The Mater

INVESTMENT WHERE IT'S NEEDED

DISCUSSION DOCUMENT
ISSUED BY
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THE MATER MISERICORDIAE UNIVERSITY HOSPITAL, DUBLIN.

Contents

1. Introduction

The Mater Misericordiae University Hospital or the Mater as it's colloquially known to generations of Dubliners, serves Dublin's North Inner City. The hospital is at the heart of the Dublin Central Constituency. Two other hospitals also serve the North inner city. The Rotunda Hospital in Parnell Square East founded in 1745 holds claim to being the oldest working maternity hospital in the world. The other hospital is Temple Street Children's University Hospital. It was founded in 1872 and is an acute paediatric hospital. Each year Temple Street can care for up to 145,000 sick children.

However, the focus of this discussion document will be on the Mater Hospital. The Mater provides acute and tertiary specialist services. It is a university teaching hospital established in 1861 under the auspices of the Sisters of Mercy. Its local catchment area has a population of approximately 185,000.

The Mater is also the national centre for a number of specialties for example, spinal injuries, cardiac surgery, heart and lung transplantations. It is also home to the National Isolation Unit, a state of the art facility caring for people with a range of infectious diseases, providing for them both inpatient and outpatient care.

This discussion document has been drafted from the information gathered from a series of parliamentary questions (PQs) submitted to the Minister for Health on the subject of the Mater Hospital. We have also spoken to service providers and stakeholders and engaged with the HSE when putting this document together. The document gives an insight into the pressures and stresses faced by both the staff of the Mater and its patients. It is obvious from the answers we have received from our PQs that the Mater requires serious capital and operational investment. As demand increases so should funding. We hope people will engage with the contents of our discussion document and be part of a process that will ultimately create a long-term vision for the future health of our nation. With the proper leadership and the proper vision we can together fix the crisis in our health service.

2. Capacity - the need to invest

Whether it's a headline about elderly patients lying on hospital trolleys, overcrowding or patients forced to travel for treatment because of the long delays in accessing health care in Ireland, the common thread across all of these stories is the lack of capacity in our health system to meet demand. There are additional pressures on the capacity of the Mater Hospital caused by the increase in population as well as the aging population in the catchment area. The transient nature of many service users such as the homeless or the tourist population passing through or office workers using the Smithfield service create extra demand on existing capacity

Some Key facts in relation to The Mater Misericodiae hospital:

(Figures were obtained from answers to parliamentary questions)

- **3188 total number of employees.**
- **1221 total number of Nurses.**
- **2 Suicide Crisis Assessment Nurses.**
- **60,882 Emergency Department attendances in 2016.**
- **9,640 ED attendances for January and February 2017.**
- **548 Number of Inpatient beds 2016.**
- **419 patients on hospital trolleys to March 2017.**
- **€26,681,486 spent agency staff from 2009 to February 2017.**
- **213 patients outsourced to other hospitals in 2016.**
- **1,142 the Number of patients waiting up to 3 months in March 2017 for an MRI scan.**
- **1,088 the number of patients waiting up to 3 months in March 2017 for a CT scan.**

Sinn Féin's proposals to increase Capacity

Sinn Féin is committed to increasing spending on health by €3.3billion over the next five years as set out in our general election manifesto. We would increase the health budget each year by the following amounts cumulatively. This would increase capacity in acute hospitals, including at The Mater Hospital.

Year	Amount
Year 1	€794million
Year 2	€771million
Year 3	€614million
Year 4	€584million
Year 5	€518million

The above figures are cumulative. The Department of Finance figures for the period 2018 to 2021 set out a combined net fiscal space of €8.7billion. In prioritising significant and targeted investment in the health service, Sinn Féin will allocate €3.3billion for health from the overall fiscal space for this period. This provision is in addition to a 2%-3% annual funding increase to accommodate demographic pressures.

By progressively replacing private spending by members of the public with public spending, allied with better stewarding of spending, we can achieve much greater efficiency and fairness. We can deliver more for the same.

3. Hospital cancellations

The Waiting list Management Protocol for the Mater Hospital (NTPF, 2017) states that:

'Once a patient has been added to a waiting list, they are actively waiting for a date 'To Come In' and receive their care and/or treatment. In order to ensure fair, equitable access to hospital capacity, patients should be scheduled 'To Come In' in the following order:

- *urgent patients with a previous hospital cancellation history*
- *urgent patients*
- *routine patients with a previous hospital cancellation history*
- *routine patients in strict chronological order, i.e. 'Treated in Turn'*
- *planned procedure patients in accordance with the indicative date assigned*

The patient's clinical requirements must be taken into consideration when scheduling'

Figure 1.[1]

The number of out-patient appointments before cancellations from 2009 to 2016 and to February 2017 including out-patient appointments rescheduled.

Attendance Year	No. Attendances	Hospital OPD rescheduled Apts
2009	198731	36444
2010	202491	35226
2011	215162	38087
2012	217199	39742
2013	227715	39924
2014	226693	40797
2015	234115	45794
2016	231344	59173
2017 as at end Feb	37893	6591

Figure 2.[2]

The cancellation of hospital appointments is a clear indicator of systemic problems. The HSE argues that hospital cancellations occur mainly because of a historical practice of the overbooking of clinics. They argue that this is not in fact a true cancellation. The figures we received from the HSE showing increasing numbers of out-patient cancellations at the Mater Hospital are also proof that hard-pressed staff

[1] PQ 4568/17
[2] PQ 12910/17

are doing their very best with fewer resources. The figures clearly illustrate that waiting lists are not being properly managed.

We also asked for the number of procedures cancelled for the Mater Hospital from 2009 – 2017 but the HSE were unable to provide us with information for the timescale requested. Figures they did provide show that from January 1st 2016 to 31st January 2017 a total of **5,368**[3] patients nationally have had their procedure cancelled on more than one occasion. Of this national figure **166**[4] people had their elective surgery cancelled or rescheduled on more than one occasion in the Mater hospital.

We were also provided with a figure of **540**[5] for January and February for the pre-admit rescheduling of procedures due to what the HSE described as being 'capacity/resourcing issues'.

Patient cancellations are a real problem and can frustrate the work of frontline staff. Figures obtained from the HSE and presented in the table below show the current DNA (did not attend) rate amongst outpatients is high and averages out at approximately 15% over the last 9 years. This presents major challenges in the face of increasing waiting lists. There can be many good reasons why a patient has not attended a hospital appointment. But it is incumbent on the Mater to be proactive in this area to help decrease the DNA rate. The Mater has introduced Text Alerts which are an effective method of reminding patients of upcoming appointments.[6]

The 'Did Not Attend' (DNA) rate from 2009 to end of February 2017[7]

Attendance Year	Did Not Attend %
2009	15.52
2010	16.55
2011	16.62
2012	15.6
2013	15.42
2014	13.98
2015	13.32
2016	13.22
2017 as at end Feb.	12.5[8]

Figure 3.

It is against a backdrop of evidence showing that thousands of patients are waiting for operations and procedures that are not included in the waiting list figures that Sinn Féin has put forward proposals for a new single, integrated hospital waiting list management system. Sinn Féin are calling this system Comhliosta. Sinn Féin's

[3] PQ 4568/17
[4] PQ 4568/17
[5] PQ 12902/17
[6] PQ 12913/17
[7] PQ 12911/17

proposal will allow people to move from one hospital to another to reduce waiting times.

Under the current system waiting lists vary drastically across our hospitals and The Mater is no exception. This can cause great uncertainty and frustration for Patients who do not know where they stand on the waiting list or how long they will be waiting. We know too that within the health service there are additional hidden waiting lists. Figures on these lists are excluded from official public figures. So we are not getting a true reflection of real time waiting lists.

Sinn Féin's response to cancellations and DNAs is for a single integrated hospital waiting list called Comhliosta. We are pleased that the Government has taken this idea on board and they are looking at piloting it in 2017.

Sinn Féin supports the introduction of a new, single integrated hospital waiting list management system, called Comhliosta.

Under the current system, waiting lists for outpatient appointments, diagnostic tests, day case and inpatient procedures vary drastically from one public hospital to the next. Patients do not know where they stand on the list or at what speed their list is moving relative to that of other hospitals within reasonable travelling distance.

People with comparable health concerns can wait very different lengths of time for assessment and treatment depending on what hospital they happen to be referred.

We would introduce a version of the integrated IT system used in the Portuguese NHS, which would help to achieve new maximum wait times by actively transferring those on the list from hospitals that are failing to meet their targets to hospitals that have the ability to offer the service on time.

The new maximum waiting times should be developed to cover the entire period from referral to the end of the episode, i.e. the time when either a decision is made not to treat or when treatment has happened.

The IT model introduced by the Portuguese, alongside greater investment in public hospitals, has delivered significant and sustained reductions in waiting times for surgery since it was first introduced in 2004. As described in the 2013 OECD publication, *'Waiting Time Policies in the Health Sector: What Works?'*, over five years waiting lists for surgery have decreased by almost 35%, the median waiting time has declined by almost 63% and variation across providers is also diminishing.

When a registered patient has reached 75% of the maximum waiting time allowed for their treatment, a voucher is automatically generated allowing the patient to obtain treatment in a different public or participating private facility - the payment is the same regardless of provider status.

Unlike the National Treatment Purchase Fund, fees for Comhliosta activity would be centrally determined and set at a rate below that paid for core activity, which must

take account of all hospitals' fixed costs. In Portugal, the additional surgeries conducted via the transfer system cost, on average, 70% of the price paid for basic surgery provision.

Hospitals in Portugal have an incentive to engage in additional transfer activities over and above that contracted in order to attract the 70% funding which comes with them. Almost 80% of Irish consultants are currently engaged in some form of private patient activity outside of their contracted hours.

This shows they have the capacity to carry out more public activity, which would allow us to treat everybody quicker and on the basis of clinical need alone rather than patient status. Coupled with greater public investment, Comhliosta could do just that.

4. Theatre space

The number of theatres and the number operational at the Mater Misericordiae University Hospital from 2009 to 2016 and to date in 2017.

	Main Theatre	Minor Theatre	Day Theatre
2009	9	1	1
2010	9	1	1
2011	9	1	1
2012	9	1	1
2013	9	1	1
2014	10	1	1
2015	10	1	1
2016	11	1	1
2017	11	1	1

Figure 4.[8]

According to the HSE the Mater Hospital had nine theatres opened from 2009 up to 2013. The hospital moved to a new twelve Main Theatre suite in February 2014, **Figure 5** outlines what the HSE has stated is the current up to date position for the Mater Hospital.

Current position of all Theaters in the Mater Hospital.[9]

Theatre 1	**open fully**
Theatre 2	**open 2 days per week from December 2016 and increased to 3 days on alternative weeks from March 2017**
Theatre 3	**open fully**
Theatre 4	**open fully**
Theatre 5	**open fully**
Theatre 6	**open fully since July 2014**
Theatre 7	**open fully**

8 PQ 12914/17
9 PQ 12914/17

Theatre 8	**open fully**
Theatre 9	**open fully**
Theatre 10	**open fully**
Theatre 11	**open 3 days per week from September 2016**
Theatre 12	**open fully**

Additionally the Mater Hospital has two Cardiac Catherisation labs and an Endoscopy suite.

Figure 5.

5. Emergency Department

Since 2009 there has been a steady increase in the number of Emergency Department attendances for the Mater Hospital. There has been an almost 15,000[10] increase in the numbers attending the Emergency Department since 2009. The numbers alone however do not reflect the fact that the age profile of patients is increasing with a consequent rise in the activity level of patients. The increase in age profile includes frail elderly, who require additional levels of care, including home care and supports. This also affects the increase in numbers who require placement in nursing homes and intermediate care, with a corresponding effect on inpatient bed capacity which has resulted in an ongoing trolley crisis in the Emergency Department at the hospital in recent years.

[10] PQ 12906/17

The number of persons placed in nursing homes that were patients of the Mater Hospital.[11]

Year	Number
2015	237
2016	271
To March 2017	58

Figure 6.

Full Capacity Protocol.

The HSE has developed an incremental process in response to hospital overcrowding which is called the full capacity protocol. This system-wide response recognizes the role of all departments within the hospital and also of community facilities and care centers. In the event that all possible escalation steps have been exhausted and overcrowding persists, a package of measures, referred to as the full capacity protocol, is to be activated. The full capacity protocol is activated when hospitals are operating in excess of 90% capacity. Admitted patients are transferred to available beds. These beds are not always the appropriate beds. We asked how many times the full capacity protocol was activated at the Mater Hospital in 2016. The HSE responded saying that it was not activated in 2016, "however unfunded beds were opened and staff were redeployed to facilitate the demand on beds in line with the Escalation Policy."[12]

When the full capacity protocol is initiated there are consequences for the hospital's ability to care for patients. There are consequences for the patients too, such as the possibility that all elective surgeries proposed for the day will be cancelled. Patients can also be put back on a waiting list for life-changing operations because a bed is not available in the hospital.

Hard pressed and over worked staff are put further under pressure because of the lack of capacity. There is the potential of staff being pressurised to discharge patients to try and free-up beds which in itself is a major safety concern. Patients could potentially be sent home earlier even if they are not ready.

Patients with specific problems such as heart or lung problems should be placed in the appropriate wards. There is the real possibility that patients lying on a trolley could be placed in the wrong ward. When additional patients are admitted on trolleys they also will most likely be placed in the wrong ward. The INMO has said that some patients in hospitals have been moved up to five times in the course of a week's stay in hospital, increasing the risk of the transmission and spread of infections. ED overcrowding potentially increases the risk of avoidable death, inferior medical outcomes or unnecessarily prolonged hospitalisation for patients.

[11] PQ 12916/17
[12] PQ 12267/17

There is concern that a measure introduced as an emergency measure could become an everyday event.

The number of emergency department attendances for the Mater Hospital from 2009 to 2016 and for Jan and Feb of 2017.[13]

Attend Year	Total Attendances to the Emergency Department
2017 Jan & Feb	9,640
2016	60,882
2015	58,900
2014	58,286
2013	54,461
2012	49,775
2011	49,587
2010	47,933
2009	44,695

Figure 7.

[13] PQ 12906/17

Mater Misericordiae University Hospital, Weekly INMO Trolley Report

Weekly data for 2016 and comparative data for 2015.

Figure 8.[14]

INMO Trolley Plus Ward Watch Analysis: March 2006 – 2017 Mater Hospital

Year	2006	2007	2008	2009	2010	2011
Number on Trollies	598	416	422	375	496	311

2012	2013	2014	2015	2016	To March 2017
380	262	264	541	356	419

Figure 9.[15]

The number of beds at the Mater Hospital from 2004 - 2016

Year	Number of Inpatient beds
2004	459
2005	507
2006	506

[14] inmo.ie
[15] inmo.ie

2007	518
2008	527
2009	506
2010	523
2011	472
2012	464
2013	480
2014	450
2015	482
2016	548

Figure 10.[16]

- The numbers provided exclude Intensive Care Unit (ICU), High Dependency Unit (HDU), Coronary Care Unit (CCU), Cardio Thoracic High Dependency Unit (CTHDU), Spinal High Dependency Unit, Acute Medical Assessment Unit (AMAU) and Day beds.

- The numbers provided include Escalation beds and Pre-Assessment Clinic (PAC).

The HSE was unable to provide figures for the number of procedure beds. The HSE told us that the only data available was the number of procedures performed. Electronic recording of data started in 2012 and therefore **Figure 11** reflects current available data.

Reporting Years: 2012-2016	Inpatient	Daycare
Principal Procedures on HIPE Record	75277	273260
All Procedures on HIPE Record	279631	352148

Figure 11.[17]

In our Better4Health policy document, Sinn Féin has committed to:

- Ensure adequate registered nurse/doctor-to-patient ratios and sufficient beds in the acute hospital sector to deal with demand and the demographics of the local area.
- Sustained investment in community services which allow for appropriate care without hospital admission and/or discharge to appropriate care settings.
- Increase nursing home bed numbers by 900 additional beds in year one, 800 additional beds in year two and 700 additional beds in years three, four.

[16] PQ 4743/17
[17] PQ 12901/17

- Increase home help hours and homecare packages in year one by 10 percent, by a further 10 percent on the baseline year in years two and three.
- Establishing an Emergency Department Taskforce on a permanent basis.

6. Patient outsourcing[18]

It is to be welcomed that the number of patients outsourced to other hospitals and clinics has decreased over the past number of years. In 2009 there was a significant level of outsourcing which continued into 2010. However there have been significant reductions in outsourcing to date. These reductions occurred in two phases. The first phase occurred from 2010 to 2011 with a reduction of almost 500 patient outsourcings (**Figure 12**). The second significant drop in outsourcing occurred from 2013 to 2016. During these years there was a particularly significant decrease on the dependence on outsourcing. Almost 800 less specialties were outsourced during these years (**Figure 12**). However, these are specialties that can and should be accommodated by a general hospital such as the Mater.

Total numbers of specialties outsourced per year[19]

Year	Number of Specialties
2009	1353
2010	1243
2011	757
2012	702
2013	990
2015	640
2016	213

Figure 12.

The significant drop overall from 2009 to 2016 of approximately 84% in outsourcing shows that it is possible in the face of increasing demands on services and pressures on capacity that the Mater can still decrease its one time dependency on outsourcing. It is important that this downward trend continues and is eliminated through the provision of increased levels of services at The Mater Hospital.

[18] PQ 12903/17
[19] PQ 12903/17

Total Patient outsourcing by specialty.

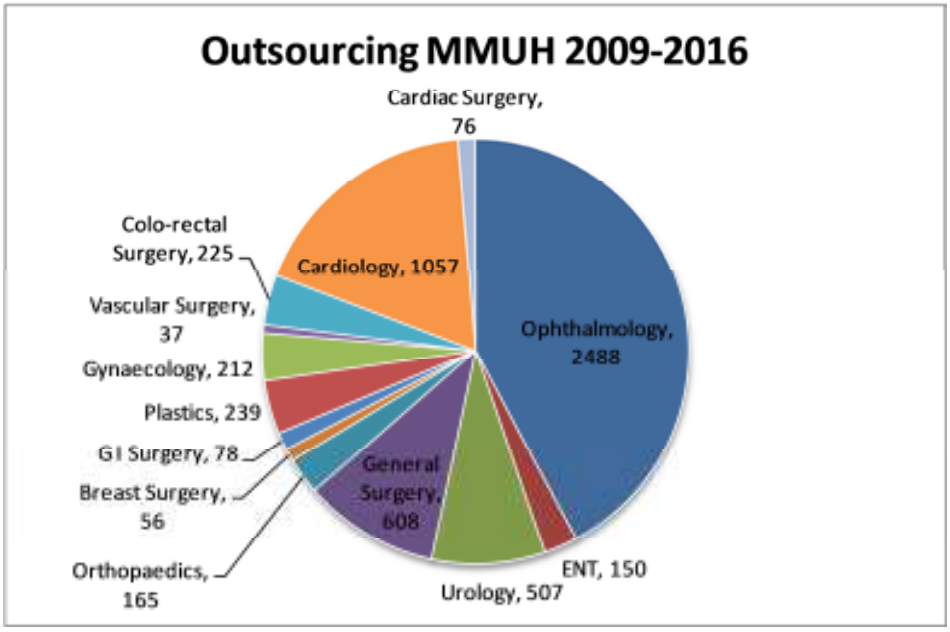
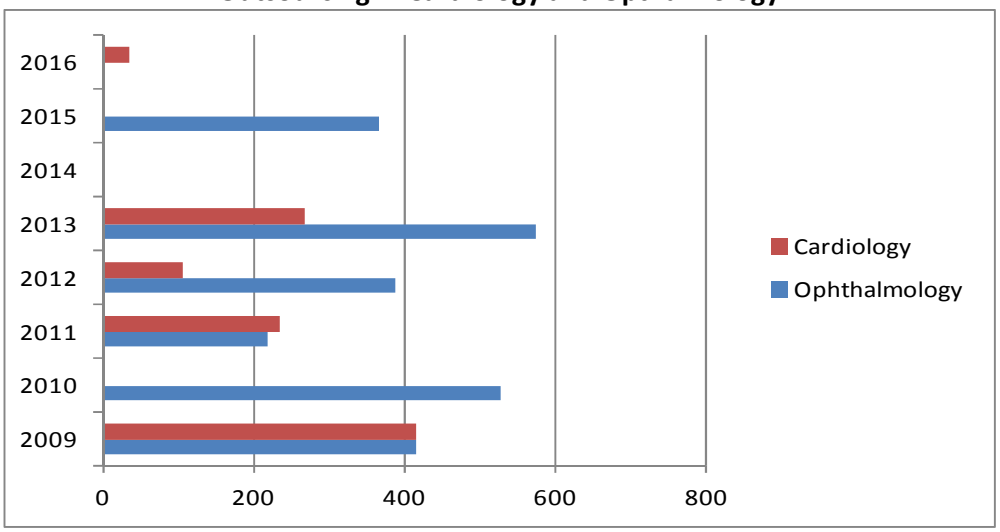


Figure 13.[20]

There has been significant outsourcing in some specialties such as Cardiology and Ophthalmology as can be seen in **Figure 14**. It has been very problematic recruiting consultants in Ophthalmology in particular.

Outsourcing in Cardiology and Opthalmology



2009 - 2016

Figure 14.[21]

[20] PQ 12903/17
[21] PQ 1203/17

The Hospitals or clinics where specialties were outsourced to by the MMUH.[22]

All Clear Clinic
Aut Even Kilkenny
St. Francis Hospital Ballinderry
Beacon Hospital
Bon Secours Dublin
Bon Secours Cork
Blackrock Clinic
Galway Clinic
Hermitage
Mater Private Hospital
North West Independent Hospital Derry
Sports Surgery Clinic
Clane General Hospital

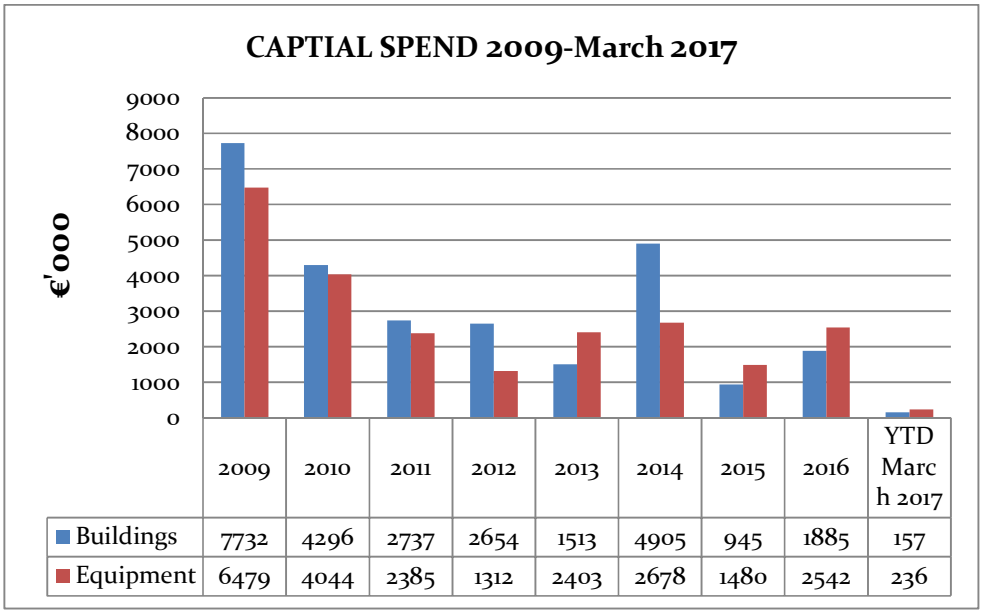
Note 1: The information made available is by specialty not procedure. In addition, the MMUH does not have available information on the hospitals where the outsourced work was completed.
Note 2: There was no outsourcing for 2014.

Figure 15.

[22] PQ 12903/17

7. Capital spend

Figure 16 shows the capital financial expenditure over the last nine years at the Mater Hospital.



	2009	2010	2011	2012	2013	2014	2015	2016	YTD March 2017
Buildings	7732	4296	2737	2654	1513	4905	945	1885	157
Equipment	6479	4044	2385	1312	2403	2678	1480	2542	236

Figure 16.[23]

Figure 16 shows that since 2009 the Mater has faced very challenging times and uncertainty as a consequence of the downturn in the economy. The hospital has suffered severe funding cuts while at the same time its service levels increased.

The new Whitty Building at the Mater Hospital opened in March 2014. The Mater Hospital Development was a €284 million redevelopment project and resulted in 55,000m2 of new acute hospital services and consolidated many inpatient services. This nine-storey over double-basement extension holds new Emergency Department and Outpatients Departments. A GI unit, 12 new operating theatres, ICU and HDU. A new Radiology Department and 120 one bed en-suite rooms.

This welcome addition to the Mater has provided the hospital with additional capacity. However, while the hospital has not reached full capacity protocol levels this year, the Mater this April has had to cancel all elective surgeries and open closed wards in older parts of the hospital to cope with the surge of mainly elderly persons attending the Emergency Department.

[23] PQ 12907/17

This illustrates clearly the stresses the hospital faces coping with an ever growing population. The Mater's challenge is to implement strategies to attend to these ever changing demographics. It is the government's responsibility to provide the Mater Hospital with the resources, funding and investment to absorb the pressures on the hospital caused by these changing demographics.

8. Operational spend

Operational Spend	2010 €'000	2011 €'000	2012 €'000	2013 €'000	2014 €'000	2015 €'000	2016 €'000	YTD March 2017 €'000
Pay	172,896	168,053	170,360	168,821	171,121	180,308	182,973	46,925
Superannuation	15,133	13,297	13,713	11,582	12,343	12,655	12,745	3,065
Non-Pay	76,834	73,045	80,808	81,659	96,918	94,681	99,702	27,109

Figure 17.[24]

There is no shying away from the need to increase funding at the Mater Hospital. Building adequate capacity across all services and eliminating unequal access to services will require significant and sustained public investment.

Successive governments have cut funding to health. Our public health system continues to suffer acute and chronic underfunding. The examples in this document of lengthening waiting lists, the outsourcing of patients and hospital cancellations are a testament to the failure of government to properly invest in the Mater Hospital.

Total number of employees and the whole time equivalent value for 2004 - 2016

Year	Number of employees	Whole time equivalent value
2004	2604	2346.68
2005	2700	2435.23
2006	2743	2481.69
2007	2861	2598.14
2008	2913	2646.94
2009	2889	2616.24
2010	2790	2520.91
2011	2738	2479.98
2012	2807	2539.63
2013	2883	2612.93
2014	2950	2682.48

[24] PQ 12908/17

2015	3066	2777.78
2016	3188	2855.25

Figure 18.[25]

Total nurse numbers from 2004 – 2016

Year	Number of Employees - Nurses	Whole time equivalent value
2004	1079	990.31
2005	1082	1004.31
2006	1092	1013.11
2007	1122	1051.28
2008	1132	1064.12
2009	1117	1050.50
2010	1082	1008.76
2011	1195	1104.19
2012	1182	1090.65
2013	1165	1071.65
2014	1170	1086.26
2015	1186	1101.28
2016	1221	1122.93

Figure 19.[26]

Rechanneling spending on health:

Sinn Féin is proposing a new funding model for health - a model in which public expenditure makes up a far greater portion of the total spend on health than it does at present.

Public investment in health from existing sources must rise by 2%-3% per annum to accommodate demographic pressures on our health system.
In addition, Sinn Féin proposes to increase public spending on healthcare by an additional €3.3billion over the next five years, beginning with €794million in year one.

The Department of Finance figures for the period 2018 to 2021 set out a combined net fiscal space of €8.7billion. In prioritising significant and targeted investment in the health service, Sinn Féin will allocate €3.3billion for health from the fiscal space.

During a second term of government we would continue with year on year increases to spending, reaching €5billion.

[25] PQ 4746/17
[26] PQ 4745/17

9. Mental health services

The St Aloysius Mental Health Ward in the Mater Hospital is a 15 bed unit with 12 female and three male residents and serves the catchment area of Dublin North Central/North West. Five of the beds are Mater Hospital beds, the remaining ten beds are part of the HSE Community Mental Health Service. Outpatient clinics are held in the new Whitty building. According to the Mater Hospital in 2015, over 1,300 ward consultations were conducted and over 1,300 patients were seen in the Emergency Department.[27]

The Mental Health Commission has conducted a number of unannounced inspections of the St Aloysius Ward and their findings have not always been positive. In 2012 an unannounced inspection uncovered what was termed 'unacceptable' privacy issues and 'entirely unsatisfactory' maintenance problems. The report for that year indicated that there were serious deficiencies in service provision in the ward. The report also indicated that there were staffing problems which impacted on the wellbeing of residents such as minimal recreational activities and no free access to outside spaces. The lack of staff also impacted on the preparation of individual care plans for residents. While there were individual care plans in place they had minimal multidisciplinary input. The commission also stated that it was evident that medical staff were not completing the relevant details in the care plans.

The inspection found the service to be 'non compliant' in the provision of 'Therapeutic Services and Programs'. Residents had minimal access to these services. The fault being place on what the MHC termed 'resource issues'. Roll onto unannounced inspections in 2015 and April 2016 and many of these problems still persist.

Inspection of the St Aloysius Ward on 21, 22 and 23 of September 2015 identified the following areas that were not compliant:[28]

Regulation/Rule/Act/Code	Inspection Findings 2016
Regulation 9 Recreational Activities	Non-compliant
Regulation 16 Therapeutic Services and Programs	Non-compliant
Regulation 23 Ordering, Prescribing, Storage and Administration of Medicines	Non-compliant
Regulation 26 Staffing	Non-compliant
Regulation 27 Maintenance of Records	Non-compliant
Rules Governing the Use of Seclusion	Non-compliant

Figure 20.

[27] http://www.mater.ie/services/department-of-adult-psych/

[28] Mental Health Commission Report on St. Aloysius Ward 2015

The most recent findings for 2016 (**Figure 21**) show continued non compliance in similar areas to those highlighted in the reports of 2012 and 2015.

Areas of non-compliance identified in 2016 Report with an associated risk rating.

Regulation/Rule/Act/Code	Risk Rating
Regulation 6 Food Safety	Moderate
Regulation 9 Recreational Activities	High
Regulation 13 Searches	Moderate
Regulation 11 Visits	Moderate
Regulation 15 Individual Care Plan	High
Regulation 16 Therapeutic Services and Programs	Critical
Regulation 20 Provision of Information to Residents	Moderate
Regulation 21 Privacy	Moderate
Regulation 22 Premises	Moderate
Regulation 23 Ordering, Prescribing, Storing and Administration	High
Regulation 26 Staffing	High
Regulation 27 Maintenance of Records	Moderate

Figure 21.[29]

There have been some improvements. The garden project a particular initiative to improve the wellbeing of residents was established to the rear of the outpatients' clinic on Eccles Street. It provides residents with fresh air and a therapeutic outdoor space. The St. Aloysius weekly activities list for residents now includes for example some 'garden time', as well as board and card games, a music group. There is also an opportunity for residents to meet and plan recreational activities for the following week. However, the limited opportunities for recreation and the types of recreational activities available are uninspiring and could easily become very monotonous very quickly. This cannot be good for a person's mental health or their wellbeing. Those who have experience of the ward speak of its sterility and dullness. It's very decor lacking warmth. One person described the common room as lacking in 'TLC'. They felt no sense of positivity or anything uplifting about their surroundings. Is this really the sort of environment for those who are there because of mental health issues? More than anyone, people in this facility need positivity and a warm loving environment. They need a safe place and they need a place that offers them hope. People with mental health issues should be treated with dignity and respect. The staff working in the ward with limited resources are doing the best they can under the circumstances. However it is clear that understaffing and a lack of resources have resulted in many of these systemic failures.

[29] Mental Health Commission Report on St Aloysius Ward 2016

Of course such reports raise serious concerns about the care of patients in psychiatric units. These problems also highlight the serious issue of the lack of a voice for mental health patients. The reality is that incidents such as the ones outlined in these reports would be less likely to happen if patients had an advocate acting on their behalf. It is important comprehensive, independent patient advocacy services are in place and resourced as a matter of urgency

Those who come into contact with people with mental health issues in the Mater Hospital including those in reception, and in particular A&E staff should have some training in suicide awareness. Most recently Sinn Féin attempted to bring forward a Bill which would have made it mandatory for all those 'frontline staff' who deal directly with the public in hospitals, the public service etc to have such training. But it was rejected on the grounds that it would impose a cost on the exchequer.

Ideally the following services should be available. The Mater Hospital does have as of end of February 2017, two Suicide Crisis Assessment Nurses.[30] We would also like to see in place the following services. (We were unable to ascertain by the time of publication how many of these services if any the Mater Hospital provides as we were still awaiting responses from the HSE to a number of our parliamentary questions on the Mater Hospital mental health services.)

- One Mental Health Nurse in A&E department outside of normal office hours to assist with crisis mental health presentations
- A fully staffed CAMHT in hospital catchment area which liaises with all related services
- A fully staffed Community Mental Health Team in hospital catchment area which liaises with all related services
- At least one Crisis House for the catchment area to offer intensive, short-term support so that you can manage and resolve your crisis in a residential setting (rather than hospital).
- Local Area plan for role out of 7 day week in CMHS with view to further develop to 24/7 service

Additionally in a broader capacity these 'A Vision for Change' recommendations should be applied based on demographics:

- One multidisciplinary CMHT per 50,000 population, with two consultant psychiatrists per team
- Three community residential units of ten places each to be provided per 100,000 population
- One to two day centres per 300,000 providing a total of 30 places
- One service user-provided support centre/social club per 100,000
- One acute in-patient unit per 300,000 population with 35 beds
- One crisis house per 300,000 with ten places n four intensive care rehabilitation units (ICRU) to be provided – one in each of the four HSE

[30] Question No. 425 for written answer 16/05/2017

regions, with 30 beds. Each ICRU to be staffed by a multidisciplinary team with additional nursing staff

- Two high-support intensive care residences of ten places each in each HSE region (a total of eight residences with 80 places nationally)
- One additional multidisciplinary team in each 300,000 catchment area to provide pediatric liaison mental health services
- One day hospital per 300,000

10. Agency spend

Figure 22 shows an increasing dependence on agency staff from 2013 to present.

Expenditure totals in respect of hiring agency staff at the Mater Hospital for the following years

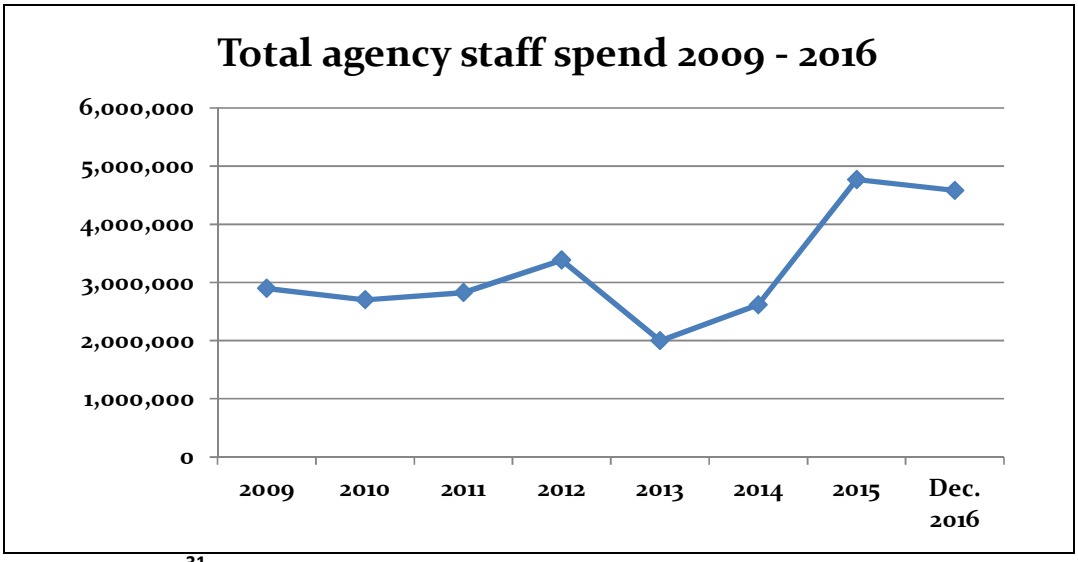


Figure 22.[31]

Total Agency Spends 2009 to Feb 2017

Year	Total Agency Spend in Euro
2009	2,896,005
2010	2,699,369
2011	2,824,190
2012	3,384,439
2013	1,996,486
2014	2,615,261
2015	4,767,051

[31] PQ 12909/17

2016	**4,581,016**
Jan & Feb 2017	**917,669**
Total Agency Spends since 2009	**€26,681,486**

Figure 23. [32]

Reducing reliance on agency staff:

A moratorium on recruitment in the health service was introduced in September 2007. It created a health system propped up by agency staff on salaries many times that of permanent staff. Certain agency doctors can cost a hospital approximately €1,000 a day. In one year alone, 50 agency doctors each earned approximately €300,000.

In their pre-Budget submission for 2016, the Irish Hospital Consultants Association made the case that an agency consultant is twice the price of a long-serving permanent consultant and three times the price of a new consultant.

We need to ensure that the HSE reduces reliance on agency staff and makes permanent posts attractive for qualified applicants. The current approach is clearly costing us dearly, and not just financially.

Continuity of care is also undermined when there is an overreliance on agency staff that are, by their nature, often employed only for short periods. While agency staff are competent and committed healthcare providers, if issues do arise they can be harder to monitor if staff are moving across facilities.

Agency spends do not represent good value for money. It is also extremely costly. **Figure 23** shows an astounding €26,681,486 over the past eight years on agency staff. This is money that could have gone into providing permanent staff at the hospital or the provision of services that are currently being outsourced. Reliance on agency staff slows things down. By its very nature a constant stream of new staff coming into the hospital starting effectively from scratch each time will impede the smooth running and efficiency of the hospital. At a very basic level permanent staff know the hospitals procedures and know where everything is. They can get things done quickly and efficiently. Agency staffs, while they may be well qualified are on a constant learning curve and this can lead to inefficiencies and time wasting. Agency staff are also reliant on permanent staff to tell them how things are done or where to find the bandages or a particular piece of equipment and so on. This is not an efficient way of operating. It leads to a loss of organizational memory.

Dependence on agency staff must be greatly reduced.

Sinn Féin's recruitment proposals outlined in our Better4Health document are designed to decrease dependence on agency staff and directly hire extra staff to meet the demand and need for services.

[32] PQ 12909/17

11. Patient waiting times

Repeated comparisons of healthcare waiting times with other OECD countries show that there is very significant room for improvement in Ireland.

New waiting time targets were introduced by then Minister Leo Varadkar in mid-2015, but rather than trying to solve the problem, the Minister simply shifted the goalposts; extending the waiting time target from 12 months to 18 months.

As far back as the 2001 health strategy, Quality and Fairness, there was a commitment that by the end of 2004, no public patient will have to wait for more than three months to commence treatment, following referral from an outpatient department.

No serious effort was ever made to active this target and waiting times have grown ever since. Former Minister for Health Dr. James Reilly set a target of one year to be seen on an outpatient basis and a target of eight months for inpatient or day case treatment. This target was nearly achieved for a brief period in 2012 but the waiting times have been increasing again since.

The fact that the number of people waiting more than 18 months for inpatient or day case treatment has soared by 7,100% since June 2014, while long waiters on outpatient lists are up 465% for the same period, shows, beyond doubt that the Governments measures on waiting lists have failed.

The ever-lengthening hospital waiting lists are a product of understaffing, a lack of capacity and inefficiencies in the system. During the economic crisis Fine Gael and Labour cut health funding by 20% and cut the number of healthcare staff by 12%.

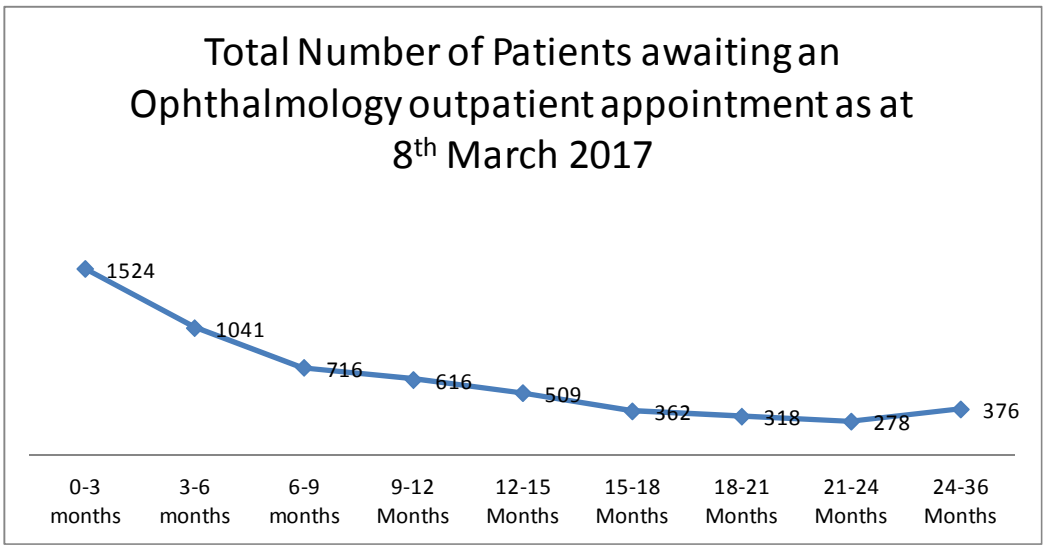


Figure 24.[33]

Snapshot of Total Inpatient waiting list at the Mater Hospital as at 5th May 2016

Speciality	6-8 Mths	8-12 Mths	12-15 Mths	15-18 Mths	18-24 Mths	24-36 Mths	36-48 Mths	Grand Total
Ophthalmology	251	322	222	213	119	6		**1133**
Cardiology	192	282	170	81	16	1		**742**
Urology	75	141	62	73	35	5		**391**
Pain Relief	78	72	2					**152**
Gastro-Intestinal Surgery	45	60	31	44	25	8		**213**
Vascular Surgery	31	51	35	16	22			**155**
Orthopaedics	22	43	20	28	26	9		**148**
Plastic Surgery	39	34	15	26	8	2	1	**125**
Otolaryngology (ENT)	16	35	12	7	3			**73**
Breast Surgery	18	25	8	20	18	1		**90**
Gynaecology	13	14	4	7	3			**41**
Cardio-Thoracic Surgery	13	3	4	2	3			**25**
Hepatobilliary Surgery		2						**2**
Dental Surgery	2	1			1			**4**
Gerneral medicine		1						**1**

[33] PQ 12796/17

Endocrinology		2	1					**3**
Neurology		1						**1**
Grand Total	**795**	**1089**	**586**	**517**	**279**	**32**	**1**	**3299**

Figure 25.[34]

Snapshot of Total Outpatient waiting list at the Mater Hospital as at 5th May 2016

Speciality	6-9 Mths	9-12 Mths	12-15 Mths	15-18 Mthss	18-21 Mths	Grand Total
Cardiology	147	76	6	6		**235**
Cardio-thoracic Surgery	8	1				**9**
Clinical (Medical) Genetics	43	5				**48**
Dermatology	360	434	242	139	76	**1251**
Endocrinology	131	64	17	1		**213**
Gastro-Enterology	51	13	8	3		**75**
Geriatric Medicine	4	1				**5**
GSU : Breast	17	1	1			**19**
GSU : CRS	50	25	3			**78**
Gynaecology	1					**1**
Haematology	98	41	24	1		**164**
Infectious Diseases	2	12				**14**
Metabolic medicine	3	3				**6**
nephrology	5					**5**
Neurology	356	220	96	42		**714**
Ophthalmology	661	602	431	368	104	**2166**
Orthopaedics	285	225	175	93	18	**796**
Otolaryngology (ENT)	390	271	158	77	10	**906**
Pain Relief	89	43	1			**133**
Plastic Surgery	229	260	161	103	47	**800**
Psychiatry	3	5	3			**11**
Respiratory Medicine	113	49	12			**174**
Rheumatology	171	135	137	38	5	**486**
Urology	302	230	104	7		**643**
Vascular surgery	33					**33**
Grand Total	**3552**	**2716**	**1579**	**878**	**260**	**8985**

Figure 26.[35]

[34] PQ 7818/16
[35] PQ 7818/16

Number of Patients waiting for Scans at the Mater Hospital March 2017

	0-3 mths	3-6 mths	6-9 mths	9-12 mths	> 12mths
GEN	308	0	0	0	0
CT	1088	402	150	39	31
MRI	1142	573	274	155	52
PET	50	0	0	0	0

Figure 27.[36]

Average Waiting Times for Scans at the Mater Hospital in March 2017

	Urgent	Routine
General	Same day	7 days
CT	30 days	200 days
MRI Angiography/Soft Tissue Pelvis/Liver/MRCP	10 days	200 days
MRI Breast	7 days	180 days
MRI - All other	100 days	400 days
PET	Next Day	7 days

Figure 28.[37]

Key Sinn Féin proposals on reducing waiting times:

Increase the capacity of the hospital system by recruiting the necessary staff, opening further beds and investing in care in the community as detailed in our Health Policy Document.

To further reduce waiting times Sinn Féin would introduce the Comhliosta Integrated Hospital Waiting List Management System, a waiting list initiative similar to that used by the Portuguese National Health System, which was successful in having a sustained positive impact on waiting times there.

[36] PQ 13391/17
[37] PQ 13391/17

Appendix.

Executive summary of Sinn Féin's Better4Health policy document published in December 2015

Part 1 - Equality

Medical card reform

- Legislate for a distinct, new 'medical need' ground for eligibility for the medical card with an associated application route, using the DCA assessment framework as a model, i.e. an assessment involving the establishment of a threshold of medical need and not tested against a household's financial means or against diagnosis titles.
- Invite applications to this distinct application process for a card that would be reviewed at intervals informed by the recommendation of the medical assessor. This new route would be open to applicants of all ages but any child who has been granted the DCA would gain the card automatically. Medical cards awarded on this new ground would not be impacted by changes to employment status or income. This is essential, otherwise the medical card system will continue to trap people with disabilities in unemployment and poverty. This reform may initially result in 14,500 additional cards at a possible cost of €27.388 million.

Free GP care

- Increase the annual GP training intake from 161 to 200 to facilitate growth in the number of qualified GPs. The cost of this expansion to training has been estimated at €4.29 million in year one, rising to €17.160 million in year four, to be sustained thereafter.

- Broaden the attractiveness of General Practice as a career choice by introducing 200 salaried GP posts over a term of government at an estimated cost of €30.385 million (this figure includes the recruitment of an additional 200 medical secretaries to work alongside the salaried GPs).
- Prioritise rural areas that are struggling to attract GPs and urban areas where services are overstretched in the deployment of the new salaried posts.
- Free up GP time through the expansion of the role of pharmacists and the recruitment of practice nurses. In conjunction with our proposed salaried GP posts Sinn Féin would introduce 200 new Practice Nurses, who would be directly employed by the State at a cost of €9.366 million.
- Extend free GP care to the remainder of the population by incrementally increasing the financial threshold for GP visit cards. Over two full terms, we propose to extend free GP care at the rate of approximately 230,000 additional people per annum. We estimate that this may cost in the region of almost €28 million in the first full year and a similar additional amount each year thereafter.

<u>Greater role for community pharmacies</u>

- Introduce a pharmacy-based minor ailment scheme.
- Reclassify certain prescription-only medicines to over-the-counter in pharmacy status.
- Introduce a Medicines Use Review Service at an estimated cost of €381,000 with a potential saving of €626,000 and a New Medicines Instruction Service at an estimated cost of €326,000 with potential savings of €2.65 million.

<u>Tackling the unequal burden of drug costs and other charges</u>

- Incrementally abolish prescription charges for medical card holders at an estimated cost of€120 million.
- Incrementally lower the maximum monthly spend required of households under the drugs payment scheme and ultimately abolish all charges for prescription drugs as part of universal healthcare at a cost in the region of €160 million.
- Abolish the €100 charge for use of Emergency Departments and the €75 per day charge for inpatient care at a combined cost of €45.2 million.

<u>Towards universal dental healthcare</u>

- Ensure that those running dental clinics have a legal obligation to register with the Irish Dental Council. This would close a loophole in the law that currently exists and would ensure the Dental Council would have oversight of dental clinics. At present the Dental Council can only uphold complaints against registered dentists. It cannot monitor other dental clinics as, under the Dentists Act 1985, a surgery can be established without registering with the Council.

- Legislate for the Dental Council to set up registers of all dental professionals, including Clinical Dental Technicians, Dental Technicians, Dental Nurses, Hygienists, etc.
- Increase funding to the Public Dental Service to allow it deliver on its remit in full, i.e. all screening for children actually taking place at the ages it is supposed to with follow-up treatment provided in an appropriate timeframe. Provide a funding increase of €21.67 million to that end. From within this increase, recruit an additional 80 dentists (including 10 orthodontists) and 120 dental nurses for the Public Dental Service at a full year cost of €11.2 million.
- Extend the direct provision of orthodontic treatment to children with less severe needs than are currently covered through an expanded HSE Orthodontic Service at an estimated cost of €27 million.
- Invite dentists to enter a contract to deliver a Universal Cycle of Dental Care and Service to all adults. This would initially involve extending an annual oral examination to an additional 445,000 people, achieving universal cover at an estimated cost of €14.7 million. Further treatments would be extended as finance allows and the payment of dentists on a capitation basis should be explored.

- The Universal Cycle of Dental Care and Service scheme would, as a priority and as resources allow, be further extended to cover biannual scale and polish, protracted gum cleaning and fillings and eventually lead to a comprehensive spectrum of dental treatments. This new scheme would immediately replace the Dental Treatment Benefit Scheme (DTBS) and gradually displace the Dental Treatment Service Scheme (DTSS) for medical card holders. It would act as a stepping stone to universal dental healthcare, which is a vital component of primary care.

<u>Rural Ireland's ambulance services</u>

- As a first step, Sinn Féin proposes to fund an additional two ambulances and the necessary personnel for each of the four regions. Overall, this would mean 88 additional staff and eight ambulances at an estimated cost of €7.8 million.
- Over the following years we would make a further €7.2 million investment and recruit an additional 202 staff.

<u>Ending two-tier access to hospital care</u>

- Increase funding for acute hospitals by €238 million over five years. This is separate to the specific recruitment proposals outlined elsewhere in this document, and over and above increases to cover demographic pressures.
- Eliminate private activity from public hospitals while replacing the revenue stream at a cost of €500 million, to be covered in part by the withdrawal of tax relief on Private Health Insurance.

- Explore the introduction of a new Sinn Féin initiative, the Comhliosta integrated hospital waiting list management system.

Championing patients' rights and safety

- Establish an independent Patient Advocacy Agency and allocate an annual operating budget of €3 million.
- Provide for the Ombudsman to take on individual cases of clinical negligence and adverse outcomes.
- Increase resources for HIQA to pursue the implementation of its recommendations.

Promoting the health of the nation

- Increase funding for Healthy Ireland by €200,000. This funding can be sourced from a portion of the revenue generated from a tax on sugary drinks.
- Restrict television marketing of unhealthy food and drinks to after 7pm.
- Introduce a sugary drinks tax.
- Introduce legislation to regulate the sale of e-cigarettes.
- Increase excise duty on cigarettes and increase resources to tackle illicit trade.
- Increase funding for the National Drugs Strategy by allocating an additional €2.4 million in year one, rising to €12 million by year five.
- Introduce an enhanced role for Public Health Nurses, with associated guidance and training.
- Introduce Low Threshold Residential Stabilisation services and pilot a medically supervised injecting centre at a combined cost of €3.2 million.
- Increase the number of addiction counsellors, including counsellors with expertise in gambling addiction, at a cost of €698,000.
- Introduce new protocols governing the filling of prescriptions and make reforms to the methadone maintenance scheme at a cost of €5 million.
- Introduce Minimum Unit Pricing for alcohol alongside increased funding provision for alcohol addiction prevention, education and treatment measures.
- Explore the potential to phase-out alcohol sponsorship of sporting events.

All-Ireland Healthcare

- Maximise the potential of all-Ireland cooperation in the field of healthcare. As the only all-Ireland political party, Sinn Féin in government would be uniquely placed to maximise this potential.

Part 2 - Capacity

Addressing the shortage of nurses

- Reverse the massive cutbacks to nursing numbers by Fianna Fáil, Fine Gael and Labour by recruiting 2,500 nurses over a five-year timeframe at an estimated cost of €24.4 million in year one, rising to €122 million. This would be followed by further recruitment in a second term of government.
- Provide 10 extra staff to the Nursing and Midwifery Board of Ireland (NMBI) to ensure that applications for registration are processed without undue delay at an estimated cost of €384,000.
- Fund the further training of an additional 100 nurses in Nurse Prescriber skills at an estimated cost of €300,000.

Addressing the shortage of doctors

- Seek to recruit 800 more consultants plus medical secretaries over five years at an estimated total cost of €290.29 million. This would facilitate a significant reduction in spending on junior doctor overtime and agency consultants, which is not accounted for in this estimate.
- Renegotiate the Consultants' Contract.

Responding to Emergency Department overcrowding

- Increase the number of hospital beds per 1,000 population from the current level of less than 4 to 4.6, with a view to further raising this ratio.
- Ensure adequate registered nurse/doctor-to-patient ratios and sufficient beds in the acute hospital sector to deal with demand and the demographics of the local area.
- Sustained investment in community services which allow for appropriate care without hospital admission and/or discharge to appropriate care settings.
- Increase nursing home bed numbers by 900 additional beds in year one, 800 additional beds in year two and 700 additional beds in year three, four and five at a cost of €125 million.
- Increase home help hours and homecare packages in year one by 10 per cent at an estimated cost of €31 million and by a further 10 per cent on the baseline year in years two and three with a resulting rise in spending of €93 million.
- Establish an Emergency Department Taskforce on a permanent basis.

Responding to lengthening waiting lists

- Increase the capacity of the hospital system by recruiting the necessary staff, opening further beds and investing in care in the community as detailed throughout Part 2 of this document.
- To further reduce waiting times, explore the feasibility of introducing the Comhliosta integrated hospital waiting list management system, a waiting list initiative similar to that used by the Portuguese National Health System,

which was successful in having a sustained positive impact on waiting times there.

Tackling the crisis in maternity care

- Recruit 621 additional midwives at a total cost of €31.8 million.
- Recruit an additional 239 obstetricians/gynaecologists, which would double the number in service. This would be pursued over five years and into a second term of government as part of the overall recruitment proposals outlined in this document.

Prioritising mental healthcare

- Increase the mental health budget in year one by €35 million.
- Complete the rollout of Suicide Crisis Assessment Nurses (SCAN) at an estimated cost of €385,000.
- Recruit mental health nurses specifically to liaise with homeless services commencing with 5 in year one at an estimated cost of €175,000.
- Reverse cuts to guidance counsellors in schools introduced by government in 2012, at a cost of €14.7 million to the Department of Education, providing approximately 700 posts.
- Increase the number of inpatient child and adolescent beds to end the inappropriate admission of children to adult psychiatric units at a cost of €14 million.
- Increase the number of Child and Adolescent Mental Health Services (CAMHS) Teams at an estimated full year annual cost of €9.8 million.
- Increase provision for people with mental health difficulties alongside intellectual disability by recruiting the full complement of mental health intellectual disability nursing posts recommended by 'A Vision for Change' at an estimated additional full year annual cost of €3.167 million.
- Increase funding for Counselling in Primary Care, which currently has long waiting lists, with an additional investment of €3.8 million.
- Update the Mental Health Act and Criminal Law (Insanity) Act to bring them into line with international human rights standards.
- Extend the Health and Social Care Professionals Act to provide for the regulation of psychotherapy and counselling.

Prioritising disability services

- Set an additional target of redirecting 5% of current spending towards de-congregation in the National Disability Strategy implementation plan.
- Allocate the €250 million of capital expenditure identified by the HSE as needed to progress de-congregation.
- Increase Personal Assistant hours by an additional 500,000 hours each year for three years at an estimated additional cost of €11.75 million in the first full year, rising to €32.25 million in the third.
- Increase the number of Speech and Language Therapists by 250, Occupational Therapists by 100, Physiotherapists by 100 and psychologists by

150 over our term in government at an estimated full year cost of €30.725 million.
- Increase Respite Care Services by 20% at an estimated cost of €11.6 million.
- Introduce a secure medical card for persons with disabilities.
- In addition to the above specific proposals, increase the budget allocation to disability service providers year on year by €32.45 million, €43.5 million and €50 million in years two, three and four, respectively.

Supports for older people

- Establish an inter-departmental and inter-agency Working Group on Community and Residential Care for Older People.
- Increase home help hours and homecare packages in year one by 10% at an estimated cost of €31 million and by a further 10% on the baseline year in years two and three with a resulting rise in spending of €93 million.
- Increase respite care service provision for older people by 20% at an estimated cost of €6.24 million.
- Fund an additional 900 nursing home beds in year one, a further 800 beds in year 2, and 700 additional beds in year 3 and thereafter. This would require an estimated budget increase of €125.4 million by year five.

Managing chronic disease

- Increase the number of consultant endocrinologists, diabetic nurse specialists and ophthalmologists as part of the wider recruitment proposals outlined in the document.
- Further roll-out the Heart Watch scheme, with a year one increase of €4.5 million.
- Provide a free annual asthma review and written asthma action plan for everybody with asthma with an investment of €2.5 million.
- Commence a targeted Coeliac Disease screening programme by offering blood testing to all first-degree relatives of people with Coeliac Disease.

Part 3 - Funding

Funding the road to universal healthcare

- Increase public investment in health from existing sources by 2%-3% per annum to accommodate demographic pressures.
- Increase spending on healthcare by €3.3 billion beginning with €794 million in year one.

Better stewarding of spending

- Reduce reliance on agency staff by recruiting for greater numbers of permanent posts across the health system as outlined in Part 2 of the document.

- Shrink the drugs bill through incentivisation measures and renegotiated Association of Pharmaceutical Manufacturers of Ireland/Irish Pharmaceutical Healthcare Association agreements to increase generic and biosimilar use. These measures would, in the first instance, involve a more vigorous approach with the existing infrastructure – reference pricing, generic substitution and influencing prescriber behaviour. Should these measures fail to deliver adequate savings for the taxpayer, Sinn Féin will introduce primary legislation with the objective of controlling on- and off-patent medicines.
- Explore the possibility of centralised bulk buying. Currently more than 1,800 community pharmacists purchase over 70 million items on an annual basis. They deal directly with wholesalers and manufacturers. Sinn Féin would explore the possibility of centralising the process in order to maximise efficiencies and savings.
- Seek to commence a Choosing Wisely Initiative to minimise unnecessary prescribing of drugs and tests in partnership with the relevant bodies here, building on the experience to date from overseas.