Departmental Brief for Minister - May 2016

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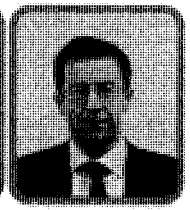
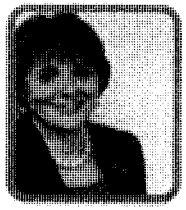
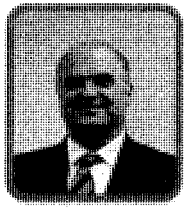
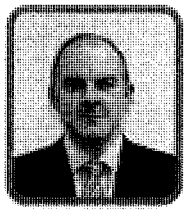
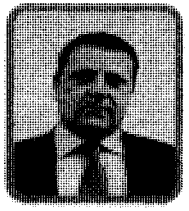
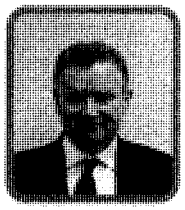
Department of Health
Secretary General Jim Breslin

Assistant Secretary Tracey Conroy	Assistant Secretary Fergal Goodman	Assistant Secretary Frances Spillane	Chief Nursing Officer Dr Siobhan O'Halloran	Chief Medical Officer Dr Tony Holohan	Assistant Secretary Teresa Cody	Deputy Secretary Colm O'Reardon	Assistant Secretary Muiris O'Connor	Assistant Secretary Greg Dempsey	Deputy Secretary Pat O'Mahony
									
Acute Care Policy on Scheduled/ Unscheduled Care, Acute Hospitals Performance Oversight & North South Co-Operation, Policy on Hospital Groups & New Children's Hospital, Maternity & National Ambulance Service Policy Cancer, Blood & Organs Policy	**Primary Care** Eligibility Unit, Medicines, Pharmacy & Controlled Drugs, Primary Care General Practice & Eligibility, Primary Care Pharmacy, Chief Dental Officer	**Social Care & Disabilities** Disability Unit, Residential Care Services for Older People, Community Care Supports for Older Long Stay Charges Unit	**Nursing/ Midwifery, Mental Health, Drugs & Social Inclusion** Mental Health Unit, Drugs Policy & Social Inclusion, Nursing & Midwifery Policy	**Office of the Chief Medical Officer** Bioethics, DCMO, Food & Environmental Health Unit, Health & Wellbeing, Health Promotion, Health Protection, Patient Safety & Quality, Clinical Effectiveness, Child Health Specialist, Tobacco & Alcohol Control	**National HR** HR & Corporate Services Unit National HR Unit Professional Regulation Unit Working Better Together	**Policy & Strategy** Private Health Insurance Health Strategy, Policy & Integration Unit, Legal Unit Universal Health Insurance, Health Systems & Structures Mother & Baby Homes Inquiry Unit, Corporate Legislation Unit	**Research & Development, Health Analytics** EU/International & Research Policy Unit Research ServicesUnit Information/ eHealthPolicy/ External ICT Statistics & Analytics Service	**Finance & Evaluation** Finance Capital, Finance Accounting, System Financing & Value	**Governance & Performance** DoH/Agency Governance & Clinical Indemnity, FOI, Media & Communications, Parliamentary Affairs, ICT Internal, Records Management, Programme Management Office, Internal Audit, Health Service Performance Management

The Department of Health - Aim

1. Our overall aim is to improve the health and wellbeing of people in Ireland by:
   - keeping people healthy;
   - providing the healthcare people need;
   - delivering high quality services; and
   - getting best value from health system resources.

2. The core aim of health policy must be to improve the health and wellbeing of people in Ireland. It encompasses increasing healthy behaviours, focussing on prevention and early detection, reducing health inequalities and improving the health status of vulnerable groups and providing children with a healthy start to life, helping older people, those with disabilities and those affected by mental illness to live as independently as possible.

3. While we seek to address health and wellbeing, we must also ensure that people can access the healthcare they need when they need it and where they need it. This encompasses improving access to emergency care, shorter waiting times, delivering services as close to home as possible and enabling prompt and fair access to those services.

4. The services delivered must be of the highest quality to ensure patient safety. Care must be delivered in the right setting with high quality clinical treatment delivered consistently and on an integrated basis.

5. Finally, and particularly given the financial constraints we must deal with, we must get best value from our resources through strong corporate and clinical governance, sound resource and financial management, skilled and motivated staff working in a nurturing and sustainable environment. We need to ensure that policy and practice are informed by appropriate health research and evidence.

6. We have a range of actions that we plan to pursue to achieve our aim (as set out in the Department's Statement of Strategy 2015-2017). They are these organised into priority areas, set out below. It's important to note that to one extent or another all of these actions are interrelated and interdependent.

   - Drive the Healthy Ireland agenda
   - Deliver improved patient outcomes
   - Reform operational systems to drive better outcomes
   - Implement agreed steps towards universal healthcare
   - Introduce innovative funding models
   - Modernise health facilities and ICT infrastructure

7. We must measure our progress so we know if we have succeeded. Some actions are self-explanatory in terms of progress, like building primary care centres, but others require different types of measures, like gathering and analysing patients' experiences of services provided or measuring patient health outcomes. Performance measures are set out in the Action Plan in the Statement of Strategy.

8. As a separate priority area (Develop the Department's workforce and capability), we've set out how we plan to develop our own workforce and our own capability. We want to

become an employer of choice. We want to empower our own staff to be the best that they can be, for themselves, and in order to enhance our ability to lead the health services in the short, medium and longer-terms.

The Department of Health – Role and Main Functions

9. Our distinct role is fourfold. We provide leadership and policy direction for the health sector to improve health outcomes. We deliver governance and performance oversight to ensure accountable and high quality services. We collaborate to achieve health priorities and contribute to wider social and economic goals. The last aspect of our role is internally focussed and is an enabler of our overall performance. As a Department, we want to be an organisation where, on an ongoing basis, high performance is achieved and the knowledge and skills of staff are developed.

10. We serve the public and support the Minister for Health, Minister for State and the Government by providing:

Leadership and policy direction for the health sector to improve health outcomes

- lead in the analysis, development, communication and review of policy and legislation
- represent Ireland and the health system at international level and ensure international evidence influences the development and implementation of Irish health policy
- promote evidence-based policy making, innovation and the public interest
- lead national planning frameworks for the whole health sector, public and private
- promote the highest levels of patient safety through systems of indemnity, licensing, clinical effectiveness and competence assurance
- fully leverage the knowledge, skills and support of the entire health system in developing agreed objectives
- develop communication strategies to represent the value of health policies, services and outcomes
- promote and monitor system progress in achieving health and social outcomes

Governance and performance oversight to ensure accountable and high quality services

- lead in the design and architecture of the whole health sector
- set and communicate priorities and performance standards
- lead the negotiation of resources and ensure they are allocated in furtherance of value for money obligations associated with public funds
- implement performance oversight systems and techniques to hold the system to account through goal definition, monitoring, evaluation and impact assessment
- support the Minister, Minister of State and Department officials in fulfilling accountability to the Oireachtas and the public

Collaboration to achieve health priorities and contribute to wider social and economic goals

- collaborate across sectors, departments and stakeholders to promote a healthy Ireland and the achievement of priority health outcomes, particularly for those who are most at risk
- promote the economic contribution of a healthy population and the health service, including research and development activities and partnerships with industry and academia

- contribute to whole-of-Government approaches to major social and economic priorities

An organisational environment where, on an ongoing basis, high performance is achieved and the knowledge and skills of staff are developed

- implement excellent systems of internal communication to promote organisation-wide knowledge of goals, values, strategy and processes and facilitate staff in contributing to organisational innovation and success
- provide support services and a work environment which ensure that all staff are valued to give of their best and provided with opportunities to learn and develop
- ensure performance is assessed and managed effectively at individual, team and corporate level
- gain recognition for our commitment to a supportive, high performance work environment amongst our staff and across the civil service and within the health sector
- support staff in accessing better evidence and the views of citizens

11. It is acknowledged that, in supporting the Minister and the Government, a very significant part of the Department's day-to-day activities involve the preparation of information for the Oireachtas. These activities cut across all dimensions of the role of the Department outlined above, particularly so in relation to that of governance and performance oversight of services.

12. In 2015, the staff of the Department prepared almost 3,500 replies to parliamentary questions (and another 4,200 were processed for direct reply by the HSE) and 5,300 responses to Ministerial representations. We prepared information for almost 600 topical issues and Seanad adjournments and over 400 briefing notes for Leaders Questions. 234 Freedom of Information (FOI) requests were responded to. Although not spread evenly across the Department's 339 staff, that represents an average of almost 30 such activities per staff member, in addition to their other duties.

The Department of Health - Values

13. In 2014, the Government published the Civil Service Renewal Plan. The success of the Plan depends on the involvement and commitment of Civil Service staff, including the staff of this Department. It will require collective ownership, strong leadership and good programme management. It will also require a commitment to shared values and so we undertake to be guided by the shared values of civil service renewal:

- A deep-rooted public service ethos of independence, integrity, impartiality, equality, fairness and respect
- A culture of accountability, efficiency and value for money
- The highest standards of professionalism, leadership and rigour.

MANAGEMENT BOARD Area: Acute Hospitals & Cancer Policy; Tracey Conroy (Assistant Secretary)

(Units & Principal Officers; Policy on Scheduled & Unscheduled Care, Acute Hospital Performance Oversight & North-South Cooperation– Marita Kinsella, Policy on Hospital Groups & New Children's Hospital – Fionnuala Duffy, Maternity & National Ambulance Service Policy- Joan Regan, Cancer, Blood and Organs Policy- Michael Conroy)

Policy on Scheduled & Unscheduled Care, Acute Hospital Performance, Oversight & North-South Co-Operation

Description of Unit functions

1. Policy on Scheduled & Unscheduled Care, Acute Hospitals Performance Oversight & North South Co-Operation also known as Acute Hospitals Policy Unit 1 carries out the following *functions*:
   - supports development and oversees implementation of Government policy regarding scheduled and unscheduled patient care in acute hospitals;
   - monitors performance and performance improvement of the delivery of acute hospital services by the HSE, including supporting other Units in monitoring EWTD compliance and implementation of activity-based funding;
   - develops and oversees North/South cooperation in acute hospital services;
   - oversees corporate governance arrangements of the NTPF and monitors its performance in data analysis and quality assurance of waiting lists, thereby supporting the HSE in delivering effective waiting list management;
   - supports Policy on Hospital Groups & New Children's Hospital Unit (Acute 2) regarding structural reform regarding hospital group implementation, and has particular responsibility for RCSI and Saolta Hospital Groups.

Unscheduled Care

2. In April 2015, the HSE published the *ED Taskforce Action Plan.* The Plan contains a range of time-defined actions to:
   - optimise existing hospital and community capacity;
   - develop internal capability and process improvement and
   - improve leadership, governance, planning and oversight.

   The HSE, by means of the Special Delivery Unit, has established a process to manage and verify implementation of the recommendations of the Plan across Hospital Groups, hospitals and the wider health system.

3. The *ED Taskforce Implementation Group*, co-chaired by the HSE Director General and the INMO General Secretary meets on a monthly basis to: oversee implementation of the ED Taskforce Action Plan; monitor ED performance; and ensure coordination across Acute Hospitals, Primary and Social Care of measures to address ED overcrowding.

4. Significant *progress* has been made to date on implementing the ED Taskforce Plan:
   - Delayed discharges, a contributing factor to ED overcrowding, have reduced steadily, from 830 in December 2014 to 575 on 26 April 2016. This frees up over 250 beds to be used by acutely ill patients every day.
   - The NHSS continues to perform to the agreed position of not having a waiting time for funding in excess of 4 weeks. As of 11 April waiting times remain at no more than 4 weeks and is not expected to increase during 2016. Also, as of 11 April, there

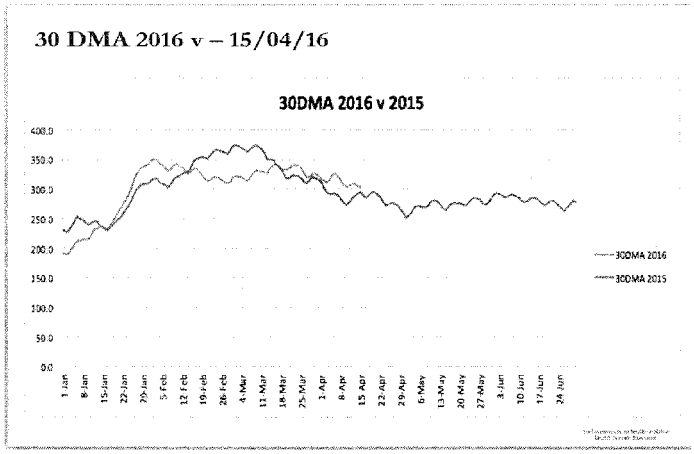
were 425 people on the waiting list for funding, this compares to 542 people waiting during April 2015.

- Transitional care funding has supported over 3,800 approvals, which is significantly above the original target of 500. As of 11 Apr, a total of 2,249 approvals have been issued, approx 32 approvals per day in April (an average of 160 per week). There has been increased responsiveness by the Community in improving access to Home Care Packages. Over 1,200 additional home care packages were provided by end 2015;
- 173 additional short stay nursing home beds are open (149 in public facilities are open plus 24 beds in Moorehall Lodge Private Nursing Home);
- A Bed Bureau for the greater Dublin area is in the process of being established. It will provide a detailed list of the availability of both public and private residential care beds and will assist in the process of providing bed options for those being discharged from the acute hospitals in the greater Dublin area.

5. In June 2015, €18m of additional funding was made available to the HSE under the *Winter Additional Capacity Initiative* to facilitate the opening of new hospital beds and the reopening of previously closed beds. As of 29 April 2016, the HSE reported that 116 of 154 previously-closed hospital beds have been re-opened. A further 234 of 301 new beds have been added to support the acute hospital system over the winter period.

6. In preparation for the 2015/16 winter period, Hospital Groups in conjunction with Community Healthcare Organisations developed comprehensive *winter resilience plans* to the HSE, to implement an integrated approach to managing winter pressures so as to avoid unnecessary hospitals admissions and to expedite efficient hospital discharges.

7. With regard to *ED activity*, between 1 Jan and 31 Mar there were 335,107 attendances recorded across all EDs (an increase of 20,262 on the corresponding period in 2015). Compared to the same period last year there is an average of 6.4% increase in the overall number attending EDs.



Scheduled Care

8. Improving *waiting times* for scheduled care for patients is a key priority. In January 2015, the Minister for Health put in place maximum permissible waiting times for inpatient and day case treatment and outpatient appointments of 18 months by 30 June 2015 and 15 months by year end. The HSE was provided with additional funding to ensure that these maximum waiting times would be achieved by maximising capacity across public and voluntary hospitals as well as outsourcing activity where the capacity is not available to

meet patient needs. Funding of €28m was spent in 2015 and the HSE is engaging with the Department regarding funding to complete episodes of care commenced in 2015.

9. HSE figures for end Dec 2015 show *progress* against the 15 months maximum wait as follows:
   - for In-patient and Day Case waiting lists, overall performance equates to 95% achievement of the 15 month maximum permissible wait time;
   - for outpatient waiting lists, overall performance equates to 93% achievement of the 15 month maximum permissible wait time.

10. The challenge in reducing waiting times is underscored in the waiting lists for April 2016. 94% of patients currently wait less than the maximum waiting time of 15 months for inpatient or daycase procedures or outpatient procedures, with over 60% of patients waiting less than 6 months for their required care. From April 2016 waiting list data published by the NTPF, it is evident that there have been reductions in outpatient waiting times year on year, however, this downward trend is not mirrored in inpatient / daycase care waiting lists.

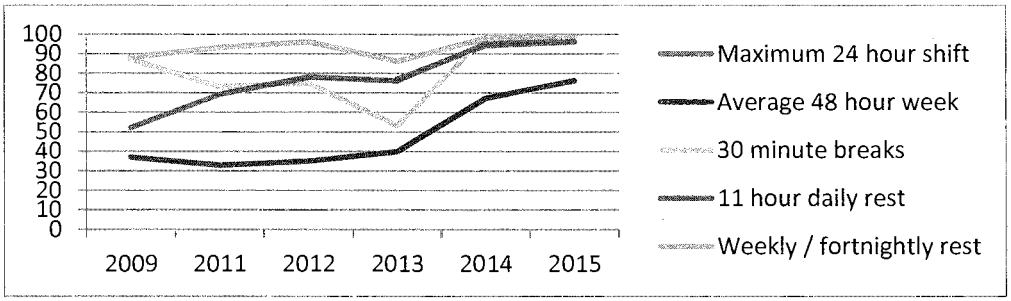
11. The Department of Health and the HSE recognise that there are resource availability and structural challenges which impact on individual specialties and hospital sites. Therefore, it is vital to effectively manage waiting lists so that those patients longest waiting are scheduled within the available capacity, once emergency and urgent cases have been dealt with.

12. The 2016 HSE Service Plan undertakes to maintain 2015 levels of service in respect of scheduled care, and acknowledges the challenges that will arise in maintaining a maximum wait time of 15 months and in driving towards lower wait times. The HSE continues to address waiting times with Hospital Groups as part of the regular performance and accountability process.

13. The HSE has established a Scheduled Care Governance Group to coordinate key initiatives to reduce waiting list numbers. In 2016, the HSE is focusing on key activities including:
   - ensuring that chronological scheduling is adhered to;
   - putting in place administrative and clinical validation procedures to ensure that patients are available for treatment;
   - relocating high-volume low complexity surgeries to smaller hospitals; and
   - designating an improvement lead for each hospital group, to provide support in meeting national targets for appointments and treatment.

European Working Time Directive compliance in respect of Non-consultant hospital doctors

14. Working with National HR Unit, the Unit monitors HSE compliance with a number of requirements of the European Working Time Directive (EWTD), in respect of non-consultant hospital doctors (NCHDs). The extent to which Ireland has accelerated compliance with EWTD requirements between 2009 and 2015 is evidenced in the figure below. The key outstanding compliance issue to be resolved is the reduction in NCHD working week to 48 hours.



National Treatment Purchase Fund (NTPF)

15. The NTPF currently performs the following functions: data management, analytics, audit and quality assurance in respect of hospital waiting lists, as well as a role in negotiating nursing home pricing under the Nursing Home Support Scheme. During 2016 the unit will work with the NTPF to explore the possibility of extending its remit into the area of community and primary care waiting lists.

Policy on Hospital Groups & New Children's Hospital

Business Plan Objectives

1. The Business Plan objectives of Policy on Hospital Groups and New Children's Hospital (AHPU2) for 2016 are:
   - To develop and oversee implementation of Government policy on **Hospital Groups**, including governance arrangements and reorganisations of hospital services to ensure the delivery of safe, high quality hospital services throughout the country.
   - To introduce legislation to merge the three paediatric existing hospitals and oversee progress on the development of the **new children's hospital**
   - To oversee acute hospital services in the **Dublin Midlands, Ireland East and Children's Hospital Groups**
   - To support the Minister and Ministers of State in meeting their parliamentary obligations.

HOSPITAL GROUPS

2. Seven Hospital Groups have been established on a non-statutory administrative basis as follows:
   - RCSI Hospitals (Dublin North East);
   - Dublin Midlands;
   - Ireland East;
   - South/South West;
   - Saolta University Healthcare Group (West/Northwest);
   - UL Hospital Group (Midwest) and
   - Children's Hospital Group

Hospital Group Governance Arrangements

3. The Hospital Group Boards are being set up in line with the Government's programme for reform of the health service, initially on a non-statutory administrative basis. Chairs are already in place (appointed on an administrative basis) for all Hospital Groups and Board members in place in three out of seven hospital groups (Saolta University Healthcare, UL and Children's Hospital Group). The appointment of members to the remaining Hospital Group Boards - RCSI Hospitals, Ireland East, Dublin Midlands and South/South West Boards will take place over the next months.

4. The current administrative arrangement needs to be replaced by a clear statutory one in the context of the overall health reform programme.

5. Pending the enactment of legislation, the implementation of Hospital Groups will progress in a phased manner, which will provide for devolved decision-making, fostering flexibility, innovation and local responsiveness, while also adhering to prescribed national service objectives and standards.

Memorandum of Agreement

6. It is critical that there is full clarity as to how authority and responsibility will be distributed within the existing legislative framework while Group Boards remain as administrative Boards. The Department, HSE and Hospital Group Chairs have been working together on a Memorandum of Agreement to describe the roles, responsibilities, accountabilities and relationships of the Department, the HSE, the Hospital Group Boards and the Hospital Group Academic partners.

Reorganisation of hospital services - Hospital Group Strategic Plans

7. The services provided by acute hospitals need to re-configured so that the majority of patients, who require only a routine, straightforward level of urgent or planned care, are safely managed locally and the minority of patients, who require true emergency or more complex planned care, are safely managed in acute regional or national centres where all the relevant clinical expertise is concentrated.

8. For reasons of volume, safety and quality, some specialist services need to be organised and planned in line with strategic guidance provided at national level.

9. This reform process will progress in a phased manner, providing for devolved decision making, fostering flexibility innovation and local responsiveness, while also adhering to prescribed national service objectives and standards. The implementation of the models of care already set out by the Acute Medicine, Emergency Medicine, Critical Care and Surgical Programmes in particular is critical to the reform.

10. The Department has developed Guidance on Developing Hospital Group Strategic Plans (to be circulated shortly) and Hospital Groups will develop their Strategic Plans in 2016 informed by this guidance document.

11. Each Hospital Group will be required to develop a plan to describe how it will;
    - provide more efficient and effective patient services;
    - reorganise these services to provide optimal care to the populations they serve;
    - and how they will achieve maximum integration and synergy with other groups and all other health services, particularly primary care and community care services.

Overarching National Policy to guide hospital service reorganisation

12. A number of regional, supra regional, and national specialist services have evolved on an ad hoc basis over decades in the absence of a national strategic plan for acute service configuration. The Department will set down the high level overarching national policy to guide overall hospital services reorganisation from a national standpoint to inform and complement the plans of the Hospital Groups.

Development of a Policy on a Trauma System for Ireland

13. Trauma services have been identified as a first priority service requiring national policy direction on the basis of the international evidence of the benefits of major trauma networks. Survival rates are greatly improved in such hospitals where clinicians can maintain their skills by treating a greater number of trauma patients.

14. A Steering Group on a Trauma Network for Ireland has been established by the Minister (Chair: Prof Eilis McGovern) and it is expected that the work of this Group will be completed by Q3 2016.

15. A recommendation on a Trauma Policy will be submitted to the Minister for consideration in advance of submission to Government.

NEW CHILDREN'S HOSPITAL

Overview

16. The new children's hospital:
    - will bring together services currently provided at Crumlin, Temple Street and paediatric services at Tallaght
    - is being developed on the campus of St James's Hospital in Dublin 8
    - will have satellite centres on the campus of Tallaght hospital and Connolly hospital, to improve access to urgent care and outpatient services for children locally.
    - will provide tertiary or more complex care for children from all over the country, and secondary or less complex care for children from the Greater Dublin Area
    - will in time be tri-located with a new Coombe Hospital on the St James's campus

17. The **National Paediatric Hospital Development Board (NPHDB)** has statutory responsibility for building the new hospital

18. The **Children's Hospital Group Board (CHGB)** is focused on the integration of the three existing children's hospitals and acting as client for the new building. The Children's Hospital Group includes the three existing hospitals, all of which are public voluntary hospitals. Their Chairs are all members of the Group Board.

Funding and cost estimates

19. The previous Government committed to making €200m available from the sale of the National Lottery for the new children's hospital, adding to the existing €450m Exchequer funding. Current estimates are that the core hospital, including both satellite centres, will be delivered within this envelope:
    - this includes provision for inflation, VAT and contingencies. It does not include equipment or ICT which can be purchased, licensed or leased separately.
    - Philanthropic and commercial funding streams will be targeted as appropriate for supporting elements of the project to include car parking and research facilities
    - Engagement is ongoing with Department of Education and Skills in relation to funding for the hospital school and the higher education facilities.

20. The estimate was based on inflation projections in the market in 2014 when the average rate for construction inflation was 3%. In 2015 and 2016 all industry commentators are reporting significant increases with current 2016 ranges of up to 7.5%. This expected impact to the cost of the overall project is currently being examined and cost estimates are being updated.

Planning Approval

21. On 10 August 2015 the NPHDB submitted a planning application for the new hospital to An Bord Pleanála. On 28 April An Bord Pleanála granted planning permission for the new children's hospital on the campus shared with St. James's Hospital and the satellite centres at Connolly and Tallaght and the research centre and family accommodation unit. The decision means that work can commence in the summer. It is expected that the satellite centres will open in 2018 with building work completed on the main site in 2020.

Major Tasks/Policy Initiatives for 2016

Children's hospital capital project

22. Following the planning decision (28 April), a Memorandum for Information of the Government is being prepared, to set out the latest position, including updated cost estimates, before commencing enabling works contracts.

23. Following receipt of main construction tenders later in 2016, a further Memorandum for Government is planned setting out Final Business Case and tender prices prior to construction investment decision.

Establishment of new children's hospital body

24. In 2015 the unit prepared a draft General Scheme of a Bill to establish a new children's hospital body to run the new hospital, and into which the services and staff of the existing hospitals will transfer. Engagement with the existing hospitals has been ongoing and it is intended to finalise the General Scheme and bring a Memorandum to Government seeking approval to draft.

Integration and change management

25. The Children's Hospital Group CEO and Board have been working closely with the three existing hospitals on integration planning to bring together three independently governed organisations as one entity. This is a complex project and will be overseen during 2016 as part of the work of the Children's Hospital Steering Group which is chaired by the Department and includes the HSE, the CHGB, the NPHDB and St James's Hospital.

National Model of Care for Paediatrics and Neonatology

26. A National Model of Care for Paediatrics and Neonatology has been developed by the HSE National Clinical Programme for Paediatrics and Neonatology. This will set out the framework for the delivery of paediatric and neonatal care nationally over the coming years.

27. The new children's hospital has a central role in the national model of care, providing specialist tertiary and quaternary services for children from all over Ireland and engaging in shared care arrangements with local paediatricians in regional paediatric units. The specialists in the new children's hospital will also provide outreach clinics in regional centres thereby bringing their expertise closer to the patient

Cancer, Blood & Organs Policy

Cancer Policy

Overall Objectives (Business Plan)

1. To finalise and publish a National Cancer Strategy 2016-2025, and to lead on its implementation in partnership with other organisations:

2. To lead on the review and development of cancer policy, and on the oversight of implementation, in co-operation with the National Cancer Control Programme and other relevant parties.

3. Cancer Statistics
   - Approximately 25,000 people are diagnosed with cancer in Ireland annually;
   - The number of new cancer cases is projected to double by 2040;
   - Survival has improved significantly over recent years and this trend will continue.

National Cancer Strategy 2016 -2025

4. A draft Strategy is being finalised at present and it will be submitted to the Minister in Q2 2016. The areas of focus will include Prevention; Treatment/Technologies; Rare Cancers; Survivorship; High Quality Care; Patient Safety and Workforce/Resources.

National Cancer Control Programme (NCCP)

5. We work closely with the NCCP which was established in 2007 in the HSE to reorganise cancer services to achieve better outcomes for patients.

Cancer Services

Surgery

6. Surgery for the main cancers has been largely organised in 8 Designated Cancer Centres (4 in Dublin and the others in Waterford, Cork, Limerick and Galway) in line with international best practice, ensuring the scale of activity to maintain surgical expertise. Some further centralisation of cancer surgery is required to secure optimum outcomes. Rapid Access Clinics to facilitate early diagnosis for breast, lung and prostate cancers are provided in the designated centres.

Medical Oncology

7. Chemotherapy services are provided in 26 public hospitals.

Radiation Oncology (Radiotherapy) Services

8. **Dublin**: Additional capacity is required to meet increasing demand. This is being met by providing 2 new Linac machines in St. Luke's (operational by early 2017) and approval is also being sought to begin design work for expanded capacity at Beaumont.

9. **Cork**: Enabling works are about to begin. The main contract will be placed in mid-year with commissioning completed by early 2019.

10. **Galway**: It is proposed to replace 2 linacs as an interim measure. Commissioning of the main project will be achieved in mid-2020;

11. **Altnagelvin, Derry**: A new Radiotherapy Unit will be opened in late 2016 at Altnagelvin. This facility will provide services to people from the North West (RoI). The project is part-funded by the Department/HSE under an MOU and an SLA.

Cancer Screening

CervicalCheck (smear tests for women aged 25 to 60)

12. A change in the screening method is under consideration. HIQA will undertake a Health Technology Assessment of the possibility of changing to HPV testing.

BreastCheck (mammograms for women aged 50-64)

13. The programme is being extended to women aged 65-69 years. This will be achieved in full in 2021. Of necessity it is being done on an incremental basis – 100,000 extra people involved. A shortage of radiographers may pose a challenge to the extension programme.

BowelScreen (colorectal screening for men and women between the ages of 60-69)

14. This is moving from a 3-year round to a 2-year round (people get screening offer every 2 years). One of the challenges is to ensure that hospitals can provide colonoscopies in a timely manner to those selected for follow-up.

National Cancer Registry

15. The National Cancer Registry (based in Cork) collects data on cancer incidence, treatment and survival. A new Director (with a joint professorial role with UCC) is due to take up post on 1 August.

Blood & Organs Policy

Overall Objectives (Business Plan)

16. To have policies in place to ensure the delivery of high quality organ donation and transplantation services that will lead to increased levels of organ donation and transplantation in line with EU Directives and EU Action Plan on Organ Donation and Transplantation.

17. To ensure that policies and structures are in place to facilitate the delivery of services relating to the use of blood and tissues in Ireland in compliance with international standards for quality and safety

18. To review policy, and to deal with issues arising, in relation to the Hepatitis C and HIV Compensation Tribunal. This includes the management of High Court and Supreme Court cases relating to Hepatitis C and HIV on behalf of the Minister.

Organ Donation and Transplantation

19. Kidney transplants are carried out in Beaumont Hospital; liver and pancreas in St Vincent's University Hospital; and heart and lung in the Mater Misericordiae University Hospital.

20. In 2015, a total of 266 transplants were carried out involving 81 deceased donors and 33 living donors. The aim is to undertake 300 transplants in 2016. In accordance with best international practice a National Organ Procurement Service has been set up, independent from transplant services. Five Organ Procurement Coordinators have been recruited and they, along with Organ Donation Nurse Managers in each Hospital Group, will play a key role in driving organ donation and transplantation in the coming years. A particular focus is retained on protecting the interests of donating families throughout the process.

Pancreas Transplant

21. Arrangements have been finalised for the transfer of pancreas transplantation to St Vincent's University Hospital from Beaumont Hospital.

Human Tissue Bill

22. We hope to begin work on the Heads of a Human Tissue Bill in the coming months. The Bill will meet the key recommendation of the Madden Report on Post Mortem Practice and Procedures that no hospital post-mortem may be carried out, and no tissue retained, without consent/authorisation. It is also envisaged that the legislation will provide for an opt-out system of consent for organ donation.

Irish Blood Transfusion Service (IBTS)

23. The IBTS is a non-commercial state body that derives its funding through the sale of blood and blood products primarily to the public health system. It has approximately 600 employees.

Finance

24. Despite the recent resolution of issues pertaining to its pension scheme, the IBTS is forecasting a deficit in the region of €2.4m in 2016. The core business of the company is performing well, but historical pension costs continue to impact on its financial viability. Increases in the price of blood/blood products will be required to put the company on a firm financial footing.

Cork Centre

25. Approval has been granted for a new IBTS centre on the grounds of the Cork University Hospital campus. This will include a donor clinic, a secondary processing facility and a distribution centre. All primary processing is now carried out in Dublin.

Deferral Policies

26. The IBTS will continue to review its deferral policies in relation to blood donation in the light of available scientific evidence. It is at present reviewing the risk assessment in relation to MSM blood donations.

Hepatitis C and HIV Compensation Tribunal

27. Approximately 1,700 people were infected with hepatitis C and/or HIV through the administration of blood and blood products in the State. The total cost of the Hepatitis C and HIV Compensation Tribunal from 1995 to end December 2015 was €1.134 billion. This includes 3,482 Tribunal awards and 392 High Court awards, as well as legal fees and administrative costs. At present 1 Supreme Court case, 2 Court of Appeal cases and 10 High Court cases are awaiting hearing and it is expected that some of these cases will be heard this year.

28. Approximately 560 applications are pending in the Tribunal at present.

Maternity & National Ambulance Service Policy

National Ambulance Service (NAS)

1. Prior to the establishment of the HSE, each health board had its own ambulance service. The NAS is now the single national service, and provides pre-hospital emergency care and non-emergency patient transport for the public health system. It has over 1,600 staff, over 520 vehicles, and a 2016 budget of €151.4m, including an additional €2m development funding. Dublin Fire Brigade (DFB) provides emergency ambulance services in greater Dublin on behalf of the HSE. The NAS provides non-emergency patient transport in Dublin, as well as some emergency capacity.

Reform Programme

2. A significant reform programme is reconfiguring the management and delivery of pre-hospital services, for a clinically driven, nationally co-ordinated system, supported by technology and data.

3. Regional control centres have been rationalised to one national centre on two sites, the National Emergency Operations Centre (NEOC) in Tallaght and Ballyshannon.

4. The reform project is delivering improved technology. Developments such as digital radio, computer-aided dispatch (CAD), mobile data and electronic patient care reporting will allow the NAS to deploy resources more effectively, nationally, rather than within small geographic areas. The national CAD system went live in September 2015, and is transforming ambulance service operations and emergency vehicle deployment. Eircode has now been mapped onto the CAD.

5. The Intermediate Care Service delivers inter-hospital transfers and low acuity work, freeing up the emergency fleet for emergency calls. ICS undertakes over 80% of inter-facility transfers.

6. The Hospital Turnaround Framework, part of the NAS quality assurance process, was introduced in 2014. It addresses risks to service delivery and capacity from ambulances delays at emergency departments. The Framework provides a standardised national patient handover process for NAS and Dublin Fire Brigade ambulances.

Emergency Aeromedical Support Service (EAS)

7. The EAS provides dedicated aeromedical support to the NAS in the west, specifically where land ambulance transit times would not be clinically appropriate. The EAS has completed over 1,250 missions to date, one third involving STEMI-type heart attack patients, who need time-critical transfers to primary PCI units for successful treatment. On 14 July 2015, the Government agreed to establish the EAS on a permanent basis.

Ambulance Service Reviews

8. Three separate reviews of pre-hospital emergency care have been initiated in recent years: HIQA's review of the National Ambulance Service; The NAS Capacity Review; and the HSE/Dublin City Council review of Dublin Fire Brigade's ambulance service. A draft Action Plan, which incorporates the recommendations of two of those reviews (HIQA and the Capacity Review) is currently being implemented. The HSE/Dublin City Council review recommendations will be incorporated into the Action Plan once that report is completed.

9. **HIQA Review:** HIQA's review of NAS governance arrangements was published in December 2014. The report was critical of relationships between the DFB and the NAS. A key recommendation is for the DFB to fully engage with the national control centre reconfiguration project. A joint forum between the HSE, Dublin City Council and DFB unions, on integration of call taking and dispatch, is progressing this issue.

10. **NAS Capacity Review:** This comprehensive capacity analysis examined overall resource levels and distribution against demand and activity. The purpose was to determine the appropriateness of current resource levels and deployment for service needs at national and regional level. The capacity review will be published following publication of the Action Plan referenced above.

11. **Dublin Ambulance Review:** Ambulance services in the Greater Dublin area are provided by DFB on behalf of the HSE. DFB has 12 emergency ambulances, crewed by paramedic-qualified firefighters. 11 of these are funded by the HSE, at a cost of €9.3m per annum. The HSE and Dublin City Council jointly commissioned an independent review of Dublin services to determine the best and most cost-effective model for the city, including coordination of Dublin services with national provision under the NAS national control and dispatch system. The review is expected to be completed in 2016, and the NAS will integrate the recommendations into the Action Plan.

12 [redacted]

13

14

Maternity Services

Overview

15. Currently, maternity services in Ireland are predominantly hospital based, with over 99% of births occurring within a hospital setting; pregnancy is the largest single reason for admission to hospital in Ireland. There were 67,347 births in Ireland in 2014. There are 19 maternity hospitals/units throughout the country, three of which, the National Maternity Hospital, the Rotunda Hospital and the Coombe Women & Infants University Hospital, are voluntary hospitals. The size of the 19 maternity hospitals/units varies significantly, with 9,261 births in the National Maternity Hospital in 2014 compared with 1,100 births in South Tipperary General Hospital in the same period. Approximately 50% of all births take place in four hospitals - the three Dublin maternity hospitals and Cork University Maternity Hospital.

National Maternity Strategy

16. *Creating a Better Future Together* - the National Maternity Strategy - was published in January 2016 and sets out the vision for the future of Ireland's maternity services. The Strategy recommends that services should be woman centred, and provide integrated, team based care, with women seeing the most appropriate professional, based on their need. An integrated model of care is set out, in which patient safety is the first and over-riding principle. A choice of care pathway will be provided – *Supported*, *Assisted* or *Specialised* - and women will be helped to make an informed decision around their care pathway. The Strategy also proposes the development of a community midwifery service which will be provided by hospital midwives operating in the community. €3m development funding has been provided for maternity services in the 2016 Service Plan; this funding will be allocated in line with the Strategy.

Implementation

17. Implementation of the Strategy will largely fall to the new National Women & Infants Health Programme. That Programme will span obstetrics, gynaecology and neonatal services, across the spectrum of primary and secondary care, and will drive integrated service reform of maternity services. The Programme will work with maternity networks and individual maternity units to ensure that maternity service provision is remodelled on the lines proposed, and that a culture of continuous improvement is fostered throughout the maternity service.

18. The Programme will develop a detailed Strategy implementation [redacted] by June 2016. Progress on implementation of the Strategy will form part of the normal performance dialogue between the Department and the HSE. In addition, the *National Women & Infants Health Programme* will submit an annual report to the Minister, with details of progress in each maternity network; the report will be published.

[redacted]

19 [redacted]

20 [redacted]

National Women & Infants Health Programme

21 [redacted]

MANAGEMENT BOARD Area: Primary Care Division; Fergal Goodman (Assistant Secretary)

(Units & Principal Officers; Eligibility & Primary Care Policy Unit – Matt Collins, Medicines, Primary Care/Pharmacy – Paul Bolger, Chief Dental Officer – Dymphna Kavanagh Medicines, Controlled Drugs and Pharmacy Unit – Eugene Lennon,)

Eligibility & Primary Care Policy Unit

Functions

1. The Eligibility & Primary Care Policy (EPCP) Unit has cross-cutting and functional policy responsibilities including:

   - to lead the development of primary care policy and to oversee its implementation, with a focus on promoting integrated multi-disciplinary care, including general practice, nursing, physiotherapy, occupational therapy, and speech & language therapy;
   - to manage and to lead the development of the policy and statutory framework for people's eligibility for health and personal social services, and to hold the HSE to account for its implementation; and,
   - to oversee the operation by the HSE of the Medical Card and GP Visit Card schemes, in accordance with legislation and Government policy.

Policy Context

Eligibility

2. Eligibility for health services is mainly governed by the Health Act 1970 (amended several times since enactment).

3. People ordinarily resident in Ireland have either "full eligibility" or "limited eligibility". Qualification for full eligibility is based primarily on financial circumstances. Full eligibility is denoted by the holding of a medical card. The Health Act 1970 provides that, where the HSE's opinion is that a person is 'unable without undue hardship to arrange' GP services for themselves and family, they qualify to have full eligibility (i.e., a medical card).

4. Under the Act, the HSE is obliged to make in-patient public hospital services (in public wards including consultant services), out-patient public hospital services (including consultant services) and maternity and infant care services available to all residents. The HSE also makes GP services available to residents with full eligibility, persons with GP visit cards (i.e., for whom it would be unduly burdensome to arrange GP care for themselves), and all residents aged over 70 years and under 6 years. The HSE is also obliged to make available to *persons with full eligibility* (i.e., medical cardholders) prescribed drugs and medicines (subject to a €2.50 charge per prescribed item up to a maximum charge of €25 per month), dental, ophthalmic and aural services, and appliances. Where available, other primary/community allied health professional services may be available to medical cardholders and other residents.

5. The number of persons with a medical card or GP Visit Card is as set out in the table below. The latest GP Visit card numbers reflect the extension to all under-6s and all over-70s in 2015.

Date	Population (CSO)	Medical Cards	*as % of Pop*	GP Cards	*as % of Pop*	All Cards	All as % of Pop
End-2006	4,232,900	1,221,695	*29%*	51,760	*1%*	1,273,455	30%
End-2007	4,375,800	1,276,178	*29%*	75,589	*2%*	1,351,767	31%
End-2008	4,485,100	1,352,120	*30%*	85,456	*2%*	1,437,576	32%
End-2009	4,533,400	1,478,560	*33%*	98,325	*2%*	1,576,885	35%
End-2010	4,554,800	1,615,809	*35%*	117,423	*3%*	1,733,232	38%
End-2011	4,574,900	1,694,063	*37%*	125,657	*3%*	1,819,720	40%
End-2012	4,585,400	1,853,877	*40%*	131,102	*3%*	1,984,979	43%
End-2013	4,585,400	1,849,380	*40%*	125,426	*3%*	1,974,806	43%
End-2014	4,609,600	1,768,700	*38%*	159,576	*3%*	1,928,276	42%
End-2015	4,635,400	1,734,853	*37%*	431,306	*9%*	2,166,159	47%

6. There has been considerable pressure in recent years for the system of assessment to take more account of other aspects of people's circumstances, including health status, such as a member of a family having a serious illness.

7. There are some charges for public services in hospitals. Firstly, the current public hospital statutory in-patient charge is €75 per night, up to a maximum of €750 in any twelve consecutive months. Secondly, attendance at an Emergency Department is subject to a charge of €100, except where the patient has a referral note from his/her doctor or is admitted to the hospital. Persons with full eligibility (i.e. medical cardholders) are exempt from all charges for public services in a hospital. A separate set of charges is applicable to all private in-patient services made available in public hospitals, which recover part of the cost of providing those private services.

8. Irish residents can also access health care in other EU countries. Under EU legislation, the HSE operates the Treatment Abroad Scheme (TAS) where an Irish-based public hospital consultant may refer a patient for medically necessary treatment in another EU Member State, where that treatment is not available within the Irish public health system. The HSE also operates the EU Directive on Patients' Rights in Cross Border Healthcare ("Cross-Border Directive"), which provides *inter alia* for the full or partial reimbursement of health care received in another EU Member State, to which the person would be entitled to within the public health system in Ireland. This Directive was transposed into Irish law in 2014/5 and has been the subject of considerable public attention as a potential means of people quickly accessing care outside the State and then being reimbursed for the costs of same.

GP Contracts

9. Excluding all children under 6 years, standard GP care services are provided to medical and GP visit cardholders primarily on the basis of a contract negotiated in 1989 between the HSE, the Minister for Health and the Irish Medical Organisation. Services are provided by over GMS 2,400 GPs, of whom about 92% have also signed the new under-6s GP contract. The Exchequer funds annual payments of about €450m to GPs for the provision of services to medical/GP visit cardholders, under-6s and over-70s, i.e. approximately 2.17 million people.

10. At the end of 2015, approximately 2.17 million people qualified for GP care, of whom about 1.73 million people were medical cardholders (i.e., full eligibility).

Magdalen Women

11. The Redress for Women Resident in Certain Institutions Act was enacted in 2015. Under this Act, women who worked in Magdalen Laundries and two similar institutions are eligible for a range of primary and community health services free of charge. These include GP services, prescribed drugs and medicines, dental services, ophthalmic services, aural services, home nursing, home support, chiropody/podiatry, physiotherapy, and counselling services. The HSE has issued a "2015 Act" card to 567 women.

Community Healthcare Organisations

12. In 2014, the HSE established new organisational arrangements to manage the delivery of primary care, social care (services for older people and for persons with a disability), mental health and health & wellbeing services. Nine Community Healthcare Organisations (CHOs) replaced 17 Integrated Service Areas, under which non-hospital services were grouped. The Primary Care Team (PCT) will continue to be the principal point of contact for individuals for non-specialist medical services. The CHOs are still in development mode and the full management team to lead the delivery and reform of service in each CHO has yet to be appointed.

Major Tasks/Policy Initiatives for 2016

13. It is widely acknowledged that the existing GP GMS contract is outdated. A major policy goal is the development of a revised and modernised contract. A new contract is necessary:

    - to enhance the focus of primary care on health promotion, prevention, early identification, simple and early interventions and patient empowerment, instead of mainly dealing with acute episodes as they occur;
    - for the development of chronic disease management within the primary health sector and in a structured manner with other parts of the health service;
    - to foster an integrated, multi-disciplinary approach to patient care that involves GP services, nursing, physiotherapy, occupational therapy psychological services, social work and other diagnostic, treatment and rehabilitation services as part of a Primary Care Team/Network approach; and,
    - for the delivery of a quality, efficient, value-for-money GP service for the public that reflects the on-going reform of public services.

    Under a framework agreement, the HSE, the Department and the Irish Medical Organisation have commenced discussions on a new contract but these are still at an early stage.

14. In Budget 2016 Government announced its intention to extend GP care without fees to all children under 12 years of age. It is estimated that some 200,000 children, who are aged 6 to 11 year olds, do not currently have access to public GP care without fees. This initiative will require primary legislation and implementation is likely to be dependent on progress with a new GP contract.

15 [redacted]

16. A fourth task is to continue to oversee the HSE's work on the assessment of eligibility in the context of ongoing trends and the output of a Clinical Advisory Group established by the HSE Director General in 2015. This work may inform changes in HSE procedures or, depending on the outputs, proposals for amendment of the legislation.

Community Pharmacy, Dental, Optical and Aural Policy

Description

1. The Unit is responsible for development and implementation of policy and legislation for community drug schemes, drug pricing and reimbursement, oral health and community optical and audiology services. The services associated with these schemes are delivered in the community mainly by private contractors, who are reimbursed by the HSE through the Primary Care Reimbursement Service (PCRS). The HSE administers these schemes on the basis of legislation and policy and direction from the Department.

2. Functions and key 2016 activities
   - Policy on community drugs schemes, drug pricing and reimbursement.
   - Oral health policy and services and fluoridation policy
   - Policy and oversight for community optical and audiology services
   - Contract issues relating to pharmacists, dentists and opticians - FEMPI unwinding

Policy on community drugs schemes, drug pricing and reimbursement

3. Under the community drugs schemes, including the General Medical Services (GMS), Long Term Illness (LTI), Drug Payments (DPS) and High Tech and Orphan Drugs Schemes, the HSE reimburses eligible prescription drug costs, incurred by members of each scheme, to the community pharmacy contractor (or manufacturer, for the High Tech). Reimbursement covers the cost of the drugs and dispensing fees.

4. The HSE PCRS budget for 2016 has been set at €2.4bn, with €1.75bn allocated to drug costs. This assumes a targeted reduction of €110m in prescribing and drug cost in the drugs schemes. Initiatives underway in the Department and the HSE include the negotiations on a new pricing and supply agreement with the Irish Pharmaceutical Healthcare Association (IPHA), enhanced probity and control measures, preferred prescribing initiatives and a range of other approaches to achieving maximum value and benefit to patients from the State's expenditure on medicines.

Community drugs schemes

5. The 2016 budget allocations for the drugs schemes[1] include:
   - GMS (€795m) – Reimbursement for drugs and appliances supplied to medical card holders. There is a prescription charge of €2.50 per item, with a €25 monthly limit per family;
   - LTI (€195m) - Reimbursement for drugs and appliances for patients with a long term illness: no prescription charge applies;
   - DPS (€60m) – Reimbursement above the monthly threshold of €144 per individual or family ;
   - High Tech (€570m) - High tech medicines are purchased by the HSE and supplied through community pharmacies, which are paid a monthly patient care fee.

Industry agreements

6. There have been a number of agreements with proprietary and generic manufacturer representatives over the years, for community and hospital supply. The last agreement ended in October 2015, although the terms continued to be honoured. Negotiations on a new agreement began in March 2016 and are still under way.

[1] Figures rounded to the nearest €5 million.

High tech drugs/medicines

7. The introduction of highly expensive new, and the increased use of existing, high tech medicines means high tech expenditure will be one of the main drivers of expenditure pressures over coming years. The HSE Service Plan for 2016 includes a budget of €570m for high tech drugs. This is equivalent to the 2015 outturn and must also cover any new drugs approved in 2016.

8. The HSE has statutory responsibility for decisions on pricing and reimbursement of medicinal products under the community drug schemes, under the Health (Pricing and Supply of Medical Goods) Act 2013. Prior to reimbursing a medicine, the HSE considers a range of statutory criteria, including clinical need, cost-effectiveness and the resources available to the HSE.

Generic substitution and reference pricing

9. The Health (Pricing and Supply of Medical Goods) Act 2013 Act provides for **generic substitution.** The Act permits pharmacists to substitute prescribed items that are designated as safely interchangeable by the Health Products Regulatory Authority (HPRA). The Act also allows the HSE to set **reference or maximum reimbursement prices** for each group of interchangeable products.

10. Generic substitution and referencing pricing are being progressed incrementally and form part of the HSE's Medicines Control Plan for 2016. Generics now account for over 70% of the off-patent market by volume and over 50% by value. Generic substitution and reference pricing generated approximately €50m in savings in 2014, and a further €25m in 2015.

Minor Ailments Service (MAS)

11. The HSE is developing, with the Irish Pharmacy Union, a model for a pilot MAS, where medical card patients can use their local pharmacy for diagnosis and treatment of specified minor conditions. Similar services are run elsewhere, but there is little research on their benefit, and no data for an Irish context. The initial pilot, which is expected to begin by June, will run for three months in four towns, including 19 pharmacies.

Legislation

12. A health (miscellaneous provisions) bill under preparation will include provision for the reimbursement of some non-prescription drugs, such as those used in a minor ailments service.

Oral health policy and services and fluoridation policy

National oral health policy

13. Policy on provision of dental services in Ireland is based on the 1994 Dental Health Action Plan. A project to develop a new national oral health policy is underway, replacing the 1994 Plan. This policy will identify key interventions and targets for children, adults and older people and develop a model of care that will prioritise preventative approaches, with improved access and support. The objective is to complete the strategy by mid-2017.

Dental Services

14. Dental services provided and their 2016 Budget allocations[2] are:

- Private dentists providing services for adults with medical cards under the Dental Treatment Service Scheme and their own (private) patients (€65m);
- The HSE Public Dental Service providing services for children of school-going age and people with specials needs or disabilities (€70m);
- The HSE provides orthodontic treatment to patients based on their clinical need. An individual's access to orthodontic treatment is determined by clinical guidelines. The HSE is putting initiatives in place to address treatment waiting list issues (€15m).

Fluoridation

15. Under the Health (Fluoridation of Water Supplies) Act 1960 and the Fluoridation of Water Supplies Regulations 2007, the HSE makes arrangements for fluoridation of public water supplies. The Irish Expert Body on Fluorides and Health, established in 2004, advises the Minister on fluoride and related matters. It is intended to bring forward proposals shortly for a reconstituted Expert Body.

Community optical and audiology services [2]

Optical services (2016 Budget €30m)

16. Ophthalmology services are provided by contracted optometrists and ophthalmologists, as well as community ophthalmic physicians and orthoptic and nursing staff. The HSE Primary Care Eye Services Review Group, in which the Department participates, is examining primary eye care services for adults and children. The Group is due to conclude its work this year.

Aural services (2016 Budget €15m)

17. Community audiology services are provided by HSE employed audiologists.

18. Implementation of the 2011 HSE National Audiology Review Group Report is ongoing, with a focus on access issues, timely diagnosis, staffing levels and training, infrastructure, information management and waiting times.

Contract issues relating to pharmacists, dentists and opticians

19. The FEMPI measures introduced in 2009, 2011 and in 2013 deliver €185m[2] in full year savings from pharmacists, €3m from dentists and €1.5m from ophthalmologists, optometrists and dispensing opticians. The 2016 Estimates provided €5m to commence unwinding, on a limited basis, of some FEMPI cuts in payments to health professionals, including pharmacists, who were subject to reductions in payments in 2013.

[2] Figures rounded to the nearest €5m.

Medicines, Pharmacy and Controlled Drugs Unit

Functions

1. Develop and implement policy and legislation to protect the health and safety of the public with regard to medicinal products, medical devices and cosmetics, and to contribute to the development of policy & legislation at EU and international level.

2. Maintain, develop and implement policy and legislation on the control of drugs and precursor substances in accordance with national and EU policy and international conventions.

3. Develop and implement policy and legislation in relation to the regulation of pharmacists and pharmacies and to provide pharmacist expert advice and support the work of other Units and other Departments.

Misuse of Drugs (Amendment) Bill 2016 and associated regulations

4. A Bill to amend the Misuse of Drugs Act 1977 is being drafted to restore the power of Government to declare substances controlled. The section in the 1977 Act which provided for this was found unconstitutional by the Court of Appeal in March 2015, resulting in the automatic legalisation of hundreds of dangerous substances, e.g. ecstasy and "head shop" drugs. This necessitated the enactment of emergency legislation to recontrol all these substances by means of primary legislation.

5. The Government decided in December 2015 to include additional provisions in this Bill to enable the Minister to issue licences for supervised injecting facilities as a harm reduction measure for injecting drug users, to help address the problem of public street injecting and to make associated regulations. It was decided that the first such centre should be established on a pilot basis to assess the effectiveness of the new policy.

6. Drafting of the Bill is at an advanced stage. The text will be finalised when judgement is received on a Supreme Court appeal on section 2 of the Misuse of Drugs Act – the case was heard on 12 April. It is intended that the Bill will be published in coming months. Once the Bill is enacted new regulations will need to be made to replace regulations confirmed by the Oireachtas in the emergency legislation. It is also intended to then make further regulations to provide for stricter controls on benzodiazepines and z-drugs and to allow for the provision of Suboxone as an alternative to methadone in opioid substitution treatment. Regulations will also be required for the supervised injecting facilities.

Drug Precursors Regulations

7. Precursors are substances which have legitimate use in industry, but which may also be used in the manufacture of illicit drugs. Amending Regulations are currently being drafted for the Minister's signature, to update a 2009 Statutory Instrument which provides for offences for persons who do not comply with EU Regulations controlling the trade and use in precursors.

New Psychoactive Substances (NPS) - EU negotiations

8. Ireland is participating in negotiations on a legislative text to provide a more effective EU mechanism to address the proliferation of New Psychoactive Substances (NPS - also known as legal highs). It is intended that the new EU legislation would replace the current 2005 Council Decision on the control of NPS under which Member States may be

required to subject to national control an NPS which is found to be abused in the EU and dangerous.

Agencies under the aegis of the Department of Health

9. Medicines, Pharmacy and Controlled Drugs unit is responsible for the oversight of two statutory agencies – the Pharmaceutical Society of Ireland (PSI) and the Health Products Regulatory Authority (HPRA).

Pharmaceutical Society of Ireland (PSI)

10. The PSI regulates approximately 5,600 pharmacists, 420 pharmaceutical assistants and 1,880 retail pharmacy businesses. It is governed by a 21-member Council (10 pharmacists, from whom the President and Vice-President are selected by the Council, and 11 non-pharmacists, 9 of whom are selected by the Minister). There have been governance issues in the past year associated with the Council, which have necessitated the involvement of the Minister and Minister of State. The Department continues to monitor this situation.

11. The staffing complement of 37 is led by the Registrar/Chief Executive. This statutory post is currently filled on an acting basis following the December resignation of the previous incumbent. The Public Appointments Service is overseeing a recruitment process to permanently fill this post.

12. The Health (Miscellaneous Provisions) Bill currently being drafted includes a number of amendments to the Pharmacy Act, including the removal of the prohibition on undischarged bankrupt pharmacists being allowed to be registered, and therefore work, as pharmacists.

Health Products Regulatory Authority

13. The Health Products Regulatory Authority (HPRA), formerly Irish Medicines Board, 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 medical devices, blood and blood components, tissues and cells, the protection of animals used for scientific purposes and organ donation and transplantation. HPRA has a staffing complement of approximately 300.

Medical Devices – EU Negotiations on new regulations

14. The European Commission published draft legislation on Medical Devices and In Vitro medical devices in late 2012. The aim is to provide an enhanced legislative framework to ensure that medical devices placed on the European market are safe for patients and also improve patient access to innovative treatments. The negotiations are taking place against the backdrop of the PIP breast implant scandal and De Puy metal-on-metal hip implant recall which have heightened public concern about patient safety issues related to medical devices.

15. These regulations are of particular importance to Ireland. The Medical Devices industry exports about €8 billion worth of product each year. Negotiations between the Council and the European Parliament are making progress and getting closer to an agreed text. It is expected that negotiations will reach a successful conclusion in June 2016.

Fees for the regulation of Medical Devices

16. [redacted]

Clinical Trials

17. Clinical trials involving medicines are regulated under EU legislation. A new Clinical Trials EU Regulation published in 2014 is due to come into effect in 2018. The purpose of this Regulation is to make Europe a more attractive place to carry out clinical trials by streamlining processes, reducing red tape and improving transparency. Under the Regulation, all applications for a clinical trial will be made via an EU Portal, and Member States will be required to complete assessments (scientific assessment which in Ireland is performed by the HPRA and ethical approval which is performed by a recognised ethics committee) within specified timelines.

18. Work in currently underway to prepare for the new Regulation. The Department is working closely with the HPRA in this regard. While the Regulation will apply directly, to give it full effect in Ireland will require new legislation and amendment to existing legislation. New systems and processes will also have to be put in place. The main policy issue for the Department is the structure for ethics committees – the option of a central committee is being considered (at present there are 12 recognised ethics committees).

MANAGEMENT BOARD Area: Social Care & Disabilities; Frances Spillane (Assistant Secretary)

(Units & Principal Officers; Disability Policy Unit – Grainne Duffy, Services for Older People – Barry Murphy, Long Stay Charges – Chris Costello)

Disability Policy Unit

Functions

1. Disability Unit is responsible for developing policy on and oversight of the provision of specialist health and personal social services for people with a disability including the reform programme for health-funded specialist disability services. In addition, it legislates for the statutory regulation of the disability residential sector by HIQA. The Unit also contributes to cross-sectoral collaboration with other Departments on national policies for adults and children with a disability.

Major tasks & policy initiatives in 2016

2. Policy development
   - Develop proposals for a new statutory Transport Support Scheme;.
   - Manage the Department's response to the personal injury claims of Irish survivors of thalidomide including possible development of legislation.
   - Support the Services for Older People Unit in the development of legislative proposals on Deprivation of Liberty.

3. Reform Programme for Specialist Disability Services
   - Oversee, support and monitor the HSE in implementing *Transforming Lives* - the programme to implement the recommendations in the Value for Money and Policy Review of Disability Services in Ireland. This includes advancing implementation of *Time to Move on from Congregated Settings*, the *Progressing Disabilities Programme for Children and Young People aged 0 – 18* and the *New Directions* report on adult day services.
   - Develop and support funding and commissioning initiatives.

4. Safe Services, quality improvement and oversight of service delivery
   - Develop Terms of Reference for the statutory Commission of Investigation into the South East foster home abuse allegations.
   - Support and monitor the HSE in the delivery of high quality, evidence based, safe and effective person centred care and support services to adults and children with a disability, including progression of inquiries and reviews.
   - Monitor, evaluate and report on the performance of the HSE in providing health and personal social services for adults and children with disabilities under the HSE's National Service Plan and National Social Care Operational Plan.

Cross- Sectoral Collaboration

5. Engage in cross-sectoral collaboration on disability issues and policy development across Government Departments and statutory agencies.

Current Issues

Commission of Investigation into South East Foster Home Abuse Allegations

6. The Government has agreed to establish a statutory Commission of Investigation into events in a foster home in the South East, subject to agreement on Terms of Reference and the approval of the Oireachtas.
7. In response to concerns raised and the on-going delay in publishing reports commissioned by the HSE, Conor Dignam Senior Counsel was appointed to undertake a review into these matters, taking account of the ongoing Garda investigation.

8. Work currently underway by Mr Dignam will greatly inform the drafting of the Terms of Reference for the Commission. Additional resources have been approved in order to allow Mr Dignam expedite his review, which it is expected will be completed in early May.

Safeguarding Vulnerable People with a Disability

9. The safety and protection of vulnerable people in the care of the State is paramount. All centre-based residential and respite care facilities are subject to registration and inspection by HIQA, in line with the commitment in the Programme for Government.

10. Over 1,650 inspections have taken place to date. By the end of April 2016, every centre in the country had been inspected at least once, with many being inspected more than once. The lessons learned from these inspections are continuing to improve the quality of services.

11. Arising from recent concerns raised by HIQA in relation to standards of residential care, the HSE is implementing a comprehensive change programme of measures in a six-step change programme. This is targeted on improving the quality of residential services for people with disabilities and includes:
    - A National Implementation Task Force;
    - Implementing the National Policy and Procedures on Safeguarding Vulnerable Persons at Risk of Abuse
    - Implementation of an Evaluation and Quality Improvement Programme in Disability Residential Centres;
    - Developing a National Volunteer Advocacy Programme in Adult Disability Residential Settings;
    - An Assurance Review (McCoy Review) of all the Units in the Áras Attracta facility;
    - A series of National Summits;
    - Appointment of an independent person, Ms. Leigh Gath, as Confidential Recipient, to receive concerns of abuse, negligence, mistreatment or poor care practices in the HSE or HSE funded services from patients, service users, families or other concerned individuals and staff.

12. In addition, the HSE is establishing a National Independent Review Panel with an independent chair and Review Team for Disability Services. The HSE has prioritised this for 2016. The Review Panel will focus on serious incidents that occur in disability services across the HSE and HSE funded services.

***Transforming Lives* – the programme to implement the recommendations of the Value for Money and Policy Review of Disability Services**

13. *Transforming Lives* is the programme to implement the recommendations of the *Value for Money and Policy Review of Disability Services in Ireland* (2012) and continues to be a priority for the HSE.

14. Under *Transforming Lives,* disability services are migrating from an approach which is predominantly organised around group-based service delivery towards a model of person-centred, individually chosen, supports underpinned by a more effective method of assessing need, allocating resources and monitoring resource use.

15. Under the overarching Transforming Lives framework, a complex range of inter-related projects are underway to implement different elements of the new person-centred supports model, including the *Congregated Settings* Report, the *New Directions* report on adult day services and the *National Programme on Progressing Disability Services for Children and Young People (0 to 18 years).*

Time to move on from Congregated Settings – A Strategy for Community Inclusion

16. National policy on supporting people who live in congregated settings, defined as residential settings where ten or more people with disabilities live together, to move to the community were described in the report HSE's report on *Time to Move on from Congregated Settings – A Strategy for Community Inclusion* (June 2011) and underpinned by the *National Housing Strategy for People with a Disability 2011 – 2016*, published jointly by the Department of Health and the Department of Environment, Community and Local Government.

17. The Congregated Settings Report found that in 2008 around 4,000 people with disabilities were living in congregated settings. At the end of 2015 this number had reduced to less than 2,800 people.

18. The HSE's Social Care Directorate has prioritized the accelerated implementation of the decongregation policy in 2016.

Early Intervention Services / Waiting Lists for Therapy Services

19. €8m in additional funding is being provided in 2016 to complete the reconfiguration of therapy resources for children with disabilities *(National Programme on Progressing Disability Services for Children and Young People (0-18 years)* and to expand the provision of speech and language therapy through primary care services.

20. The key objective is to achieve equity of access and consistency of service delivery, with a clear pathway for children with disabilities and their families to services, regardless of where they live or go to school, or the nature of the individual child's difficulties.

Access to Free Pre-School Programme (ECCE) for Children with a Disability

21. This year, a key priority for the Department of Health and the HSE is to support the implementation by the Department of Children and Youth Affairs of the *Report of the Interdepartmental Group on Supporting Access to the Early Childhood and Education (ECCE) Programme for Children with a Disability.*

Part 2 of the Disability Act 2005 – Assessment of Need

22. A review of the assessment of need provisions in Part 2 of the Disability Act 2005 is planned for 2016.

23. Part 2 of the 2005 Act, which provided for a statutory system for the assessment of individual health service needs, service statements and redress for persons with a disability, was partly commenced in 2007 in respect of children up to the age of five. Arising from a High Court ruling in 2009, all children born on or after 1 June 2002 have been deemed as being eligible to apply for an assessment of need under the Act.

Day Services for School-leavers with Disabilities

24. The HSE is responsible for meeting the needs of around 1,500 young people with disabilities who require continuing health-funded supports on leaving school each year. A national planning and assessment process has been established to respond to the needs of these young people and to ensure a consistent approach is taken across the country to meeting those needs.

25. To ensure that identified needs are met, additional funding of €7.25m is being allocated by the HSE to provide services and supports for school-leavers and rehabilitative (life-skills) training graduates this year.

Transport Supports for People with Disabilities (Replace the Mobility Allowance)

26. Work is ongoing on policy proposals to be brought to Government for the drafting of primary legislation on a new Transport Support Scheme. The Department is seeking a solution which would best support people with severe disabilities who require additional income to contribute towards the cost of their mobility needs, while remaining within the available budget and satisfying all legal and equality concerns.

27. Payments of up to €208.50 per month are continuing to be made by the HSE to 4,700 people who were in receipt of the Mobility Allowance at the time that the scheme closed, in February 2013. Any proposals to be put to Government will seek to take account of this group.

Thalidomide

28. Irish survivors of thalidomide are seeking additional supports (financial and public service supports) from the State. Given the challenges that persist for each individual, the aim is to address the health and personal social care needs of thalidomide survivors living in Ireland. Of the 32 Irish survivors of Thalidomide, 22 have initiated personal injury claims in the High Court against the State. The personal injury claims are currently the subject of formal mediation.

29 [redacted]

Services for Older People

Main Functions:

1. This Unit is primarily responsible at a policy level for Older Persons services:- the HSE is responsible for front-line service provision. The Unit oversees the Nursing Homes Support Scheme (Fair Deal) which provides financial support to those (mainly but not exclusively older people) who are assessed as requiring long-term residential nursing home care. We are also responsible for Home Care and Palliative Care. The Unit also contributes to cross-sectoral collaboration with other Departments on national policies for older people.

Nursing Homes Support Scheme

2. The NHSS is a system of financial support for those in need of long-term nursing home care. Participants contribute to the cost of their care according to their means while the State pays the balance. In 2016 with a net budget of €940m the Scheme will support:
   - **23,450 clients** (on average per week) - an increase of 649 clients per week on 2015 projections.
   - Waiting times for approved applicants to receive funding should not exceed 4 weeks during 2016.

Home Supports

3. The HSE provides home support services, either directly or through service agreements with private and voluntary sector providers, to assist older people to live independently in their own homes. In addition to the mainstream Home Help Service, enhanced home care is provided through the Home Care Packages (HCP) Scheme. Services are provided on the basis of assessed health-care need and there is no means-testing. Other services include day care and meals-on wheels.

4. With a Budget of **€324m** in 2016 the HSE's projected target, set out in its National Service Plan, is to deliver
   - **10.4 million** Home Help Hours to about 47,800 people at any one time
   - **15,450 people** will be in receipt of a HCP at any one time.
   - **130 Intensive HCPs** for clients with complex needs (A further 60 clients with dementia will be supported by funding provided by Atlantic Philanthropies. (AP))

Community Supports

5. The provision of Short Stay Beds is a key component of the integrated model of care planned for the delivery of services to older people. Short stay beds are allocated across 'step up/step down' care, intermediate care, rehab and respite care depending on current demands. In 2016 the HSE will provide
   - **Over 2,000** short-stay residential care beds.
   - **313 transitional care beds**, targeted at 17 acute hospitals, and aimed at reducing delayed discharges, delivering 109 places per week.

Palliative care

6. At present, approximately 28,000 people die in Ireland each year. While many people will maintain good health into old age, it will be a challenge to ensure that high-quality end-of-life care is available to the increasing numbers of people with life-limiting illnesses, in all care settings. Palliative Care is moving beyond the traditional life limiting area of

cancer to address other non-malignant or chronic conditions (primary diagnosis: 77% cancer, 23% non-cancer).

7. The 2016 palliative care budget of €72m includes provision for the opening of 15 inpatient beds at Kerry Hospice which will bring the total number of specialist palliative care beds in 11 locations countrywide to 217. It follows the opening in 2014/2015 of 24 beds at Blanchardstown Hospice, an additional 20 beds in Marymount Hospice and an additional 6 beds in Galway Hospice. All HSE areas have Community Specialist Palliative Home Care Teams. The budget does not include expenditure on specialist palliative care provided in 38 acute hospitals, nor does it include the 170 palliative care support beds in 80 locations, or designated home care packages. Most of the funding is channelled through service level agreements between the HSE and voluntary hospices and homecare providers.

Current Issues.

NHSS Review

8. When the Nursing Homes Support Scheme was established in 2009, a commitment was given that it would be reviewed after three years. This Review was published in July 2015. An Inter-departmental Working Group has been established to oversee implementation of the Review recommendations which include:
   - Improvements to the administration of the Scheme;
   - A review of how prices for private and voluntary nursing homes are set by the National Treatment Purchase Fund;

9. The Working Group will make an interim report on progress to the Cabinet Committee on Health in June, 2016. Insofar as possible, the Review will be completed by the end of 2016.

National/Standards

10. Since 2009 all nursing homes - public, voluntary and private - have been registered and inspected by HIQA. Requirements for such facilities are set down in Regulations made by the Minister, which are complemented by National Quality Standards framed by HIQA for the Minister's approval. When HIQA oversight of nursing homes commenced, it was announced that all nursing homes, whether public or private, would have to comply with relevant National Standards by 2015. In the event this has not proved possible, as the State has suffered its worst ever economic crisis in the years since 2009, and many public facilities are housed in very old buildings.

11. Accordingly, funding totalling **€385m** (€148m in current capital plan, together with €237m new Capital Programme) has been made available from 2016-2021 to bring these units to compliance with HIQA Standards by 2021. An additional **€150m** may be sourced through PPP or alternative funding arrangements. The programme of refurbishment and replacement of facilities is based on a planned programme of works from 2016 to 2021prepared by the HSE taking account of HIQA's priorities.

Regulation of Home Supports

12. Home care services are not subject to a statutory regulatory regime and this situation has been under consideration by the Department and the HSE for some time. To inform this exercise, the Health Research Board has been asked to identify and describe approaches to this issue in other relevant jurisdictions. In the meantime the HSE is considering how it

can foster higher standards of homecare provision both across its directly-provided services and those externally procured by HSE.

Home Support Services

13. The HSE's objective for Q1 2016, in line with Winter Planning for ED Taskforce, was to target homecare to have as much impact as possible on delayed discharges. However, responding to the needs of acute hospitals in the context of a 7.5% increase in attendances since January involved costs which exceed what can be sustained over the full year. The HSE must reduce current activity or face an overrun of an estimated **€14.55m** by end-December. Accordingly, service provision is being generally scaled back to a level that will avoid an overrun at year end.

National Dementia Strategy

14. There are approximately 50,000 people with dementia in Ireland today. These numbers are expected to increase to over 140,000 by 2041, mostly because of overall increases in the numbers of older people. In recognition of this a National Dementia Strategy was published in 2014. Under the Strategy, the Department and the HSE have agreed a joint initiative with Atlantic Philanthropies to implement significant elements of the Strategy over the period 2014-2017. This programme will represent a combined investment of **€27.5m** (AP €12m/HSE €15.5m) over 3 years to 2017.

National Positive Ageing Strategy (NPAS)

15. The National Positive Ageing Strategy was published in 2013. This Strategy highlights that ageing is not just a health issue, but requires a whole of Government response to address a range of social, economic and environmental factors that affect the health and wellbeing of our ageing citizens. The Department of Health has an overall coordinating and collating role and a more direct role for the health-related objectives. As part of the implementation process, a Healthy and Positive Ageing Initiative has been established in collaboration with Atlantic Philanthropies to measure the impact of the Strategy and establish an ongoing system for measuring and reporting on Positive Ageing.

TILDA

16 [redacted]

17 [redacted]

Palliative Care

18. The HSE has set up a steering group to review the existing national strategic and policy documents and develop a new framework which will provide a direction for adult palliative care services over 2016-2018. The framework is due to be published in the first

half of 2016. This will call for significant increases in funding and it may therefore be problematic for the Minister to accept this document without qualification.

Long Stay Charges Unit

Unit Responsibilities

1. Long Stay Charges Unit has responsibility for all aspects of charges that apply to service users in receipt of long stay residential care other than those supported under the Nursing Homes Support Scheme (Fair Deal).

2. The unit also deals with litigation relating to long stay charges and nursing home fees as well as special needs education and related therapies in which health authorities are joined with the education authorities as co-defendants.

Unit's Key Objectives for 2016

3. Commencement of Residential Support Services Maintenance and Accommodation Contributions. This new contributions regime will replace existing long stay charges which were introduced in 2005. It has been provided for by the Health (Amendment) Act 2013 as amended by Part 3 of the Health (Miscellaneous Provisions) Act 2014. RSSMACs will apply to residents of long stay settings where accommodation and/or maintenance are provided by the HSE or by a service provider acting on the HSE's behalf. When RSSMACs are commenced, the relevant provisions of the Health (Amendment) Act 2013 will also ensure that acute hospital charges are provided for under a separate section of the Health Act 1970 (both long stay charges and acute hospital charges are currently provided for by section 53 which will be repealed).

4. Continued management of any relevant litigation in conjunction with the Department's co-defendants and our legal advisers.

5. Closure of the Health Repayment Scheme (administered by the HSE).The scheme was introduced in 2006 to provide a legal basis for the repayment of charges which, prior to the introduction of long-stay charges under the Health (Amendment) Act 2005, had been imposed on those with medical card entitlement in public long stay care. The scheme closed to new applications at the end of 2007 and has to-date (May 2016) provided for a total of almost 20,300 repayments with an overall value of over €452m. There are a very small number of claims remaining to be finalised and some legal measures to be put in place in order to formally close the scheme.

MANAGEMENT BOARD Area: Nursing/Midwifery, Mental Health, Drugs Policy & Social Inclusion; Dr. Siobhan O'Halloran (Chief Nursing Officer)

(Units & Principal Officers; Office of the Chief Nursing Officer Unit including Nursing Policy and Reform Programme Management – Larry O'Reilly Drugs Policy and Social Inclusion Unit – Susan Scally, Mental Health – Colm Desmond)

The Chief Nursing Officer's Office

Function of the CNO's Office

1. The Chief Nursing Officer's Office (CNO's Office) plays an important strategic and leadership role and provides professional policy direction and evidence based advice in relation to nursing and midwifery services. The appointment of the first CNO at Assistant Secretary level in 2013 was designed to ensure that a nursing and midwifery perspective was brought to bear on the development of policy. The Office is built on a partnership model, with clinicians and civil servants working together to develop policy. The CNO is supported by specialist nursing and midwifery expertise from three Deputy CNOs. The three general areas for which the Deputy CNOs currently have respective responsibility are
   - Women's Health, Child Health and Welfare, and Primary Care Services;
   - Nursing and Midwifery Policy, Education and Legislation; and
   - Clinical Governance and Practice.

Major Tasks/Policy Initiatives for 2016

Strategy for the CNO's Office

2. A three year (2015–2017) Strategy for the CNO's Office was launched on the 3 February 2016 and its implementation is already well underway.

3. The purpose of the Strategy is to ensure there is broad understanding, both internally and externally, of the role of the CNO's Office and the link between the Office and overarching health policy.

4. The Strategy sets the direction for the Office up until end 2017 and is underpinned by four strategic objectives:
   - To provide expert policy input and direction to support government priorities and to optimise public investment in the health system;
   - To strengthen the role of nurses and midwives to optimise the scope of practice across the health service;
   - To enhance the impact[3] of nurses and midwives and demonstrate this through the utilisation of robust data intelligence;
   - To enable nurses and midwives to serve as full partners in health care design and improvement by enhancing leadership, competency and opportunities.

5. The **Vision** of the CNO's Office is a future where the contribution of nurses and midwives to the achievement of national public health goals, in partnership with other health and social care professionals, is optimised through policy development and implementation.

[3] Impact refers to productivity, stability, capacity and capability.

6. The **Mission** of the CNO's Office is to optimise the contribution of nursing and midwifery to health service priorities, in partnership with other health and social care professionals, and in the interests of service users, their families, and the wider community.

7. The Office's **Values** are Accountability, Care, Collegiality, Excellence, Integrity and Safety.

8. The **Priority Actions** for 2015 (the first full year in the existence of the CNO's Office) were:
   - A policy framework for staffing and skill mix for nursing (Phase I);
   - A policy on future nursing and midwifery in the community capable of driving integration of primary care and acute nursing and midwifery services;
   - A policy to provide direction on the future development of advanced and specialist nursing and midwifery practice within the context of the overall health reform programme;
   - A policy on key performance indicators to measure the outcome and impact of nursing and midwifery;
   - A position paper reaffirming the values of nursing and midwifery.

9. An associated Communications Strategy is also being implemented in 2016.

Initiative on Nursing and Midwifery Values

10. A communication and consultation initiative on the affirmation of values that underpin nursing and midwifery practice was launched on 3 February 2016. Its objective is to identify values that support behaviours associated with care, compassion, and competence and ensure that they are reinforced in nursing and midwifery practice and culture across all settings. The initiative involves extensive consultation with stakeholders and the development of a repository of good practice. This will help the nursing and midwifery professions contribute to a culture of safe patient care. The culmination of this initiative will be a conference entitled 'Reaffirming the Values of Nursing and Midwifery' that will take place on 1 June.

Taskforce on Staffing and Skill Mix for Nursing

11. In 2014, a Taskforce was established to develop a framework to support the determination of staffing and skill mix in nursing (whereby nursing refers to the nursing team including both the nurse and healthcare assistant workforce) in a range of major specialities. Phase I of the Taskforce is focused on the development of a framework for staffing and skill mix in nursing in general and specialist medical and surgical care settings in acute adult hospitals. This work is critical in the context of the current, largely historical approach to nurse staffing determination. An Interim Report on the *Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings in Adult Hospitals in Ireland* was approved by the Minister in November 2015 and launched on 1 February 2016 with approval to proceed to pilot throughout 2016.

12. The Taskforce is chaired by the CNO. The Terms of Reference for the Taskforce are:
   - To develop a staffing (nurse and healthcare assistant) and skill mix ranges framework related to general and specialist adult hospital medical and surgical settings based on best available international evidence;

- To set out clearly the assumptions upon which the staffing and skill mix ranges are determined;
- To make recommendations around implementation and monitoring of the framework including the necessary education, training, and guidance required;
- To present a written report to the Minister for Health.

13. For the first time there will be a defined evidence based process and governance mechanism to determine optimum nurse staffing levels to deliver high quality safe care that will equally add order and structure to the process for resolving staffing/IR disputes.

Pilot project on nurse staffing in medical and surgical wards

14. As a prototype in the Irish health system, whereby assumptions have been made on the estimated cost/savings on implementation, it is important to test the capability of the Framework to deliver on its intended outcomes through a pilot project. A budget of €2m has been included in the HSE NSP to carry out the pilot in 2016. The pilot is being managed and co-ordinated by a subgroup of the Taskforce Steering Group, established as a pilot planning and implementation group for the duration of the pilot throughout 2016. The chair of this group is the CNO. The pilot is being undertaken in a selection of general and specialist medical and surgical wards across three hospitals, representing each of the hospital model types: Model 4, Model 3 and Model 2. On subsequent completion of the pilot the planning and implementation group will formulate a report of the pilot for submission to the Taskforce Steering Group that will be used to inform the Final Report and Recommendations of the Taskforce for submission to the Management Board and the Minister.

15. This Framework presents multiple benefits with the potential to stabilise and optimise the nursing workforce across medical and surgical care settings in acute hospitals, in addition to contributing to the wider benefits of a healthier work environment to positively impact on recruitment and retention, along with the potential for strengthening health pricing and benchmarking of the nursing resource.

Future integrated nursing and midwifery models in the community

16. In 2015 the CNO commissioned an evidence review on future nursing and midwifery models in the community capable of driving integration of primary care and acute nursing and midwifery services. This evidence review, completed in February 2016, will support the work of the Department of Health to inform future policy development in line with Government reform. Findings of the evidence review will be explored by a stakeholder group and the essential components of a proposed integrated model of nursing and midwifery across the health services will be developed for consideration.

Significant events/milestones

17. The recent significant events/milestones for the CNO's Office are as follows:
    - The Programme of Work for 2015 was completed by end 2015.
    - A Programme of Work for 2016 was developed and is being implemented.
    - A Communications Strategy for the Office was developed and is being implemented.
    - An Interim Report on the *Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings in Adult Hospitals in Ireland* approved in November 2015 and launched on 1 February 2016. The pilot of the Framework commenced on 2 February 2016.

- A three-year Strategy for the Office was launched on 3 February.
- An Initiative on Nursing and Midwifery Values was launched on 3 February.
- The monitoring and implementation of the Report of the Review of Undergraduate Nursing and Midwifery Degree programmes was completed.

Drugs Policy and Social Inclusion Unit

Main Functions

1. Government policy on tackling the drug problem is set out in the National Drugs Strategy (NDS) 2009-2016. Its overall strategic objective is to tackle the harm caused to individuals and society by the misuse of drugs through a concerted focus on the five pillars of supply reduction, prevention, treatment, rehabilitation and research. Drugs Policy Unit is responsible for driving and coordinating the effective implementation of the NDS. It is also responsible for developing national policy on drugs and for ensuring that drugs policy is informed by evidence on the nature and extent of problem drug use in Ireland and internationally. The remit of the Unit has recently been expanded to include social inclusion. This covers the development of policy to meet the health needs of vulnerable groups i.e. Traveller/Roma, Refugees/Asylum Seekers and homeless persons.

Implementation of the National Drugs Strategy

2. An Oversight Forum on Drugs (OFD) is responsible for the high level monitoring of progress being made in the implementation of the NDS across Government departments and agencies. The OFD is chaired by the Minister with responsibility for the NDS, and meets quarterly. It produces an annual progress report each year. The 2015 report has recently been published on the Department's website.

Development of new National Drugs Strategy

3. Drugs Policy Unit is responsible for leading the development of a new National Drugs Strategy, which is to commence in January 2017. A Steering Committee, chaired by John Carr, former secretary general of the INTO, has been established to advise the Minister with special responsibility for a NDS on the development of a new Strategy. An international Expert Review Group has been appointed to carry out an independent high level review of the current Strategy. The review will consider the overall impact of the strategy in tackling the drugs problem in Ireland and progress in terms of developments internationally. The outcome of the review will assist in determining areas for consideration in the new Strategy.

4. The development of the new Strategy will also involve an examination of the approach to drug policy in other jurisdictions, a review of international evidence on interventions to tackle the drug problem and a comprehensive consultation process. In addition, focus groups with cross-sectoral membership are being established to advise the Steering Committee on priorities for the next Strategy in the areas of supply reduction, continuum of care, education and prevention and evidence and best practice. It is anticipated that the final report of the Steering Committee will be submitted to the Minister with responsibility for the NDS by the end of the year.

Publication of the results of the 2014/2015 Drugs Prevalence Survey

5. The Unit oversees the implementation of the National Advisory Committee on Drugs and Alcohol (NACDA) work programme, and provides administrative support to its committees. The 2014/15 Drugs Prevalence Survey was commissioned by the NACDA and the Public Health Information & Research Branch of the Department of Health, Social Services and Public Safety. The first results of the Survey are expected by the end of June 2016.

Medically Supervised Injecting Centre (MSIC)

6. The Unit will provide policy input into the preparation of legislation and regulations to enable the operation of an MSIC, and will commence preparatory work on the development of a plan to establish a pilot MSIC, in consultation with the HSE, An Garda Síochána and other relevant interest groups.

UNGASS

7. The UN General Assembly held a Special Session (UNGASS) on drugs from 19th to 21st April 2016 in New York. This Special Session was an important milestone in achieving the goals in the policy document of 2009 "Policy Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem" which defined action to be taken by Member States as well as goals to be achieved by 2019. An Outcomes Document, adopted by acclaim at the first plenary session, contains a series of operational recommendations to counter the world drug problem. It showed progress in agreeing language on proportional sentencing, the importance of evidence-based policies, gender mainstreaming, greater consideration of human rights aspects, new psychoactive substances/NPS, and in taking account of WHO resolutions.

8. The Unit co-ordinates the Irish drug policy responses at international level through the International Drug Issues Group, which meets every quarter. Its membership includes the Departments of Justice & Equality, Foreign Affairs & Trade, Revenue's Custom Service, An Garda Síochána, the Health Products Regulatory Authority and the Health Research Board. The Unit represents the Department on the EU Horizontal Working Group on Drugs, which is responsible for leading and managing the EU Council's work on drugs. It also coordinates the EU input into UNGASS negotiations.

EU Membership

9. The European Monitoring Centres on Drugs and Drug Addiction is an EU agency based in Lisbon. It provides the EU and its Member States with information on the nature, extent, consequences and responses to illicit drug use. The Unit is on the Management Board of the Centre and is a member of the Executive Committee.

10. The British-Irish Council was established as part of the multi-party agreement reached in Belfast in 1998 to further promote positive, practical relationships among the people of the islands and to provide a forum for consultation and co-operation. Its membership comprises representatives from the Irish Government; UK Government; Scottish Government; Northern Ireland Executive; Welsh Government; Isle of Man Government; Government of Jersey and Government of Guernsey. Ireland chairs the Misuse of Substances Sectoral Group, which meets approximately 3-4 times a year.

Framework to measure the performance of Drug and Alcohol Task Forces

11. Drug and Alcohol Task Forces play a key role in assessing the extent and nature of the drug problem in their areas and co-ordinating action at local level so that there is a targeted response to the drug problem in local communities. 14 Local Task Forces cover areas where there is the highest concentration of drugs activity i.e. 12 in Dublin, 1 in Bray and 1 in Cork. 10 Regional Task Forces cover the rest of the country. Each Task Force has an allocation for community-based drugs initiatives set up to tackle the drugs problem under each pillar of the National Drugs Strategy.

12. Arising from a request of the Cabinet Committee on Social Policy, a review of Drugs Task Forces and the National Structures under which they operate was carried out in 2011/ 2012. The review identified a series of reforms to better equip the Task Forces to respond to the current patterns of substance misuse. Arising from the review, Drugs Task Force were given a role in tackling alcohol misuse and a National Coordinating Committee (NCC) was set up to oversee and monitor their work and drive implementation of the NDS at the local level. This committee meets every two months and is chaired by Siobhan O'Halloran, Assistant Secretary.

13. The review of Drugs Task Forces recommended that the NCC should develop a common evidence based assessment tool incorporating key performance indicators to measure the impact of the Drugs Task Forces, having regard to best practice internationally. In line with this recommendation, the Department has commissioned external consultants to develop a performance measurement framework for Task Forces. The framework will provide a mechanism to target funding allocations on the basis of objective criteria, having regard to the drugs situation in the Task Forces catchment areas and other demographic factors. The new funding model will also incentivise the use of evidence-based interventions by Task Forces. The objective is to have the framework ready when the new Drugs Strategy is in place in January 2017.

Service provision and expenditure under the Drugs Initiative

14. This Unit oversees service provision and expenditure under the Drugs Initiative (Subhead B3) which has an allocation of €6.026m for 2016. This funding supports 80 community drugs prevention projects while the remainder funds the National Advisory Committee on Drugs and Alcohol, the National Family Support Network and the Citywide Drugs Crisis Campaign. Since 1 January 2014, over €22.9m has transferred to the HSE in respect of 241 treatment and rehabilitation community drugs projects in order to strengthen accountability for their activities and expenditure. The Unit continues to have a governance role in relation to the HSE projects.

Improving health outcomes for vulnerable groups

15. €2m is being provided to address the mental health needs of homeless persons in the Dublin region this year, from additional funding secured for mental health in the 2016 HSE National Service Plan. The funding will support care and case management and intensive addiction and mental health in-reach programmes for homeless people in supported temporary accommodation and in long-term accommodation. The increased funding will also support long-term intensive care for homeless people with chronic and enduring health needs living in long-term supported accommodation that do not require acute hospital care, but have high support needs. The Unit also oversees the implementation of recommendations relevant to the health sector in the Implementation plan on the State's Response to Homelessness.

16. During 2016 the Unit will work closely with the HSE on a plan aimed at responding to the general health, mental health and psychological needs of incoming refugees, and will represent the Department on the Irish Refugee Protection Programme Task Force.

17. The Unit also oversees the implementation of recommendations relevant to the health sector in the National Traveller and Roma Inclusion Strategy, and represents the Department on the Steering Group developing a new Strategy.

Mental Health Unit

Mental Health Unit - Functions

1. As part of the Nursing/Midwifery, Mental Health, Drugs/Social Inclusion Division, the Mental Health Unit is responsible for policy on Mental Health including *A Vision for Change:* Report of the Expert Group on Mental Health Policy (2006), *Connecting for Life* Ireland's Suicide Prevention Strategy (2015-2020), monitoring and supporting the HSE on implementation of all aspects of the 2016 National Service Plan relating to mental health; the Mental Health Act 2001 and the review of the Act; governance of the Mental Health Commission; monitoring HSE mental health capital projects, including developing a new National Forensic Mental Health Service.

Mental Health Budget

2. The overall gross non-capital mental health budget for 2012 – 16 is as follows:

2012	2013	2014	2015	2016
€711m	€737m	€766m	€791.8m	€791.6m*

**excludes the €35m held by the DOH*

Overall Mental Health funding balance

3. An additional €160m has been provided on a ring-fenced basis since 2012 specifically for new developments in mental health. However, on a year-by-year basis the HSE mental health budget has also been subject to downward adjustments for pay and procurement savings, similar to other HSE service areas, and offset by some upward technical adjustments across the HSE service budgets. In addition, difficulties in recruiting to new posts in 2012 and 2013, in particular, led to the use of new funding in these years for alternative service purposes. The recruitment situation improved by late-2014 but remains challenging. The recruitment situation, and the technical adjustments outlined above, have meant that the budget for mental health in the Service Plan has increased by €115m (including 2016's €35m) since 2012.

Time-Related Savings

4. The HSE National Service Plan for 2016 states: '*The €58.5m being held by the DoH relates to specific initiatives in the areas of mental health €35m, primary care €13.5m, therapy services for young people €8m, and the nursing taskforce pilot implementation €2m. The release of these funds will be approved as specific implementation plans are agreed during the year. The HSE will use €20m in time related savings from these planned initiatives, on a once off basis, to continue to provide the 2015 outturn levels of home care and transitional care beds, which is above the 2015 planned service level and up to a further €1.5m to put in place an advance purchase agreement in relation to vaccines.*' On the basis of the €20m TRS figure, HSE Mental Health Division have set aside approx. €12m as their contribution (a proportional calculation) from the additional funding for mental health in 2016 of €35m.

Recent Investment in Mental Health

5. The additional funding has served to modernise mental health services in line with *A Vision for Change* (AVFC) and previous Programme for Government commitments. A key focus has been additional posts to strengthen Community Mental Health Teams for both adults and children. It has also been used to enhance specialist community mental health and forensic services, increase the access to counselling and psychotherapy and for suicide prevention initiatives. Approximately 1,550 new posts have been approved since 2012 up to the end of 2016, of which some 1,153 have been recruited or are in the

recruitment process, by the end of 2015. These posts facilitate the policy of moving away from traditional institutional based care to a patient-centred, flexible and community based mental health service where hospital admissions are greatly reduced, while still providing in-patient care when appropriate.

6. **Priority initiatives in 2016:**
   - The continued development of counselling services across both primary and secondary care, including the provision of three new Jigsaw youth mental health services in Cork (2) and Dublin (2) and Limerick (1) city centres.
   - The continued development of Community Mental Health Teams and improved 24/7 response and liaison services.
   - Psychiatry of Later Life.
   - Perinatal Mental Health.
   - Two new mental health clinical programmes, specifically, ADHD in Adults and Children, and Dual Diagnosis of those with Mental Illness and Substance Misuse.

Mental Health Policy – *'A Vision for Change'*

7. *'A Vision for Change'* Ireland's policy for mental health services is ten years old this year and work is underway to scope out proposals for a review of the policy.

Child and Adolescent Mental Health Services (CAMHS)

8. The HSE is committed to ensuring that all aspects of CAMHS services are delivered in a consistent and timely fashion, including improved Access. The Executive introduced in mid-2015 a new **Standard Operating Procedure** for both in-patient and community CAMHS services. This has helped improve the service overall, such as reducing inappropriate admissions of adolescents to adult units, and reducing Waiting Lists, particularly for those waiting over 12 months. The total number of children waiting to be seen increased slightly from 2,273 in November to 2,298 in December. The numbers waiting less than 3 months increased from 1,096 to 1,166. Those waiting 12 months or more decreased from 207 in November to **181** in December. To put this achievement into context, those waiting 12 months or more at end December 2014 was 405, a reduction over twelve months of 55% (or 60% reduction compared to April 2015, when the CAMHS Waiting List Initiative for those over 12 months was commenced by Minister Lynch.)

Admission of Children to Child and Adolescent Acute Inpatient Units (CAMHS)

9. The HSE annual target for admission of children to CAMHS units is 95%. For December last, an 80 % admission rate was achieved (20 out of 25 admissions). The December rate of 80% is a significant improvement from 55% in January 2015. In 2015, there was a total of 356 CAMHS admissions, of which 261 (73%) were to age-appropriate units and 95 (27%) to Adult Units. The 95 CAMHS admissions to Adult Units in 2015 compared to 89 in 2014. CAMHS admissions to Adult Units therefore are showing an increase year-on-year for the first time since 2008, when there were 247 admissions. The HSE is monitoring this situation closely with a view to limiting inappropriate admissions as much as possible. An additional 8 CAMHS beds were added with the opening of Linn Dara in early December 2015, thus increasing the total number of operational CAMHS beds to 66, allowing greater capacity for admissions to appropriate child and adolescent units.

National Forensic Mental Health Services

10. Funding is included in the HSE capital programme to develop the National Forensic Mental Health Service. This involves a new 120 bed hospital at Portrane, to replace the existing Central Mental Hospital at Dundrum, and four new Intensive Care Rehabilitation Units (ICRUs) - at Portrane, Cork, Mullingar, and HSE West). Planning permission for Phase 1 was granted in June 2015, and the HSE recently commenced advanced works at Portrane. The main construction work is expected to start in Q4 2016, and finish in Q4 2018 - with the new hospital opening in mid-2019. Phase I comprises of core forensic project requirements at St. Ita's, Portrane for a 120-bed National Forensic Hospital, and a 10-bed Mental Health Intellectual Disability (MHID) Unit and a 10-bed Child and Adolescent Mental Health (CAMHS) Unit. Phase II includes three new 30 bed Intensive Care Rehabilitation Units (ICRUs) envisaged on completion of Phase 1, along with a fourth possible unit in an existing facility in Mullingar. The HSE capital programme allows for planning for the new ICRUs - proposed for Portrane, HSE South and HSE West - but not construction/equipping.

Review of Mental Health Act 2001

11. The report of the Expert Group set up to review the Mental Health Act 2001 was published by Minister Lynch on 5 March 2015. The report contains 165 recommendations and proposes a move away from the often paternalistic interpretation of the existing legislation as well as including provisions which are intended to strengthen the protections for people who are detained without consent in approved centres. The Minister has accepted the broad thrust of the changes recommended by the Expert Group and Government approval has been received for the drafting of a General Scheme of a Bill to amend the existing legislation to reflect the recommendations of the Expert Group and work is progressing in the Department on these important amendments.

12. In addition, priority amendments to the Mental Health Act 2001 regarding the administration of Electro-convulsive Therapy (ECT) and the administration of medicine (after three months) were passed in both the Dáil and the Seanad in December 2015. These changes mean that when a person with capacity refuses ECT or medicine (after three months), this decision will be respected. A commencement order to bring the amendments to the Mental Health Act 2001 into operation was recently signed by the Minister with an effective date of 15 February.

Suicide Prevention

Suicide Rate

13. The most recent confirmed CSO figures indicate there were 487 deaths by suicide in 2013 (391 men and 96 women), equating to 10.6 per 100,000 of the population. This represents a 10 % decrease when compared to 2012 (541 deaths which equates to 11.8 per 100,000). While Ireland's suicide rate is not high by European comparison, suicide rates among young males and females are high. Taking males and females aged 15-19 years together, the rate was 10.5 per 100,000 of the population, the fourth highest rate in this age group across the 31 European countries studied.

National Strategy to Reduce Suicide (2015-2020)

14. Launched in June 2015, *Connecting for Life* is Ireland's National Strategy to Reduce Suicide (2015-2020). It sets out a vision of an Ireland where fewer lives are lost through suicide, and where communities and individuals are empowered to improve their mental health and well-being. This National Strategy is being led by the Department of Health

and involves actions assigned to the HSE and various Government departments. Responsibility for monitoring and reporting systems to support the delivery of the Strategy has been assigned to the National Office for Suicide Prevention. The Cross-Sectoral Steering Group, established to implement the Strategy, held its first meeting on 23 February. Given the cross Departmental dimension to *Connecting for Life* it has been selected as one of the Pathfinder Projects as part of the Civil Service Renewal Plan.

Funding for Suicide Prevention

15. Funding for suicide prevention has increased significantly in recent years from €3.7m in 2010 to the current level of €11.55m, which includes an additional €2.75m provided in 2015 for additional Resource Officers for Suicide Prevention and for priority actions in *Connecting for Life.*

MANAGEMENT BOARD Area: Office of the Chief Medical Officer; Dr Tony Holohan (Chief Medical Officer)

(Units & Principal Officers or Equivalents; Health & Wellbeing Programme Unit– Dr Kate O'Flaherty, Health Promotion Unit – Dr. John Devlin, Tobacco & Alcohol Control Unit – Geraldine Luddy, Health Protection Unit – Dr. Colette Bonner, Child & Wellbeing Advisor – Dr Sean Denyer, Bioethics Unit– Dr. Siobhan O'Sullivan, Food Safety & Environmental Health Unit– Audrey Hagerty, Patient Safety – Dr Eibhlin Connolly/Dr Kathleen MacLellan, Clinical Effectiveness Unit – Dr. Kathleen MacLellan).

Health & Wellbeing Programme Unit

Healthy Ireland

1. The Health and Wellbeing Programme leads the coordination of implementation of Healthy Ireland, the national framework to improve health and wellbeing. Healthy Ireland takes a 'whole of government' and 'whole of society' approach to tackling the major lifestyle issues which lead to negative health outcomes, and seeks to address wider social and environmental factors that impact on health and wellbeing. It aims to shift the focus to prevention, seeks to reduce health inequalities, and emphasises the need to empower people and communities to better look after their own health and wellbeing.

2. Since the publication of Healthy Ireland in 2013, the Health and Wellbeing Programme has worked to build relationships and strengthen partnerships with other Government Departments, Local Authorities, the education sector, as well as the wider business, voluntary and community sectors. The Programme works closely with the Health and Wellbeing Division in the HSE. It is supported by a Cross Sectoral Group of senior officials from Government Departments and key agencies; and a Healthy Ireland Council made up of a wide range of stakeholder sectors. Implementation is overseen by the Cabinet Committee on Social Policy and Public Sector Reform.

2016 Priorities and Significant Issues:

3. **Implementation of the National Physical Activity Plan.** Early implementation of the Plan, published in January 2016, will include the development of a communications campaign, supporting physical education in schools, and programmes to increase participation at community level.

4. **Healthy Workplaces Framework.** Development of a national framework for healthy workplaces has commenced. The subgroup overseeing this work is co-chaired by the Department of Health and the Department of Jobs, Enterprise and Innovation.

5. **Health and Wellbeing (Calorie posting and workplace wellbeing) Bill**. The workplace wellbeing element of the Bill will require all public sector workplaces to have and to report on a healthy workplace policy. It is intended that heads of the Bill will be prepared by end Q2 2016.

6. **Healthy Ireland Survey 2016**. The first annual Healthy Ireland Survey was published in October 2015, giving an up-to-date picture of the heath of the population. Findings of the second wave are expected to be ready for publication in September.

7. **'Warmth and Wellbeing' Pilot Project.** The Health and Wellbeing Programme is supporting this project, which is being led by the Department of Communications, Energy

and Natural Resources. The pilot aims to carry out deep energy efficiency improvements to the homes of people with identifiable health issues and measuring the benefits to health and wellbeing. The pilot will be formally launched in Q2 2016.

8. **Healthy Ireland Outcomes Framework**. The Outcomes Framework will provide evidence to support an objective assessment of the impacts of Healthy Ireland and to help partners in wider government and society to prioritise their actions on improving health and wellbeing. The development of the Outcomes Framework is nearing completion and a first version is due for publication in Q2.

9. **Healthy Ireland Communications**. In 2015, the Programme developed a website, newsletter and social media platforms to support communication and engagement around the Healthy Ireland agenda. In 2016, a number of co-branded/supported initiatives will be further enhanced and promoted, including Operation Transformation, GAA Healthy Clubs, parkrun, Get Ireland Walking, Active School Flag, and new opportunities for partnerships progressed.

Health Promotion Unit

1. The Health Promotion Unit aims to develop policy on obesity and nutrition, monitors and evaluates the continued implementation of disease strategies, including the National Cardiovascular Health Policy and diabetes, leads the development of policy on rare diseases and supports those relating to non-communicable diseases (NCDs).

2016 Priorities and Significant Issues:

2. **Obesity Policy and Action Plan:** The development of a new national Obesity Policy and Action Plan is a major project for 2015 – 2016. The policy has been informed by comprehensive consultation with major stakeholders, health experts, health care providers and children. Every sector will have a role to play, with the principle of a 'whole of Government and a whole of society' approach at the heart of the new policy. The draft policy has been presented to the Senior Officials Group (SOG) and to the Healthy Ireland Cross-Sectoral Group.

3. **Calorie Posting in Restaurants:** As Irish consumers spend €6.1 billion on out-of-home food and drink consumption, legislation is being prepared on calorie labelling in order to help educate the general public on the calorie content of food portions. To inform this process, a public / industry consultation on the proposed legislation and an independent evaluation of the current voluntary calorie posting scheme have recently been finalised with a view to drafting Heads of legislation.

4. **Review of Healthy Eating Guidelines:** Following a scientific review of current Healthy Eating Guidelines by the HRB, the Special Action Group on Obesity established a working group to update and issue new Healthy Eating Guidelines. They have been focused tested and the resources are currently being amended in line with feedback. They are expected to be finalised in the coming months and an implementation plan will be developed.

5. **Rare Diseases:** A National Plan for Rare Diseases was launched in mid-2014. An Oversight Group chaired by the Department has been established to monitor progress with the implementation of its 48 recommendations. A National Clinical Programme for Rare Diseases has been established in the HSE and a Clinical Lead has been appointed. A National Office for Rare Diseases has also been funded and established and will be a focal point for information on rare diseases. The key issue in 2016 is the designation of Irish Centres of Expertise for the purpose of participating in European Reference Networks.

6. **NCDs/Chronic Diseases:** NCDs and chronic diseases often require lifelong monitoring and treatment, but many NCDs can be prevented. The development of a chronic disease framework by the HSE aims to provide patients with a continuum of diagnostic, care and support services according to need over time, across different areas of the health service. The intention is to ensure joined up health services and improve patient outcomes. The HSE has National Clinical Programmes for chronic diseases such as diabetes, stroke, heart failure, arthritis, COPD. The aim of these programmes is to design models of care, guidelines, pathways and associated strategies for the delivery of clinical care, which will feed into the GP contract.

7. **Health Behaviours in School Children (HBSC) survey**: The HBSC is a WHO (European) collaborative study. In Ireland, it is a national survey of school-going children

on various topics such as smoking, alcohol, diet, physical exercise, etc. The results of the survey were launched in December 2015. In 2016, it is expected that a trends report will be published. This will consolidate results from all previous surveys to show long term trends in the health behaviours of school children.

Tobacco and Alcohol Control Unit

1. The remit of the Tobacco and Alcohol Control Unit is to develop and implement policy and legislation in the area of tobacco and alcohol. The Department's tobacco policy is set out in *Tobacco Free Ireland*; alcohol policy is outlined in the *National Substance Misuse Policy*. The Unit also provides oversight of the Protection of Life During Pregnancy Act, and policy issues in respect of abortion.

2016 Priorities and Significant Issues:

2. **Public Health (Standardised Packaging of Tobacco) Act:** Amendments to the *Public Health (Standardised Packaging of Tobacco) Act 2015* are being made under the Health (Miscellaneous Provisions) Bill 2016, initiated in the Dáil in January this year. The amendments set out further provisions for retail packaging of tobacco products, some which are of a technical and practical nature and some of which seek to provide basic information to the consumer. Draft regulations on the prescribed aspects of the Act have been notified to the EU under the Technical Standards Directive. A legal challenge to the Act has been initiated on behalf of Japan Tobacco Ireland Limited (JTI); it is envisaged that more challenges to this legislation will arise in 2016.

3. **EU Tobacco Products Directive:** The revised EU Tobacco Products Directive (2014/40/EU) has been in force from 20 May 2014. This Unit is preparing regulations to transpose the Directive into Irish law by 20 May 2016. The Tobacco Products Directive was challenged on a number of grounds in the Court of Justice of the European Union (CJEU). The Court judgments in these cases were delivered on 4 May and provide a strong endorsement of the legal provisions of the Directive.

4. **Licensing legislation:** The Government approved the drafting of a General Scheme of a Bill to provide for introduction of a licensing system and other measures in relation to the sale of tobacco products and non-medicinal nicotine delivery systems, including e-cigarettes. The licensing system will further regulate the selling of tobacco products in line with *Tobacco Free Ireland.* A public consultation has been held; subject to resources the intention is to draft the General Scheme in 2016.

5. **Public Health (Alcohol) Bill:** Second stage of the Public Health (Alcohol) Bill was completed on 17 December 2015. On 22 January 2016, the European Commission was formally notified of Ireland's intention to introduce the proposed legislation on minimum unit pricing, labelling and control of marketing and advertising under the Technical Standards and Regulations Directive (Directive 98/34/EC). The initial standstill period ended on 28 April 2016 but as 9 Member States issued a detailed opinion the standstill period is extended until 28 of July 2016. The EU Commission and two other member states issued comments. Labelling provisions were also notified under EU Directive 2000/13/EC on the labelling and presentation and advertising of foodstuff. The Commission has sought additional information and the Unit will respond shortly. A recent European Court of Justice ruling on proposals by the Scottish Government to introduce Minimum Unit Pricing (MUP) may have implications for the Public Health (Alcohol) Bill; officials from this Department and the Office of the Attorney General have met to discuss the implications.

6. **Annual Report on the National Substance Misuse Strategy:** It is intended to publish the First Annual Report on the National Substance Misuse Strategy in Q2 2016.

7. **Abortion policy**: Section 20 of the Protection of Life during Pregnancy Act requires the Minister to prepare an annual report by 30 of June each year on the number of terminations notified to the Department carried out under the Act in the previous calendar year. This annual report must be laid before the Houses of the Oireachtas.

Health Protection Unit

1. Health Protection Unit provides national leadership, policy advice, analysis, coordination and communication of health protection strategies. Key priorities are to develop policy and suitable legislative framework to support public health protection through: control of infectious diseases; national immunisation and vaccination programmes; and public health emergency planning (including pandemic planning).

2016 Priorities and Significant Issues:

2. **Narcolepsy:** As of 30 April 2016, the Health Products Regulatory Authority (HPRA) has received 81 reports confirming a diagnosis of narcolepsy with symptom onset following pandemic vaccination. The HSE and the Department of Education and Skills are providing a range of supports and services to those affected.

3. **Narcolepsy Discovery:** Legal proceedings against the Minister, the HSE and GlaxoSmithKline Biological SA (GSK) have been initiated by 42 individuals. The State Claims Agency (SCA) has the delegated authority to manage legal claims on behalf of the State. The plaintiff's solicitors have submitted an extensive Voluntary Discovery request in respect of one case. A High Court hearing has been scheduled for 11 June 2016 at which an Order of Discovery is expected to be made. Legal advices indicate that the Department is likely to be given approximately three months from the making of the Order to complete the process and swear the affidavit.

4. **Immunisation Policy:** Budget 2016 contained additional funding of €2.5m for expansion of the childhood immunisation schedule, which will allow for Meningococcal B and Rotavirus vaccination to commence in Quarter 4, 2016. The HSE has indicated that incremental funding of €7.75m in 2017 and €2.5m in 2018 will be required to fund the vaccination programme.

5. **Emergency Planning:** The National Framework for Emergency Management in Ireland is currently being finalised by the Office of Emergency Planning. This Department will lead on three emergencies under the new framework - Pandemic Influenza and Other Public Health Emergencies; Biological Incident; and Food Contamination impacting on Public Health.

6. **Infection Control Guidance for Tattooing and Body Piercing:** Infection control guidance for tattooing and body piercing have been formulated and subjected to public consultation. The finalised guidance will be published shortly.

7. **Zika Virus Disease:** Zika virus infection in pregnant women has been linked with microcephaly. The Director of the WHO declared the spread of ZIKAV to be a Public Health Emergency of International Concern on 1 February 2016. Department of Health is working with the Department of Foreign Affairs to ensure travel advisories are up to date. ZIKAV will be on the agenda of the next meeting of Health Threats Coordination Group is scheduled to take place on 25 May 2016..

8. **HPV vaccine:** HPRA has continuously monitored the safety of HPV vaccines used in Ireland. Up to 30 April 2016, the HPRA received 1020 reports of suspected adverse reactions/events in association with the use of HPV vaccines. The European Medicines Agency's detailed scientific review, in which the HPRA participated, found no evidence of a causal link between the vaccine and the conditions examined. The European

Commission endorsed the conclusions of the European Medicines Agency, that there is no change to the way HPV vaccines are used, or to amend the current product information. The Commission decision is binding in all members states.

Child Health and Wellbeing Unit

1. The Child Health and Wellbeing Unit is responsible for supporting the Departments of Health and of Children and Youth affairs and key stakeholders in accessing better evidence in relation to the health and wellbeing of children and young people and analysing the implications of this evidence for policy and practice. The Unit also facilitates joined up working with the Department of Health and Department of Children and Youth Affairs (DCYA) in relation to child and youth health policy. It also supports the implementation of policy through engagement with agencies and stakeholders and the monitoring of the health outcomes of children and young people.

2016 Priorities and Significant Issues:

2. **Gender Recognition Bill:** Recommendations on amendments to Gender Recognition Bill 2015 for children and young people.

3. **Child Injury Prevention Action Plan** (joint project with DCYA)

4. **Healthy Pre-Schools Policy and Plan** (joint project with DCYA)

5. **New HSE Child Health Services Model/Early Years Strategy** (aligning the model with the strategy)

6. **Child Injury Prevention Action Plan**: It is intended that the Plan will be published in Q4 2016.

7. **Early Years Strategy: It is intended that the Strategy will be published by** DCYA in Q2 2016.

8. **Child Health Services Model Report**: It is intended to publish the report in Q2 2016.

Food Safety & Environmental Health Unit

1. The Unit ensures that an appropriate legal framework, policies and relevant structures are in place to achieve the highest standards of food safety and environmental health (in conjunction with other Departmental Units, Government Departments and agencies as appropriate). It contributes to relevant EU policy development and transposes relevant EU legislation into Irish law. The Unit manages the Department's policy and governance responsibilities for the *Food Safety Authority of Ireland (FSAI)* and the *Food Safety Promotion Board (Safefood)* and oversees/monitors the work of the *Environmental Health Service (HSE)* with regard to food safety. The Unit is also responsible for ensuring DoH response to food safety outbreaks/incidents if/when they occur (in consultation with relevant Departments/agencies).

2016 Priorities and Significant Issues:

2. **Transposition of EU law:** Transpose EU legislation into Irish law (91 pieces processed producing 10 Statutory Instruments in 2015). In 2016 this will include legislation on bottled water, import controls, food improvement agents, vitamins & minerals and infant formula.

3. **Introduce national legislation on labelling:**
   - Oversee stakeholder consultation on national legislation exempting producers of small quantities of food from labelling requirements (and introduce necessary national legislation)
   - Introduce national legislation on Country of Origin Labelling

4. **Food safety:** Negotiate at EU level on a number of food safety issues, including Infant Formula.

5. **Monitor agencies:** Monitor the performance of the FSAI, Safefood and the Environmental Health Service (food safety); ensure that FSAI and Safefood have sufficient resources to perform their work (funding, staff & Board).

6. **Medical Ionising Radiation Protection (MIRP)**: Commence the transposition of the medical components in the Basic Safety Directive (2013/59/Euratom) including the implementation of the recommendations of the 2015 International Atomic Energy Agency (IAEA) Audit Report. This will be progressed with Patient Safety Unit.

7. **Public Health (Sunbeds) Act 2014**: Finalise policy/action submission regarding training requirements (section 14) of the Public Health (Sunbeds) Act.

Patient Safety & Clinical Effectiveness Unit

1. The aim of the patient safety programme of work is to provide leadership for patient safety and quality policy and legislation. In November 2015, Government approved a major package of patient safety reforms, including the establishment of a National Patient Safety Office (NPSO) in the Department of Health. The NPSO will provide the required leadership and direction on patient safety policy and legislation for the healthcare system. Through surveillance of patient safety trends, production of patient safety and complaints profiles, and delivery of the national framework for clinical effectiveness it will identify, based on evidence, patient safety priorities and initiatives.

2016 Priorities and Significant Issues:

2. **National Patient Safety Office (NPSO):** Establish and launch the NPSO in 2016. Three patient safety workstreams will be formalised in the NPSO (patient advocacy, patient safety surveillance and clinical effectiveness) through integration of the current Patient Safety and Clinical Effectiveness Units and recruitment of new staff.

3. **National Patient Safety Advisory Council:** Establish a new Council with significant representation from patients as a resource for advice and guidance to inform policy direction for the NPSO. It will publish independent patient safety reports to be laid by the Minister before the Houses of the Oireachtas.

4. **National Patient Advocacy Service**: Define the national model for patient advocacy through review of international advocacy models and scoping of current advocacy services.

5. **Patient Complaints:** Review, in association with the HSE, the Office of the Ombudsman and the Department of Public Expenditure and Reform, of S.I No. 652/2006 Health Act (Complaints) Regulations 2006 with a view to enhancing statutory provisions for management of complaints within the health services.

6. **National Patient Safety Surveillance System:** Establish the national patient safety surveillance function. This will produce national patient safety profiles which will be generated by bringing together data from health information resources across the three NPSO workstreams and drawing conclusions for patient safety. These profiles will inform patient safety prioritisation and planning. Publish the second National Healthcare Quality Reporting System Annual Report.

7. **Programme of Patient Safety Legislation:** Support the progression of: finalisation of the Heads of the Patient Safety Licensing Bill; extension of HIQA's remit to the Private Sector, in line with the General Scheme of the Health Information and Patient Safety Bill; inclusion of Open Disclosure provisions in Department of Justice and Equality Legislation.

8. **National Patient Experience Survey:** Work with HIQA and the HSE to progress a National Patient Experience Survey in acute in-patient settings.

9. **National Framework for Clinical Effectiveness:** Extend the current suite of National Clinical Guidelines (NCGs), develop a guideline implementation framework and increased alignment with clinical indemnity arrangements. Progress commissioned NCGs in line with the new Maternity Strategy. Establish the National Clinical Audit function.

Establish a new HRB Collaboration in Ireland for clinical effectiveness evidence reviews. Support the HSE to develop a framework for implementation of the *Standards for Clinical Practice Guidance.* Develop NCEC strategy/framework for patient engagement.

10. **Anti-Microbial Resistance (AMR):** AMR is one of the critical emerging public health risks for our health care system and for the global community. The National AMR Consultative Committee will examine joint surveillance and reporting across the human and animal health sectors, in line with European requirements.

Bioethics Unit

1. The Bioethics Unit has both an advisory and an executive function in supporting the Department to achieve its mandate and strategic objectives. The Unit advises across the Department on ethical approaches to a wide range of policy questions including resource allocation, mental health, transplantation, health information and the conduct of health research. The Bioethics Unit also has executive responsibility in the areas of reproductive medicine and end of life issues.

2016 Priorities:

2. **Assisted Human Reproduction:** In February 2015, Government approved the drafting of a General Scheme of legislative provisions dealing with assisted human reproduction (AHR). The legislation will cover: consent; welfare of the child assessments; embryo transfer; gamete (sperm and egg) and embryo donation; surrogacy; pre-implantation genetic diagnosis; sex selection; posthumous reproduction; stem cell research and the establishment of a regulatory authority. It is envisaged that the draft General Scheme will be completed by the end of 2016. The Department has commissioned an evidence review of international public funding models for AHR. It is anticipated that this review will be completed by the end of 2016.

3. **Advance Healthcare Directives:** The Assisted Decision-Making (Capacity) Act was signed into law on 30 December 2015. Part 8 of the Act provides a legislative framework for advance healthcare directives (AHDs), which were drafted by the Bioethics Unit. Under the Act the Minister for Health is responsible for establishing a multidisciplinary working group to assist in the development of the Code of Practice. The Code of Practice will provide advice and guidance on how the AHD legislation will operate on a day-to-day basis. It will address the needs of a variety of stakeholders including: people preparing their own AHDs; healthcare professionals; and designated healthcare representatives.

4. **Newborn Bloodspot Screening:** In 2009 the Data Protection Commissioner (DPC) received a complaint from a member of the public regarding the retention of Newborn Screening Cards (NSCs). The basis of this complaint (upheld by the DPC) was the NSCs should not be retained indefinitely without consent as this constituted a breach of the Data Protection Acts 1988 and 2003. [redacted] It is intended to bring recommendations to the Minister in Q3 2016 for a proposed course of action to maintain the integretity of the National Newborn Bloodspot Screening Programme whilst meeting the required ethical and legal obligations.

MANAGEMENT BOARD Area: National HR ; Teresa Cody (Assistant Secretary)

(Units & Principal Officers; HR and Corporate Services Unit– Luke Mulligan, National HR – Lara Hynes, Professional Regulation Unit – Deirdre Walsh, Working Better Together – Gabrielle Jacob)

HR and Corporate Services Unit

Function of Human Resources (HR) and Corporate Services Unit

1. To manage the Internal HR & Corporate Services functions in support of the Department's business objectives.

2. To implement workforce planning and promote staff learning and development throughout the organisation.

Major tasks/policy initiatives for the year – HR

3. Secure and allocate staff resources effectively in line with the Working Better Together (WBT) organisation development framework and Workforce Plan 2016

4. In 2015, around 20 additional personnel in a range of generalist and specialist grades were recruited through PAS competitions or seconded from the health family to fill posts identified under the WBT development framework agreed by MB at the end of 2014. This included 1 new Deputy Secretary, 1 new Assistant Secretary, 2 POs and 6 AOs from PAS panels, 1 AO Economist, 1 Statistician, 1 Project Manager (HEO) and 2 Clinical Effectiveness Officers.

5. In 2016, it is planned that up to 90 additional personnel, both specialist and generalist, will be recruited through PAS competitions and secondment to fill further posts identified under WBT, including the following:
   - 2 POs, 11 APs, 2 APs &1 AO (Economists), 14 AOs, 4 EOs and 7 COs from PAS panels
   - 1 Deputy Chief Medical Officer to be recruited through PAS
   - 1 Director of the National Patient Safety Office (NPSO) to be recruited through PAS
   - 2 POs and 8 APs for the NPSO to be recruited through PAS/seconded from the health family
   - 1 AP Communications Specialist, 1 Project Manager (AP), 1 AP for Governance & Risk Management, all to be recruited through PAS
   - 1 PO Head of Research Services, 1 AP Accountant, 1AP & 1AO (Health Data Analysts) to be seconded from health family or civil/public service
   - Other support staff below AP level for the NPSO and additional staff yet to be identified under Phase 2 of WBT

6. Since 2015, the filling of additional posts is contingent on a Delegated Sanction from the Department of Public Expenditure and Reform (DPER) on the basis of a Staff Numbers and Pay Strategy from the Department. The sanction allows the Department to fill vacancies through recruitment and/or promotion in grades up to and including PO standard or equivalent, subject to the overall pay bill ceiling. The 2016 Staff Numbers and Pay Strategy was submitted to DPER in February 2016 and delegated sanction for this year is expected shortly.

Run internal promotion competitions to establish AP, HEO, EO and PO panels

7. In 2015 1 PO, 4 HEOs and 5 EOs were promoted from internal promotion panels which were set up in 2013 and which expired at the end of 2015. In 2016 competitions to set up new internal promotion panels for all grades will be run, commencing with the competition for promotion to AP which took place in February 2016.

Deliver staff learning and development programme for all staff

8. WBT Project Group 5 is tasked with the development of a learning and development (L & D) strategy that will address the personal and professional development needs of staff across the Department. Once the strategy has been finalised, the Training Section in HR Unit will be responsible for its delivery. In 2016 the budget for training is €350,000, an increase of 50% on the 2015 allocation.
9. In addition to L & D, HR Unit will also be implementing policies/guidelines arising from the work of WBT Project Group 5 on succession planning, staff mobility and placement and coaching and mentoring.

Management of various HR functions

10. With PeoplePoint, HR Unit manages various HR functions such as Time and Attendance, annual leave, sick leave, special leave, study leave, career breaks and retirements/resignations. HR Unit reports on key metrics to D/PER and liaises with D/PER on the implementation of various service wide policies/codes such as Dignity at Work, Disciplinary Code, Grievance Procedure and Conciliation and Arbitration.

Major tasks for the year – Corporate Services Unit

11. Corporate Services Unit (CSU) oversees a wide range of activities to support the work of the Department. These include the provision of accommodation, building maintenance, security, health and safety, catering, cleaning and phone services. In addition, the Unit manages all support and ancillary services for c.400 staff within Hawkins House including mail, stationery, ID cards, business cards, asset register etc.

12. The Unit works closely with the OPW (Office of Public Works) and the OGP (Office of Government Procurement) to provide the necessary goods and services to support the work of the Department.

13. CSU is also responsible for maintaining, altering and upgrading Hawkins House. This is managed through a mixture of in-house and contracted resources. However, as part of wider developments, the Hawkins House site is due to be vacated to facilitate a refurbishment of this area of the city centre.

14. Therefore, the priority item for CSU in 2016 is the proposed relocation of the Department to Miesian Plaza (former Bank of Ireland HQ) in Baggot Street, to commence in Quarter 1 of 2017. This will be a significant project which will require extensive liaison with the OPW to deliver a modern, fit for purpose headquarters.

15. At the same time, the Unit will need to make plans to decommission Hawkins House and oversee the conclusion of all contracts and services to the building. This will also represent a significant block of work. It is envisaged there will be an overlap where both locations will be running simultaneously.

National HR Unit

Overall Function of the Unit

1. To get the best value from health system resources by ensuring the implementation of Government policies on employment in the health sector in respect of numbers employed, pay and pensions and the terms and conditions of employment for all grades in the public health service. To drive the implementation of the Public Service Agreements 2010-2018 as they relate to the health sector. Support the recruitment and retention of sufficient numbers of staff.

2. To lead on a strategic approach to health workforce planning aligned with the achievement of national priorities, clinical and operational improvement and the appropriate configuration of health service staff while ensuring a stable and sustainable supply of appropriately skilled and trained health workers in the Irish health system.

Major tasks/Policy Initiatives 2016

Doctors Issues

Consultant Pay

3. On 18th December, 2015 the Employment Appeals Tribunal (EAT) found in favour of two Consultants pursuing "payment of wages" claims. The claims relate to a significant pay increase for consultants (of about €25,000 p.a.) who moved from the 1997 Contract to the 2008 Contract. The 2008 Contract provided for a series of phased increases in pay. The Minister delayed payment of the first two phases to 1 January 2009. The then Minister decided not to sanction the outstanding phase due from 1 June 2009.

4 [redacted]

5 Separately, the HSE has received nearly 400 pay claims from solicitors representing consultants on the same issue over the past 6 months and such claims could be the subject of High Court hearing in the period ahead. The Department of Health is liaising with the Department of Public Expenditure and Reform on the progress of these cases on an ongoing basis [redacted]

NCHD Retention

6. There is ongoing monitoring of the implementation of the MacCraith report recommendations arising from the 2013–2014 Strategic Review of Medical Training and Career Structure, established primarily to deal with the recruitment and retention of medical doctors.

Contract negotiations

7. This unit will progress contract discussions with IMO relating to Academic Consultants, Public Health Specialists, Non-Training Non-Consultant Hospital Doctor (NCHD).

Nursing Issues

Nursing Strike – Emergency Department

8. Following agreement on revised WRC Proposals on 11 January, the INMO deferred strike action at Emergency Department. The proposals included detailed arrangements around activation of the Escalation Policy and a range of IR measures that are to be progressed in the coming months.

Task Transfer

9. In February 2016, the Minister for Health and the Minister for Public Expenditure and Reform (February 2016) sanctioned an agreement on the transfer of four tasks by NCHDs to Nurses/Midwives in return for a payment equivalent to time and a sixth between 6pm and 8pm for nurses. Implementation will commence nationally in 2016 and will be subject to a verification process that means that payment will not arise until July, though backdated to 1 January, where appropriate.

Student Nurses Pay and Incremental Credit

10. In February 2016, pursuant to a chairman's note to LRA, this Department and DPER agreed to increase the rate of pay for clinical nursing/midwifery in the 4th year of their degree programme to 70% of the 1st point of the Staff Nurse salary scale. DPER agreed to restore recognition of the 36 week placement for the purposes of incremental progression for 1,400 student nurses/midwives currently undertaking the placement and for all future students. **However**, the position of those who have graduated since 2011 is to be considered further in the context of a review of the impact of these initiatives on retention rates of student nurses/midwives.

Workforce Planning

11. This Unit is leading the development of a national integrated strategic framework for health workforce planning, in collaboration with Government Departments and agencies by the end of the year; to include an implementation plan outlining objectives, deliverables, owners, timescales and benefits.

Pay Policy

12. Issue revised pay policy circular and commence review of remuneration levels for 2nd tier management in Section 38 agencies and the agencies under the aegis of the Department.

European Working Time Directive (EWTD)

NCHDs

13. National HR Unit continues to support the development and implementation of measures by HSE to progress EWTD compliance in conjunction with Acute Hospitals Division. The EU Commission took Ireland to court for our non-compliance. In 2015 the Commission lost on a technicality. Ireland has now reached 80% compliance with an average 48 hour working week (in 2011 this was as low as 33%, and 47% in 2014). An Implementation Plan for achieving compliance by 2017 has been submitted to the EU Commission. This was followed by a positive meeting with the Commission last month. There is a risk the Commission could (again) refer Ireland to the Court of Justice.

Sleepovers (Social Care Division)

14. In September 2014, the Labour Court recommended that major restructuring of services in social care settings be undertaken in order to ensure compliance with the EWTD. A joint management and union working group is putting together a process to achieve EWTD compliant rosters and to clarify the timescale and steps involved in reaching

compliance. Separate to this process, IMPACT lodged a complaint to the European Commission. In June 2016, Ireland will submit a national implementation plan to the EU which will be used to monitor EWTD compliance in this sector.

Significant events/milestones

Section 38 Agencies – Internal Audit Report

15. Following Department of Public Expenditure and Reform sanction in relation to the Department's approach to unapproved pay and allowances in Section 38 agencies, the HSE has carried out a due diligence review of the agencies and has compiled a list of cases, indicating which meet the criteria for approval, including which salaries meet the criteria for red-circling on a pensionable basis and which allowances meet the criteria for red-circling on a non-pensionable basis. It has also identified those business cases which are to be rejected under the criteria for approval. The HSE communicated its decisions to the relevant Section 38 agencies at the beginning of March.

16. On foot of the HSE internal audit report into the remuneration of senior managers in S38 agencies, this Department conducted a review of the appropriate salary levels for the CEOs of Section 38 agencies, in conjunction with the HSE and DPER. New remuneration levels were agreed with DPER and communicated to the HSE. A review of remuneration levels of 2nd tier management in Section 38 agencies will commence this year.

Pay and Numbers Strategy

17. Arising from Budget 2015, the Minister for Public Expenditure and Reform announced that restrictions on the employment of additional staff would be eased in 2015. Submission of a Pay and Numbers Strategy for the HSE, outlining planned staffing levels and pay/pensions expenditure was required to obtain sanction for the lifting of the moratorium and ECF arrangements. Due to Departmental concerns around the HSE's ability to meet the planned pay and staffing levels, the 2015 strategy was not approved.

18. At the time of writing, the HSE are currently preparing the 2016 Pay and Numbers Strategy based on 'bottom up' plans developed at hospital and community service level pay. The Department of Health has requested an early submission of the strategy to facilitate approval of delegated sanction for the HSE.

Professional Regulation Unit

Overall Function of the Unit

1. Professional Regulation Unit (PRU) develops regulatory policy and legislation for medical practitioners, nurses and midwives, dental practitioners, auxiliary dental professionals, the 14 professions designated under the Health and Social Care Professionals Act 2005 and empowers their statutory regulators.

Major tasks/Policy Initiatives 2016

2. These are:
   - Preparation of new health professions regulatory legislation (Health Miscellaneous Provisions Bill and Dental Bill plus a range of secondary legislation).
   - Ongoing implementation of legislation on professional regulation (Directive on recognition of professional qualifications and Health & Social Care Professionals Act, 2005).
   - Identification of legislative solutions on regulatory policy issues arising (protection/use of title, designation /regulation of additional professions, further amending of regulatory Acts).
   - Governance of the Health & Social Care Professionals Council (Direct funded health multi-profession regulator).

Significant events/milestones in PRU's remit

3. In January 2016, EU Directive 2005/36/EC on qualification recognition was updated into law through Directive 2013/55/EC. The Department of Education and Skills is the lead Department but we must work with them to transpose the Directive. We are providing for the transposition of the health profession specific elements through the national transposition Instrument and the enactment of the Health (Miscellaneous Provisions) Bill. The Bill also provides for appeal against sanctions for all health professional regulatory Acts; and other essential amendments to these Acts including giving effect to the January 2016 decision on use/protection of the title of physical therapist. Parliamentary Counsel has been assigned.

4. The Directive also requires us to prepare a national action plan for the health sector on the proportionality of regulatory measures for health professions (in co-ordination with the Department of Education and Skills) and to oversee implementation of the European Professional Card and the Alert Mechanism. The former will provide for a speedier recognition of qualifications process and the latter provides for information to be shared on health professionals who have been convicted of an offence or been suspended.

5. Other priorities include drafting a new Dental Bill (after the Health Miscellaneous Provisions Bill and consulting with stakeholders on the options for the possible regulation of counsellors and psychotherapists.

6. In relation to the Health and Social Care Professionals Council and the fourteen registration boards (CORU), in 2016, around 30 vacancies must be filled via PAS, three (laboratory scientists, podiatrists and psychologists) of the remaining five boards must be established by S.I., we must continue to secure additional /replacement staff and oversee the procurement of new office accommodation.

Working Better Together

Functions of the Unit

1. The Unit has responsibility for managing the coordinated delivery of the *Working Better Together* change programme in collaboration with key Units and colleagues across the Department, in addition to supporting the delivery of the Department's obligations under the Civil Service Renewal Plan.

Overview of the Change Programme

2. A significant organisational development initiative – *Working Better Together* – is underway to improve the effectiveness of the Department of Health. This process is being led by the Department's Management Team.

3. A new organisational design has been developed and implemented, and revised Management Team responsibilities have been introduced. Recruitment processes through the Public Appointments Service saw the filling of four Management Team vacancies in the last quarter of 2015, with positions filled in the new and existing portfolios of: Governance and Performance, Strategy and Policy, R&D and Health Analytics, and Human Resources. Existing staff at all levels have been allocated to new roles within this revised organisation design and recruitment of further expertise is underway within the total payroll resources allocated to the Department. This includes introduction or planned recruitment of additional skills in areas such as accounting, health economics, statistics and data analytics, health research, public health, allied health professionals, patient safety, project management and communications.

4. In addition to the new organisational design and structure, improving organisational effectiveness will involve changes in how decisions are made; how work processes are designed and implemented; staff are trained, developed and supported; resources are deployed and managed; technology is used and performance is reviewed. In September 2015, an integrated programme of work was finalised to achieve this organisational development.

5. Following an expressions of interest process among staff a Steering Group, chaired by the Secretary General and comprising colleagues with a diverse range of experience and skills, was established to direct the programme. The *WBT* Unit has lead responsibility for driving day-to-day delivery of the programme, in collaboration with those actively contributing from across the Department. A project management approach to delivery has been adopted, with responsibility assigned for meeting measurable objectives within agreed timeframes.

6. Some 111 people (or about one-third of the Department's staff) are participating in 9 Project Groups to identify organisational improvements. Each Group is sponsored by a member of the Department's Management Team. The nine Groups are tasked with:
   - Developing organisational arrangements for policy, legislation and governance functions for professional regulatory bodies
   - Strengthening the performance dialogue with the HSE and other health agencies
   - Enhancing the Department's approach to policy development
   - Providing effective support services to assist staff in fulfilling the Department's role
   - Improving staff learning and development, coaching and mentoring, succession planning and staff mobility

- Strengthening internal communications
- Enhancing collaboration and strategic network-building within the health sector and cross-sectorally
- Developing an integrated, unified approach to business planning, risk management and corporate governance
- Examining the Department's approach to parliamentary work, including Parliamentary Questions.

Major Tasks, Events and Milestones in 2016

7. The Project Groups recently completed their work and have submitted their reports and proposed implementation plans to the Steering Group and the Management Team for approval during Q2 2016;

8. The organisational approach to integrated implementation of the change programme, (including Project Group outputs) will be developed and finalised in Q2 2016, with implementation across the Department to follow.

MANAGEMENT BOARD Area: Policy & Strategy; Colm O'Reardon (Deputy Secretary)

(Units & Principal Officers or equivalent; Private Health Insurance - Patsy Carr, Universal Health Insurance/Health Systems & Structures Unit – Laura McGarrigle, Health Policy, Strategy & Integration Unit – Rhona Gaynor, Legal Section – Angela O'Floinn, Corporate Legislation & Mother and Baby Homes – Bernadette Ryan)

Private Health Insurance

Overview of the Private Health Insurance market (PHI)

1. The Irish health insurance market is community rated whereby everyone pays the same price[4] for the same product regardless of age or health status. This principal of intergenerational solidarity needs a constant stream of young people entering the market to balance the increasing number of older insured who are generally less healthy. According to the Health Insurance Authority, employment is the biggest determinant of numbers holding health insurance. Building on the recent upturn in the economy two initiatives were introduced from 1 May 2015. The first, Lifetime Community Rating, encourages people to take out PHI at a younger age and by 35 years of age thereby avoiding late entry loadings of 2% per year. The other market support introduced provides for the introduction of 'Young Adult' rates of premium, which are based on a sliding scale of maximum chargeable rates up to age 26.

2. Without these measures, there would be a continued deterioration in the age profile of the insured population, which in turn would contribute to claims inflation and result in higher insurance premiums. The sum effect of these measures has been an increase in the number of people with health insurance, up to **2.122 m (46% population),** having plateaued in June 2014 at 2.017m (43.8% population). This includes an increase of 104,667 from January 2015 to January 2016 which contributes positively to controlling premium inflation and thereby helps to keep health insurance affordable for those who wish to avail of it. In addition to the growth in numbers insured, the impact of these two initiatives to support the market can be seen in greater detail as follows:
   - the additional lives may be healthier than the average customer of the same age, as their decision to buy health insurance is influenced by the financial impact of future LCR loadings.
   - there has been an increase of 6,951 in the number of insured lives aged 18-25 during 2015 (in contrast to a reduction of 3,267 lives in the same age cohort the previous year). It is expected that this new structure of premium rates may reduce the volume of policy cancellations that previously occurred at renewal date when a large premium increase from student rates to adult rates occurred.
   - overall the insured population increased by 6%. The largest increases occurred for the age group 40 - 49 and ages 85+ (10% and 8% respectively), driven by LCR for the former and ageing demographics of the insured population for the latter.
   - more favourable ageing of the insured population in 2015 (more younger members balancing older members) resulted in claims being c0.2% lower than would have been the case had the age profile of the insured population remained at the 2014 age profile (when ageing contributed c2.6% to claims inflation).

[4] Subject to Lifetime community rating loadings where applicable

3. The role of Private Health Insurance Unit is to support and promote a sustainable, community-rated health insurance market. This includes:
   - managing and responding to ongoing market developments,
   - monitoring the operation of the risk equalisation scheme and ensuring its continued effectiveness,
   - providing effective governance of the Health Insurance Authority and the Voluntary Health Insurance Board, and
   - developing and drafting any legislation as may be required, including the annual primary legislation to provide for revised Risk Equalisation credits.

Major Tasks/Policy Initiatives for 2016:
Proliferation of Health Insurance Products.

4. The Department and the Health Insurance Authority have identified the continued increase in the number of products on the market as undermining community rating and the Principal Objective of the Health Insurance Acts. The very large number of products available (360 approximately) makes it very difficult for consumers to distinguish between product benefits and to select products that best meet their individual needs.

5. Following consultation with the HIA, an amendment to the primary legislation is now being proposed to (i) provide the legal clarity necessary to facilitate insurers to formally withdraw products from the market, while also (ii) protecting the consumer from circumstances where benefits are being changed or eroded year-on-year, in a market where segmentation is prevalent. Further discussions will be held with the HIA (regarding measures which may help address the proliferation of products), subject to Government approval as part of the development of a planned Health Insurance (Amendment) Bill later this year.

Minimum Benefit Regulations

6. Under the Minimum Benefit Regulations, 1996, all health insurance products that provide cover for inpatient hospital treatment must provide a certain minimum level of benefits. The key purpose of the Regulations is to ensure the continued availability of the type of broad hospital cover traditionally held as a minimum by the insured population and to ensure that individuals do not significantly under-insure. The specified monetary amounts and some medical/ surgical practices listed in the regulations are no longer appropriate.

7. The Department are currently reviewing a report submitted recently by the HIA to inform the Department's policy considerations. The issue will also need to be considered in conjunction with broader health policy as determined by the formation of the next Government. Any necessary legislative provision required to implement policy will then be progressed.

Risk Equalisation

8. The Risk Equalisation Scheme is a State aid and must operate in accordance with the European Union Framework for State Aid in the form of public service compensation. The Framework sets out a range of requirements in relation to the amount of compensation provided, transparency arrangements and other related matters. In February 2016, formal approval was received from the European Commission for the Risk Equalisation Scheme for the period 2016 to the end of 2020.

9. The RES protects community rating by equalising the risk of insuring older or less healthy members across the private health insurance market. This makes it easier for older and less healthy people to afford private health insurance. Under the RES, insurers receive risk equalisation credits to compensate for the additional cost of insuring older and less healthy members. The credits are funded by stamp duty levies payable by open market insurers in respect of each insured life covered. The scheme is self-funding i.e. all of the monies collected in stamp duty by the Revenue Commissioners levies are transferred directly to a Risk Equalisation Fund administered by the HIA. (The Fund circulates circa €650 million annually). Legislation is required each year to revise the applicable risk equalisation credits and the corresponding stamp duty levies necessary to fund them.

10. As required under the Health Insurance Acts, the HIA submits a report to the Minister for Health in October each year recommending the risk equalisation credits and corresponding community rating levies for the following year. The Minister sets the RE credit rates for the following year and the Minister for Finance sets the stamp duty levy required to fund them.
11. Over time the RES will be improved through the introduction of a more robust measure of health status based on Diagnostic Related Group (DRG) data. This will provide a more effective means of equalising for differences in risk due to differences in health status. This is dependent on access to and the collection and use of DRG data.

The Health Insurance Authority (HIA)

12. As the independent regulator of the private health insurance market in Ireland, the HIA also provides information to consumers regarding their rights and health insurance plans and benefits. The HIA monitors the health insurance market and advises the Minister (either at his or her request or on its own initiative) on matters relating to health insurance.

13. The HIA will submit its Annual Report and Accounts for 2015 to the Minister mid-2016. The Minister is responsible for appointments to the Board of the Authority. There is one outstanding vacancy on the Board (Chair) to be filled in 2016.

The VHI

14. The Voluntary Health Insurance Board is the only commercial State Body under the aegis of the Department. The relationship between the Minister for Health and the Voluntary Health Insurance Board and its subsidy VHI Group Limited and in turn, its subsidy VHI Insurance DAC is set out in an agreed Relationship Framework. VHI Insurance DAC was authorised as a non-life insurance undertaking by the Central Bank on 22 June 2015. Following the signing of S.I 324 of 2015 [Voluntary Health Insurance (Amendment) Act 2008 (Transfer Day) Order 2015] by the Minister for Health, the insurance business of the VHI Statutory Board was transferred to VHI Insurance DAC with effect from 31 July 2015. In addition, VHI Healthcare Limited was also authorised on 22 June 2016 as an insurance intermediary. It is responsible for the sale of health insurance and diversified products underwritten by VHI Insurance Ltd. All responsibility for the selling and underwriting of insurance business has been transferred from the Voluntary health Insurance Board to VHI Healthcare Limited and VHI Insurance DAC respectively.

15. VHI is a commercial entity operating in a competitive private health insurance market and the Framework Agreement specifies the future governance arrangements including

Board appointments. As there are significant advantages for good governance of the same individuals occupying directorship positions it is intended that the membership of the Voluntary Health Insurance Board, VHI Group Limited and VHI Insurance DAC will mirror each other.

16. The Minister for Health retains sole responsibility under the Voluntary Health Insurance Acts 1957-2008 to appoint, re-appoint and remove members of the Voluntary Health Insurance Board. However, consistent with existing practices and good governance procedures, all proposed appointments to the Voluntary Health Insurance Board should meet the requirements of the Central Bank of Ireland under its fitness and probity rules and all proposed appointments to VHI Insurance DAC shall be subject to the approval of the Central Bank of Ireland under its Corporate Governance Code for Insurance Undertakings 2015.

17. VHI will submit its Annual Report and Accounts 2015 to the Minister mid-2016. The Minister is responsible for appointments to the Board of the VHI. There is one vacancy on the VHI Board (ordinary member) to be filled in 2016.

Significant events or milestones relating to the PHI Unit

18. Subject to government approval the Health Insurance (Amendment) Bill 2016, to provide for revised RE credits/stamp duty, will be drafted with a view to enactment by end of 2016.

19. PHI Unit will continue to monitor developments in the health insurance market, including the operation of the LCR Scheme. The HIA will carry out a planned Review of its operation after April 2017.

Health Policy, Strategy and Integration Unit

Overview of Policy and Strategy in the Department

1. One of the key roles of the Department is to provide leadership and policy direction for the health sector to improve health outcomes.

2. To fulfil this role, the Department is managed through 10 Divisions which hold a range of policy responsibilities.

3. In November 2015 a new Deputy Secretary Policy and Strategy role was established in the Department to drive, coordinate, support and quality assure the overall policy and legislative output across the Department, including outputs confined to particular care domains or functions, so as to ensure all work meets a defined standard and timetable.

4. In Q1 2016 a new Policy, Strategy and Integration Unit was established to strengthen policy capability in the Department. Resourcing for the Unit was completed on 2 May 2016.

Objectives of the Policy, Strategy and Integration Unit

5. The Policy, Strategy and Integration Unit (PSIU) which works on a project basis, supported by a small, skilled team aims to achieve a number of important objectives for the Department:
   - Improving capability to address long-term and/or cross-cutting strategic policy challenges; and
   - Promoting objective and innovative thinking in the development and implementation of health policy initiatives.

Functions of the Policy, Strategy and Integration Unit

6. The PSIU will support the work of the Minister, Management Board and the Policy Units in the Department through 4 new "value adding" functions:
   a. Leading medium and long term policy analysis, insight and preparedness in a range of health policy areas
   b. Ensuring policy coherence and managing policy integration across the Department
   c. Working in partnership with lead Policy Units on key policy priorities for the Department
   d. Setting policy standards and building policy capability in the Department across the policy lifecycle from initiation through to implementation

Priorities for the Policy, Strategy and Integration Unit

7. The PSIU is commencing work on a number of whole of Department and/or whole of Government priorities.
   a. *Integrated Care Programmes* – to lead a department-wide project to develop clear, strategic policy direction on the approach to achieving integrated care and services in the Health Sector over the next 5 years.
   b. *Youth Mental Health & Suicide Prevention* - to manage the Youth Mental Health and Suicide Prevention Pathfinder Project to achieve the outcomes set out in *Connecting for Life* by establishing new ways of achieving effective whole-of-Government working.

c. *Health Taxation Review* - to manage and support an inter- Departmental project team to identify the current overlap between the Irish Tax code and public health policy goals and recommend further areas for exploration.

8. It is intended the Unit will operate a strategic cross-cutting resource to the Minister and the Management Board. An early meeting will be scheduled with your office to identify how the Unit can support the delivery of your policy priorities.

Integrated Care Programmes - Background

9. Integrated Care Programmes seek to transform the delivery of health services and improve health outcomes by establishing person-centred, coordinated care.

10. Learning from previous achievements in this area, the HSE has identified 5 target areas and is commencing the implementation of Integrated Care Programmes in each.

11. The 5 Integrated Care Programmes in pilot are:
    - Prevention and Management of Chronic Disease
    - Older Persons
    - Maternity
    - Children
    - Patient Flow

12. Where successful, the effective implementation of Integrated Care Programmes can improve and standardise quality of care – the patient experience - while at the same time improving the flow of information, increasing accountability, and aligning financial resources with desired outcomes.

13. Integrated Care Programmes are managed by the Clinical Strategy and Programmes Division of the HSE.

14. The Department is working with the National Director of the Clinical Strategy and Programmes Division to shape both the development and implementation of the policy.

Legal Unit

1. The Legal Unit provides independent, objective legal advices to the Minister and the Department including advising on Heads of Bills and contents of statutory instruments.

2. It also devises and advises on litigation strategy as required by each Unit and processes statutory instruments

3. The Legal Unit prepares a bi-monthly report for the Secretary General for presentation at Management Board meetings summarising the most important legal matters arising in the previous two months and delivers a number of talks to Departmental staff throughout the year on relevant legal topics.

Universal Health Insurance, Health Systems and Structures

Functions of Unit

1. The functions comprise:
   - Provision of overall policy direction on universal healthcare.
   - Supporting the achievement of universal healthcare by:
     - identifying and analysing key underlying system challenges and barriers with regard to universal healthcare;
     - modelling demand and analysing unmet need for healthcare;
     - supporting the development of overarching policy on preferred design features for the future universal healthcare system;
     - supporting the development of a blueprint setting out the overall health system architecture and building blocks needed to deliver on the preferred universal healthcare system, and
     - analysing key health reforms against Government policy on universal healthcare and against the blueprint for a preferred universal healthcare system.
   - Provision of strategic policy direction to guide health reform work in the wider Department, the HSE and elsewhere so as to ensure alignment with overall policy on universal healthcare.

Major tasks for 2016

2. A key element of the work involves policy input to and oversight of the ongoing joint Department of Health/ESRI Three-Year Research Programme on Health Reform. Two key elements of this Programme are:

(i) Modelling demand and analysing unmet need for healthcare, including :

- development of a framework for investigating unmet need;
- assessment of unmet need for healthcare services;
- the carrying out of a baseline utilisation of public hospital care in Ireland;
- examination of hospital waiting lists as an indicator of unmet need, and
- development of a medium term forecasting model of healthcare demand and expenditure.

(ii) Developing policy on a preferred universal health system

- Analysis of alternative funding models for universal health care including:
  - development of policy options paper outlining alternative funding models for universal healthcare;
  - short listing of options for analysis by the ESRI, and
  - agreement on next steps on analysis and cost modelling.
- Supporting ongoing deliberation on health reform by Management Board and the Minister.

Background context

3. The Programme for Government 2011-2016 commits to a major programme of health reform, the aim of which is to deliver universal healthcare, with access to quality services based on need and not ability to pay. In April 2014, the *White Paper on Universal Health Insurance* was published. It proposed a competitive, multi-payer model of universal health insurance as the means to achieve universal healthcare.

4. Arising from a consultation process on the White Paper, 137 submissions were received from various sources and an independent analysis of these was undertaken. A key issue raised was that of cost. The analysis concluded that, while overall, "*there was a substantial level of support for reform of health services to bring about a single-tier health system with equity of access, the strong sense emerging from the analysis is that those who participated in the consultation process are generally unconvinced by the UHI proposals*". The independent analysis was published on the Department's website on the 21 January, 2015.

5. Following publication of the White Paper, the Department of Health initiated a major costing project, involving the ESRI, the Health Insurance Authority and others, to estimate the cost implications of a change to the multi-payer model proposed in the White Paper. The reports outlining the findings of the initial costing project from the ESRI and KPMG, on behalf of the HIA, were published on the 18 November, 2015.

6. The project finds that there is no one cost of UHI, rather there is a range of costs based on range of different assumptions. However, the analysis finds that the introduction of the White Paper model of UHI is likely to increase health expenditure, with additional costs arising as a result of addressing unmet need for healthcare and operating in an insured environment.

7. Having reviewed the results from the costing project, it was concluded that the high costs associated with the White Paper model of UHI were not acceptable and that there was a need for further research and cost modelling in relation to the best means to achieve universal healthcare.

8. The next phases in the costing exercise include deeper analysis of the key issue of unmet need and a more detailed comparative analysis of the costs and benefits of alternative funding models. This work will be supported by the joint Department of Health/ESRI Three-Year Research Programme on Health Reform. The next phase will encompass the following elements:

   a) *Further Research on Unmet Need*: The fundamental goal of the health reform programme is the provision of timely access to care on an affordable and universal basis. Accordingly, a more detailed analysis of unmet need using patient-level data and bottom-up costing techniques is required to inform the determination of entitlements under UHI, and the associated costs.

   b) *Analysis of Alternative Models of Universal Healthcare:* This will involve the Department of Health developing a short-list of policy options which will then be the subject of in-depth appraisal. The will allow a 'like-with-like' comparison between the White Paper model of UHI and both variations on this model and alternative models, and will offer a robust analytical foundation for taking decisions on the precise model of universal healthcare for Ireland.

   c) *Development of a Medium-term Forecasting Model for Health Expenditure*: The development of a detailed health expenditure forecasting model represents a valuable research project in its own right. However, it also dovetails with proposed research on unmet need and can contribute to cost analysis of alternative universal healthcare models. It will also ultimately take account of demographic and epidemiological

trends, price inflation and other relevant variables, thereby addressing factors that were beyond the scope of the initial UHI costing project.

9. The introduction of universal healthcare is the most fundamental reform of our health service in the history of the State. Both the research undertaken to date and that planned in the next phases of the UHI costing exercise will assist Government in deciding the best long-term approach to achieving this important goal.

10. The Minister committed to push ahead with the fundamental building blocks for universal healthcare, including: the strengthening of primary care; improved management of chronic diseases; the introduction of more efficient payment systems such as activity-based funding; the creation of Hospital Groups and Community Healthcare Organisations; implementing Healthy Ireland; the introduction of a wide-ranging package of patient safety reforms; strengthening ICT and the maintenance of a vibrant and sustainable health insurance market.

11. As well as representing major milestones on the road to universal healthcare, these are also important initiatives in their own right with the potential to drive performance improvement and deliver significant benefits in terms of timely access to high quality care.

Mother and Baby Homes Inquiry Unit

Functions

1. The Mother and Baby Home Inquiry Unit manages issues arising for the Department from the Commission of Investigation on Mother and Baby Homes and related matters, to ensure that the Department meets its responsibilities to the Commission. This will include undertaking the discovery process for all relevant records that fall within the Department's remit and also arranging for a socio-historic research project on the Department's historic remit in relation to the Commission's terms of reference.

2. The Unit is working closely with the Department of Children and Youth Affairs to identify relevant documents and to prepare these for the discovery process, including the scanning of these into electronic records to aid the Department and the Commission in their work. A Request for Tenders is currently being finalised on scanning files and providing the Departments with a searchable document management system to facilitate the discovery of documents to a legal standard.

Corporate Legislation Unit

Functions

1. Corporate Legislation Unit's function is to prepare cross-cutting Bills. We are currently responsible with relevant policy Units for preparing four pieces of legislation in the legislative programme and, when those Bills are published, supporting the Minister in taking those Bills through the Oireachtas. These are (1) provisions to support (voluntary) open disclosure of patient safety incidents to patients (2) the Heath Information and Patient Safety Bill (3) the General Scheme of the Patient Safety (Licensing of Health Facilities) Bill and (4) the General Scheme of the Human Tissue Bill. We will also work with the relevant policy Unit - eHealth/External ICT Unit - to prepare further Commencement Order(s) and Regulations and also, if required, a further Delegation Order for the implementation by the HSE of the Health Identifiers Act 2014.

2. Corporate Legislation Unit also coordinates the Minister's legislative programme and other legislative projects that span the Department. Information on all the Department's Bills as at January 2016 is set out in the Appendix.

Provisions to support open disclosure

3. In November 2015 the Government approved a general scheme to support open disclosure to patients of patient safety incidents, for inclusion in planned Department of Justice and Equality legislation on periodic payment orders. Legal protections will be given to health service providers in relation to the disclosure, as long as the disclosure is made in line with standards set jointly by the Health Information and Quality Agency (HIQA) and the Mental Health Commission. Access by patients to their medical records will not be affected. Parliamentary Counsel has been assigned to draft the Bill. The lead policy Unit for the open disclosure provisions is Patient Safety Unit.

Health Information and Patient Safety Bill

4. Government approved a revised general scheme of the Health Information and Patient Safety Bill in November 2015. The Bill covers a range of issues including:
   - promoting health research in Ireland by providing for a new voluntary streamlined research ethics approval structure for health research not otherwise governed by EU law (The Bill will not therefore apply to clinical trials on medicinal products which already has its own structure);
   - supporting significant national health information resources and data matching programmes as well as encouraging best practice in health information management;
   - providing a supportive framework for the (a) external reporting of patient safety incidents (including the mandatory reporting of serious adverse events) and (b) quality based clinical audit;
   - prohibiting the selling of patient identifiable information by any organisation or person who acquires it in the course of their business or profession;
   - facilitating regulatory bodies in the health service that have personal information that they believe may be relevant to another body to disclose such information to that body;
   - facilitating a standards based approach to supporting inter-operability between computer systems. This is in place of a Big Bang approach to a National Electronic Health Records System which international evidence shows is very costly.

5. The Bill also provides for the extension of HIQA's remit to private health service providers in regard to setting standards, monitoring compliance with those standards and undertaking investigations. Parliamentary Counsel has been assigned to draft the Bill.

Draft General Scheme of the Patient Safety (Licensing of Healthcare Facilities) Bill

6. The draft general scheme of the Patient Safety (Licensing of Healthcare Facilities) Bill provides for licensing to apply to public and private hospitals and also to public and private high risk clinical activities wherever the setting. These clinical activities will be designated by the Minister by Statutory Instrument. HIQA is to be the licensing authority. Under the draft scheme, it will be an offence to carry on a hospital or a designated activity unless licensed to do so. New services will require a licence before opening. Transitional arrangements will be made for existing providers. Licensed providers must comply with mandatory licensing standards set by HIQA and such standards will require Ministerial approval. HIQA will be able to take various steps if a licensed provider fails to meet requirements under the Bill with the ultimate sanction being to revoke the licence. Fees payable under the scheme will be set by the Minister and payable to HIQA.

7. The General Scheme is well advanced. A Working Group has been established to support the finalisation of the Scheme and consider the practical implementation and operation of the licensing system. The lead policy Unit for the licensing legislation is Patient Safety Unit.

Draft General Scheme of the Human Tissue Bill

8. The draft General Scheme of the Human Tissue Bill meets the key recommendation of the Madden Report that no hospital post-mortem may be carried out and no tissue retained after post-mortem without consent. The draft scheme also addresses other matters relating to human tissue including consent arrangements for transplantation and anatomical examination purposes. The lead policy Unit for the human tissue legislation is Cancer, Blood and Organs Policy Unit

MANAGEMENT BOARD Area: Research & Development, Health Analytics; Muiris O'Connor (Assistant Secretary)

(Units & Principal Officers; International & Research Policy – Kieran Smyth, Information/eHealth policy/External ICT – Kevin Conlon, Research Services Unit – Teresa Maguire, Statistics & Analytics – Alan Cahill)

International and Research Policy Unit

Unit's Overall Objectives

1. The Unit is part of the newly formed Research & Development and Health Analytics Division in the Department. The Unit has three main areas of responsibility:
   - Promoting and protecting Ireland's interest at, and managing the Department's responsibilities to, the EU and other relevant international fora such as the World Health Organization (WHO) and the United Nations (UN) on health policy and related matters.
   - Co-ordinating the Department's responsibilities with regard to North/South and Ireland/UK matters
   - Leading and supporting a strong research capability in the health sector as well as leading on the Department's responsibilities with regard to the Action Plan for Jobs and other related initiatives.

Major Tasks 2016

EU Engagement

2. 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.

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

4. The Council Presidency is currently held by the Netherlands (to be followed by Slovakia Jul -Dec '16, Malta Jan- Jun '17 and the UK Jul –Dec'17).

5. The Netherlands Presidency has identified a number of priority issues in the health sphere which Ireland has a keen interest in. These include:
   - reaching agreement with the European Parliament on the two draft regulations concerning medical devices and in-vitro diagnostic medical devices;
   - enhanced collaboration by member state on antimicrobial resistance; and
   - an initiative on access to innovative and affordable medicines.

Milestones

6. The Dutch Presidency informal is to be held over the **17, 18 and 19 April** in the Netherlands and the (health) EPSCO on **17 June** in Luxembourg.

7. Other events of significance include the transposition of the EU Tobacco Products Directive later this year and the ongoing engagement with the EU Commission on the issue of the implementation of the European Working Time Directive, managing the health dimension of the Semester process (the next Country Specific Reports are expected to be published by the end of February) and the EU/US negotiation of the TTIP trade agreement which is led by DEJI.

Other International Fora

8. The Department engages with other international fora in the area of health and related matters. This includes the World Health Organisation, the United Nations and the Council of Europe as appropriate. The Unit manages and contributes to the Department's input to EU positions for
   - WHO Executive Board Meeting (January)
   - WHO World Health Assembly (May)
   - WHO EURO Regional (September)
   - UN General Assembly in New York (September)

North/South

9. The Unit co-ordinates the preparation for North-South Ministerial Councils (NSMC) Plenary (2 per year) and Health Sectoral Meetings (2 per year).

10. In conjunction with the Department of Health and Social Services and Public Safety in NI and with other DOH Units, it reviews the work programme of the NSMC Health area.

11. It also participates in the steering group of the INTERREG V 2014-2020 Programme deciding on the successful projects for the €53m health element of the programme. INTERREG V is an EU structural funds type programme specifically designed to address problems that arise from the existence of borders.

Ireland/ UK

12. The main task is to continue to develop Ireland/UK relationships on a range of health issues, including through the development and co-ordination of a joint work programme in areas such as co-operation on anti-microbial resistance (AMR) or on tobacco control or alcohol control. Regular summits are scheduled between An Taoiseach and the British Prime Minister at which inter country co-operation across Government is kept under review.

Research and Innovation and the Action Plan for Jobs

13. The Unit is responsible for governance of **the Health Research Board (HRB)**, which is directly funded by the Department and has a budget in the region of €40m (with €31.5m non capital expenditure allocated in 2016 –representing an increase of 3% or €0.9m over 2015 levels). This includes monitoring the HRB's new Strategy 2016-2020.

14. The **HRB Strategy** has defined three key areas of focus:
   - Innovative, investigator-led and internationally competitive research to address major health challenges in society.
   - Translation of research findings into practices and products through support for the design, conduct and evaluation of healthcare interventions.

- Partnership-driven research, information and evidence that meet the needs of the Irish health and social care system will address short- to medium-term evidence gaps and health system needs.

15. In addition the Unit is providing policy input to the drafting of Part 3 of the Health Information and Patient Safety Bill. This section of the Bill will provide for a streamlined system of research ethics approval. The Heads of the Bill have been approved by Government and the Parliamentary Counsel's Office has commenced the process of legislative drafting.

16. The Unit also co-ordinates the Department's response to the health related actions in **the Action Plan for Jobs 2016** and **Innovation 2020** which are being led by the Department of Jobs, Enterprise and Innovation.

17. Areas covered include: biobanking, ehealth and improved accessibility and usage of the connected infrastructure for clinical studies and/or clinical trials and the implementation of the recently launched **National Health Innovation Hub** which is a collaborative project between the enterprise and health sectors.

Research Services Unit

Functions of Unit

1. The Unit is part of the newly formed Research & Development and Health Analytics Division in the Department. The overall objective of the Research Services Unit is to support and embed an evidence-informed approach to policy development and decision-making within the Department and to ensure that research, data and innovation is more fully exploited in the wider health system. It aims to do this by:
   - providing appropriate in-house R&D capability and systems to respond to requests for research and advice;
   - building the capacity of others working in the Department through formal and informal education and training;
   - Providing advice on research commissioning and on technical and governance-related research issues;
   - Brokering and managing collaborative programmes with external researchers/organisations to inform the work of the Department on key issues; and
   - Working with others in the health sector, and beyond where appropriate, to deliver integrated approaches to research strategy, policy and/or evidence.

Major tasks for 2016

3. Build and develop a **high-performance, inter-disciplinary team** to deliver fully on the objectives of the unit and engage in a vibrant and proactive communications programme to raise awareness of the supports and services available.

4. Provide a **fit-for-purpose library service** to all staff in the Department, and provide informal and formal training events and resources to support staff in searching for evidence, critical appraisal of the evidence and use of evidence.

5. Develop and deliver a programme of research **seminars and workshops** on selected topics to raise awareness of research groups, methods and/or findings.

6. Manage an **Evidence Synthesis Service** in conjunction with the Health Research Board. In line with best international practice in evidence-informed healthcare, policymakers and decision makers require reviews of the literature which utilise comprehensive, systematic and standardised methods to summarise and report the evidence. To that end, the Research Services Unit manages an annual programme on behalf of the Department which delivers Rapid Evidence Reviews and Research Briefs into the policy units in areas of interest and priority which have been agreed as part of business planning. During 2016 this service will undertake a synthesis of international evidence on the following:
   - Internet pharmacy: arrangements in countries where it is permitted and its impact on patient health, cost of medicines and traditional pharmacy services and local communities
   - Approaches to implementing interventions which increase breast feeding
   - International approaches to the regulation and funding of home care services
   - Models of national patient advocacy services: a review of international models and their key components
   - International approaches to public provision and funding of Assisted Human Reproduction services.

7. Manage an on-going three-year Department of Health/ESRI **Research Programme on Healthcare Reform**. In 2016 this Programme will:
   - analyse unmet need for healthcare, including a baseline review of hospital utilisation and waiting list data,
   - start to develop a medium-term demand and expenditure forecasting model for health,
   - undertake the groundwork for costing of alternative funding models for universal health care

8. Oversee governance of the on-going three-year **SWITCH Research Programme**. SWITCH (**S**imulating **W**elfare and **I**ncome **T**ax **Ch**anges) is a micro-simulation model for the population in Ireland developed by the ESRI and used by the ESRI, the Department of Social Protection, Department of Public Expenditure and Department of Finance, and since 2014 the Department of Health. As a micro-simulation model it simulates the entire population and offers flexibility to test a range of "what if" policy scenarios and to examine simulated results by different characteristics included in the model, such as by income groups. SWITCH can be used to simulate rules (e.g. medical card eligibility) of current and potential reform systems to compare outcomes. In 2016 work will be undertaken to:
   - extend the model to allow for recent policy developments regarding GP visit cards for different age groups,
   - model for potential extension of medical card/GP visit card eligibility to different groups.

9. Deliver high-quality, **targeted research** and analytical supports **in areas of high priority** for the Department, including:
   - Supporting a programme of work in relation to healthcare performance and performance measurement;
   - Providing a range of analytics and supports in relation to healthcare costs, expenditure, financing and funding models (e.g., activity-based funding, community care costs, Nursing Home Support Scheme Pricing Review, developing a business case for taxation as a policy tool (e.g., on sugar sweetened beverages));
   - Supporting work in relation to population health, in particular work aligned with Healthy Ireland (Healthy Ireland survey, Healthy Ireland Outcomes Framework, advice on National Indicator set for Healthy and Positive Ageing initiative);
   - Providing advice and operational support for delivery of the first National Patient Experience Survey;
   - Provide research and analytics as an input to deliberations around integrated care and healthcare reform;
   - Provide research and evaluation advice in relation to workforce planning and skill-mix initiatives.

10. Providing inputs and **advice on technical, governance or other research-related issues** (including analysis and advice on research/costings for new strategies/policies (e.g., Cancer, Oral Health), inputs in relation to national research ethics framework, oversight role on behalf of the Department in respect of publically-funded longitudinal studies (The Longitudinal Study of Ageing (TILDA) and Growing Up in Ireland (GUI)), inputting to policy on health information, advising in relation to R&D in the new National Children's Hospital).

11. Arising out of the Working Better Together initiative, and working closely with the Strategy and Policy Unit, develop and integrate a suite of research services and supports into new organisation-wide processes and frameworks for policy development, implementation and evaluation.

Resources

12. The Unit consists of a Principal Officer, 3 APs, 2 AOs, 1 HEO and 1 EO

Information/eHealth policy/External ICT

1. ICT Unit up until September 2015 was composed of **External ICT** and **Internal ICT Units**. It is now part of a new Unit, Information/eHealth Policy & External ICT within the new Division, R&D and Health Analytics. Internal ICT is part of Media, Comms, Parl, ICT (internal), Records Management, FOI Division.

2. The role of the Unit is to develop policy and approve capital funding, in conjunction with DPER, for health services ICT related spend. It also
   - Oversees the eHealth agenda which includes progressing ICT related developments with the HSE and for smaller agencies under the aegis of the Department
   - Provides capital funding for ICT developments in the HSE and for smaller agencies under the aegis of the Department
   - Operates an approval mechanism for ICT capital spending with the Department of Public Expenditure and Reform
   - Has oversight of HSE implementation of the new Health Identifiers Act
   - Works on EU and international developments in relation to eHealth.
   - Assists in progressing the eHealth strategy with HSE and the Office of the Chief Information Office, the development of the Irish eHealth ecosystem and the eHealth Ireland Committee.
   - Develops an Information Policy framework for health information.

3. The eHealth agenda has developed significant interest in recent years. As part of the existing agreement with the TROIKA, the eHealth strategy, *an eHealth strategy for Ireland* and the Health Identifiers legislation were published after cabinet approval in December, 2013. The TROIKA were also keenly interested in the implementation of a system of ePrescribing.

4. In 2015 several developments were made in relation to ICT/eHealth were as follows;
   - Improving the capital position in relation to HSE ICT (see below)
   - Completing an Knowledge and Information Plan in HSE
   - Progressing the FoM (Financial Operating Model)
   - Commencing implementation of Health Identifiers Act 2014
   - Establishing the Office of CIO and setting up eHealth Ireland Board
   - Set up of an eHealth ecosystem and inclusion of eHealth in the Action Plan for Jobs 2015.

Key Considerations

5. ICT is seen as a key enabler for change in the health services. HSE ICT capital spend is currently at **€55m** for 2016 (same as 2015 but an increase of €15m on 2014 figure). This funding is generally targeted to support those business functions and areas that are driving the change agenda in the Programme for Government. Funding also targets those systems that support areas of Primary Care and Chronic Disease Management and priorites set by the Minister. There is a need to increase the capital envelope significantly in future years to meet known projects currently being finalised.

6. However, up to 2011 progress on new ICT and eHealth developments in HSE has been slow due to lengthy approval processes, peer review process and complex procurements resulting in a significant budgetary underrun, the bulk of expenditure being on various aspects of the maintenance of existing systems. Since 2012 a considerable improvement

in developments has been achieved. The HSE ICT strategy, the Knowledge and Information Strategy completed in 2015 is addressing some of these constraints.

7. Recent take up in ICT capital spend can be used as an indicator of the pace of recent developments:

HSE ICT	2012	2013	2014	2015	2016
Capital	**€22m**	**€39m**	**€39m**	**€53.3m**	**€55m Budget**
Revenue	**€88m**	**€87m**	**€94.6m**	**€100m**	**€103m Budget**

8. HSE had indicated it would require increases in capital funding of the following magnitude to meet its future needs.

2016	**2017**	**2018**	**2019**
€106m	€140m	€163m	€166m

9. The increased demand in the coming years is being driven by a number of issues including
   - New National Children's Hospital and its requirement for an EHR (electronic healthcare record).
   - New Financial Operating Model (FOM) in HSE
   - Health Identifiers
   - Cumulative demand build up in recent years for hospital systems and also replacement of previous generation systems such as labs, PAS, NIMIS etc. and increased computerisation generally.

10. Increases in capital will have significant revenue implications. It is generally accepted that 20% of capital spend transforms to Revenue in subsequent years.

11. Health agency ICT spend (i.e. agencies under the *aegis* of the Minister non HSE) HRB, NCRI, CORU, HIQA. ICT Capital spend for 2015 was €1m with and estimated spend in 2016 of €2m.

Non HSE Agency ICT	2013	2014	2015	2016 (estimated)
Capital	**€0.5m**	**€0.5m**	**€1m**	**€2m**

12. A key issue for ICT has been access to skilled ICT resources and this issue will need to be focused upon in the context of the implementation of the new HSE ICT strategy. This will impact on the future delivery capacity. Options to address these issues are being examined including using procurements frameworks and IAAS (Infrastructure as a Service) – a form of managed service.

13. The future positioning of ICT is crucial and must be carefully considered in the reform agenda. The 'national single systems' approach to implementing ICT systems in the health service has had significant benefits in terms of process alignment and costs of

delivery of individual systems. A number of new national single systems are at an advanced state of planning for implementation in 2016 onwards e.g. Medical Oncology Clinical Information System (MOCIS), Maternal & Newborn Clinical Mangagment System (MN-CMS) and the National Medical Laboratory Information System (MedLIS). The future approach needs to be carefully considered, in the context of any new reconfiguration of the health system, in particular as hospital groups are established and other elements of the health service gain degrees of autonomy.

Information Policy Framework

14. The aim of this planned piece of work, which is a shared collaborative effort across the constituent areas of the new Division R&D and Health Analytics is to develop a high level policy framework on health information. The paper will set out to define a strategic approach to the use, management and governance of health information and health data in the context of the current and future arrangements for health delivery for health and social care services in Ireland.

15. The scope of health information and health information technology for this purpose is very wide. It covers operational information for the delivery of patient focussed services across the acute, primary and community sectors, information for the planning and management of health services including staff resources, financial and performance data. It also includes information and data to underpin health research, the industry and academic sectors, including clinical research, Open Data and statistical data underpinning performance and reporting nationally and internationally. It also included medicinal products and clinical knowledge bases which are becoming more integrated with patient management systems. The policy paper is intended to provide a framework setting out the optimal arrangements including legislative supports needed to realise an optimal information environment in health.

16. Health information policy has not been comprehensively examined since the National Health Information Strategy (NHIS) in 2004. Since that time then a wave of structural reforms have been initiated with proposed changes to the delivery system. With the emergence of hospital groups and new community and primary care arrangements the information landscape has changed dramatically and these changes are also reflected in health information structures. The development of the national eHealth strategy in 2013, the Health Identifiers Act 2014, the drafting of the Health Information and Patient Safety Bill and the new EU regulation on data protection all have a critical dependency on a clear and comprehensive information policy. The health information landscape faces significant challenges if the quest for a safe, efficient healthcare environment dependent on information is to be realised.

17. **Staffing:** ICT External Unit has 3.3 WTE. Kevin Conlon PO (1.0), Aidan Clancy APO (0.8), Caitriona Wray, HEO (0.5), Gerard Balfe, AO (1.0WTE).

Statistics & Analytics Service

Aim

1. To support, develop and enable the Department's monitoring, evaluation, policy development and planning roles through improved availability and use of information. To contribute, through data provision and policy work at EU and international levels, to the better availability of comparative health statistics. In conjunction with the Division and wider Department, we aim to show the value of analytics to evidence-based decision making through demonstrator projects such as PQ analytics and HSE performance data review.

Scope of service

2. The unit provides statistical and analytical capacity to the Department through timely responses to requests for analysis and advice. We produce, publish and disseminate health data by various means including Health in Ireland Key Trends, the Department's statistics website and the Public Health Information System. We provide advice on the development of indicators and data in areas such as health surveys, the National Healthcare Quality Reporting System and the System of Health Accounts. We also contribute to developments at international level by compiling statistics for Ireland, participating in various Commission and OECD groups and contributing to international indicator development. The unit is also involved in several Working Better Together project groups.

Resources

3. The unit currently has a WTE total of 3. This is comprised of 1 Senior Statistician, 1 Statistician, 0.8 HEO and 0.2 AP. We also have approval to recruit 2 WTE health data analysts and plan to employ 1 WTE via the CSO graduate program for a 6 month period.

Main priorities for 2016

4. In addition to continuing to provide a statistics and analytics service to the Department, main priorities for the unit in 2016 include:
   - Publication of Health in Ireland Key Trends 2016
   - Meeting international reporting requirements of Eurostat, OECD and the WHO
   - Increased dissemination of health statistics via the Public Health Information System and the Department's website
   - Commencement of a data collection on private hospitals
   - Development of inventory of morbidity statistics in compliance with the Eurostat morbidity statistics project.

MANAGEMENT BOARD Area: Finance & Evaluation; Greg Dempsey (Assistant Secretary)

(Units & Principal Officers; Finance Unit Health Capital Allocation - John Keegan, Financial Performance – Fiona Prendergast, System Financing &Value – David Smith)

Finance Unit Health Capital Allocation

Health Capital Allocation

1. DPER notifies the capital programme funding envelope for a five/six year period.

€3,098m: is the total health capital allocation.

€2.8m: is allocated for the Department's in-house ICT and office equipment needs such as PCs, servers, laptops, photocopiers, etc.

€87m: is allocated for smaller directly funded agencies under the aegis of the Department. The Health Research Board (HRB) is the only agency that receives funding for research; circa **€60m** over the period 2016-2021 will be provided to the HRB for research. The balance circa **€27m** will enable these agencies (including the HRB) to deliver their programmes by funding requirements such as ICT, office equipment, accommodation fit-out / expansion where necessary.

€2,596m: is allocated for building, equipping and furnishing health facilities. This is further supplemented by the proceeds of the disposal of surplus assets – maximum to date – circa €5m annually.

€412m: is allocated to support HSE's ICT needs. A separate submission will be provided by ICT in respect of this programme.

HSE's multi-annual Capital Plan 2016-2021

2. The HSE's Capital Plan is multi-annual (2016-2021) but approval is granted by the Minister for Health each year, with the consent of the Minister for Public Expenditure and Reform. Over the extended multi-annual period 2016-2021 the construction allocation has been increased by €524m, principally over the later years 2019-2021. See table below. Current expenditure projections for the priority projects show that these projects will absorb the bulk of the annual allocation in the over the period 2016-2018.

HSE - building, equipping & furnishing health facilities	2016	2017	2018	2019	2020	2021	Total
	€m	*€m*	*€m*	*€m*	*€m*	*€m*	*€m*
Envelope notified in 2015 REV	380	380	376	312	312	312	2,072
New Envelope 2016-2021	344	384	398	502	470	498	2,596
Increased allocation	**-36**	**4**	**22**	**190**	**158**	**186**	**524**

3. The 2016 plan is currently under review. In addition to the numerous small projects underway across the country it contains provision for the Government's major priority projects. These are:

- The New Children's Hospital including satellite centres at AMNCH, Tallaght and Connolly Hospital, Blanchardstown.
- The relocation of the Central Mental Hospital, Dundrum as the National Forensic Mental Health Services (NFMHS) Facilities Project, Portrane.
- The relocation of the National Maternity Hospital, Holles Street to the St Vincent's University Hospital Campus.

- National Plan for Radiation Oncology (NPRO) at Cork University Hospital (CUH) and University Hospital Galway; CUH - four replacement and one additional linear accelerators (linacs); UHG - three replacement and one additional linacs.
- Primary Care Infrastructure Programme: Delivery of primary care centres by means of
    - HSE traditional / direct build,
    - private sector operational lease mechanism and
    - public private partnership.
- Community Nursing Home (CNU) Programme: In January 2016, the Ministers announced details of the multi-annual programme to improve accommodation standards for long-stay residential care.
- The National Rehabilitation Hospital (NRH), Dun Laoghaire: The project underway will provide replacement accommodation – 120 beds and some therapy space.

Finance Unit EU Healthcare Reimbursement & UK Bilateral Arrangements

4. Finance Unit attends meetings of the Audit Board of the EC Administrative Commission in relation to healthcare reimbursement arrangements and the administration of the Ireland / UK bilateral healthcare reimbursement arrangements.

5. Under EU Regulation (EC) 883/2004 on the Coordination of Social Security Systems, people who are insured with (or covered by) the healthcare system of one member state but residing or staying in another member state can access the public healthcare system of that member state, at the cost of member state in which they are insured. The Regulation provides for the reimbursement of such costs between member states.

6. Ireland's main interaction is with the United Kingdom, with whom it operates a bilateral reimbursement arrangement. The payment due in any year is determined on an estimate of the number of persons falling within categories eligible for reimbursement and for whom each country is liable and an estimate of the average cost of providing healthcare treatment. Ireland has always been the net beneficiary under the arrangement. Payments received from the UK have averaged almost €250m annually over the last five years.

7. Costs associated with pensioners and their dependents account for the major portion of the total payments made. Discussions are ongoing between the two administrations on the operation of the bilateral arrangements, including annual payment arrangements and the introduction of a revised method for determining pensioner number liability.

Cash Management/National Lottery

8. Main Duties: Process and manage cash drawdowns for the HSE and certain other health agencies; report to the Department of Public Expenditure & Reform and to Government on the cash position of the Health Vote; and administer the National Lottery Discretionary Fund.

Vote 38

9. The 2016 Health vote is €13.609 billion gross comprising €13.195 billion current and €414m capital. The element relating to the HSE is €12.887 billion current and €399m capital.

National Lottery Grant Discretionary Fund

10. Funding of €3.286m is available to the Minister for Department of Health National Lottery grants in 2016. Funding of €445,000 has been allocated to date leaving a balance of €2.841m.

11. Applications for funding are accepted from community groups and voluntary organisations with an involvement in the provision of health services to specific client groups, national groups providing information and support for various disabilities and illnesses, and groups with a specific interest.

12. Applications for National Lottery funding must be made using the standard application form. Applications are referred to the relevant Service Division within the Department for assessment, evaluation and recommendation of the proposed project in consultation with the HSE. Each application is then reviewed and prioritised by the Minister according to their merits before funding is awarded.

13. It is a condition of the grant that it may only be used on the authorised project and may not be used for any other purpose.

14. All organisations who are awarded a grant must furnish a certified invoice or an audited statement of accounts which clearly shows where the grant was spent. In the event that the grant has not been spent, in whole or in part, a statement of the amount expended and a schedule of the proposed spending of the unused balance must be supplied.

Financial Performance Unit

Main Duties of the Unit

1. The Unit is responsible for management of the **Budget, Estimates and Supplementary Estimates process** for the Department on a planned and evidence based approach, working in close collaboration with line divisions and the HSE, and providing support and information to the Minister and senior management;

2. **Reporting to Minister, senior management, Department of Public Expenditure and Reform and Government** in respect of expenditure funded through the Health Vote.

3. **Strategic development of the finance function**, through strengthening the capacity/capability of the Unit to provide an enhanced financial management analytical function for the Department through better cross functional/divisional collaboration both within the Department and with the HSE.

4. **Monitoring the performance of the HSE** against approved net non-capital determination on a monthly basis to provide an enhanced resource to underpin decision making in relation to the performance of the HSE and a robust evidence basis to support the Estimates process.

5. **Monitor and assess the ongoing development of the Integrated Financial Management System (IFMS) Project** within the HSE.

6. Provision of **technical accounting expertise** in relation to accounting matters; review of the annual financial statements of health bodies and the HSE and arrange for their statutory presentation to the Oireachtas.

Key 2016 Priority

7. Specific emphasis in 2016 is being given to developing a strategic plan to strengthen the capacity of the Unit to provide an enhanced financial management analytical and reporting function for the Department.

8. A key element of this strategy will involve collaborating closely with key stakeholders, in particular the Department's Line Divisions and relevant personnel from the HSE Service Areas to develop an enhanced management information reporting system for the Department.

9. This reporting system will enable the Unit to better fulfil its role in holding the HSE to account and reporting on the performance of the HSE to key stakeholder groups, while also providing a key resource to facilitate the development of an evidence based Estimate bid.

System Financing and Value Unit

The Functions of the Unit

1. System Financing and Value Unit was recently set up under the Finance and Evaluation Division. Its key objectives include: oversight of the HSE implementation of Activity Based Funding; drafting a Commissioning Framework for Irish healthcare; and managing the process around Value for Money and Policy Reviews. It will also be developing its role around health system financing and resource allocation, building on the work carried out under the above objectives. A brief update on these issues is provided below.

Activity Based Funding (ABF)

2. Activity Based Funding (ABF, also referred to as Money Follows the Patient) is a new model for funding public hospital care. It involves moving away from inefficient block grant budgets to a new system where hospitals are paid for the volume and quality of care provided. Budgetary discipline will be delivered through the use of fixed budgets for ABF activity. It is expected to drive efficiency and increase transparency. The ABF approach is initially being applied to inpatient and daycase activity in public hospitals.

3. Full roll-out of ABF is a multi-year project and a phased approach to implementation is being taken in order to ensure operational stability in hospitals. The preparatory element of Phase 1 commenced in January 2014 in the 38 largest hospitals in the country. The live implementation of ABF commenced in January 2016. This is referred to as the "conversion year" where the 38 hospitals moved from historical block grants to ABF.

4. The 2016 HSE National Service Plan reflects the key objectives of the ABF Implementation Plan 2015 - 2017, in particular the "conversion year" and the work developing ABF for Outpatients. The NSP also acknowledges some additional funding (€1m) being put into resourcing the ABF programme.

5. From 2016, hospital budgets will be separated into ABF and Non-ABF budgets. Hospitals will be given fixed ABF allocations, and hospital funding associated with inpatient and day case activity will effectively be withdrawn from hospitals and earned back following delivery in line with agreed ABF activity targets, up to a maximum of the fixed ABF budget. The 2016 ABF targets are based on the most recent Outturn activity data with some necessary adjustments. Full detail of activity targets for inpatient and day cases is provided in terms of volume of cases and weighted units in each hospital group's Operational Plan.

6. In early January 2016, the HSE's Acute Hospital Division issued activity based funding levels (ABF targets and ABF allocations) to the 7 hospital groups. A guidance document accompanied the letters to each Hospital Group CEO.

7. In order to maintain stability in the hospital system, hospitals will be given transition adjustments (or payments) in addition to their funding to reflect the difference between their current costs and the national average cost; these adjustments will be phased out over time [yet to be detemined]. Hospitals will be required to develop plans to address inefficiencies in their cost base over some years.

Governance and Oversight of ABF

8. Appropriate governance arrangements have been put in place to oversee implementation of the new funding system including an ABF Oversight Group which is comprised of

senior officials from the Department of Health and HSE; a HSE Steering Group; and a HSE Implementation Team.

Healthcare Pricing Office Legislation

9. The Healthcare Pricing Office (HPO) was established on an administrative basis in January 2014, attached to the HSE, in advance of becoming a statutory body. This Office will play a central role in the implementation of ABF. The HPO has been formed through the merging of the HSE Casemix Unit and the ESRI Health Research and Information Division. The key functions of the Healthcare Pricing Office (HPO) are to:
   - set the national Diagnosis Related Group (DRG)[5] prices on which the ABF system will be based; and
   - manage the HIPE[6] dataset.

Commissioning Framework

10. System Financing & Value Unit (SF&VU) is continuing to carry out research into the experiences of other countries that have implemented commissioning models with a view to informing the development of a healthcare commissioning framework for Ireland. A Policy Dialogue with the OECD and the European Observatory on Health Systems and Policies was held late last year. The Dialogue focussed on the following areas of commissioning: (i) the Commissioning Process, (ii) Organisation of Commissioning and (iii) Accountability, Governance and Data. SF&VU will use the findings from the Policy Dialogue and other research to help develop a draft framework for a healthcare commissioning process, in the Irish context.

11. SF&VU has also engaged with two other streams of Commissioning-related work ongoing elsewhere:
    - A Strategic Community Costing Programme project led by the HSE Finance Directorate. This will look at options to classify and cost social care services in the longer term. SF&VU has also identified work being carried out by National University of Ireland (NUIG) and in the UK which may provide useful research for pursuing this objective.
    - The Unit has engaged with the Department of Public Expenditure and Reform in relation to their proposals for commissioning of human, social and community services. This initiative is cross-sectoral as opposed to being focused on health.

Value for Money and Policy Reviews

12. The Unit will develop a model (including processes and governance) to oversee VFM and Policy Reviews (VFM&PRs)[7] and Focused Policy Assessments (FPAs)[8] in the Department. This will involve putting in place health economics and evaluation support from within the Department's Research and Development/Health Analytics Division and

[5] Diagnosis-Related Groups (or DRGs) are a classification which groups hospital case types that are clinically similar and are expected to have a similar hospital resource usage. There are currently 1,050 DRGs overall covering inpatient (698) and daycase activity (approx 350). The price for each DRG is set at a national level by the HPO based on the average cost of all cases in that DRG.

[6] HIPE (Hospital Inpatient Enquiry) is the principal source of national data on discharges from acute hospitals in Ireland.

[7] A Value for Money and Policy Review is an evaluation of a spending programme, using key evaluation criteria (rationale, efficiency, effectiveness, impact and continued relevance).

[8] A Focused Policy Assessment (FPA) is a sharper and more narrowly focused assessment (completed within a tight timeframe) designed to answer specific issues of policy configuration and delivery.

setting out a schedule of VFM&PRs and FPAs. Later in 2016, the Department will mobilise the first VFM project participants (lead reviewer/ project manager, steering group, chair, line unit, etc) and the first FPA project.

Other unit responsibilities

13. The Unit participates in the Department of Health – ESRI Research Programme on Health Reform. The Principal Officer is a member of the HSE's statutory audit committee which meets at least six times per year.

14. As part of the Department's "WBT" change and reorganisation programme, members of the Unit are also involved in a number of project and focus groups.

MANAGEMENT BOARD Area:Governance & Performance; Pat O'Mahony (Deputy Secretary)

(Units & Principal Officers & Equivalents; DoH/Agency Governance & Clinical Indemnity Unit – Mary Jackson, Media & Communications Unit, Parliamentary Affairs Unit, ICT Internal Unit, Records Management Unit, Freedom of Information Unit, - Seamus Hempenstall; Health Service Performance Management – Greg Canning, Internal Audit – Jane Craig, Programme Management Office).

Health Service Performance Management Unit

HSE National Service Plan

Purpose

1. Under the Health Act 2004 (as amended), the HSE is required to prepare and adopt an annual **National Service Plan** (NSP) setting out the type and volume of services to be provided with the funding approved by Government.

2. The NSP sets out the range of services to be delivered across each HSE Division, i.e. Health and Wellbeing, Primary Care, Mental Health, Social Care, Pre-Hospital and Emergency Care and Hospital Care. The Plan highlights key quality and patient safety requirements and sets out how the programme of health reform is expected to progress during the year. The NSP must, in addition to setting out the funding framework, identify the staffing levels that will be available to deliver health and social care services across the country.

3. The timelines for submission and approval of the NSP are set out in the legislation. The Minister may issue a direction to the HSE in respect of the form and manner in which the NSP is to be prepared and may also specify priorities to which the HSE should have regard in preparing the NSP. The NSP includes performance indicators and activity measures (KPIs) which are tracked and reported through the monthly performance reporting procedure (see under Point 2 below). Progress and outcomes against this plan are reported fully in the HSE Annual Report and Financial Statements (see under point 4 below). The NSP is required to be laid before the Houses of the Oireachtas and published by the HSE once approved by the Minister.

2016 National Service Plan

4. The Minister for Health approved the 2016 NSP on 16 December, 2015, following the granting of two requests from the HSE for time extensions. It was launched by the HSE the same day.

5. The National Service Plan is supported by Divisional Operational Plans (DOP) covering the areas of Health and Wellbeing, Primary Care, Mental Health, Social Care, Pre-Hospital and Emergency Care and Hospital Care. Divisional Operational Plans provide further information in relation to the implementation of priorities and actions including quality, finance, HR, activity and performance at Community Healthcare Organisation (CHO) and Hospital Group level as appropriate.

6. Divisional Operational Plans were finalised by the HSE on 29 January 2016, and are expected to be published, alongside CHO and Hospital Group Plans, during the first week of March, 2016.

2017 National Service Plan

7. The HSE is expected to commence preliminary work on the 2017 NSP in the second quarter of 2016 with the issuing of guidance notes on budgeting and service planning from the Office of the Chief Operations Officer to national leads for planning and performance.

8. The HSE will thereafter undertake an analysis of the emerging 2016 funding position and of the 2017 costs of initiatives introduced this year, and will evaluate the implications of such factors as run rates, demographics, core deficits, human resource implications etc. in order to assess 2017 requirements (on a pre-budget basis) and advise the Department and Minister for Health accordingly in the early autumn.

9. In past years, the level of engagement between the Department of Health and the HSE in the relation to the development of the NSP intensified from September onwards. It is the Department's intention to start the process earlier in 2016 in respect of NSP 2017 to allow for increased engagement with the HSE at an early stage.

HSE Performance Reports

10. The HSE prepares a monthly Performance Report (PR) detailing activity under each of its Divisional Areas against the targets set out in the NSP. PRs are published on the HSE website following approval by the HSE Directorate and consultation with the Department of Health.

11. Following a review by the HSE, PRs in 2016 are being presented in a new format. They will have less text, more visualisation and will include trends over time. The PR will include an Overview section, Heatmaps for each Division and an Escalation Report under the Accountability Framework (see under Point 3 below). The PRs will be supported by a Data document which will give further activity, financial and HR data.

12. The Performance Reports are normally prepared and reviewed two months in arrears i.e. the Department of Health will review the January, 2016 PR in March, 2016.

Monitoring of HSE Performance by DoH

13. Performance monitoring of the HSE by DoH includes a monthly performance review by the DoH Management Board (MB) followed by a monthly Performance Review meeting with the HSE Leadership team.

14. Performance Management Unit (PMU), a new Unit under the Governance and Performance Division, coordinates this high level monitoring of HSE performance by the Department and engages with both DoH Line Units and the HSE Business Intelligence Unit (BIU) in this regard (Note: the role of PMU was formerly incorporated within Finance Unit).

15. PMU will this year undertake a review of the performance dialogue with the HSE. The Unit, in conjunction with Project Group 2 of the WBT process and the HSE, is examining how the performance dialogue and performance monitoring can be improved and strengthened.

HSE Accountability Framework

16. The HSE's 2015 National Service Plan included, at the request of the Minister for Health, an enhanced **Accountability Framework** which makes explicit the responsibilities of all managers to deliver on the targets set out in the National Service Plan across the balanced scorecard of Quality and Safety, Access, Finance and HR. 2015 was the first year of operation of the Accountability Framework.

17. A key feature of the new Accountability Framework has been the introduction of formal **Performance Agreements**. These Agreements have been put in place between:-the HSE Director General and each HSE National Director for services and between the head of each Hospital Group and Community Healthcare Organisation
    and the HSE National Director to whom they report.

18. A **National Performance Oversight Group (NPOG)**, chaired by the HSE Deputy Director General, has been established and serves as a key accountability mechanism for the health service and supports the Director General and the Directorate in fulfilling their accountability responsiblities. The NPOG meets with each National Director for services on a monthly basis to review the performance of their Division against the National Service Plan.

19. Where the data indicates underperformance in service delivery against targets and planned levels of activity, the NPOG explores this with the relevant National Director at this monthly performance meeting and seeks explanations and remedial actions where appropriate to resolve the issue.

20. As part of the Accountability Framework, an **Escalation and Intervention process** has been developed and is up and running since April, 2015 The Escalation Framework sets clear thresholds for intervention for a number of priority Key Performance Indicators (KPIs) and a rules-based process for escalation at four different levels:
    - **Level 1 (Yellow)** requires action at Hospital Group CEO or CHO Chief Officer level
    - **Level 2 (Amber)** requires action at National Director level
    - **Level 3 (Red)** requires action at NPOG level
    - **Level 4 (Black)** requires action at Director General level

21. Since July, 2015, the monthly Performance Reports include an Escalation Report which lists the service issues that have been escalated to or remain in escalation at Red and Black level, the actions taken to address these issues and the progress made.

22. A review of the operation, effectiveness and application of the Accountability Framework throughout the HSE during the first six months of 2015 was completed in late 2015 (Flory Review) and the HSE is expected to report shortly on its plans for the implementations of the recommendations from this review.

HSE Corporate Plan and Annual Report

23. The Health Act 2004 (as amended) also requires the HSE to prepare, intera alia, a Corporate Plan and an Annual Report.

24. The **Corporate Plan** specifies the Executive's key objectives over a 3 year period, the strategies for achieving those objectives, the manner in which the Executive proposes to measure its achievement of the objectives and the uses for which it proposes to apply its

resources. In developing its Corporate Plan, the HSE must have regard to the policies of the Government or the Minister. After being approved by the Minister, the Corporate Plan is laid before the Houses of the Oireachtas and published by the HSE. The current HSE Corporate Plan covers the period 2015-2017.Under the legislation, the HSE is required to submit a new Corporate Plan within six months after the appointment of a new Minister, if the Minister so requests. The HSE also produces and publishes an **Annual Report** which includes its Annual Financial Statements. Ministerial approval is not required in respect of the Annual Report however, the Minister must ensure that copies of the Annual Report are laid before each House of the Oireachtas within 21 days of receipt.

DoH/Agency Governance and Clinical Indemnity Unit

Major Tasks/Policy Initiatives

Governance

1. The Unit is responsible for oversight of:
   - compliance with the Civil Service Standard for Corporate Governance and the Governance Framework for the Department of Health
   - compliance with the Lobbying Act
   - compliance with the Protected Disclosures Act

2. It also holds a central database of State Boards under the aegis of the Minister and is responsible for overseeing that vacancies are filled in accordance with Department of Public Expenditure and Reform Guidelines. A separate note is being provided on board vacancies, as no positions have been filled since early February, 2016.

3. It is also responsible for governance of the Medical Council, set up under the Medical Practitioners Act 1978 (as amended in 2007). The Council is the statutory body for the registration and regulation of doctors engaged in medical practice. The primary objective of Council is to protect the public by promoting and better ensuring high standards of professional conduct and professional education, training and competence among registered medical practitioners (around 19,000).

Significant Events/Milestones

4. The Department's Risk Register will transfer to the Unit (from National HR Unit) as soon as a Governance and Risk Manager is appointed.

Legacy Issues

Symphysiotomy Payment Scheme

5. The Surgical Symphysiotomy Payment Scheme commenced on 10 November 2014. The ex-gratia Scheme caters for women who underwent a surgical symphysiotomy or pubiotomy in the State between 1940 and 1990. The Scheme's Assessor is a retired High Court Judge - Maureen Harding Clark. The Scheme is voluntary and in applying to the Scheme women did not waive their rights to take their cases to court. Women could opt out of the Scheme at any stage in the process, up to the time of accepting their award; it was only on accepting the offer of an award that a woman had to agree to discontinue legal proceedings. 578 applications were accepted and to 21st March 2016, 400 offers have been made. 156 applications were deemed ineligible. Of the offers made, 386 have been accepted and only 1 offer has been rejected. The offers made ranged between €50,000 and €150,000. The total cost of the Scheme is approximately €31m to mid-April 2016 (this includes payment of awards and payment of legal costs). Judge Clark has completed all assessments and is in the process of writing her report to the Minister, which should be submitted by end Q2.

Lourdes Hospital Payment Scheme

6. Government agreed to the establishment of a Scheme to compensate those women who were excluded on age grounds alone from the Lourdes Hospital Redress Scheme. The Scheme commenced in November 2013. To date the Scheme has cost €2.9m and 46 awards have been made, with a small number of cases outstanding.

Significant events/milestones:

7. The Lourdes Hospital Payment Scheme will conclude and a Report from the State Claims Agency, which administered the Scheme, will be submitted to the Minister in Q2.

Drogheda Review and calls for an inquiry into allegations of sexual abuse by a former Consultant at Our Lady of Lourdes Hospital, Drogheda

8. A report was prepared by retired Judge TC Smyth on procedures and practices in Our Lady of Lourdes Hospital between 1964 and 1995. For legal reasons this report was not published, and it recommended that a further review should not be undertaken. As there are currently on-going criminal proceedings against the former consultant it is not appropriate for the Department to take any action that could in any way prejudice these proceedings.

Significant events/milestones:

9. The Unit will continue to examine how closure might be brought to Drogheda Review issues by end Q4. However, with the DPP proceedings against the consultant due for hearing in February 2017 it is difficult to see how progress can be made.

Clinical Indemnity Issues

MDU Refusals

10. In 2012 the Medical Defence Union made a settlement with the State Claims Agency amounting to €45m in settlement of outstanding past liabilities relating to indemnity cover for medical consultants. Work is underway to delegate responsibility for managing these claims to the State Claims Agency.

Significant events/milestones:

11. MDU delegation order transferring claims to the State Claims Agency will be finalised and signed into law by the Minister for Finance by end Q2, following the putting in place of a Delegation Order which must be approved by Government in the coming months.

Increase in the cost of Professional Indemnity for Consultants in 'off-site' Private Practice

12. The Medical Protection Society is the main indemnifier for consultants in Ireland who are not covered by the Clinical Indemnity Scheme, i.e. who are working in wholly private practice.

13. Professional indemnity subscriptions to MPS for these Irish consultants increased by an average of 43% in 2014, with a further small increase in 2015. The MPS attributes the high cost of clinical negligence claims in Ireland to the necessity for tort reform, including a reduction of the period that it takes before a case comes to trial, which in turn results in significant increases in awards and in higher legal costs.

14. Caps on the level of indemnity cover to be taken out by medical consultants in wholly private practice were introduced, with Government approval, in February 2004, following the incorporation into the Clinical Indemnity Scheme of hospital consultants engaged in public practice. In July 2013, Government decided to continue to provide the Caps scheme for the next five years and to adjust the Caps annually in line with the Consumer Price Index. It is important to note that without the Caps, indemnity subscription rates for consultants in private practice would have increased to a far greater extent than they have.

15. The Department asked the State Claims Agency to undertake two evaluations of the Caps:

- High and medium risk specialties, where subscription premiums had increased significantly, last reviewed by PWC in 2011. The SCA commissioned PWC to undertake this review,
- Abolition of Caps: The SCA commissioned Lane Clark and Peacock (LCP) to undertake an actuarial study of the financial impact if the State was to indemnify consultants on a "ground up" basis i.e. abolition of the Caps and assuming the collection of subscriptions from consultants in whole-time private practice where the subscriptions are based on the pre MPS increases in such subscriptions.

Significant events/milestones:

16. Following an assessment of the two reports commissioned by the SCA, which were received by the Department at the end of December, the Unit will report to the Minister and send a Memo to Government advising on options relating to the cost of indemnity for medical consultants in private practice by end Q2.

Developing a risk based approach to Indemnity

17. Action 7.3.1 of the Health Service Reform Programme, states that '*the Department of Health will work with the HSE and the State Claims Agency to develop a risk based approach to the provision of indemnity to services and professionals*'.

18. To implement this action the Department is working with the HSE and the State Claims Agency to ensure that the indemnity provided to health service providers aligns with health systems policy. A number of milestones and target dates have been agreed in order to make progress on this project. A major milestone has been the implementation of a National Incident Management System (NIMS). The system enables risk management with end-to-end incident reporting, incident investigation, outcome and recommendation tracking and powerful data analysis tools.

Significant events/milestones:

19. Having consulted with key stakeholders, the Unit will develop a roadmap for action based on a risk based approach to clinical indemnity by end Q2.

20. It will also continue to work with the State Claims Agency and the Department of Justice and Equality on areas of tort reform in order to improve the experience of plaintiffs in clinical negligence cases and to reduce the costs of clinical negligence claims.

Parliamentary Affairs Unit

Aim

1. Our aim is to support the Minister, Minister of State and colleagues in fulfilling accountability to the Oireachtas and the public by co-ordinating and managing Oireachtas matters within the Department (Oireachtas Committees, Cabinet Committees, monitor the work of HSE Parliamentary Affairs Division (PAD)) and providing administrative and secretarial support to the Minister, the Ministers of State, the Secretary General and the Management Board

Scope of Service

2. We liaise with internal and external customers. Internal customers include our colleagues in the Department and the HSE. External customers include Oireachtas officials, members and citizens. We co-ordinate the collation of briefing for Ministers' appearances before Oireachtas committees and manage PQs for answer by units across the Department. We follow up on PQs referred to the HSE and work closely with the HSE PAD, monitoring their progress and liaising on joint Minister-HSE Oireachtas committee appearances. We advise colleagues on Oireachtas issues and maintain the Oireachtas staff guide. We co-ordinate Ministerial observations on Memos for Government from other Departments. We man the Department's customer service telephone and e-mail.

Resources

3. Parliamentary Affairs Unit (PAU) is part of Governance and Performance Division and consists of 1 WTE HEO, 1 WTE EO and 1 WTE CO, reporting to an AP who also has responsibility for Freedom of Information (FOI) and Records Management Units (RMU). A PO has responsibility for PAU along with FOI, RMU, Press and Communications and Internal ICT.

Key Statistics

Parliamentary Questions answered	8,025
Of which referred to the HSE for Direct Reply	5,195
Notes for Leaders Questions prepared	431
Representations received	7,109
Topical Issues Prepared	438
Topical Issues Selected	116
Seanad Commencements Prepared	138
Seanad Commencements Selected	81

4. In the year since June 2015, PAU has processed over 2,500 customer service e-mails and around 1,300 phone calls as well as meeting personally with around 20 callers to the Department.

Main Priorities for 2016

5. PAU will continue to maintain its high standards of co-ordination in relation to Oireachtas business. Specific priorities include:
   - Publishing the 2015 Annual Report for the Department;
   - Publishing an updated and renewed customer service action plan and charter for the Department;
   - Work with Internal ICT on the Build to Share project (e-Submissions and ePQs).

Programme Management Office

1. The overall objective of the Programme Management Office is to provide effective project and programme management (PPM) within the Department. To do this the Department needs three things; good governance, good processes, and good people.

2. Part of the work of the Department of Health's (DoH's) Reform Governance and PMO project in 2016 will be a recommendation on a PPM Framework, which can be used to select and approve the right programmes and projects and then monitor and control them effectively. The PMO will present this Framework to the Management Board.

3. In recognising that good processes enable anyone in the organisation to speak the same Project Management language with the same understanding and to make sure that anyone working in the system understands how programmes and projects are organised and run, the PMO will develop and publish a comprehensive set of project management guidelines and templates that are appropriate to the nature of the project being undertaken.

4. In recognising that good people who know and understand the process, approach and methodology, as well as having a good understanding of the totality of PPM are important, it will be necessary to initiate and continue to support the development of a project management organisation supported by training and internal coaching. This aligns with promoting staff learning and development as listed in the Statement of Strategy 2015-2017.

5. During 2016 the PMO will be working on the following tasks;
   - Preparation and reporting on the Integrated Reform Delivery Plan (IRDP) for the Health Sector for 2016.
   - Providing oversight on the Reform Programme in the HSE.
   - Operating, monitoring and reviewing the Programme Management Office (PMO) reporting system.
   - Contributing to the implementation of the outputs of various WBT Group.
   - Meeting all the requirements and timelines arising from parliamentary business relating to the PMO Office and other Departmental Business.
   - Developing the PMO Office by adding real value to the Department Projects currently underway.

6. The work being done by one WBT Group will produce an implementation plan for a more unified and integrated business planning and risk management approach for the Department. A decision has been made to move the Business Planning work into the PMO in 2017. The PMO is currently a one person PMO so an additional resource for the PMO will be necessary to take on this work. The PMO is currently supported by a PWC resource on the Reform and Governance Project.

Freedom of Information Unit

Aim

1. Our aim is to coordinate and manage the Department's statutory responsibilities under the Freedom of Information Act 2014 and Access to Information on the Environment Regulations 2007 – 2011.

Scope of Service

2. The Unit co-ordinates FOI requests on behalf of the Department, reporting to the Management Board and the Secretary General. It also tracks progress in responding to requests. The Unit deals with some FOI requests that might relate to the Ministers' offices or have a significant corporate dimension and provides advice and guidance on applying the Act. The Unit liaises closely with the FOI Unit in the HSE and FOI Units in other Departments in relation to FOI requests/issues as appropriate.

Resources

3. FOI Unit is part of Governance and Performance Division and consists of 1 WTE HEO, 1 WTE EO and 2 WTE CO (1 currently vacant), reporting to an AP who also has responsibility for Parliamentary Affairs Unit (PAU) and Records Management Unit (RMU). A PO has responsibility for PAU along with FOI, RMU, Press and Communications and Internal ICT.

Key Statistics

4. FOI Unit processed almost 350 requests in 2015 (50% more than 2014, the increase probably due to the removal of fees for non-personal requests). 70% of requests are from the media and this requires close liaison between FOI Unit, line units and the Press and Communications Office.

Main Priority for 2016

FOI Unit will continue to maintain its high standards in relation to co-ordination and guidance. In particular, under Section 8 of the Freedom of Information Act 2014, the Department was required to publish a 'Publication Scheme' no later than 14 April 2016. The deadline for this requirement was met

Press and Communications Office

Aim

1. The Press and Communications Office aims to provide an effective and responsive communications function, including contributing to excellent systems of internal communications and to the development of external communications strategies which convey the value of health policies, services and outcomes

Scope of Service

2. The office deals with the media on behalf of the Department, in conjunction with the Ministers' (media) advisers. An on-call service is provided outside office hours during the week and over the weekends. The office monitors the media (broadcast and print) and updates colleagues as appropriate and liaises with other Departments, GIS (including attending weekly Press Office meetings) and other stakeholders (like the HSE and other bodies under the aegis) as required, reactively and proactively. The office is webmaster for www.health.gov.ie and manages @roinnslainte. The Office also manages the Department's Intranet and with HR, WBT and other relevant Units, has an important role to play in facilitating internal communications.

Resources

3. The Press and Communications Office is part of Governance and Performance Division and comprises 2 WTE HEOs, 2 WTE EOs and 1 WTE CO. A communications specialist at AP level is being recruited through the Public Appointments Service and will replace one HEO.

Main priorities for 2016

4. The PCO will continue to maintain its high standards of proactive and reactive media responses. Specific priorities include:
    - Conducting the Department's annual stakeholder consultation event;
    - With the new communications specialist, renewing the Department's communications strategy
    - Working with WBT Unit and other Units on implementing an agreed internal communications and engagement plan.

Records Management Unit

1. Records Management Unit (RMU) is responsible for the provision of records management services to Units of the Department. This includes the decant/retrieval of inactive files to/from off-site storage at the request of Units and the auditing of the off-site file holdings. The Unit also processes requests from applicants for personal information under the Access to Industrial and Related Records (AIRR) Project.

2. The AIRR Project, undertaken by the Department from 2004 to 2006, involved the indexing of all papers held by the Department relating to child care services, some of which contain information referring to individual children who were in care. The personal information references have been indexed onto a specialised 'names index' along with other relevant information. The purpose of the Project was to create a comprehensive archive of historical child care records and to enable efficient release of papers on foot of requests from and on behalf of individuals seeking their own information.

3. Records of the Department of Health are held on a Central Records and File Tracking System (CRAFTS). The system includes two databases –
   - CRAFTS Active and
   - CRAFTS Inactive and National Archives.

4. There are currently just under 50,000 CRAFTS registered files listed on the Active Database. The CRAFTS Inactive database has a listing of 241,000 files including almost 18,500 files held in the National Archives.

5. 389 boxes containing files being sent off-site for the first time were transferred to storage in 2015. This compares with a figure of 650 in 2014 and 679 in 2013.

6. 1,641 boxes of files were recalled in 2015, compared with 1,538 in 2014 and 1,612 in 2013. Such files would be recalled for action within the line unit or for auditing purposes by RMU.

7. There were 38 requests for information under the AIRR Project in 2015 compared with 19 and 33 in 2014 and 2013 respectively.

8. The Department has a contract with GRM for storage and retrieval of the Department's inactive records. The Department pays for the delivery/collection services of the contract and the OPW covers the costs of the storage of boxes and the high security vault (as checked and approved by RMU).

9. The Department's service charges in 2015 were €3,390 compared with €3,597 in 2014 and €3,694 in 2013. The storage costs covered by OPW were €60,092 in 2015, similar to 2014 at €60,012 and €59,807 in 2013.

Upcoming Issues

New Contract

10. The Contract is due for renewal at this time and arrangements are being made in co-operation with the Office of Government Procurement, through its Document

Management Services Framework, to seek tenders for the provision of services into the future.

Mother and Baby Homes Commission of Inquiry

11. As part of RMU's function relating to the retrieval of inactive files, RMU is currently supporting the Mother and Baby Homes Inquiry Unit relating to the Department's input to the Mother and Baby Homes Commission of Inquiry. This includes the recall, identification, sorting and delivery of files that may be relevant in respect of the anticipated Order of Discovery.

Internal Audit Unit

Function

1. Internal Audit is an independent appraisal function which provides independent and objective assurance to the Secretary General and Management, that the systems, processes and procedures which underpin the Department's operational activities are properly, efficiently and effectively managed, or otherwise to recommend appropriate corrective measures. Internal audit unit also provides advice on the adequacy of controls where new systems or programmes are being developed.

Work Programme

2. During 2016 Internal Audit Unit will carry out the programme of audits agreed by the Audit Committee and the Secretary General and will continue to provide secretarial support to the Audit Committee. We will advise and inform the Secretary General and Senior Management as required and provide advice to Units on request. We will continue the programme of implementation of the CIIA International Standards within the Unit during 2016.

ICT Internal Unit

Aim

1. We aim to provide a modern, centralised, standardised and rationalised ICT infrastructure, leveraging the Office of Government Chief Information Officer's 'Build to Share' programme, to support improved Departmental business systems and to continue to deliver ICT-related services to other bodies under shared services arrangements.

Scope of service

2. Under shared services arrangements we support the DCYA, the Adoption Authority of Ireland (AAI), the Ombudsman for Children (OCO), the Mother and Baby Homes Commission of Investigation and the Symphysiotomy Scheme as well as facilities in Dáil Eireann and the DR site. See diagram.

Main functions

3. Our functions include monitoring network security, maintaining and developing appropriate disaster recovery (DR) infrastructure, manning a helpdesk that deals with up to 8,000 calls per annum, project management and procurement (in respect of specific projects and 8 external contractors). There are over 100 individual databases (PQs, representations, correspondence, eCabinet, payroll, flexi) that must be maintained, as well as the DCYA ECCE/CCS processes which we manage under the shared services arrangements. We also account for all the ICT expenditure and assets.

Resources

4. Internal ICT Unit is part of Governance and Performance Division and consists of 1 WTE AP, 2.5 WTE HEOs and 3 WTE EOs, reporting to a PO. Services are provided on an outsourced basis across a number of external contractors, currently comprising 7.1 WTEs. List of contractors and our annual budget are set out below:

Name	Service	Annual Cost €	End date
Planet 21	LAN support	[redacted]	31/03/16
Tomorrow's World	Helpdesk		30/04/16
Bluewave Technologies	Domino		31/10/16
IT Force	Network support		31/05/17
Datapac	Backup		31/05/17
Grant Thornton	Security Partner	On demand	July 2017
Future Range	Citrix		14/01/18
IP Options	Perimeter Security		N/A
Waterford Technologies	Archiving support		Rollover
Servaplex	Double Take		Rollover
Netfort	Languardian		Rollover
Renaissance	Safend		Rollover
Total		[redacted]	

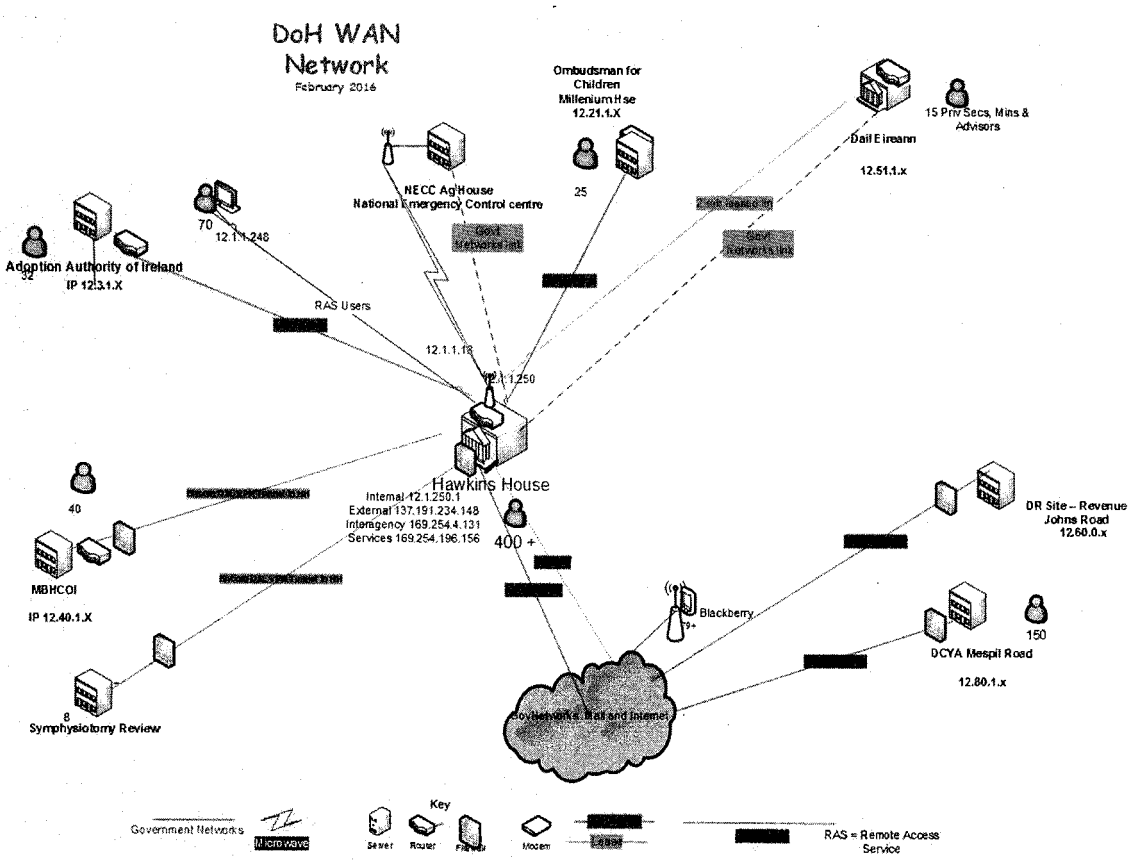
Internal ICT Annual Budget €			
2013	2014	2015	2016
1,480,000	1,580,000	1,600,000	1,700,000 (provisional)

Main Priorities for 2016

5. The possibility of moving to a new building has crystallised over the past while. Should a decision be taken, it will require a major planning and logistical exercise across the

Department, including Internal ICT. We are factoring this into our strategy (being drafted) and having initial discussions with the Office of the Government Chief Information Officer (OGCIO). Priorities for this year otherwise are:

- Draft a 3-5 year strategy for the Department's ICT network and infrastructure;
- In conjunction with the OGCIO, implement the Build to Share project (e-Submissions scheduled for Q1 2016 and ePQs for Q4 2016).
- Implement a centralised Mobile Device Management and Support system and policy to provide secure encrypted management of a standard range of mobile devices.
- A number of critical applications are 'mirrored' to out DR site in St. John's Road. We will complete our DR site development by testing payroll and FMS infrastructure in disaster scenarios.
- Testing our perimeter security (firewall, mail scanning, web scanning software, remote
- access, secure email) and reviewing our entire access control mechanism to ensure all users have only the necessary required access for the work they are currently engaged in.
- We outsource many services (see table above). This year we must retender for Lotus Domino Development and Administration and support and maintenance of LAN network and switches



Appendix: Department of Health Legislative Programme

1. Bills before the Oireachtas at January 2016

Bills that are before the Oireachtas lapse on the dissolution of the Dail. 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. There were three Bills before the Oireachtas at end January 2016.

The suggested priority order for the three Bills is shown below.

Priority	Name	Purpose	Current position	Unit responsible
1	Health (Miscellaneous Provisions) Bill 2016 [formerly H(MP)(No. 2) Bill]	The Bill: (1) amends the Nursing Homes Support Scheme Act 2009 in order to exclude certain ex-gratia payments which have been, or will in the future be made to individuals under specific schemes approved by Government, for the purpose of assessment of means under that Act (2) amends the Health (Pricing and Supply of Medical Goods) Act 2013 Health (Pricing and Supply of Medical Goods) Act 2013 to ensure that over - the - counter products, which do not require a prescription, continue to be available under the GMS and community drug schemes. The amendment proposed will allow the HSE disapply the criterion regarding prescription only medicines when considered appropriate in the interests of patient safety or public health (3) amends the Public Health (Standardised Packaging of Tobacco) Act 2015 to provide by way of regulations for a number of elements relating to the appearance of tobacco packaging (4) amends the Irish Medicines Board Act 1995 to allow for the payment of fees to members of the Health Products Regulatory Authority (HPRA). An amendment is to be made at committee Stage to amend the Health Act 2007 to extend the timeframe under the transitional provision in	The Bill was published in January. In relation to the standardised packaging of tobacco products, the required regulations cannot be made until the Bill has progressed through the Oireachtas. Because of complex technical issues, the proposed amendment to section 69 of the Health Act 2007 was not in the Bill as published and is to be included at Committee Stage. The current transitional period ends on 31 October.	Various units

		section 69 of that Act for registration by HIQA of designated centres for people with a disability.		
2	Medical Practitioners (Amendment) Bill 2014	This Bill will make it mandatory for all medical practitioners who practice medicine in the State to provide evidence to the Medical Council of minimum levels of indemnity cover in order to be placed on the Medical Council's register.	The Bill had been passed by the Seanad. Second stage began in the Dail on 27 January, 2016.	Agency Governance and Clinical Indemnity Unit Mary Jackson – PO Kara Prole – AP
3	Public Health (Alcohol) Bill	To provide for, inter alia: (1) Minimum unit pricing for retailing of alcohol products. (2) Regulation of marketing and advertising of alcohol. (3) Regulation of sports sponsorship. (4) Structural separation of alcohol from other products. (5) Health labelling of alcohol products.	The Public Health (Alcohol) Bill completed Second Stage in the Seanad on 17 December 2015. A date is awaited for Committee Stage.	Tobacco and Alcohol Control Unit Geraldine Luddy – PO Alessandra Fantini – AP

Government Legislative Programme

The Government Legislative Programme is considered by Government and published at the start of each new Dail session. The Legislative Programme divides Bills being prepared into three categories. The A List Bills are Bills where the Heads were approved by Government, the Bill is being drafted by Parliamentary Counsel and the Bill is expected to be published that session. The B List Bills are Bills where Heads have been approved by Government, the Bill is being drafted by Parliamentary Counsel but the Bill is not expected to be published that session. The C List Bills are Bills where Heads have not yet been approved by Government.

Bills currently being drafted by Parliamentary Counsel

Name	List	Purpose	Current position	Responsible Unit
Health (Miscellaneous Provisions) (No. 2) Bill [formerly H(MP) (No. 1) Bill]	Had been on A list	To amend the Medical Practitioners Act 2007, the Dental Act 1985, the Health & Social Care Professionals Act 2005, the Pharmacy Act 2007, the Nurses & Midwives Act 2011 and the Health Acts 1953 and 2004 to provide for: (1) Consequential amendments required by the transposition of Directive 2013/55/EU. (2) An appeal against minor sanctions. (3) Amendments in relation to a number of issues, including the removal of the requirement for an equivalence of a certificate of experience for doctors seeking registration in the Trainee Specialist Division of the register, by doctors qualified outside the EU and removal of the equivalence of a certificate of experience as a way of registration for doctors with a non-Irish/EEA	The General Scheme was approved by Government on 17 November 2015. The Bill is expected to be ready for publication in Q4 2016.	Professional Regulation Unit Deirdre Walsh – PO Catherine McManus – AP

		qualification seeking registration in the General Division of the register. The Medical Council will amend its Rules accordingly when the legislation is enacted.		
Health Information and Patient Safety Bill	Had been on B list	To provide a legislative framework for the better governance of health information and initiatives including data matching and health information resources for use in the health service and support for clinical audit and patient safety notifications. The Bill will also provide for the extension of HIQA's remit to private health service providers.	Parliamentary Counsel has been assigned to draft the Bill. The Joint Oireachtas Committee on Health and Children issued an interim response in relation to pre-legislative scrutiny on 28 January and advised that the incoming Health Committee be requested to consider additional pre-legislative scrutiny on the Bill as part of its Work Programme.	Policy Lead: Various Units. Drafting of Bill: Corporate Legislation Unit Bernie Ryan - PO Peter Lennon - AP
Misuse of Drugs (Amendment) Bill	Had been on B list	As a consequence of a Court of Appeal adverse decision in Constitutional challenge to powers of Government to control substances under the Act, to reintroduce those powers and to amend other sections identified by the AGO as being vulnerable to similar challenges. On 15 December the Cabinet approved additional heads to provide for supervised injecting facilities for chronic drug users.	Drafting is at an advanced stage. The Supreme Court (SC) heard the State's appeal to the Court of Appeal decision on 12th April. The SC judgment will inform the final text of the Bill.	Medicines Unit Eugene Lennon - PO Siobhan Kennan - AP
Open disclosure provisions to be included in	Had been on B list	To provide support for open disclosure of patient safety incidents.	Heads were approved by Government on 3 November 2015. Parliamentary Counsel has	Policy Lead: Patient Safety Unit Kathleen MacLellan

legislation on Periodic Payments Orders (Department of Justice & Equality).			been assigned to draft the Bill.	Susan Reilly - AP Drafting of Bill: Corporate Legislation Unit Bernie Ryan - PO Peter Lennon - AP

Bills where Heads are being prepared in the Department

Name	List	Purpose	Current position	Responsible Unit
New Children's Hospital Establishment Bill	C	To establish a statutory body to provide paediatric acute services in Dublin at the new children's hospital, taking over those services currently provided by Our Lady's Hospital Crumlin, Temple Street and the paediatric service at Tallaght Hospital. The Bill will also make amendments to the National Paediatric Hospital Development Board (Establishment) Order, relating to the functions of the Board.	Work is continuing on the preparation of a General Scheme to go to Government in May 2016.	Acute Hospitals Division Fionnuala Duffy – Head of Unit Celeste O'Callaghan – AP
Health (Transport Support) Bill	C	To provide for a scheme to make individual payments as a contribution towards transport costs to people with severe disabilities who cannot access public transport.	General Scheme being developed - working towards Q2 2016.	Disability Unit Gráinne Duffy – PO Harry Harris – AP
Assisted Human Reproduction Bill	C	To provide a legislative framework for the regulation of assisted human reproduction (AHR) practices and associated research in respect of commitments made in the Programme for Government (2011).	It is intended to have a General Scheme prepared by the end of Q2 2016.	Bioethics Unit Siobhán O'Sullivan – Chief Bioethics Officer
Human Tissue Bill	C	To meet the key recommendation of the Madden Report that no hospital post-mortem may be	It is intended to have a General Scheme prepared in 2016.	Policy Lead: Cancer and Blood Policy

		carried out and no tissue retained after post-mortem without consent. The Bill also addresses other matters relating to human tissue including consent arrangements for transplantation and anatomical examination purposes.		Unit Michael Conroy – PO Maeve O'Brien - AP Drafting of General Scheme: Corporate Legislation Unit Bernie Ryan - PO Valerie Hughes - AP
Health & Wellbeing (Calorie Posting and Workplace Wellbeing) Bill	C	To provide for: (1) Mandatory calorie-labelling in restaurants, takeaways and premises selling non-pre-packaged foods. (2) A legislative requirement, as a positive action measure, on all public service organisations to have, and report on, a 'healthy workplace' policy in order to support an enabling workplace environment.	It is expected to have draft Heads prepared by Q2 2016.	C.M.O's Office Dr John Devlin – Deputy CMO Malachy Corcoran - AP – Health and Wellbeing Programme
Patient Safety licensing Bill	C	To provide for a mandatory system of licensing for public and private healthcare facilities.	The General Scheme will be finalised in 2016.	Policy Lead: Patient Safety Unit Kathleen MacLellan David Keating – AP Drafting of Bill: Corporate Legislation Unit Bernie Ryan – PO Margaret McDonnell - AP
Public Health (Retail Licensing of Tobacco Products) Bill	C	The introduction of a licensing scheme and other measures in relation to the sale of tobacco products and non-medicinal nicotine delivery systems including e-cigarettes.	Intention to have a General Scheme prepared in 2016 (subject to resources).	Tobacco and Alcohol Control Unit Geraldine Luddy – PO Nuala O'Reilly/Dilly O'Brien – AP

Health Act 2007 (Amendment) Bill	C	To extend HIQA's remit to include functions with regard to Medical Ionising Radiation Protection and a supervisory body function in respect of research ethics committees for clinical trials on medicinal products and medical devices.	Date for General Scheme not yet confirmed. A decision will be made on whether to proceed with transferring the Supervisory Body function to HIQA.	Tony Holohan - CMO Fergal Goodman - Asst.Sec.
Health Reform Bill	C	To put in place new structures for the health service.	This will need to be given further consideration following engagement with the new Government on plans for the HSE.	System Financing and Value Unit formerly Health Reform Unit

List of abbreviations used in the document

A

ABF	Activity Based Funding - also referred to as Money Follows the Patient
ADHD	Attention Deficit Hyperactivity Disorder
AGO	Attorney General's Office
AHD	advanced healthcare directive
AHR	assisted human reproduction
AIRR	Access to Industrial and Related Records
AMNCH	Adelaide Meath & National Children's Hospital
AMR	anti-microbial resistance
AVFC	A Vision for Change

C

CAD	Computer Aided Dispatch
CAMHS	Child and Adolescent Mental Health Services
CHO	Community Healthcare Organisation
CNO	Chief Nursing Officer
CNU	Community Nursing Unit
CORU	Registration Board for Health & Social Care Professionals
CRAFTS	Central Records and File Tracking System
CSO	Central Statistics Office
CSU	Corporate Services Unit
CUH	Cork University Hospital

D

DCYA	Department of Children & Youth Affairs
DFB	Dublin Fire Brigade
DOP	Divisional Operational Plans
DPC	Data Protection Commissioner
DPER	Department of Public Expenditure & Reform
DR	Disaster Recovery
DRG	Diagnostic Related Group

E

EAS	Emergency Aeromedical Support Service
EAT	Employment Appeals Tribunal
ECCE	Early Childhood and Education
ECT	Electro-convulsive Therapy
ED	Emergency Department
EPCP	Eligibility & Primary Care Policy
EPSCO	Employment Social Policy Health & Consumer Affairs
ESRI	Economic & Social Research Institute
EWTD	European Working Time Directive

F

FOI	Freedom of Information
FPA	Focused Policy Assessment
FSAI	Food Safety Authority of Ireland

G

GMS	General Medical Service
GRM	Glenbeigh Records Management

H

HBSC	Healthy Behavoiurs in School Children
HCP	Home Care Package
HIA	Health Insurance Authority
HIPE	Hospital InPatient Enquiry
HIQA	Health Information & Quality Authority
HPO	Healthcare Pricing Office
HPRA	Health Products Regulatiory Authority
HPV	Human Papilloma Virus
HR	Human Resources
HRB	Health Research Board
HSE	Health Service Executive

I

IAEA	International Atomic Energy Agency
ICRUs	Intensive Care Rehabilitation Units
ICT	Information & Computer Technology
IFMS	Integrated Financial Management System
IGEES	Irish Government Economic and Evaluation Service
IMO	Irish Medical Organisation
INMO	Irish Nurses & Midwives Organisation
INTO	Irish National Teachers Organisation
IR	Industrial Relations

J

JTI	Japan Tobacco Ireland Limited

K

KPIs	Key Performance Indicators

L

L & D	Learning & Development
LAN	Local Area Network
LCP	Lane Clark Peacock
LCR	Lifetime Community Rating
linacs	Linear Accelarators

M

MB	Management Board
MDU	Medical Defence Union
MHID	Mental Health Intellectual Disability
MIRP	Medical Ionising Radiation Protection
MPS	Medical Protection Society
MSIC	Medically Supervised Injecting Centre
MUP	Minimum Unit Pricing

N

NACDA	National Advisory Committee on Drugs & Alcohol
NAS	National Ambulance Service
NCC	National Coordinating Committee
NCD	non communicable disease
NCGs	National Clinical Guidelines
NCHD	Non Consultant Hospital Doctor
NDS	National Drugs Strategy

NEOC	National Emergency Operations Centre
NFMHS	National Forensic Mental Health Services
NHSS	Nursing Homes Support Scheme
NIMS	National Incident Management System
NMH	National Maternity Hospital
NPAS	National Positive Ageing Strategy
NPOG	National Performance Oversight Group
NPRO	National Plan for Radiation Oncology
NPS	New Psychoactive Substances
NPSO	National Patient Safety Office
NRH	National Rehabilitation Hospital
NSCs	Newborn Screening Cards
NSP	National Service Plan
NTPF	National Treatment Purchase Fund
NUIG	National University of Ireland Galway

O

OECD	Organisation for Economic Cooperation & Development
OFD	Oversight Forum on Drugs
OGCIO	Office of the Government Chief Information Officer
OGP	Office of Government Procurement
OPW	Office of Public Works

P

PAD	Parliamentary Affairs Division (HSE)
PAS	Public Appointments Service
PAU	Parliamentary Affairs Unit
PHI	Private Health Insurance
PMO	Programme Management Office
PMU	Performance Management Unit
PPM	Project & Programme Management
PR	Performance Reports
PRU	Professional Regulation Unit
PSIU	Policy Strategy & Integration Unit
PWC	Price Waterhouse Cooper

R

RCSI	Royal College of Surgeons in Ireland
RES	Risk Equalisation Scheme
RMU	Records Management Unit
RSSMACs	Residential Support Services Maintenance and Accomodation Contributions

S

Saolta	Previously West North/West Hospitals Group
SCA	State Claims Agency
SF&VU	System Financing & Value Unit
SOG	Senior Officals Group
STEMI	ST segment elevation myocardial infarction

T

TAS	Treatmenht Abroad Scheme
TILDA	The Irish Longitudinal Study on Ageing

U

UHG	University Hospital Galway
UN	United Nations

UNGASS	United Nations General Assembly Special Session

V

VFM	Value for Money

W

WBT	Working Better Together
WHO	World Health Organization
WTE	Whole Time Equivalent

Z

ZIKAV	Zika Virus