park Agreement is designed to enable the provision of at least the same level of services despite substantial reductions in funding and employment levels. The focus of the health sector action plan is, therefore, primarily on specific changes which will reduce the cost and/or improve the quality of particular services. Significant progress has already been made in relation to (i) the transfer of the Community Welfare Service to the Department of Social Protection from 1 January 2011 (ii) reductions in the cost of out-of-hours payments for medical laboratories and (iii) redeployment to facilitate, for example, the centralisation of medical cards and the reassignment of staff following the departure of 2,000 people under the VER/VSR. Current significant IR issues are also included in this section of the brief.

(b) Clinical Programmes

The objective of the clinical programmes is to the improve the quality, cost effectiveness and access to services. There are currently 31 clinical programmes in different stages of development and these are central to the Health Sector Action Plan under Croke Park. The Acute Medicine Programme is one of the most significant and is outlined in detail.

Corporate/Functional Enablers

(c) Information

Good information is fundamental to achieving a high performing health system and is key to driving improvements in safety, efficiency and effectiveness of health services. Since 2008 the Dept has chaired a Health Information and Inter-agency Group which also includes the HSE and HIQA and aims to ensure a coherent and co-ordinated approach to health information and ICT developments. A major priority is the publication of the Health Information Bill by mid 2011 which will provide the statutory basis for the Individual Health Identifier. Significant progress has been made in the development of performance indicators and the Dept and the HSE work closely in this regard.

(d) ICT

The HSE is currently preparing a new corporate strategy and is also finalising an ICT and e-health strategy that will address the future implementation and environment for the delivery

of key business systems. The strategy will guide ICT investment priorities and issues of governance and implementation into the future.

(e) Research and Information functions (within the Dept)

The Dept established a Research Unit in 2009 aimed at increasing the analytical capacity of the Dept and using evidence to develop policy. The Unit supports staff in the Dept in integrating research findings into their daily work and has developed effective links with the Evidence Centre in the Health Research Board. The Information Unit has a similar Department wide role in supporting staff to access and analyse information and performance data.

(f) Workforce Planning

The Dept is responsible for formulating overall policy on workforce planning in the health services. This area has received considerable attention in recent years with the publication of a number of important reports including an "Integrated Workforce Planning Strategy for the Health Services 2009-2012".

(g) Education and Training

The main issues in this area at present include

- Commencement of the professional competence provisions of the Medical Practitioners Act so that from 1 May 2011, doctors will be legally obliged to maintain their competence by enrolling in professional competence schemes.
- Requirement in the EU/IMF programme to eliminate restrictions on the number of GPs qualifying and removing restrictions on GPs wishing to treat public patients as well as restrictions on advertising.
- Controversy concerning the Government decision to initially reduce the pay of student nurses during their rostered placement and to phase it out entirely form 2015. (This is dealt with as an IR issue in Section (a) above).

Policy Enablers

(h) Eligibility

The Department undertook work between 2005-2010 to review the current eligibility framework. A draft memorandum for Government was prepared and circulated to Departments for observations in December 2010. The draft memorandum sought approval to prepare legislative proposals for a more up-to-date legal framework for the existing eligibility arrangements for health services, and to formulate proposals for a revised and more graduated approach to eligibility. The memorandum had not been considered by Government prior to the General Election.

(i) Resource Allocation

The Expert Group on Resource Allocation and Financing in the Health Sector was established in April 2009 to examine how the existing system of resource allocation within the Irish public health service could be improved to better support the aims of the health reform programme. It was also asked to take a view on the most appropriate financing mechanism for this purpose for Ireland. The Report of the Expert Group was published in July 2010 and made 34 recommendations in total .

(j)Citizen Participation

The report of the Organisation Review Programme (ORP) on the Dept stated (page 25) that

"In the light of its changed role since the establishment of the HSE the Dept must, as a priority, clearly identify its customer and stakeholders groups (eg the Minister, the Minister of State and Oireachtas ; the HSE and other health agencies; and the public), fully understand their needs, ensure each gets appropriate service and regularly measure their satisfaction."

In response the Department's ORP Action Plan established a **Citizen Participation Unit** (CPU) in September 2010 so that more attention would be given to the voice of the service user/public in the Dept's work. Staff in this Unit have been working on children and young people's participation in decision-making, as part of the Office of the Minister for Children and Youth Affairs (OMCYA), since 2003. The CPU established a Citizen Participation Advisory Group in February 2011 to oversee the development of a policy paper on citizen participation on issues relating to health and well-being and this policy paper will be completed by December 2011.

ENABLERS

(A) Brief on Croke Park and IR issues

Public Service Agreement (Croke Park)

The PSA was ratified by the Public Services Committee(PSC) of ICTU on 15 June 2010. Within the PSC umbrella, IMPACT and SIPTU accepted the agreement but it was rejected by the INMO.
The TEEU and Unite opposed the agreement although Unite has said that it will be bound by the majority decision.
Unions outside of Congress; Irish Hospital Consultants Association (IHCA) and the Irish Dental Association (IDA) have accepted agreement. After months of prevarication, the PNA is currently balloting its members and recommending acceptance.

Health Sector Chapter of Public Service Agreement

There are 11 measures which are to be implemented immediately. These cover areas such as redeployment/reassignment, further development of integrated patient-centred care, changing organisational structure as the integrated services programme is rolled out, multi-disciplinary working and reporting, revised cross-cover arrangements, reduction of non-pay expenditure, performance measurement.

In addition the agreement provides for the introduction of the extended working day where it is required to meet service needs and reviews of rosters and new arrangements to support the delivery of services over an extended period up to and including 24/7 emergency services. These will be dealt with under a specific, time-bound Consultation/Adjudication Process.
The agreement provides for compensation for loss of earnings as part of the adjudication process. This also applies to the process for redeployment.

Sectoral Action Plans
A revised Health Sector Action Plan was submitted to the Implementation Body by the Secretary General of the Department on 13th January. This was requested by the Implementation Body, to take account of the Budget and the National Recovery Plan. Informal feedback from the IB has been very positive.

The health service section of the Croke Park Agreement is designed to enable the provision of at least the same level of services despite substantial reductions in funding and employment levels. The focus of the health sector action plan is, therefore, primarily on specific changes which will reduce the cost and/or improve the quality of particular services. Significant progress has already been made in relation to (i) the transfer of the Community Welfare Service to the Department of Social Protection from 1 January 2011 (ii) reductions in the cost of out-of-hours payments for medical laboratories and (iii) redeployment to facilitate, for example, the centralisation of medical cards and the reassignment of staff following the departure of 2,000 people under the VER/VSR.

Implementation Body
The Independent chair of the Implementation Body under the PSA is Mr PJ Fitzpatrick (former Director of the Courts Service). There are three management nominees (two from

the Department of Finance and one from D/Taoiseach) and four union nominees (from IMPACT, SIPTU, PSEU and INTO). The Implementation Body has been meeting regularly.

Health Sector Implementation Body (HSIB)
The HSIB was established by the Implementation Body to drive implementation of the PSA in the health sector and to report on progress to the Implementation Body. Its structure reflects that of the Implementation Body, with three management (D/Health and Children; two, HSE) and four union nominees (INMO, IMPACT, SIPTU and the IMO). The HSIB has met seven times to date.

Regional Teams
Regional networks are also being put in place across the HSE. These will have an important role as it is intended that this is where the majority of local issues will be resolved. Regional Directors of Operation (RDO) for each region are chairing their respective teams and will be reporting/liaising closely with the HSIB.

To date the HSIB meetings have focussed on the HSE setting out their plans. The need for 'pace' and 'product' as distinct from just an engagement process is being made the clear objective to all involved.

Monitoring/Reporting
The HSIB will monitor more closely a number of the significant, central themes such as the Redundancy/Early retirement schemes, Centralised Shared services, Medical Laboratory Modernisation, Ambulance service, Rostering, Support Stat project. A watching brief will be maintained on the remaining issues.
As much as possible will be resolved by the regional networks.
A reporting template was developed but will need to be revised again, in light of the revised Action Plan

Adjudicators
A panel of six adjudicators has been established and these will be overseen by a co-ordinator from the Labour Relations Commission.

TRANSFER OF FUNCTIONS – COMMUNITY WELFARE SERVICE

The Government Decision (S224851 of 23 February 2006) accepted the recommendations of the Core Functions Report, including the transfer of income and support schemes, together with associated resources from the HSE to the then Department of Social and Family Affairs. This decision was reaffirmed by the Government in April 2009 and again in the revised programme for Government in October 2009.

Talks on this transfer with the relevant unions have been going on, on a stop-start basis, since 2007.

A small group from both sides was convened for intensive negotiations in October 2010. Following this, management agreed to put forward a further revised position, in an effort to get the transfer finally implemented.

Management set 1 January 2011 as the target date for the transfer to take effect.

On 30 September, it was proposed that the full cohort of staff involved in the Community Welfare Service (CWS) would transfer from the HSE to the Department of Social Protection. This was intended to make the transfer easier to implement and to ease the pressure on the CWS service because of rapidly increasing unemployment.

Management then further revised this position by proposing that all staff would transfer on a secondment basis initially, with all existing terms and conditions during this period of secondment. Any anomalies in these terms and conditions would be worked on in this period, at the end of which the staff would become fully integrated Civil Servants.

A Transfer Protocol was agreed with the unions on 19 November 2010

Responsibility for the CWS transferred to DSP on 1 January 2011, with staff on secondment from the HSE, until October 2011. During that period the outstanding issues in relation to terms and conditions will be dealt with through the LRC/Labour Court following which it is intended that the staff will become Civil Servants.

This transfer is one of the first tests of the effectiveness of the Public Service Agreement.

LABORATORY SERVICES – REVISED WORK PRACTICES

The HSE is currently progressing a process of significant reform of laboratory medicine service (including the introduction of cold labs, revised skill mix, utilisation of technology, etc.). As part of this process, discussions took place on revised work practices, including an extended working day and revised on-call payment structure. The HSE's NSP 2011 had already provided for €5m savings in 2011 for laboratory modernisation. This is the minimum savings required.

Labour Court Recommendation

Following discussions at the Labour Relations Commission, the Labour Court made recommendations (February 2011) on the out of hours payment from midnight to 8am, Monday to Friday and rate of payment for stand-by off site. It also recommended a compensation arrangement for loss of earnings (1.5 times the actual loss) similar to compensation arrangement for redeployment under the Public Service Agreement.

The HSE and the Medical Laboratory Scientists Association have accepted the LC recommendation as binding. The HSE are in the process of establishing an implementation group which will monitor on an ongoing basis throughout 2011 the implementation of the revised agreements throughout the country and the actual impact on costs.

RADIOGRAPHERS

[redacted]

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AMBULANCE STAFF

[redacted]

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NURSING IR ISSUES

1.1 Reduction in Salary Scales for Student Nurses – Annual Cost €32m

On 2 December 2010 the Government decided to reduce by 10% the pay of new recruits to the public service in traditional entry grades. This included qualified staff nurses. As a result the pay of student nurses during their 36 week rostered placement in the 4th year of their degree programme has been reduced to €20,680. In addition, the Government approved the phased abolition of this payment over the years 2012 to 2015, i.e. the payment would be abolished from 2015 for students entering the undergraduate degree programme in 2011 and the following reduced rates would apply in the meantime:

€16,326 in 2012
€13,606 in 2013
€10,884 in 2014

The nursing unions have been advised that the decision to phase out student nurse pay was a Government decision, part of the budget process and did not breach Croke Park as pay of serving public servants had not been affected. It also reflected the fact that Irish student nurses have been favourably treated compared with those in other countries who, typically, are not paid for their clinical placements.

A review of the decision was announced on 11 February [redacted]

The above italicised and bolded material should not be released and is exempt under Sections 20 (1) and 21 (1)(c) of the FoI Act

1.2 Senior Staff Nurse - Long Service Increment

Following consideration by the HSE, this Department and Finance, it was agreed in November 2009 that these posts would be covered by the Moratorium on the basis that they constitute promotion for qualifying staff nurses – those with 20 years service. The Labour Court, however, has rejected management's view that the post is a promotion post. LCR19935, issued on 1 November 2010 stated that, for industrial relations purposes, it would not normally consider this a promotional post *"but rather an additional recognition of long service that was subject to some formalities that were primarily designed to distinguish it from other long service payments."* The Court also stated that *"interpretation of the Moratorium and what comes within its scope is not a matter for this Court. The Moratorium is a Government decision and it alone can clarify its intentions as to its scope and application."* Finally the Court stated that *"in light of this recommendation the parties might wish to approach the relevant Government Departments with a view to engaging further on this matter."*

[redacted]

The above italicised and bolded material should not be released and is exempt under Sections 20 (1) and 21 (1)(c) of the FoI Act

1.3 Performance Related Pay (PRP) Scheme for Directors of Nursing

PRP for Directors of Nursing, introduced in 1999, was paid annually in respect of the previous year. In the light of the serious national economic and budgetary difficulties no performance related awards were approved in the Civil Service in 2008. Payments under PRP for 2008 were suspended by the Board of HSE in July 2009. The Rights Commissioner subsequently upheld a claim by 28 Directors of Nursing under the Payment of Wages Act 1991 for payment of performance related pay for the year 2008 on the basis that the PRP payments come within the definition of "wages". The HSE was directed to pay each of the named claimants the requisite payment due for 2008.

[redacted]

The above italicised and bolded material should not be released and is exempt under Sections 20 (1) and 21 (1)(c) of the FoI Act

CONSULTANTS

2.1 Medical Consultants - Pay

In May 2010, the IHCA made submissions on behalf of a number of consultants under *'Consultant Contract 2008 - Grievance and Dispute Procedure'* seeking confirmation from the Mediator that their Contract of employment has been breached. The submissions relate to salary increases allegedly due to consultants that were withheld due to the economic downturn. A "test case" is concluding (latest hearing on 9 November) with final submissions now being considered by the Mediators. Typically the disputed amount could be up to €40k per consultant per annum from June 2009 and €30k backmoney in respect of period up to June 2009 for Type A contract holders. Consultants who signed up to type B contracts would be due lesser amounts.

[redacted]

The above italicised and bolded material should not be released and is exempt under Sections 20 (1) and 21 (1)(c) of the FoI Act

2.2 Change of Contract Type

The IHCA has repeatedly asked that Type A Contract holders (public only) be allowed to change to a Type B Contract allowing private practice, given the non-payment of salary increases set out in the contract.

[redacted] The main focus of Consultant Contract 2008 is to improve access to services for public patients. Allowing consultants generally to change from a public only contract to a contract which allows private practice could have a negative impact on public patient services.

The above italicised and bolded material should not be released and is exempt under Sections 20 (1) and 21 (1)(c) of the FoI Act

2.3 Consultants exceeding the agreed private practice limit

Consultant Contract 2008 includes new measures to strengthen the management, monitoring and control of activity in hospitals with a view to ensuring that the level of consultant private practice within public hospitals does not exceed the permitted ratio. The HSE in conjunction with the ESRI has introduced a range of new measurement systems in order to meet the requirements of the contract. The HSE has moved to enforce the agreed ratios focusing on those where private activity significantly exceeds the permitted level and requesting that they remit the excess private income to the HSE. Final letters have been sent to 33 consultants who are in excess of 50% of their public private ratio and 34 consultants in excess of 40% seeking remittance of the excess to the Research and Study fund as provided for in the contract. [redacted]

[redacted]

The above italicised and bolded material should not be released and is exempt under Sections 20 (1) and 21 (1)(c) of the FoI Act

NCHDS

3.1. Shortages

There are significant challenges for hospitals and for the HSE in relation to the employment of Non-Consultant Hospital Doctors - filling vacancies and compliance with the European Working Time Directive.

At present approximately 150 of 4,638 Non Consultant Hospital Doctor (NCHD) posts are substantively vacant. Vacancies are disproportionately located in small to medium-size hospitals in non-training posts and concentrated in six areas - Emergency Medicine, Anaesthesia, General Surgery, Orthopaedic Surgery, General Medicine and Paediatrics. The moratorium on public sector recruitment is *not* a factor in the shortage. Other countries are also encountering difficulty in recruiting junior doctors.

July 2011 Recruitment and Rotations

The HSE has developed a strategy for the July 2011 cycle to address a range of issues associated with recruitment, terms and conditions, rotational arrangements and aligning NCHD workforce with changing service needs. Measures in train include: Service Contingency Plans in each HSE area, the creation of 'Professional Development Posts' for posts not recognised as training posts which are very difficult to fill, international recruitment, increase in training posts – in December 2010, 78% of NCHDs are in structured training, from July 2011, that will rise to 81%; increases in Consultant posts, revised Visa and Employment Permit arrangements, changes in doctors' work practices, new Locum provided contracts, and NCHDs registered on Trainee Specialist Division working in other hospital sites.

[redacted]

The above italicised and bolded material should not be released and is exempt under Sections 20 (1) and 21 (1)(c) of the FoI Act

3.2. Compliance with European Working Time Directive

EWTD allows a maximum average working week of 48 hours. A letter of formal notice was issued by the Commission on 20 November 2009 alleging non compliance. In January 2010, the Department issued a comprehensive reply [redacted]

[redacted]

The above italicised and bolded mate rial should not be rele ased and is exempt under Sections 20 (1) and 21 (1)(c) of the FoI Act

(B) Clinical Programmes

Overview of the National Directorate of Clinical Strategy and Programmes and the Development of Clinical Programmes

The Directorate of Clinical Strategy and Programmes (previously the Directorate of Clinical Care and Quality) was established to improve and standardise patient care throughout the Health Service Executive (HSE) by bringing together clinical disciplines and enabling them to share innovative solutions to deliver greater benefits to every user of HSE services.

The national clinical programmes have three main objectives:

- **To improve the quality of care delivered to all users of HSE services**
- **To improve access to all services**
- **To improve cost effectiveness**

The clinical programmes are a multidisciplinary initiative between the HSE, the Royal College of Physicians of Ireland (RCPI), the Irish Association of Directors of Nursing and Midwifery (IADNAM), the Therapy Professions Committee (TPC) and the Irish College of General Practitioners (ICGP). They also generally include a patient representative.

Currently **there are 3 1 clinica l programmes** in different stages of developm ent, across a number of different areas including:

Chronic disease management programmes for the management of Stroke, Heart Failure, Acute Coronary Syndrome, Chronic Obstructive Pulmonary Disease (COPD), Asthma, Diabetes, Mental health and Epilepsy,

Emergency functions including Emergency Medicine Teams, Acute Medicine, Critical Care and Surgery

Outpatient Care specifically in the areas of Dermatology, Rheumatology, Neurology, Kidney Medicine, along with the development of community interventions and Out-Patient Antibiotic Therapy (OPAT)/Home Intravevous (IV)

Other programmes including Clinical Governance, Orthopaedics, Primary Care, Medication management, Radiology, Care of the Elderly, Rehabilitation, Palliative care, Audiology, Paediatrics Obstetrics and Gynecology, Pathology and Healthcare associated infections (HCAI)

The role of the Department of Health and Children (DOHC)

The role of the DOHC is to work with the HSE in identifying priority areas for development and to evaluate the im plementation of the clinical programm es committed to in the National Service Plan.

Progress achieved and next steps for the clinical programmes

The HSE National Service Plan 2011 has committed to the implementation of 20 of the clinical programmes in 2011.

In 2010, all the programmes committed to in the 2011 Service Plan commenced, set goals, defined measures and solutions, completed baseline studies and developed detailed plans for implementation in 2011. The other 11 programmes were commenced in 2010 or are being initiated in 2011.

On the 28th January 2011, the implementation phase of the clinical programmes was launched.
The national implementation strategy was presented by Dr Barry White (National Director of Clinical Programmes and Strategy) and identified actions at local, regional and national level to implement the programmes across the system.

Opportunities associated with the clinical programmes
The clinical programmes are a sea-change in the way we provide healthcare in Ireland. The programme approach use the key proven drivers of success in improving disease management and have the opportunity to improve patient care through the following:

- **Patient at the centre of care.** Patients have been key players in the development of the clinical programmes. There is a strong commitment in the programmes to providing care for the patient from prevention through early identification, treatment and disease management. Involvement of primary care and public health is essential in ensuring that the correct reorientation of disease management towards primary care and prevention occurs.
- **Clinical leadership and buy-in.** The engagement of clinicians in leading change across all the programmes has led to huge commitment and is driving changes that will lead to real health improvements.
- **Structured approach focusing on simple interventions.** The programmes focus on using the right intervention, at the right time, in the right setting.
- **Meaningful measurement.** The programmes will identify metrics in terms of real outcomes that matter to patients, that are meaningful and that can be used to inform decisions, without being excessive or creating an unnecessary burden on the system.
- **Clinical accountability** as a key focus of the programmes ensures a system through which each member of the health service is accountable for continuously improving the quality of the service and safeguarding high standards of care**.**

Risks associated with the clinical programmes
Given the number and ambitious nature of the clinical programmes there will be significant challenges in implementing them across the system.

- Ensuring that the interdependencies across the programmes that have been identified can be achieved within specific hospitals, primary care areas and regions will be difficult.
- Ensuring that different hospitals and primary care areas are supported through the changes based on their different states of readiness for implementation of the clinical programmes will be essential. The acute medicine programme has provided good example by going to each of the areas to analyse the state of readiness of individual hospitals for the implementation phase of the programme and by providing them with support in implementing the required changes.
- Close coordination will be required between those working on the clinical programmes and those working on hospital reconfiguration and other operational parts of the HSE in order to maintain current services while implementing change.
- Work practice changes required for the successful implementation of the programme need to be achieved in the context of the Croke Park Agreement.

HSE Acute Medicine Programme

Key Points
The Acute Medicine Programme represents one of the most significant elements of the HSE's National Clinical Programmes.

The aims of the programme are to ensure that all acute medical patients have:

- Safe, quality care
- Timely diagnosis
- The correct treatment
- An appropriate environment
- Respect of their autonomy and privacy
- Timely care from a senior medical doctor working within a dedicated multidisciplinary team
- Improved communication
- A better patient experience

The 2011 National Service Plan provides for individual hospitals to implement the model of service set out in the Acute Medicine Programme.

The programme recognises the essential role of large and small hospitals, general practitioners (GPs) and community service

Background and objectives
The Acute Medicine Programme is a multidisciplinary initiative between the HSE's Directorate of Clinical Strategy and Programmes, the Royal College of Physicians of Ireland (RCPI), the Irish Association of Directors of Nursing and Midwifery (IADNAM), the Therapy Professions Committee (TPC) and the Irish College of General Practitioners (ICGP).

The Programme provides a framework for the delivery of acute medical services in hospitals which seeks to substantially improve and standardise care of acutely ill medical patients across the country.

Hospital Models
The programme recommends four generic models of hospital, which would operate in a coordinated manner to ensure that patents receive the level of medical care most appropriate to their needs, and in a timely manner. The models are based on the safe provision of patient care within the constraints of available facilities, staff, resources and local factors in each hospital. The four models of hospital will be:

Model 1
A community/district hospital, with sub-acute in-patient beds. Admissions can be requested by a GP, consultant geriatrician and/or other consultants following agreement with the medical officer. This hospital will not function as an emergency service but may provide certain outpatient services.

Model 2
These hospitals will provide in-patient and out-patient care for low-risk medical patients and will have a daytime medical admissions unit. They will link closely with hospitals that provide more complex care, so that there is an appropriate two-way flow of patients depending on care needs. The hospital may have a minor injury unit (MIU) and will provide a wide range of more routine services, especially day surgery, diagnostics and outpatient clinics.

Model 3
These hospitals will admit acute medical patients and will have an Acute Medical Admissions Unit on a 12 to 24-hour basis. There will be an emergency department and intensive care/high dependency capacity also.

Model 4
These hospitals will admit acute medical patients including tertiary referred patients, i.e. very ill patients with the most complex care needs. They will have a 24-hour emergency department and acute medical unit and the highest level of intensive care capability.

Key features are:
Acute Medical Units (AMUs) are to be established in all major (Model 4) hospitals and similarly functioning but smaller Acute Medical Assessment Units (AMAU) will be established in smaller (Model 3) acute hospitals. These units will facilitate the immediate medical assessment, diagnosis and treatment of medical patients requiring urgent or emergency care.

Patients referred from a GP will be prioritised and the emphasis will be on same-day diagnosis, treatment and discharge. Patients who are referred by a GP will be seen within one hour by a senior medical doctor who will be able to make treatment and discharge decisions. Every AMU and AMAU will have access to a senior clinical decision maker at all times.

There is also an emphasis on seven-day ward rounds and a "Home before 11" approach to allow for earlier discharge of hospital inpatients, especially at weekends. This enables the vacated beds to be available much earlier for emergency admissions.

A national early warning score (EWS) is being developed to help determine the severity of illness and predict patient outcomes. This will enable early identification of deterioration in patients and how they should be best managed.

A central system of monitoring bed availability across a geographic area, in hospitals and community services will be developed. This will allow for an improved patient flow allowing patients to access available beds in the appropriate care area.

A national model for retrieval services is being developed to improve patient flow and transfer across acute and community based healthcare facilities in an area/region, based on patients' needs.

Current Status
Some hospitals (e.g. Cork University Hospital and St Luke's, Kilkenny) have already established Medical Admissions Units. The HSE is supporting the change process in other hospitals by visiting them and working with them to identify the changes needed and how they need to proceed.

Known Risks
The 2011 National Service Plan commits to having Acute Medical units functioning in six hospitals by quarter 2 of 2011 and in a further six locations by year-end. The HSE needs to specify where these will be and how it will track progress.

The Acute Medicine Programme is ambitious and requires a co-ordinated and complex series of changes to be implemented across the acute hospital system and in community services.

Furthermore the changes planned under the Acute Medicine Programme also need to be coordinated with a series of improvements under several other clinical programmes.

March 2011

(C) Information

Briefing Material for new Minister (Feb 2011)

Health Information as enabler

1 Importance of quality health information

Good information is fundamental to achieving a high performing health system. It is key to driving improvements in safety, efficiency, quality, effectiveness and sustainability of the health services. Information must be accurate, produced in a timely manner and available to those who need it for decision-making, both clinicians and management. Good information systems that facilitate the flows of information are vital.

2 Progress towards achieving quality information

The following are key elements of the drive towards achieving high quality information/information systems.

2.1 Health Information and Quality Authority

The Health Information and Quality Authority, established in 2007, has a statutory role in evaluation health information, advising the Minister and the HSE on gaps/deficiencies identified, setting standards and monitoring compliance with the standards.

2.2 Health Information Inter-agency Group (HIIAG)

With a view to providing leadership and guidance on health information and ICT developments and ensuring a coherent and co-ordinated approach in this area, the Health Information Inter-agency Group, chaired by the DoHC and including representatives from the DoHC, HSE and HIQA, was established in 2008. The Group has developed and monitors implementation of a Plan for health information and ICT developments that has regard to the broad thrust of National Health Information Strategy (NHIS). Among the principal health information and ICT developments proceeding under its aegis are-

- ***Health Information Bill*** **-** The proposed Health Information Bill will provide a legislative framework for the governance of information in the health sector. It is expected that the Bill will be published in early to mid-2011.

- ***Individual Health Identifier*** **-** The proposed Health Information Bill will provide a statutory basis for the Individual Health Identifier (IHI). In 2010, a Working Group with DoHC, HSE, HIQA and D/Finance representatives, clarified policy in this area for the purpose of informing the drafting of the Bill, e.g. in areas such as registration/issue, uses and users of the IHI, etc. The intention is that this Group will be reconvened to consider the next steps for advancing the IHI (subject to Health Information Bill approval).

- ***Information Standards*** **–** The HIQA standard for GP messaging was approved by the Minister in mid-2010. The standard will facilitate

HIQA is also leading on the development of other information standards, e.g. as regards Health Information Sources to ensure overall quality and maximize the use of the sources in question. Initial work has also been done on developing standards in areas such as laboratory and radiology coding terminologies.

GP Referral Project - This is a priority project to develop national guidance in relation to referral pathways between GPs, acute hospitals and diagnostic services. The final report will be published Q1 2011 and will make recommendation on processing referrals to outpatients services and radiology department.

- ***Information Governance)*** HIQA is developing a national framework for health information governance. Once the proposed Health Information Bill is enacted, work will start on developing high level standard codes of practice for information governance. The Authority has documented best practice in relation to a number of areas, notably data quality and information governance management standards and these are currently awaiting publication on the HIQA website. In addition, HIQA is currently commencing the drafting of standards for Privacy Impact Assessments.

- ***Inter-operability of health systems*** The HSE is developing a framework for applications, information, communications and technical architecture to ensure that the required levels of integration between systems are achievable. The framework will be used to ensure that key systems can share data in a timely and organised fashion and so facilitate integrated service delivery, which is a fundamental strategic objective for the HSE.

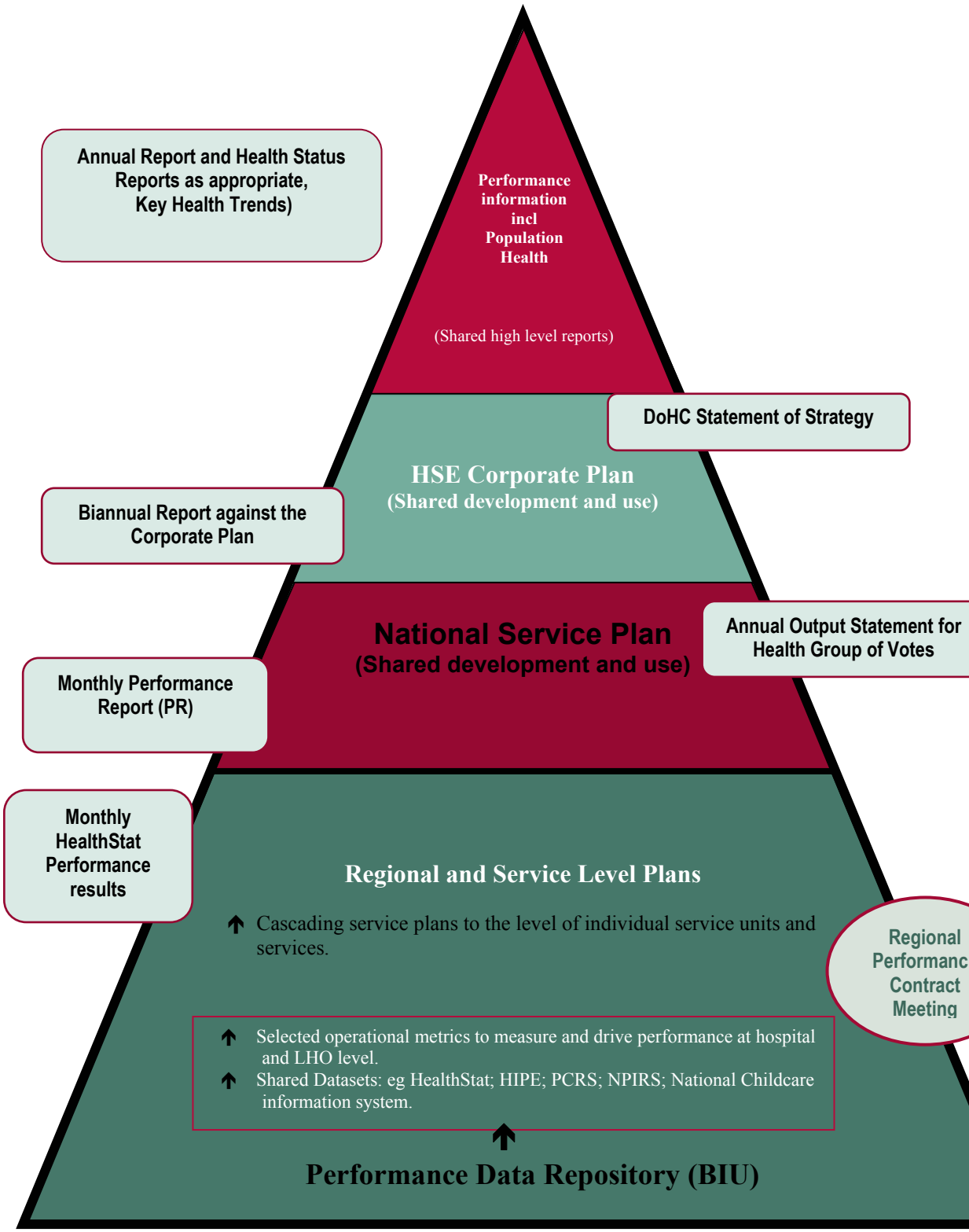
- ***National Client Index (NCI) -*** The purpose of this project is to establish a client index service for the public health and personal social services to facilitate better linkage of health records for safer and more efficient services and administration. Work is currently underway to secure necessary linkages between hospital PAS systems and the NCI. The project aims to provide the NCI Service to the National Integrated Medical Imaging System (NIMIS) adoption sites first.

2.3 Use of Performance Information

Significant progress has been made in the development of performance measures for the HSE Service and Corporate plans. The DoHC and HSE worked closely under the auspices of the Joint Performance Information Group (JPIG) to streamline collation and presentation of information and to provide more capacity for better use and analysis of data. Ongoing improvement of selection and development of relevant indicators will continue, involving the DoHC, HSE and HIQA, including consideration of how best to ensure that knowledge gained from the collection, validation and analysis of information is used to improve and/or change performance, as appropriate.

Levels to Performance Implementation

HSE/DoHC Joint Performance Information Framework



2.4 Performance Framework for the Health Service

The DoHC *Statement of Strategy (2008-2010)* sets out a high level P*erformance Framework for the Health System* that covers the full spectrum of health and personal social services and allows the Minister to assess the performance of the health system. In line with the 2001 Health Strategy, the Framework is underpinned by the following four principal aims and objectives of the Irish health system and sets out a conceptual basis for the selection and classification of indicators - to keep people healthy, to provide the health care people need, to deliver high quality care and to get best value from health system resources

The MAC Sub-Group on Performance Evaluation has developed a draft set of performance indicators (50) to support the Performance Framework and to evaluate and measure progress on the four strategic objectives referred to above across the health system. A consultation process has been used to finalise the indicator set and a publication and dissemination strategy is being drawn up.

3 Risks

The non availability of high quality information will hinder achieving a high performing health service that delivers safe and effective care. The governance framework being developed through the Health Information Bill is important in providing for the routine usage of health information while offering assurance in terms of privacy and confidentiality. The developments underway, as outlined above, should assist in mitigating this risk.

(D) ICT

1. Introduction

ICT is a critical enab ler in developin g a modern, high quality and cost effective and health service. The HSE in recent years has lacked a com prehensive ICT strategy. There are m any factors com plicating th e technology environm ent including the multiplicity of systems that ex isted in the old health board struc ture and th e requirements of servicing a sing le nation al s ystem. The health boards and the voluntary hospitals had diverse system s at different stages of developm ent and unifying this environment is proving a major challenge. The negative publicity around projects such as PPARS and the h ealth po rtal has ham pered e fforts to progress the implementation of systems.

2. What does the Department do?

External ICT: The ICT Unit is working with the HSE to develop a viable IC T strategy. The Unit works closely with CMOD in the Department of Finance on project approval and alignm ent with G overnment policies. A key prio rity is to pr ogress large system developm ents for the HSE such as the NFPS (National Financia l a nd Procurement Solution), NIMIS (radiology), cl ient identity, eheal th, communications and patient and clinical system s. A key cha llenge is to iden tify a viable way f orward for the HSE to acquire a financial and proc urement syste m. This has been identified as a high priority by DoHC, HSE, De partment of Finance, C&AG and other stakeholders.

3. Background facts and figures

Current Levels of spen ding on ICT in the health serv ices. ICT spending on both capital and revenue costs in 2010 was approximately €108.5m (m ade up of €6.5m capital and €102m revenue). The total capit al available for draw dow n was €40m approx. Delays in procurem ents, project appr oval and peer review partially account for the low take up in capital spen d. Othe r constraints in term s of ICT usage and penetration is the HSE capability in te rms of business tr ansformation and chan ge management. The total spend on ICT therefore is les s than 1 per cent o f the entire HSE budget and com pared with available inte rnational benchmarks, the level of ICT spending in Ireland is low.

Staffing ICT in Health Service

The total number of ICT staff within the core HSE is approxim ately 400. W ithin the ICT Directorate there is 329 staff with up to another 70 staff working on ICT but reporting to m anagers of other services. Within the v oluntary se ctor there is approximately 200 ICT staff, of whom about 150 work within the Dublin Academ ic Teaching Hospitals.

Main Issues

4. ICT Strategy for HSE

Considerable progress has been made in recent years in doing the ground work to improve the environment for the roll out of national ICT systems. *The HSE are currently finalising a corporate strategy and also finalising an ICT and e-health strategy that will address the future implementation and environment for the delivery of key business systems.* The strategy will guide ICT investment priorities and issues of governance and implementation into the future.

For sometime the HSE has been working with both the Department and CMOD (Department of Finance) on rationalising and unifying the approach to the implementation of systems. In order to overcome the fragmentation of the disparate systems in the old health boards, a single ICT infrastructure in terms of application rollout and technology is being adopted. This approach will be rigorously adhered to in order to bring benefits and reduce risks across the range of systems.

An important component for the future of the health system is the development of an integrated electronic health record (EHR), allowing the system to track the patient across the acute and primary care systems. A fundamental building block in the eventual delivery of the EHR is the legislative framework envisaged in the **Health Information Bill** which is to be published by mid 2011.

The head of the ICT function in the HSE is currently on administrative leave.

5. ICT Project Highlights:

Integrated Patient Management System (IPMS)
A decision was made in 2010 to halt further rollouts of iPMS until a single configuration upon which subsequent rollouts to all other sites could be based was established. After some consideration it was decided that the iPMS solution in HSE South could form the basis of this single design/ configuration.

NIMIS
There were significant developments for the NIMIS (National Integrated Medical Imaging System) project in 2010 with the main vendor on site working with the project team to develop the core system in preparation for deployment to initial sites. Sanction was received for major components of supporting infrastructure that will be procured in 2011 via framework agreements. The objective of the project is to procure and implement a national integrated PACS/RIS (Radiology Information System) solution with voice recognition, electronic requesting of radiology procedures, image and results viewing facilities, along with the functional and technical capability to facilitate the viewing of patient image and report data at a regional / national level.

Clinical Systems
Implementation of Clinical Systems continued during 2010. Contracts were signed for the supply of national solutions for Nephrology (Renal), Sterile Instrument

Tracing and Endoscopy Systems implementation of these systems will complete in 2011.

National Child Care Information System (NCCIS)
NCCIS is currently subject to a peer review process and work will commence shortly on the next phase of the project which is completion of the RFT.

Environmental Health System (EHIS)
Requirements specification and preparation for tendering was completed in 2010. We would expect procurement will be completed in 2011 with substantial progress made in the implementation of this system.

Nursing Home Support Scheme (NHSS) 'Fair Deal'
Most of the additional functionality required to complete delivery of this system was developed and deployed in 2010. There are still some additional features that must be completed and that work will now conclude in 2011.

Health Atlas
The Health Atlas project is now complete and the service is operational, providing significant benefit to the organisation. Work on related initiatives will start in 2011.

Healthlink
This web-based messaging service enables the secure transfer of patient information over the internet between hospitals and GPs. Further substantial rollout of this project took place in 2010 with additional features supporting electronic referral of patients to specialist cancer teams (prostrate, breast and lung cancers) going live in 2010. The team have documented their plans for the next 3 years and these will form part of a request for sanction early in 2011.

The Pandemic Vaccination Programme Information System
There were no further developments on this in 2010 but the system remains live should it be required urgently again in early 2011.

ICT for Ambulance Services
There were significant investments by ICT in the ambulance service in 2010 particularly with regard to the ICCS and ACAS systems. This is part of a broader program to reconfigure pre hospital care services to align with the re configuration of hospital services as defined by the HSE Integrated Services Directorates programme.

Regional and Local Initiatives
In the context of supporting regional / local initiatives, numerous ICT projects were delivered. The implementation of Intensive Care Unit (ICU) Clinical Information Systems continued in many hospitals including Crumlin and these will have a very positive impact on services provided.

ICT Technical Infrastructure
Some of the more significant developments in this area during 2010 included deployment of ICT support to primary care areas and ICT improvements in Cork,

Galway and Sligo Hospitals. Plans for a second national data network NHN2 will begin in 2011 to provide resilience for NHN1.

Internal ICT Function:

Role of Internal ICT Unit: The Unit supplies a full range of ICT related services to the Department including the OMCYA, the Adoption Authority of Ireland, the OCO, the ODOA and a number of smaller bodies. These services include helpdesk support, mail and web services, web and software development, LAN and WAN management to 9 sites, maintenance and security in relation to the ICT infrastructure. The Unit manages the ICT infrastructure for a range of corporate systems that support the organisation including payroll, financial management, PQ's and Rep Systems. In addition, ICT provides support for systems in relation to managing briefing material, risk management, flexi, board appointments, Lottery Grants and FoI tracking. The Unit also supports ICT aspects of the ECCE/CCS Scheme for the Office for the Minister for Children and Youth Affairs.

DoHC Internal ICT Budget: The expenditure in 2009 was €1.54m. in 2010 it was €1.53m. The expected spend in 2011 is €1.615m.

Staffing: The Unit has 8.5 staff.

(E) Research and Information Functions (within the Dept)

Goals

A Department-wide approach to increase the analytical capacity of the Department and to use evidence as a central component of the policy process has been underway. This is in keeping with the DoHC Statement of Strategy 2008-2010 which notes that:

> *In developing policy, the Department must be in a position to access and analyse the relevant existing evidence base. To do so it needs to develop strong links with research institutes, to commission research as appropriate and to ensure that the evidence base is promoting horizon scanning, risk assessment and future planning (p11).*

Objectives, Actions and Outputs

The goals above are being jointly progressed by the Research Unit and the Information Unit in the Department.

The Research Unit seeks to:

> *'support DoHC personnel towards more effective and efficient use of research evidence in their work and to contribute to an overall enhancement of analytic capability within the Department.'*

The Research Unit was established in 2009 through the extension of the remit of the existing OMCYA Research Unit.

The Information Unit has a strong role in providing data access and statistical analysis for the Department. It also has a strategic function in the improvement of information systems and sources.

Both units benefit from having a significant professional expertise in the areas of health and social research and statistics.

The key activities and outputs for each Unit are set out below.

The strategic actions of the Research Unit to meet its objectives and their associated outputs in 2011 are:

Action 1: Provision/development of library and awareness services (e.g. provide access to journals, books and other research)
Action 2: Development of key resources tailored for individual sections (e.g. development of a guide 'Evaluation: Key Concepts in Five Pages'.)
Action 3: Assist DoHC personnel in understanding key messages from research (e.g development of research briefing notes; Issue Synthesis and analysis of existing research material in association with Evidence Centre, HRB).
Action 4: Build capacity in identifying reliable research evidence and appropriate application and utilisation (e.g. information and training seminars on

resources available on healthnet, s earching for evidence and good practices on Research Commissioning and Governance

Action 5: Assisting the integration of research into the daily work of DoHC personnel by w orking w ith other units w ithin the Finance, Performance Evaluation, Information and Research Division and the Evidence Centre, HRB to develop an enhanced analytical approach. (e.g. technical support provided as well as support for a specific project on m edical cards through a "Co-ordinated Evidence and Information Support Team" (CEIST)).

Action 6: Communic ations w ith exte rnal stakeholders in r elation to r elevant Research Unit w ork. (e.g. jointly hosting a seminar f rom the Sax Institu te o n 'Evidence Infor med Policy and Knowl edge Brokering' for researchers/agencies/policy-makers in association with Evidence Centre, HRB) .

Action 7: Support the development of the new National Children's Strategy through convening and chairing an International a nd National Expert Policy Review Group and developing Goal 2 of the new national children's strategy being developed.

Principal activities and outputs for the Information Unit are as follows:

- Annual publication of ***Health in Ireland: Key Trends***. This booklet provides a useful overview of trends over the past decade in the health status of the population and in the provision of services.
- Provision of access to data and data tools for all members of staff. A software application called **DataPoint** has been developed in the Information Unit for this purpose. This includes access to national and international data. Data are also provided on the Department's website.
- Analysis, interpretation, and synthesis of data for a wide range of purposes including performance evaluation, policy analysis, parliamentary questions, and support for Policy Units.
- Close collaboration with Performance Evaluation Unit to streamline dissemination and analysis of monthly and quarterly HSE Service Plan indicators.
- Development and implementation of a set of high level Performance Evaluation Framework (PEF) indicators for the health system. These, approximately 50, indicators will be used for annual assessment of the performance of the health system across four categories as follows:
    - To keep people healthy.
    - To provide the healthcare people need.
    - To deliver high quality services.
    - To get best value from health system resources.
- Participation in the Coordinated Evidence and Information Support Team (CEIST- see Section on Information and Research) to develop an enhanced analytical approach in selected policy areas. The current work concerns a review of income and other qualifying criteria for medical cards.
- Production of the Public Health Information System (PHIS) which enables rapid and detailed presentation and analysis of major public health and demographic indicators such as population projections, mortality, hospitalisation and cancer survival. PHIS data is used widely throughout the health system.
- Compilation of data for supply to EU, WHO, OECD and other international organisations. This is essential to the accurate representation of health

(F) Workforce Planning

Background

The Department of Health and Children is responsible for formulating overall policy in relation to workforce planning in the health services.

Workforce planning identifies the composition of the workforce required to deliver health service goals. It encompasses a range of human resource activities aimed at the short, medium and long-term. Workforce planning that is integrated with service and financial planning offers the best opportunity for linking human resource decisions to the strategic goals for the health services.

In total, approximately 235,000 individuals work in the health sector in Ireland. There are around 135,000 employees in the public health sector, with the balance in the independent and private sectors, which includes GP practices, private hospitals and clinics. The health workforce, public and private, increased by more than 60% between 2001 and 2010, and accounts for over 12% of the total number in employment.

Short-term measures

Moratorium on Recruitment in the Health Service

In the short term, the operation of the Employment Control Framework (ECF) for the health sector is pivotal to workforce planning. There are a number of grades exempted from the moratorium (see below), under the ECF 2011-2014, to maintain key front line services and to support the development of policies in relation to disability, mental health, cancer, and child care. These exemptions are subject to certain conditions being met by the HSE and employers concerned.

a. **Medical Consultants**
b. **Speech and Language Therapist, Occupational Therapist, Physiotherapist**
c. **Clinical Psychologist, Behavioural Therapist**, **Counsellor**
d. **Social Worker** (incl. Posts for implementation of Ryan Report)
e. **Emergency Medical Technicians**
f. **Psychiatric Nurses** — up to 100 posts to support the implementation of *A Vision for Change*.
g. **Public Health Nurses** — up to 70 posts to facilitate the recruitment of student public health nurses.
h. **Nurse Sponsorship Scheme** — up to 30 posts to facilitate the appointment successful students from this sponsorship scheme.
i. **Advanced Nurse Practitioner/Clinical Nurse Specialist** — 50 posts to allow for improved skill mix and better utilisation of the nursing resource in priority areas (acute/chronic illnesses).
j. **Additional Intern Places** — 40 additional training places
k. **National Cancer Control Programme posts** —
    - Clinical engineering technician
    - Dosimetrist
    - Physicist
    - Radiation Therapist

In addition the ECF allows for some flexibility in regard to "exceptional posts". However, this discretion is only available if targets for pay savings and number of posts are met and if a post at similar level can be suppressed. Its use is to be kept to a minimum and must be approved by the National Director of HR.

Medium-term measures

Working Group

A joint Department of Health and Children/ Health Service Executive Working Group on Workforce Planning was established in June 2006 and includes representatives of the Departments of Health and Children, Finance, Education and Skills, HSE and the Higher Education Authority.

Workforce Planning Strategy

An Integrated Workforce Planning Strategy for the Health Services 2009–2012, was published in November 2009. The Strategy was designed and developed to ensure integration of workforce planning activity with the broader objectives of financial and service planning in the Irish health and social care system.

As a significant proportion of health funding is spent on staff costs, it is necessary to ensure that it is spent efficiently and delivers on key health goals. The Strategy sets out the four key principles to guide integrated workforce planning, i.e. patient/client focus, sustainability, availability and flexibility.

The Strategy supports the development of health service human resources including initiatives already underway such as improved Consultant/Non-Consultant Hospital Doctor (NCHD) ratios and Nurse Prescribing. It also provides health service planners with the tools to assess other sources of supply through redeployment, retraining or changed skill mix.

FÁS Report

The Strategy follows the publication in June 2009 of the report by the Expert Group on Future Skills Needs (EGFSN) and FÁS (Skills and Labour Market Research Unit) - *A Quantitative Tool for Workforce Planning in Healthcare*. The report contains workforce planning analysis for selected healthcare occupations and provides a valuable evidence base for workforce planning decisions resulting from policy and demographic changes.

The Department is very keen that the particular analytic and research skills of the FÁS research team, which allow for an independent and objective assessment of workforce planning issues for the health sector (public and private), continue to be carried out periodically under the auspices of the EGFSN. This would assist in policy decisions being made on the best available evidence and would provide an objective re-examination of the methodologies for analysing health workforce data.

OECD Report

The OECD report on the Irish Public Service "Ireland - Towards an Integrated Public Service" (2008), highlights a number of areas in workforce planning, including the supply of general practitioners, the ratio of nurses in Ireland compared to other OECD countries and the potential for improved skill mix between nurses and health care assistants.

International Context

EU Green Paper on Health Workforce

In December 2008, the EU Commission launched a Green Paper on the *European Workforce for Health* which identified a number of areas where further action could be undertaken by the Commission in cooperation with Member States with the intention of stimulating debate on these issues. A Europe wide public consultation followed and a report on the consultation was published by the Commission in 2009.

Council Conclusions

The European health workforce was one of the themes for the Belgian Presidency (July - December 2010) and a Ministerial Conference took place in September 2010. Following the conference discussions took place at the Working Party on Public Health on draft Council Conclusions. Council Conclusions on *'Investing in Europe's Health Workforce of Tomorrow: Scope for Innovation and Collaboration'* were produced in December 2010.

Action Plan

One of the Council Conclusions invited member states and the Commission to develop an action plan by 2012. The action plan would provide options to support the development of Member States' health workforce policies, recognising the competencies of Member States, in particular in the areas of the assessment of competence profiles, the improvement of planning methodologies taking into account identified health needs, continuous professional development and recruitment and retention strategies, and to tackle the key challenges for the health workforce throughout the EU in the medium and long-term perspectives. The Working Group on Health Workforce, on which the Department of Health and Children is represented, is progressing the development of the Action Plan.

WHO Code of Practice on International Recruitment

The *'WHO Global Code of Practice on the International Recruitment of Health Personnel'* was agreed at the World Health Assembly in May 2010. This voluntary instrument seeks to establish and promote principles and practices for the ethical international recruitment of health personnel, as a core component of national, regional and global responses to the challenges of health personnel migration and health systems strengthening. The Code includes articles advocating the establishment or strengthening of health personnel information systems, including health personnel migration and its impact on health systems, and the collection, analysis and translation of data into effective health workforce policies and planning in countries. Since the Code was agreed at the World Health Assembly, the OECD

and WHO have worked closely with the EU (Eurostat) and Member States to develop a dataset for the collection of statistics on health workforce migration in order to support the reporting requirements of the Code.

(G) Education and Training

(i) Medical Education and Training

Statistics

There were 694 graduates in medicine in 2009.

Background

Recommendations on reforms in undergraduate and postgraduate medical education and training are set out in the Report of the Undergraduate Medical Education and Training Group (Fottrell Report, 2006) and the Report of the Postgraduate Medical Education and Training Group (Buttimer Report, 2006). The Government accepted the broad thrust of the two Reports and approved funding (for the health and education sectors) to support their implementation.

Current Issues

- With the overall increase in the numbers of medical students, an increase in the numbers of interns is currently being examined from a national perspective. There are sufficient intern posts for all EU students graduating from Irish medical schools up to 2012 after which additional posts will be required. The HEA have stated that they inform all non-EU medical students that they are not guaranteed an internship in Ireland.

Progress to Date

- An Interdepartmental Policy Steering Group, jointly chaired at Principal Officer level by the Department of Health and Children and the Department of Education and Skills, was established in February 2006. The Group, which also includes representatives from the Department of Finance, the Health Service Executive and the Higher Education Authority, is continuing to co-ordinate and progress implementation of Government policy on medical education and training reform.
- A National Committee on Medical Education and Training (NCMET) representing all stakeholders, chaired by John Malone former Secretary General of the Department of Agriculture, was established by the Interdepartmental Policy Steering Group. The NCMET has an oversight and consultative role in implementing the reform programme.
- In 2006 the HSE established a Workforce Planning and Professional Education Department led by an Assistant National Director in the HR Directorate. The Board of the HSE adopted a Medical Education, Training and Research Strategy in October 2007.
- The Medical Practitioners Act 2007 provides the statutory basis for many of the reforms proposed in the Buttimer Report including the phasing out of NCHD posts of limited training value.
- **The provisions of the Medical Practitioners Act 2007 relating to the maintenance of professional competence of registered medical practitioners were commenced with effect from 1 May 2010. Under the Act the Medical Council is required to operate professional competence schemes no later than the first anniversary of the commencement of these provisions i.e. 1 May**

- In March 2010, the HSE signed a concord with the universities to bring greater co-ordination to clinical placements. Clinical sites will be agreed and covered by site agreements with the HSE, thus allowing for good governance and evaluation.
- Work is on-going in relation to the development and implementation of academic clinician posts. All six medical schools are involved in this initiative in conjunction with their partner clinical sites. A total of 25 posts have been approved and almost all have been filled.
- Under the new NCHD Contract, all NCHDs must participate in and meet the requirements of any specialist training and competence assurance programmes on which they are registered. NCHDs are prevented from working outside the confines of their contract if the combined working time exceeds European Working Time limits.

(ii) General Practitioners

There are 12 General Practitioner (GP) Specialist Training Programmes currently in operation which are all of four years duration – two years spent in hospital posts (Senior House Officer), under the supervision of hospital consultants, and two years in an approved general practice at registrar level, under the supervision of a general practice trainer.

Separate reports in 2009 by FÁS, ESRI and the Competition Authority and in 2010 by the Joint Oireachtas Committee on Health & Children referred to the GP manpower issue and stated that the current number of training places of 120 per year was not sufficient to meet the demands of a growing and ageing population. The reports recommended that the number of GP training places be increased from 120 to 150.

<u>Progress to Date</u>

- Following collaboration between the ICGP and the HSE, the number of GP training places was increased from 120 per annum to 157 per annum, with effect from July 2010. These additional training places were effected through the streamlining of existing training programmes. The following are the enabling steps in this process:-
    - additional GP training places will be made available via a formal re-alignment of existing NCHD training posts to the ICGP training programme;
    - an additional GP training programme is being implemented in Dublin's North Inner City, an area identified by both the ICGP and the HSE as requiring additional GPs;
    - forty-five additional GP trainers will be appointed to expand the number of general practice placements on training programmes, with a particular emphasis on areas of deprivation and GP shortage;
    - training programmes will be restructured on a regional basis in line with the new HSE regional structures;

- the additional training places will be allocated as appropriate to meet the projected needs of the regions as informed by work force planning exercises.

- The HSE is continuing to work with the Irish College of General Practitioners (ICGP) to explore a process to fast track GP training for doctors who have the relevant hospital training and experience. Proposals from the ICGP are awaited and this will be discussed again at the HSE's next meeting with the ICGP.
- The HSE is also in discussion with the ICGP to identify a mechanism of up-skilling long term locums or assistants who are not eligible for GMS contracts because they have not undertaken/passed the Membership of the ICGP examination and have not obtained membership of the College through the award of a Certificate of Satisfactory Completion of Training from the Medical Council. An alternative model of training has been discussed to enable them to access the specialist register and thus become eligible to take on GMS posts. It is estimated that there could be up to 250 doctors involved here.

Policy Issues

The EU/IMF programme provides for the introduction of legislative changes to remove restrictions to trade and competition in sheltered sectors by the end of the 3rd quarter in 2011, including:

- medical services, eliminating restrictions on the number of GPs qualifying and removing restrictions on GPs wishing to treat public patients as well as restrictions on advertising.

GP trainees receive remuneration from the HSE during the 4 years of training. No recognition is granted where a trainee has previously obtained equivalent training in a hospital setting.

Risks / Sensitive Issues

- Whereas the additional 37 training places were achieved in 2010 on a cost neutral basis, the ICGP has indicated that there would be a cost implication in up-skilling long term locums or assistants who are not eligible for GMS contracts.

(iii) Nursing Education and Training

Degree Programme

The Nursing Degree Programme, scheduled over 4 years with a rostered clinical placement in the final 9 months, currently has an intake of a maximum 1,570 students, down from 1,880 following a Government decision in 2009.

Current Issues

The recent Government decision to initially reduce the pay of student nurses during their rostered placement, and to phase it out entirely from 2015, is being addressed as an IR issue by National HR Unit (see separate briefing).

Advanced Nurse Practitioners

As at 22 February 2011, there were:

- 154 approved Advanced Nurse Practitioner/ Advanced Midwife Practitioner posts and 95 accredited practitioners in post;
- 2,275 approved Clinical Nurse Specialist/ Clinical Midwife Specialist posts and 1,799 accredited specialists in post.

Role Expansion for Nurses and Midwives

Background

Nursing and midwifery role development occurs within the context of reform and transformation of Irish healthcare provision in order to provide high quality integrated services to the Irish public. Models of care delivery are evolving in line with Department of Health and Children policy and Health Service Executive strategic and service plans. This is in order to meet the healthcare priorities of the population in an efficient, effective and quality assured manner.

The *Framework for Role Expansion of Nurses and Midwives* outlines step by step processes for consideration of nursing and midwifery role expansion. The purpose of this policy paper is to provide a strategic framework to further expand the role of nurses and midwives to promote delivery of quality care by nurses and midwives. This promotes the development and enhancement of nursing and midwifery roles in response to patient and service need and national policy direction.

The policy paper was guided by a Steering Group of key stakeholders which was established in May 2009

Current Position

The policy document is due to be published shortly.

Prescribing of Controlled Drugs by Nurses and Midwives

Background

The prescribing of controlled drugs by nurses and midwives with prescriptive authority is regulated by Schedule 8 of the Misuse of Drugs Act. This was introduced specifically to identify the drugs and route of administration for which Registered Nurse Prescribers can prescribe Schedule 2 or 3 medications. The National Independent Evaluation of the Nurse and Midwife Prescribing initiative stated that *"In its present format, Schedule 8 is inhibiting the prescribing practice of nurses/midwives, especially those working in the area of pain management, due to the restrictions on the type of controlled drugs that they are permitted to prescribe"* and recommended that:

> "*The Department of Health and Children review the relevant medicines products regulations for Schedule 8 with a view to enabling all nurses and midwives prescribe controlled drugs in Part II of Schedule 8 where the drug is normally used in a specific clinical setting and falls within a nurse's/midwife's scope of practice."*

Current Position

The Department is continuing to progress the recommendation's relating to Schedule 8. A meeting is to be scheduled with medical practitioners and other interested parties to progress the recommendations.

Frontline Services

The role of nurses in delivering other frontline services has expanded greatly in recent times to include

1. Medicinal Product Prescribing
2. Nurse Prescribing Medical Ionising Radiation
3. Forensic Examination of Sexual Assault
4. Venepuncture and IV Cannulation
5. Human Papillomavirus (HPV) Vaccination Programme
6. National Dementia Training Programme

The HSE office of the Nursing and Midwifery Services Director is closely involved in

- the development of the national clinical programmes in conjunction with the Quality and Clinical Care Directorate
- the community oncology nursing programme and
- the development of a national cancer nursing strategy in conjunction with the national cancer control programme

Mr Michael Shannon, recently appointed Director of Nursing & Midwifery Services within the HSE, reports to Dr Barry White, National Director of Quality & Clinical Care.

More detailed briefing on these issues is available if required.

(iv) Other Grades

Separate detailed briefing is available in relation to training and education arrangements for Dentists, Pharmacists, and Health and Social Care Professionals.

(H) Eligibility for Health & Personal Social Services

What does the Department do?

- The Department is responsible for the legislative framework that governs eligibility for all publicly-funded health services.
- The Department provides clarification to the HSE on policy and legal issues in relation to eligibility and the levying of charges.

Background Facts

- Under the current framework, almost 40% of the population has full eligibility, under which they are provided with publicly-funded hospital and primary care services, subject in most cases to none or very limited charges. The remainder of the population has limited eligibility, under which they are provided with publicly-funded hospital services, subject in some cases to charges.
- There have been substantial developments in health and personal social services over the last forty years, which are not adequately reflected in the text of the Health Act 1970. Many key terms and concepts used in the 1970 Act are vague, which leads to some uncertainty in relation to some services/circumstances.
- The Department has reviewed the current eligibility framework. A draft memorandum for Government was prepared and circulated to Departments for observations in December 2010.
- The draft memorandum sought approval to prepare legislative proposals for a more up-to-date legal framework for the existing eligibility arrangements, and to formulate proposals for a revised and more graduated approach to eligibility.
- The memorandum had not been considered by Government prior to the General Election.

Current Issues

Uncertainty about a spects o f the curre nt legal fra mework is of con cern and will be the subject of a submission to the Minister in the near future.

EU Health Cards (EHIC, E121, etc.)

What does the Department do?

- This Department participates in European Commission deliberations on the on-going administration of health aspects of Regulation 883/04, which primarily integrates social security systems to facilitate the free movement of labour with the EU. (The lead Irish Department is the Department of Social Protection.)
- The Department provides clarification and guidance to the HSE on the legal requirements of Regulation 883/04.
- The HSE is responsible for administering the Regulation, which includes applications for EHICs, and other European health cards, as well as the provision of services to EU citizens.

Background Facts

- The rules on the coordination of social security systems, including healthcare within the EU/EEA and Switzerland, are contained in the EU Regulation 883/04. Broadly in relation to health, this Regulation ensures that citizens of EU Member States receive certain health services when they are in other Member States.
- The most familiar health provisions under the Regulation are:
  - European Health Insurance Card (EHIC): allows access to immediate necessary medical and dental treatment during a temporary stay in another EU Member State, on the same basis as if the person was in insured resident of that Member State.
  - E121: provision of medical benefits to a pensioner resident in another Member State, while in receipt of a social security pension from his/her 'native' Member State.
  - E112 (soon to be S2): pre-approved referral of patients by one Member State to access public health facilities of another Member State for the purpose of receiving specific medical treatment.

(I) Resource Allocation

1 Achievements/Current Issues

1.1 Publication of the Expert Group Report on Resource Allocation and Financing in the Health Sector

- The Expert Group on Resource Allocation and Financing in the Health Sector was established on 1 April 2009 to examine how the existing system of resource allocation within the Irish public health service can be improved to better support the aims of the health reform programme. It was also asked to take a view on the most appropriate financing mechanism for this purpose for Ireland.

- The Report of the Expert Group was submitted to the former Minister and made publicly available on 9th July 2010.

1.2 Main Findings of the Report

- The Expert Group made thirty four recommendations in total, some of the key recommendations are set out below:

A. Financing Health Care

The Irish Health Care system is financed by a mix of public and private expenditure. It is primarily funded from general taxation, but also includes out of pocket expenditure and claims expenditure by private health insurance companies. The Report looked in detail at the area of financing and did not recommend a change from the present mainly tax-based financing to universal/social health insurance. Rather the Group was more concerned about how the mechanisms for collecting and managing funds are structured and the effectiveness of the system.

B. Population Health Funding

The Group has recommended the development of an operational population health resource allocation model for Ireland which would allocate budgets transparently to each local area on a population basis.

C. Prospective Activity Based Funding

The Group recommends that prospective based funding as a method of reimbursing health-care providers should be introduced for all relevant areas of the health and social care system on a phased basis. National plans should be drafted and this method should be introduced on a phased basis beginning in the acute hospital sector where existing data collection arrangements could support such a development.

D. Possible Framework for Resource Allocation for Integrated Health Care Delivery

The Group suggests a need for a new graduated form of eligibility to better address the burden of chronic disease management. An illustrative framework proposed by the Group looks, in particular, at offering pro-active care at primary and community levels though a system of graduated eligibility for GP services and prescription medicines. The Report also identifies the need to develop other primary care services. The Report acknowledges that the roll-out of such an approach is dependent on resources.

E. National Treatment Purchase Fund (NTPF)

The Group recommends that as prospective based funding mechanisms are rolled out the role of the NTPF in relation to waiting lists should be mainstreamed within the HSE. The transfer to the HSE would not only include the transfer of resources but also responsibility for monitoring waiting times to achieve centrally set targets to ensure that patient benefits are preserved.

F. Other Issues

The Group supports many of the recent health reform initiatives, including Fair Deal, the development of clinical care pathways, the policy of delivering integrated care outside hospitals as far as possible, the work being done on a unique health identifier and the development of more individualised funding options for persons with a disability.

[redacted]

[redacted]

1.3 VFM Review of the Economic Cost and Charges Associated with Private and Semi-Private Treatment Services in Public Hospitals

- The previous Government approved the findings and recommendations of the above VFM Report in December 2010. In particular, the VFM recommended:
  - The immediate implementation of a revised per diem costing methodology for calculating charges for private and semi-private patients in public hospitals;
  - The development of a pilot project on the introduction of case-based charges for private and semi-private patients in public hospitals using diagnosis related groups with a view to fully implementing case-based charges by 2013;
  - Certain measures for improved income collection by HSE / public hospitals;
  - Negotiations between the HSE and private health insurers to achieve a decoupling of billing for private accommodation charges from consultant fee claims to be concluded as a matter of urgency.
- The VFM also informed the increase in private patient charges for 2011 announced by the former Minister in the context of Budget 2011.

Resource Allocation Unit
21/02/11

(J) CITIZEN PARTICIPATION

Citizen Participation

In response to the Organisational Review Programme (ORP), the Department of Health and Children ORP Action Plan established a **Citizen Participation Unit** (CPU) in September 2010. Staff in this Unit has been working on children and young people's participation in decision-making, as part of the Office of the Minister for Children and Youth Affairs (OMCYA), since 2003.

- In order to develop a policy framework for this work, the CPU established a Citizen Participation Advisory Group in February 2011, to oversee the development of a policy paper on citizen participation on issues relating to health and well-being. This policy paper will be completed by December 2011. The work of the Advisory Group will build on the model used by the OMCYA on the voice of the child and other successful citizen participative practice.
- During 2011, the Unit will oversee a consultation process with service users on the new DoHC disability policy.

The Citizen Participation Unit will continue to work as part of the OMCYA in relation to participation by children and young people in matters that affect them.

Children and Young People's Participation

The OMCYA has the lead role under *the National Children's Strategy* (2000), in ensuring that children and young people have a voice in the design, delivery and monitoring of services and policies that affect their lives, at national and local level. Goal 1 of the *National Children's Strategy* (2000) states that 'children will have a voice in matters which affect them and their views will be given due weight in accordance with their age and maturity'. The *Strategy* is based on the principles of the United Nation's Convention on the Rights of the Child. The *Report of the Taskforce on Active Citizenship* (2007) also promotes the need for all citizens, including children and young people, to become involved in social and community life.

The OMCYA is committed to ensuring best practice, robust and evidenced-based outcomes and the inclusion of seldom-heard children and young people in participation structures and initiatives.

Establishment of Participation Structures

In the last eight years, the OMCYA has worked to ensure the establishment or consolidation of the following key structures:

Comhairle na nÓg (local child/youth councils)

- Comhairle na nÓg were set up under the National Children's Strategy in the 34 City and County Development Boards to give children and young people a voice in the development of local services and policies. From their inception, Comhairle na nÓg received baseline funding from the former National Children's Office and subsequent OMCYA.
- In 2007, the OMCYA set up the Comhairle na nÓg Development Fund to improve the operation of Comhairle na nÓg. The three Reports of the Independent Evaluator for the Comhairle na nÓg Development Fund (2007-2010), highlight significant improvements in the operation of many Comhairle na nÓg as a result

of this Fund. The Reports showcase good practice and identify issues that require improvement in ensuring that young members of Comhairle na nÓg are being provided with opportunities to work on issues of importance to them and have formal and sustained links with adult decision-makers.

- Expenditure in this area in 2010 was €787,470.

Dáil na nÓg (national youth parliament)

- Dáil na nÓg is the annual national parliament for young people aged 12-18 years. The OMCYA funds and oversees Dáil na nÓg, which is hosted annually by the Minister for Children and Youth Affairs. Delegates are elected to Dáil na nÓg by the 34 Comhairle na nÓg.
- Successive independent evaluations note that Dáil na nÓg has gone from strength to strength, with more challenging and contentious debate each year.
- 200 delegates attended the ninth annual Dáil na nÓg which took place on 5 March 2010 in Croke Park, Dublin and discussed the issues of mental health and access to education.
- Dáil na nÓg 2011 will take place in November .
- Expenditure in 2010 for Dáil na nÓg was €250,252

OMCYA Children and Young People's Forum (CYPF)

- OMCYA Children and Young People's Forum (CYPF) was established in 2004 as a reference panel:
    - to advise the OMCYA and the Minister for Children and Youth Affairs on issues of concern to children and young people;
    - to undertake projects at the behest of the Minister or the OMCYA in advising on policies that require an input from children and young people.
- There are 35 young people on the CYPF aged 12 – 18 years, from all parts of the country, nominated through Comhairle na nÓg and organisations representing seldom-heard children.
- The CYPF has been an invaluable resource to the OMCYA and its members have been consulted on, or been involved in many initiatives.

Student Councils

In 2009, the OMCYA entered into a formal partnership with the Department of Education and Skills to support the effective development of student councils and oversee the running of the student council support service.

Consultations/Dialogues

The OMCYA has conducted consultations/dialogues with children and young people on a range of issues including:

- The development of the Children's Code of Advertising (2004)
- The development of the National Recreation Policy (2005)
- The development of the *Taskforce on Active Citizenship* (2006)
- The age of consent for sexual activity (2006)
- The development of the Irish Youth Justice Strategy (2007)
- The misuse of alcohol among young people (2007)
- Teenage Mental Health: What Helps and What Hurts (2008)
- Consultations with children and young people in the care of the State (Jan – Dec 2010)

- Consultations with young people on reform of Junior Cycle in second-level schools (Nov 2010)
- Consultation with young people on the White Paper on Crime (Nov 2010)

Mental Health Consultations with Teenagers
In October 2008, the OMCYA conducted nationwide consultations with 277 teenagers aged 12-18 years entitled, *Mental Health: What Helps and What Hurts,* to inform the development of more effective HSE services and a HSE advertising and public awareness campaign on mental health aimed at teenagers. Young people from the Dáil na nÓg Council and the OMCYA Children and Young People's Forum were involved in supporting these consultations and in developing the HSE TV/Cinema advert, which continues to be screened in cinemas throughout the country.

Consultations with Children and Young People in the care of the State
- The Report of the Commission to Inquire into Child Abuse (2009) recommended that *children in care should be able to communicate without fear*. In response, a consultation process with children and young people in State care was conducted by the OMCYA during 2010.
- The consultation process was spearheaded by the OMCYA, in co-operation with an Oversight Committee comprising key stakeholders including, the HSE, the Irish Youth Justice Service (IYJS), HIQA, the Irish Association of Young People in Care (IAYPIC), the Probation Service and other key stakeholders. Seven teenagers who are themselves in care are also members of the Oversight Committee and formed a Youth Advisory Panel for the consultation process.
- 15 consultations were conducted with 211 children and young people between January and July 2010. A separate process was conducted with children in care with limited or no capacity to communicate in November and December 2010.
- A report of the consultations has been compiled and will be launched by the Minister for Children and Youth Affairs during 2011.

Consultations with Children and Young People on the new National Children's Strategy (2012-2017)
A consultation process with children and young people will feed into the new Strategy, identifying what's good, what's not good and what they would change about being a child or young person. This nationwide consultation process will take place from 28th March – 1st April 2011.

Development of a Policy on Children and Young People's Participation under the new National Children's Strategy
The new National Children's Strategy (2012-2017) will follow the structure of the first Strategy and will have the same national Goals. A Thematic Group on the development of Goal 1 of the new Strategy was established in February 2011, comprising representatives of Government Departments, State agencies and other key stakeholders. A consultant has been appointed to work with the Group and develop an outline policy paper on children and young people's participation in decision-making for inclusion in the new Strategy.

Audit of children and young people's participation in decision-making
In January 2010, the OMCYA commissioned a nationwide audit of children and young people's participation in decision-making to document activity in both

statutory and non-statutory organisations. The audit will be completed by March 2011 and will inform the development of the new National Children's Strategy.

Building an evidence-base on children and young people's participation
In December 2011, the OMCYA Participation Team commissioned two pieces of research:

- an examination of children and young people's perspectives on the impact of participation in decision-making;
- a literature review and identification of good practice on participation in decision-making of seldom heard children and young people relevant to the Irish context.

Existing/Known Risk
Mitigation management of Risk (RR/07//70): Protection and welfare of children and young people involved in OMCYA initiatives.

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Oifig an Stiúrthóra Náisiúnta, Acmhainní Daonna
Feidhmeannacht na Seirbhísí Sláinte
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By Email only:
13th January, 2011

Mr. Michael Scanlan
Secretary General,
Department of Health & Children,
Hawkins House,
Dublin 2.

Re: Public Service Agreement 2010 – 2014 (Croke Park Agreement).

Dear Michael

I refer to your correspondence of 7th December 2010 in relation to the above and specifically the request of the Implementation Body that the Action Plan for the Health Sector be reviewed in light of the decisions taken by the Government in the context of the Estimates and Budget 2011 in order to ensure that the Plan supports the changes to follow from those decisions.

As you know the budgetary measures decided by Government to implement the National Recovery Plan, require underlying savings of €960m in the HSE budget for 2011 (which includes the cut in cash terms and the cost of unavoidable cost increases) allied with reductions in numbers required under the employment control framework.

Notwithstanding these reductions the HSE has committed, in National Service Plan, approved by the Minister on 21st December, to maintaining services at last year's level. In order to achieve this, the HSE needs to make significant savings in non-pay costs and in non core pay expenditure and crucially has to deliver the same quantum of services with less staff. The revised action plan has been prepared with this imperative in mind. I should stress that this is the real litmus test for Croke Park, i.e. the extent to which services can be delivered as planned within the reduced resources approved by Government and this requires pro-active co-operation from staff at all levels with procurement and other economy measures (including local measures to minimise wastage and reduce usage of "consumables") as well as changes in staffing levels / ratios and work practices.

The action plan for the health sector identified in your correspondence of 8th October 2010 has been extracted and updated below where progress has been made and the additional requirements, based on the Service Plan for 2011 and the Estimates and Budgetary process, have been included.

It is worth highlighting the significant progress made in a number of areas which include the agreement to transfer Community Welfare Staff to the Department of Social Protection from 1st January 2011 which was agreed by the parties following an intensive series of discussions facilitated by the Labour Relations Commission. A protocol of transfer was agreed during this process and discussions with the parties will continue to address priority issues associated with the transfer.

There has also been significant engagement by the parties in progressing the requirements to change laboratory work practices and in particular the requirements to delivery efficiencies to service and cost imperatives. The requirements for change focus on the delivery of a patient centred system of service delivery, which complements the requirements for health reform. Laboratory medicine services are critical to supporting the delivery of high quality patient care and the parties are presently engaged in intensive discussions facilitated by the Labour Relations Commission to bring about changes required for the provision of services on an extended working day / week and 24 hour basis where required with effect from 1st February 2011.

The introduction on 1st November 2010 of a targeted Voluntary Early Retirement (VER) and Voluntary Redundancy Scheme (VRS) for management administration and support grades, which concluded on 31st December 2010, was a challenging process for all stakeholders. The schemes, which were targeted at achieving a permanent reduction in the numbers employed in the public health sector from 2011 onwards to facilitate public health reform, achieved a reduction of in the region of 2,003 employees. There was significant cooperation from all the relevant stakeholders in addressing the challenges presented in delivering the schemes within the specified timeframes and in addressing the changes required to working arrangements to meet emerging service deficits.

2011 will see significant developments to progress changes to clinical services that will substantially improve patient care from a quality, access and cost perspective. This area is outlined in detail in the report under section 4.14.

1. Laboratory Modernisation

The Public Service Agreement (PSA) recognises and acknowledges the advanced level of engagement of the relevant stakeholders *'to deliver major change to the medical laboratory services and associated work practices.'* (Paragraph 2.9.15 of the PSA refers). The HSE has commenced a process of engagement with the MLSA, IMPACT and SIPTU to implement changes to work practices for service delivery arrangements in preparation for full national implementation of the modernisation of Laboratory medicine. Changes required include inter alia:

1.1 The requirement to review opening hours / service provision with the emphasis on a 24 hour service over 7 days liability to address regular work overspill on the same payment structure as nurses where required or an extended working basis (8am to 8pm);
1.2 The introduction of revised rosters to ensure optimal and flexible rostering to meet service requirements;
1.3 The provision of cross cover for specialised areas (e.g. malaria testing) across clinical sites;
1.4 Improved skill mix ratios with particular reference to pre-analytical work.

The initial focus is on the requirement for extended working day/week working and changes required to the existing emergency call system. Following the intervention of the Health Sector Implementation Body to address specific process issues, discussions under paragraph 1.23 and 1.24 of the PSA, commenced in December 2010 under the auspices of the LRC, are scheduled to conclude on 14 January 2011. The LRC proposal provides that any outstanding issues from this process will be addressed by urgent hearing of the Labour Court. Revised working arrangements are scheduled to commence in Q1 of 2011 (1 February 2011).

2. Revised nursing rostering arrangements (paragraph 2.9.14 of the PSA refers).

2.1 An evaluation of existing e-rostering systems in Ireland has been completed and a guidance document to support the implementation and introduction of e-rostering in the HSE has been developed.
2.2 A software specification criteria, specific to the needs of the identified pilot site in Donegal has been developed and is due for sign off when the Group meet on 20th January 2011.
2.3 The interface with business and human resource solutions (PPARs) is a requirement within the specification, which may result in changes in practices, which require consideration in the context of the Donegal pilot site.

2.4 The pilot will facilitate development of an automated rostering system to ensure staff rostering is aligned to service acuity and demand to achieve the optimal match between staff levels, service activity levels and patient dependency level across the working day/week/year.

2.5 It will also provide evidence to support the previous indications about the potential savings accruing from more flexible rostering practices.

2.6 At a minimum it is expected to realise savings incurred by the use of manual rostering practices.

3. Radiology Services

3.1 The requirement to align diagnostic services with service and access requirements is currently under internal review. This review is being driven out by the National Director of the Radiology Programme under the Quality and Clinical Care Directorate.

3.2 In advance a first phase engagement will take place with SIPTU nationally in the context of the introduction of extended day working day provisions (Monday / Friday, 8am – 8pm) where currently this is required (paragraph 2.9.12). Discussions will commence in the first quarter 2011.

3.3 The requirement to ensure radiology diagnostics are aligned to meet the requirements of the Acute Medicine Programme, to allow rapid access to CT, Ultrasound and MRI on a 24 hour 7 day a week basis, are a priority for the health services.

3.4 The requirements will focus on the ability to increase output with no additional cost by extending the working day and increasing efficiency within the existing working day. This will need to be achieved by the introduction of more efficient work practices, more efficient scheduling and reporting of radiology diagnostics, reviewing the ratio of staff required and same day diagnosis reporting for acute medicine.

4. Actions for Immediate Implementation

Under the Health Sector Agreement (Chapter 2) of the PSA, there is a list of 11 items which both union and management have agreed will be implemented 'with immediate effect'.

Required actions for implementation of these items includes those listed below. It should be noted, that many of these actions will cut across several of the 11 'immediate action' items, and may not typically sit under one action. For example, developing Community Nursing Units in a primary care setting will require redeployment of staff but it is also a further development of integrated care and is also aimed at improving the delivery of elderly services.

These items will involve communication with staff and appropriate consultation with unions.

4.1 Staff Levels: The HSE is reviewing its clerical/administration staffing levels in the context of the requirement to deliver more cost effective services with lower staffing ratios. The review is exploring the current management administration structures to ensure that the existing layers of management match the requirement that decision making is appropriately placed in the organisation. The review will be considered in light of the numbers of staff exiting the health service under the targeted voluntary exit schemes (Voluntary Early Retirement and Voluntary Redundancy) from 1 January 2011. It is anticipated that consultation will commence by the end of Q1, 2011.

Management will also be reviewing existing nurse staffing levels with a view to securing reductions and greater flexibility (e.g. temporary redeployment of nurses from one ward to another). Changes in this regard will respect the provisions in the Agreement about safety/quality.

4.2 Redeployment: Redeployment of staff remains a key area where we should see immediate results. There is already a specific Health Sector Redeployment Protocol contained in the Agreement, and the parties have reached agreement on a panel of Adjudicators for the Appeals process.

The HSE is proposing the following reconfiguration of services / reallocation of resources in the following areas:

4.2.1 Relocation of Orthopaedic Services from St. Mary's Orthopaedic Hospital to South Infirmary Victoria University Hospital:

- Orthopaedic services including elective in-patient, rehabilitation, trauma and day surgery are being relocated from St. Mary's Orthopaedic Hospital to the South Infirmary Victoria University Hospital.
- The transfer of service involves the relocation and redeployment of approximately 220 staff of all grades, the workforce plan to facilitate the relocation has been finalised and management have commenced engagement with the trade unions in December 2010.

4.2.2 North East: Louth Meath Hospital Group reconfiguration programme. Patient safety and quality issues identified as a result of changes by the relevant colleges in the designation of NCHD training posts and Medical Council regulations necessitated stringent service reconfiguration of services which have now all be implemented including inter alia:

- The opening of a new Emergency Department in Our Lady of Lourdes Hospital.
- Conversion of Emergency Services in Louth County Hospital to a Minor Injury Unit.
- Closure of 20 medical beds to facilitate the release of staff for to a Medical Assessment Unit.
- Closure of two medical wards in Louth County Hospital.
- Expansion of short stay service, transfer of acute medical services from Louth County Hospital to Our Lady of Lourdes hospital.
- Ongoing discussion with staff and unions to transfer staff to OLOL e.g. Support services, radiography, clerical admin and nursing.
- Cavan / Monaghan Hospital Group – Work is ongoing to consolidate the reconfiguration of the Cavan Monaghan Hospital Group in line with the recommendations of teamwork including:
  - Centralisation of critical care services in Cavan;
  - Centralisation of emergency services in Cavan with the development of a Minor Injury Unit in Monaghan;
  - Transfer of acute medical services to Cavan;
  - Development of enhanced ambulance services including rapid response advanced paramedic services;
  - Development of medical assessment unit in Cavan;
  - Development of 26 rehabilitation / step down beds at Monaghan and additional packages of care at community level.
- St. Josephs Community Nursing Unit, North County Dublin, (100 Beds) has opened in last quarter 2010.

4.2.3 Cavan / Monaghan: Home Support Review – redeploy existing co-ordinators to one per network, realign clerical admin to networks

4.2.4 Cavan / Monaghan: amalgamation of mental health long stay units – staff reassigned form two wards into one

4.2.5 North West Dublin: redeployment of clerical administration staff based in health centres to 12 Primary Care Teams as admin support member of PCT – consultation complete and training in progress.

4.2.6 North West Dublin: Haven House – with the reconfiguration of Homeless Services and the handover to Dublin City Council of Haven House, staff in the hostel will be redeployed. Consultation with union and staff in progress.

4.2.7 Beaumont Hospital: realignment of services between Beaumont Hospital and the North East Region including associated redeployments

4.2.8 HSE West: active engagement to review potential to consider redeployment from corporate services e.g. Merlin Park, Catherine Street to front line service priority posts.

4.3 National Children's Hospital

The new National Children's Hospital will be established on a site provided by the Mater Hospital and will operate as a single hospital. The three existing children's hospitals in Dublin will work together now to agree on a single governance arrangement as soon as possible. This approach will facilitate a smooth transition to the new facility, and will help promote a high quality service for patients.

4.4 Community Nursing Units

In general, there needs to be greater skill-mix in community nursing units. This is one of the actions required in order to reduce the cost differential in unit cost, compared with private nursing homes. Within the HSE the following developments in community nursing units are progressing.

4.4.1 HSE South: Development of the integrated model of care for services for older people across hospital and community services.

- The model of care continues to be progressed in Cork and Kerry linking this work with the development of Primary Care Teams and the opening of new community nursing units in the following locations – St. Mary's Cork, An Daingean, Dingle, Tralee, Kerry, Ballincollig, Farranlea Road Cork.
- Review the mechanisms to provide the Community Nurse Unit model of care.
- Closure of Heatherside Hospital and redeployment of staff to other locations in North Cork & Cork city i.e. CNU in St. Mary's – discussions with the relevant stakeholders are presently underway with a targeted closure in 1st Quarter 2011.

4.4.2 HSE West:

- Two new community intervention teams have been established in Clare and North Tipperary.
- The established CIT in Limerick has been enhanced to provide an expanded service over a larger geographical area. The CIT will provide a 7-day service from 8am until midnight to patients in both urban and rural locations and will work closely with acute hospitals, GPs and Primary Care Teams in the region.
- In tandem a new service for providing 'community response beds' have been established in a number of community nursing units in Clare and North Tipperary, others are in development in Limerick. The purpose is to facilitate direct admission by GPs of patients who require 24 hour nursing care but not acute clinical care, for a defined period, who otherwise would be admitted to an Acute Hospital bed. This service is under continued review and continues to be developed in areas where required.

4.4.3 Louth: Opening of St. Josephs CNU 100 bed – transfer Beaumont Staff from Rockfield and main hospital

The development of these community response beds would need to take account of the Nursing Homes Support Scheme Act 2009 and be developed in conjunction with the lead HSE officials on Fair Deal.

4.5 Ambulance Services

<u>National Control Reconfiguration</u>

4.5.1 The requirement to ensure that patient safety and efficiency issues are addressed as a priority. This includes the reduction in the number of ambulance control centres to ensure safe and effective deployment of emergency resources.

4.5.2 The National Ambulance Service currently operates from 98 stations located throughout the country and is controlled from 10 Command and Control Centre locations.

4.5.3 The HSE has concluded, in conjunction with HIQA and the Department of Health and Children, that the optimal configuration of Ambulance Control Centres is two. This should include a single ambulance control centre in Dublin. (This is a cross-sectoral issue involving staff employed by Dublin Fire Brigade).

4.5.4 This configuration needs to be supported by the introduction of modern technologies, including the Advanced Medical Priority Dispatch System (AMPDS). This is a medically approved, unified system used to dispatch appropriate aid to medical emergencies.

4.5.5 Co-operation with the full implementation and use of this system is critical to the management of emergency calls and deployment of appropriate resources to patients in emergency situations. The benefits to patient safety and improved patient outcomes are clearly defined and have already being achieved in other jurisdictions.

4.5.6 Discussions are to be scheduled to commence implementation in the first quarter 2011 with full implementation by the last quarter 2011.

Advanced Paramedic Deployment

4.5.7 Implementation of effective rostering arrangements to ensure that Advanced Paramedics are effectively deployed in line AMPDS criteria.

4.5.8 Co-operation with changes to rosters which ensure effective deployment of resources and ensures that every paramedic works on a rotational basis with an Advanced Paramedic or to accommodate an alternative deployment option by either the Paramedic or Advanced Paramedic.

Clinical Governance

4.5.9 Co-operation with the introduction of Clinical Audit, Data collation and submission by individual practitioners, clinical supervision by existing supervisory grades and participation in reflective practice, incident review and case study sessions during down time at stations.

Elimination of restrictive work practices

4.5.10 Co-operation with the elimination of restrictive practices to include the provision of locum cover for sick leave, call rotation, long distance journeys, overnight stops and any other practice that inhibits the maximum efficiency from available workforce.

4.5.11 Implementation of changes required to ensure full utilisation of existing relief factor and review of relief factor where required.

Response Times

4.5.12 Implementation of new work practices to achieve significant improvements in response time's performance as required by HIQA Response Time Standards including technological driven activation (to include inter alia, alerting, mobile data, automatic vehicle location and satellite navigation), 45-second targets for allocation and mobilisation, tactical deployment including dynamic deployment to non HSE locations.

Alternative Models of Service Delivery

4.5.13 Co-operation with the introduction of new services such as Intermediate Care Services. Cooperation with alternative models within the National Communications Centres to support alternative models of care including referral to other health services, activation and support of other services and integration of new functions including bed bureau management, GP out of hours call handling, social alarm monitoring etc.

ICT

4.5.14 Co-operation with the introduction and operation of ICT systems to include Fleet Management System, Workforce Planning System, electronic patient care reporting, clinical audit software, roster management system etc. designed to achieve improvements against HIQA response times performance.

Reorganisation of on-call working

4.5.15 Review of existing work practice and rostering arrangements to eliminate inefficiencies and reduce the out of hours working requirements. Co-operation with roster changes to eliminate any health and safety issues.

Acute Hospital Reconfiguration

4.5.16 Co-operation with implementation of acute hospital reconfiguration programmes including changes to destination and retrieval hospitals and adoption of new work practices designed to ensure patient safety is foremost.

Centralisaton of Support Functions/NAS Management Restructuring

4.5.17 Co-operation with the reconfiguration of NAS management structures.

4.5.18 Co-operation with the centralisation of business support functions for ambulance services.

4.6 Mental Health Services

4.6.1 Work towards the implementation of Community Mental Health Units across all disciplines as provided for in *A Vision for Change* to include:

- Reduction in acute beds;
- Realignment to extended catchment areas (or Integrated Service Areas – ISAs);
- Cooperation with the new management structures for mental health (as described in Vision for Change);
- Full Participation in assisted admissions;
- Second opinion for medical staff;
- Authorised officers – designated in the system;
- Move towards the provision of medium and low support in the community – social housing provided by local authorities and supported by appropriate health staff;
- Community Mental Health and Home Care Teams;
- Re-visit and re-balance the available resources nationally;
- Enhance child and adolescent mental health services;
- Cooperate with new technologies and service efficiency measures associated with access and referrals;
- Relocate to new facilities and premises including community mental health centres, new acute units, ICRUs, national forensic facilities (Dundrum etc);
- Full Garda clearance for all staff – including serving staff;
- Collaboration in recovery orientated training and linking services to safety;
- Full provision of data on community mental services, including the provision of updates and reports against agreed targets set for vision for change progress (online tool for independent monitoring group).

4.6.2 The planned new Child and Adolescent mental health service in Merlin Park Galway is opening on Friday, 14th January 2011. A second unit in Cork is due to be opened by the end of January 2011. The units are staffed by new and re-deployed personnel – approximately 60 staff X two units.

4.6.3 Acute Units are also in development in Letterkenny, Beaumont, Galway and Cork and these will be staffed by redeployed personnel.

4.6.4 The adapted community nursing unit has opened in Ballinsloe and further units are progressing in Mullingar, Cherry Orchard, Wexford and Clonmel and are scheduled to go live in 2011. The purpose is to move long stay patients from existing residential services facilitating the closure and sale of the traditional psychiatric hospital buildings.

4.6.5 North West Dublin –St. Brendan's acute mental health has transferred to Pine Unit at Connolly Hospital and is fully functional since September 2010.

4.6.6 South Tipperary – reconfigure acute in patient beds as part of the overall development of the Carlow / Kilkenny / South Tipperary extended catchment area for mental health services. This involves:

- The provision of a 40 bed residential unit on the existing site to accommodate current residents of St. Luke's.
- High support hostel, Clonmel.
- Day Hospital / CMHT HQ Clonmel.

- Crisis House, South Tipperary.
- Provision of 2 community residences to accommodate remaining ID residents.

4.6.7 The changes will require significant flexibility from staff in relation to work practices, redeployment and revised rosters etc.

4.6.8 Wexford: Acute admissions to St. Senan's in Wexford will cease in January 2011 and admissions from Wexford will be received in Newcastle, Co. Wicklow and the Department of Psychiatry Waterford Regional Hospital.

4.6.9 Waterford / Wexford: Reconfiguration to extended catchment area for mental health for Waterford and Wexford.

4.6.10 Carlow / Kilkenny: reconfiguration St. Dympna's Hospital and St. Canice's Hospital. This involved the closure of 42 beds with the relocation of all residents to appropriate community facilities.

4.6.11 As part of this process 11.5 WTEs were reassigned (9.5 staff were re-assigned to community developmental posts and 2 HSC post to rehabilitation / community teams)

4.6.12 North Dublin: St. Ita's Portrane – older persons services transferring on an interim basis to Vincent's Fairview and inpatient admissions will be facilitated in new premises on the same campus.

[Note – the PNA have not yet confirmed their position in relation to the PSA. The PNA are not part of the public service committee of the ICTU].

4.7 Child Care Services

4.7.1 Implementation of the recommendations of the PA Consulting Report to support the reconfiguration of childcare services nationally.

4.7.2 Improved information and data collection, including the roll-out in 2011 of standardised business processes across all 32 LHOs and progress in introducing the National Child Care Information System.

4.7.3 Implementation of the recommendations of the Ryan Report as set out in the Government's Implementation Plan and the findings and recommendations of independent investigation reviews and inspection reports.

4.7.4 The development of clearer lines of accountability, quick decision-making and reorganisation of staff resources.

4.7.5 Out-of-hours pilot sites in the South and West fully operational and evaluated; further expansion of services progressed in light of evaluation findings.

4.7.6 Dublin / Mid Leinster: implement extended working day in social work services.

4.7.7 Laois / Offaly: Rosters & Skill mix – explore with staff opportunities for revised rosters that include appropriate skill mix and optimal roster arrangements in Residential Child Care Services.

4.8 Children's Palliative Care

4.8.1 Establish, document and maintain linkages between Palliative Care teams in specialist settings and Local Services (particularly GPs and PHNs) to enable more people to be maintained at home for as long as possible.

4.8.2 Nurses are to be re-designated (total of 8, with one already in place) as Outreach Nurses (2 per HSE region), for Children's Palliative Care. This is linked with the newly appointed Consultant in Paediatrician with Special Interest in Children's Palliative Care. This is in line with the recently approved Government policy to enable such children to be cared for at home to the greatest extent possible.

4.9 Care of the Elderly

4.9.1 Dublin South, South East and Wicklow: the amalgamation across 3 Local Health Offices in the East Coast of Long Stay Units for Older Persons is ongoing and will result in an improved use of staff resource for patient care.

4.9.2 Dublin South East: the reconfiguration of older person's services from Sir Patrick Dun's to Clonskeagh to fit for purpose unit to improve service for patients is ongoing.

4.9.3 Longford West Meath:

- The closure of Loghloe House and transfer of staff to St. Vincent's to provide improved quality of services to clients is now complete.
- The reconfiguration of older person's services in St. Mary's Mullingar and St. Joseph's Longford to improve quality of service to clients is ongoing.

4.9.4 Meath:

- To improve the quality of services to older persons the County Infirmary Navan was closed and staff were temporarily reassigned to Trim (September 2010) pending the opening of new CNU in Navan. The new CNU is scheduled to open in January 2011 subject to HIQA registration.

4.9.5 Residential Care: Redeployment of staff to facilitate opening of new residential units and from units being replaced, e.g. Bru Chaoimhinn to Inchicore where plans are at an advanced stage and subject to HIQA registration.

4.9.6 Home Help / Home Care Packages:

- National Guidelines for the provision of Home Care Packages have been introduced.
- Progress on the introduction of a single assessment tool (Single Care Needs Assessment Tool for Older People) to ensure equal access to and a standard approach to the delivery of home help services is well advanced. Agreement will need to be sought from Clinicians to co-operate with this.
- The procurement process for the home care services to ensure standards of service are met is well advanced.

4.9.7 The redeployment of nurses in elderly and palliative care services is ongoing.

4.9.8 Introduction of alternative skill mix/ratio in public residential care – to max 50% Nursing – v- 50% Care Attendant.

4.9.9 Laois / Offaly: Explore and develop a social elderly day care model in partnership with the voluntary organisations.

4.9.10 Laois / Offaly: Rosters & Skill mix – explore with staff opportunities for revised rosters that include appropriate skill mix and optimal roster arrangements in Older Persons Services.

4.9.11 Kildare / West Wicklow: Jockey Memorial Hospital – reconfigure services under direction of DON Naas Hospital – reconfigure older person's beds to level 11 palliative care beds in line with national policy.

4.10 Disability Services

4.10.1 Move away from residential provision to community based disability services.

4.10.2 Dublin South City / Dublin West: Integrate Assessment of Needs units for both areas (provided for under the Disability Act 2005), to maximise the use of health professional staff.

4.10.3 Meath: the transfer of adult respite facility from Navan to Kells is ongoing.

4.10.4 South / North Lee: reconfigure developmental coordination delay (DCD) unit to EIT. This is nearing completion and will enhance the service to clients with a reduction in waiting lists.

4.11 Dental Services

4.11.1 Implementation of the *Independent Strategic Review of the Delivery and Management of HSE Dental Services*. Consultation will take place with the staff associations in relation to the implementation of this review in January 2011.

4.11.2 The Review focussed on assessing existing arrangements, with a key emphasis on the requirement for integrated service delivery, to consider whether they were fit for in achieving safe and high quality public dental services consistent with statutory obligations.

4.12 Procurement

4.12.1 Work will continue on the implementation of a comprehensive materials management framework across the HSE and associated agencies to enable best possible value for money

in the procurement and appropriate use of all materials supplies and services eliminating as far as is possible any waste.

4.13 Multi-Disciplinary Working and reporting arrangements (no.4), initiatives to reduce non-pay expenditure (no. 5): The HSE is proposing multi-disciplinary team working, cross community and acute services in the following area:

4.13.1 The development of multi-disciplinary Primary Care Teams facilitates the provision of care as close as possible to people's homes and the integration of primary, secondary and tertiary care services.

4.13.2 The HSE has targeted the delivery of 530 local teams to be in operation by the end of 2011. The HSE is currently defining the organisational changes required to enable it to deliver hospital and community services in an integrated manner.

4.13.3 The overall aim is to enhance integration and to remove the need for people to navigate between unconnected services. The changes will result in a less hospital-oriented system with the requirement to reallocate hospital resources to expanding community-based services.

4.13.4 A multidisciplinary PCT provides health and personal social services to a local population of approximately 7,000 – 10,000. The PCT will liaise and collaborate with other community based professionals such as mental health, specialist child protection and disability services and with acute hospital services in order to:

- deliver a seamless service for patients,
- reduce hospital admissions,
- facilitate early discharge, and,
- strengthen the delivery of chronic disease management programmes.

4.13.5 Health and social care professionals will work collaboratively in a multidisciplinary environment to address the totality of the patient / client needs. Agreement will need to be reached on the required multidisciplinary model of work. However, these negotiations should not delay the rolling out of the PCTs.

4.13.6 The HSE has finalised a document to address the governance issues associated with cross disciplinary working so that clear lines of responsibility and accountability are in place to support organisation and management arrangements for PCTs. There has being ongoing consultation with stakeholders in the examination of the requirements. Discussions will commence with the staff associations on formal proposal for the delivery of PCT structures.

4.13.7 Dublin South, South East, and Wicklow: Dental Services – the review of current provision and the requirement to merge service across 3 local health areas to improve use of staff resource for patient care is ongoing.

4.13.8 Kildare West / Wicklow: merge into one single Allied Health Professional team across Naas Hospital, Kildare Mental Health Service and Kildare West Wicklow Community Services (e.g. Occupational Health, Speech & Language, Social Work etc) to maximise the use of health professional staff – ongoing.

4.13.9 Kildare / West Wicklow: merge into one single administrative team across Naas Hospital, Kildare Mental Health Service and Kildare West Wicklow Community Service to maximise the use of clerical administrative staffing.

4.13.10 Cavan / Monaghan: Primary Care Team Development – development of clerical staff to PCTs (0.5wte per team initially). Targeting development of 5 teams in 2011.

4.13.11 North West Dublin: Primary Care Team Development – deployment of clerical staff to support 12 PCTs for development in 2011.

4.13.12 Louth: commencing discussions with acute hospital re integrated care planning for diabetics across hospital and community

4.14 Better management of risk, safety and quality (no. 7): Adherence to systems, care pathways, disease programme, protocols etc, will underpin the proposals set out above.

4.14.1 Clinical Strategy and Programmes:

The focus of this area is on the provision of a framework for the delivery of clinical services that substantially improve patient care from quality, access and cost perspectives.

- If patients receive the right treatment lives and resources can be saved.
- 80% of healthcare spend is on 6 chronic diseases (with 80% of this on patients with more than 3 chronic diseases). 80% of deaths are associated with these illnesses.
- Chronic disease management needs to be delivered in a structured manner in order to ensure the right treatment at the right point of care is delivered. This would save between 25% and 40% of healthcare spend and provide sustainable healthcare improvements that are clinically led.
- This will be achieved through the implementation of clinically led chronic disease management programmes.

The programmes are recommending four generic hospital models with clear delineation of hospital services based on safe provision of patient care. The level of service that can be safely provided in any hospital will determine which model applies.

Clinical Care Programmes targeted for 2011

Acute Medicine

- Acute Medical Programme: the management of acute medical patients in dedicated acute medical units with a focus on:
  - Timely care from a senior medical doctor.
  - Continuous consultant presence.
  - Same day diagnostics.
  - Expedite discharges with integrated discharge planning 7 days per week.
  - Rapid access to OPD.
  - Access to community intervention and home/nursing home IV therapy services.
  - Elderly outreach, triage and rapid rehabilitation.

Emergency Medicine

- The overall aim of the Emergency Medicine Programme is to improve safety and quality of patient care and reduce waiting times. This will be achieved through the use of emergency care networks in a new national emergency care system and the development of clinical guidelines for the top 20 emergency conditions (e.g. pain management, abdominal emergencies, head injuries etc).

  The benefits of the Emergency Services programme include:
  - Standardised care in every Emergency Department.
  - Guidelines for top 20 conditions.
  - Reduced numbers of patients on trolleys in Emergency Departments.

Critical Care Programme

- The critical care programme comprises of a regional / supra-regional operational framework containing innovative patient –centred elements to improve the outcome / survival of critically ill patients.

  The benefits of the Critical Care programme include:
  - Benchmark quality of care in each unit.
  - Measure activity in ICU to enable planning of service.
  - Provide data on complexity of care for each patient.
  - Provide data to facilitate appropriate allocation of resources based on demand.

- Provide data on cost efficiency by linking cost per bed day to complexity of care.
- Enable reconfiguration decisions based on activity level data.

Elective Surgery Programme

- The overall aim of the Elective Surgery Medicine Programme is to improve access, safety and quality of patient care.

  The benefits of the Elective Surgery programme include:
  - The audit programme will reduce death rates in surgical patients from adverse events by 10% over 10 years.
  - Further improvements in clinical outcomes due to reduction in surgical complications and mortality will be derived from the Productive Theatre programme.
  - Reduced average length of stay for selected procedures will save bed days.
  - Decreased unit cost of surgical procedures by improving theatre utilisation from estimated 50% to 90%.

Outpatient Programmes

(Improved access to outpatients through better process management, standardised guidelines and balancing demand with supply):

- Epilepsy: establishment Epilepsy Regional Centres, providing rapid access seizure clinics to all patients presenting with seizure to ensure optimal clinical management, reduction in admissions and bed days and enhanced community provision. Implementation of this programme will save 50 lives per year over the term of the programme and increase the prevalence of patients who are seizure free by 2000.
- Dermatology: increase of 30% in new dermatology outpatient attendances over 12 months Jan-Dec 2011. The benefits of the Dermatology programme include:
  - Timely intervention will lead to a reduction in patients requiring surgery. Reduced waiting lists will reduce DNA's and result in less OPD processing.
- Rheumatology: The benefits of the Rheumatology programme include:
  - Early intervention limits disease severity and hinders progression. Patients can self-manage when disease diagnosed at early stage.
  - Timely intervention will lead to a reduction in patients requiring high cost medication. Reduced waiting lists will reduce DNA's and result in less OPD processing.
- Neurology: increase of 30% in new neurology outpatient attendances over 12 months Jan-Dec 2011.
- Rheumatology & Orthopaedic: establishment of musculo-skeletal physiotherapy led clinics reduce the waiting list in Orthopaedics and Rheumatology.

Chronic Disease Programmes - The integration of chronic disease management between primary and secondary care is required to reduce admissions/ length of stay and improve patient outcomes:

- Stroke: Development of regional stroke units and local stroke teams (hospital and community) with effective evidence based protocols and pathways. Programme implementation will provide rapid access for patients with TIA nationally, prevent admissions, shorten length of stay and prevent strokes. Average length of say should be reduced by 2 days over 3 years and admissions of patients with stroke to nursing homes reduced by 1.5% nationally.
- Acute Coronary Syndrome: The overall aim is to implement a targeted programme to prevent Coronary Heart Disease. Programme implementation will prevent a 100 cardiac deaths and 24 strokes based on achieving 3.5% mortality for 80% of patients with STEMI who will receive primary PCI.

- Heart Failure: Heart failure affects 2% of the population (90,000) and is one of the commonest reasons for hospital admission. (19,000 admissions in 2009, 90% of which were emergency) Patients with heart failure have a 50% 5 year survival with an average admission rate of 20% per year. Quality and cost effectiveness of care for heart failure patients can be improved

through structured heart failure programmes in hospitals and primary care. The benefits include the prevention of some 1000 heart failure admissions per year which should result of a reduction in average length of stay for primary heart failure by 2 days over 3 years. Reduction in 3 month re-admission rate from 30% to 20% by year 3 with a consequential bed saving.

- Diabetes (Footcare): A national foot care programme for people with diabetes will be established. It is anticipated that the programme will prevent 519 foot ulcers and 135 lower limb amputations per year by 3 equating to a 40% reduction in amputations and foot ulcers with a resulting saving in bed stay.
- Retinopathy Care Programme: Diabetic Retinopathy is the leading cause of blindness and serious visual impairment in Ireland. 90% of people with diabetes will develop retinopathy, 10% will be sight threatening if undetected and not treated. The service will be provided in conjunction with the National Cancer Screening Service.
- COPD: is the most prevalent respiratory disease in Ireland (110,000 patients diagnosed, 300,000 potentially undiagnosed) It is one of the most commonest reasons for hospital admission – 13,000 admissions with the primary diagnosis of COPD, majority are emergency admissions. The national average length of stay is 9.2 days. Primary focus in 2011 is to improve the care of patients admitted to hospital, to define a primary care intervention and to establish COPD outreach programmes.
- Asthma: is the most common chronic disease in the Republic of Ireland and affects people of all ages, from all socio-economic groups and all geographic regions; it is the most common chronic disease in childhood and it is the most common respiratory disease. The programme objective is to reduce asthma deaths in the Republic of Ireland by 100 lives over 5 years and 500 lives over 10 years by establishing a national network for guideline-based asthma care.

<u>Acute Medical Programme</u> – one of the first areas where the AMP is being rolled out is in the HSE West.

4.14.2 The development of a medical model for the Mid West hospital group is progressing in conjunction with the establishment of a regional department of medicine with representation from the MWRH Limerick and the local hospitals. This process should conclude by Q1, 2011.

4.14.3 The model is being informed by recommendations from Teamwork and the HIQA report on Ennis in addition to discussion documents prepared by physicians in the mid west, which are consistent with the national medical programme.

4.14.4 The role and use of Acute Medical Assessment unions in all hospitals and the structure of the on-call rota involving all medical consultants throughout the region will form part of the new medical model for the region.

4.14.5 In addition a single on call structure for the region is currently being developed in line with the time above e.g. Q1, 2011.

4.14.6 Health and social care professional will work collaboratively in a multidisciplinary environment to address the totality of the patient/ client needs. Agreement will need to be reached on the required multidisciplinary model of work.

4.14.7 South: The introduction of the QCC programmes of care, such as the Acute Medicine Programme and the COPD Programme, will require changes in work assignments and work practices for staff. For example the COPD programme proposes implementation of the programme through the reassignment of existing staff (nursing and paramedical) to new duties and the refocusing of work practices and priorities. Flexibility is critical as the introduction of the programmes will need to be achieved and sustained within the current or reduced levels of resources.

4.14.8 South: CUH – the transfer of cardiac renal services to CUH is ongoing. Renal services transferred in July 2010 and the cardiac services are transferring, due for completion early 2011.

4.14.9 North West Dublin: Physiotherapy Manager in St. Mary's now cross hospital and community based physiotherapy services.

4.14.10 Emergency Department Overcrowding: Implementation of the agreed framework "Whole health system approach to improving patient throughput / flow and Emergency Department performance, including adoption of the admission, discharge and system-wide escalation framework and procedures.

Patient Flow

4.14.11 The process of managing patient flow has been identified as a key performance target for the ongoing reconfiguration of services. Region wide bed management is required to ensure a seamless and appropriate service to the patients that are delivered in the correct location.

4.14.12 The Mid Western Regional Hospital pilot site for testing aspects of the Code of Practice on Integrated Discharge Planning is ongoing. The expected outcomes include a positive impact on patient waiting times in Emergency Department.

4.14.13 Work has commenced on the examination of processes through Lean facilitators to identify in-efficiencies and improve quality of the patient journey.

4.15 Centralisation of function, transactional, support and other services (paragraph 2.9.11):

Centralisation of Services

4.15.1 Medical Cards: full centralisation of medical card services to PCRS, Finglas scheduled for implementation by first quarter, 2011.

4.15.2 The Supplementary Allowance Scheme and associated resources, including staff (the Community Welfare Service of the HSE) has been transferred to the Department of Social Protection with effect from 1st January 2011.

4.15.3 Fair Deal:

- Reorganisation of services from 18 NHSO's to 4 Regional and 1 Central Office is a priority for the HSE in 2011.
- The new IT system scheduled for the Nursing Home Support Scheme has been introduced with the full cooperation of staff in the last quarter 2010.

HR Shared Services

4.15.4 Over the last few years, major work has been completed on the development to HR Shared Services. This approach has seen the development of three key services:

- National Recruitment Services (NRS) (located in Manorhamilton).
- National Pensions Management (NPS) (located in Manorhamilton) and,
- National Personnel Administration (NPA) (located in Dublin).

4.15.5 The NRS is the furthest along its project plan, with the consolidation and management of all recruitment. This project will be fully completed by 2011 with the transfer of all recruitment activity for NCHD's (currently planned for completion by end Q2, 2011.

4.15.6 The other two services will utilise the PSA by redeploying staff currently undertaking work in former health boards to the services and, in turn, have staff redeployed to Manorhamilton. [for example, it is envisaged that staff currently undertaking finance work in Manorhamilton will transfer to NRS and NPM in the near future, with staff undertaking Recruitment work in Dublin transferring to Finance Shared Services. There are detailed plans including timelines and resourcing models in place for each of the above].

4.15.7 Dublin South City / Dublin West: integrate HR functions for both areas.

Finance Shared Services

4.15.8 The main focus in 2011 is the implementation of the Torpey report recommendations.

4.15.9 In particular the re-alignment of all processing staff into the Shared Services structure, the main focus will be payroll and accounts payable. This will allow finance focus on national standardisation in accounts payable and when finalised, implement the national payroll strategy.

4.15.10 Another key priority for 2011 is in the area of income collection and a number of initiatives are already underway in this area. The recent HSE exit schemes, and the priority to meet

front-line service requirements will impact on resources and the speed of implementation. However, all of these finance initiatives and objectives are in line with the redeployment and transition arrangements agreed under the Public Services Agreement.

4.15.11 Dublin South City / Dublin West: integrate Finance functions for both areas.

SupportStat

4.15.12 On 1st November 2010 a Contract Notice was dispatched to the Official Journal of the European Union announcing the commencement of a procurement process for the delivery of a system of measuring the performance of facilities management services, called SupportStat.

4.15.13 A total of 11 tenders have been received.

4.15.14 The evaluation of these tenders is ongoing and it is expected that a Preferred Bidder will be selected in early Feb 2011 with a contract awarded end Feb 2011.

4.15.15 The HSE requires the full implementation of SupportStat by the successful Bidder to be completed within twelve (12) weeks from the date on which the contract is awarded. Accordingly it is expected that SupportStat will be fully implemented early June 2011.

The implementation of reform is a dynamic process and will require input on an ongoing basis as new/additional service imperatives require. As such it is expected that the Action Plan for change for the Health Sector will grow and change over time.

Finally management engaged with the staff side at the Health Sector Implementation Body (HSIB) on the proposed revisions to the Health Sector Action plan and have taken on board comments presented in that forum and the Chair of the HSIB has advised that is his understanding that there are no major issues anticipated with managements revised action plan for the Health Sector.

Yours sincerely,

Séan McGrath,
National Director of Human Resources.