PRIORITIES FOR CHANGE IN HEALTH AND SOCIAL CARE

Consultation Document

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Summary of Proposals

1. Affordability, Universal Healthcare, and an Irish NHS

- End unfair charges, reduce the Drug Payment Scheme threshold, and increase eligibility thresholds for Medical Cards and GP visit cards on the path to universal healthcare,
- Establish a single integrated health benefits scheme to be known as *Sláintecard*,
- End the two-tier health service and remove private healthcare from our hospitals,
- Deliver free GP and primary care under the terms of a keystone agreement on universal healthcare,
- Plan healthcare on the basis of the whole island to leverage the critical mass of the population, provide seamless care in the border region, and prepare for an all-island NHS.

2. Reduce Wait Times and Improve Access to Hospital

- Invest, on the basis of ESRI projections, in at least 2,000 additional hospital beds and 1,500 community-based care beds over a term in Government,
- Continually develop capacity to meet expanding need on the basis of expected population increases and demographic shifts, ranging from 300 to 500 additional beds every year,
- Prioritise the development of regional elective centres and hospital-adjacent surgical hubs to deliver protected surgical capacity,
- Take a zero-tolerance approach to hospital trolleys,
- Work with healthcare workers to deliver a seven-day health service,
- Underpin service expansion with strategic workforce planning and substantially increase training places,
- Legislate for safe staffing levels and engage with workers to improve retention,
- Engage with Irish-trained healthcare professionals working abroad to bring healthcare workers home, and engage with those who have returned to learn from their experience abroad,
- Better support out-of-hours GP and late pharmacies to provide alternatives to emergency departments,
- Invest in community-based intermediate care to reduce admission to hospital and speed up discharges from hospital,
- Conduct a population-based review of emergency and urgent care services,
- Resource the ambulance service to implement its strategic workforce plan and deliver a safer and more responsive service.

3. Deliver More Care in the Community

- Target investment in a decade of expanding multi-disciplinary primary care and community specialist teams,
- Deliver a keystone agreement to underpin the delivery of universal healthcare and transition to the *Sláintecard* scheme,
- Establish a Working Group on the Future of Primary Care with relevant stakeholder professions to guide strategic investment and identify areas for deeper collaboration,
- Develop publicly employed GPs and launch a pilot scheme for out-of-hours and locum support,
- Increase the number of undergraduate, postgraduate, and advanced or specialist practice training places for primary care professions,
- Increase the use of nursing and advanced practice therapy grades across primary care services,
- Invest in a Pharmacy First approach to minor ailments and move appropriate care from GP practices to community pharmacy,
- Deepen the integration of pharmacy into primary care and preventive healthcare,
- Invest in universal oral and dental health cover for children while re-building the public dental service,
- Better support hospitals by investing in community-based care, such as step-down facilities and home care, and improve access to public community-based diagnostic services,
- Reset the balance in the nursing home and home care sector and reverse privatisation by investing in public community nursing units and home care,
- Ensure a living wage and appropriate travel remuneration to address recruitment and retention challenges in home care and the nursing home sector,
- Link additional public funding for nursing homes to the promotion of better terms and conditions for the workforce for the portion of services which are provided on behalf of the State,
- Take a whole of Government approach to preventive healthcare and invest across education, sports and exercise, housing, transport, healthcare, and more to improve health outcomes,
- Improve access to eye care including a standardised 0-16 eye care scheme, delivery of more post-cataract care through optometrists,
- Implement a national hearing plan to ensure that people receive appropriate hearing supports throughout their lives and improve access to hearing aids,
- Advance an inquiry into the handling of Covid-19 in residential care homes and deliver transparency for bereaved families,
- Legislate to apply the framework for safe staffing and skills mix across all public healthcare facilities and those which are providing services on behalf of the State.

4. Towards a sustainable, skilled and diverse health sector workforce

- Implement a multi-annual strategic workforce plan to meet rising demand and deliver universal healthcare, and develop this plan with healthcare workers, the health service, and higher education institutes to address short-, medium-, and long-term workforce challenges,
- Establish a high-level group, including the Taoiseach and the Ministers for Health and Further and Higher Education, to oversee implementation of a multi-annual health workforce strategy,
- Significantly increase undergraduate places, clinical placements, and post-graduate specialist training places,
- Legislate for safe staffing levels and fund staffing accordingly across wards, emergency services, community care, and long-term care,
- Give Irish-trained healthcare professionals a job guarantee, and mandate the HSE to work with them as they approach graduation to ensure timely placement into work,
- Engage with healthcare workers to improve retention, encourage Irish-trained healthcare workers home, and engage with those who work or have worked abroad to improve the health service based on their experiences,
- Tackle workplace pressures such as overcrowding, bullying and harassment, negative cultures, and high-pressure environments, increase security in hospital, and increase occupational healthcare supports to improve staff welfare and wellbeing,
- Work with allied health and social care professionals to address deficits in professional regulation, review career structures, enable AHSCPs to practice at the top of their licence, deploy more clinicians in advanced practice and specialist grades, and increase access to training including the use of assistant grades,
- Fund the establishment of a Health and Social Care Advisory Committee in the Health and Safety Authority.

5. Reform and Accountability

- Streamline management through Health Regions and simplify processes for planning, designing, and funding of large strategic infrastructure developments to deliver a rapid expansion of capacity,
- Establish *Oifig an Chomhliosta* to deliver an integrated waiting list management system which prioritises public investment, reduces outsourcing, and delivers sustained reductions in waiting lists,
- Deliver modern IT systems such as electronic health records, integrated financial and care management systems, and an integrated waiting list management system to underpin new schemes such as the *Sláintecard* and improve efficiency in the health service,
- Develop independent complaints processes to improve trust in the outcome of investigations,
- Enact Adult Safeguarding legislation which include a legal authority responsible for investigating individual complaints. We would increase resources and powers for safeguarding teams and for HIQA.

6. Mental Health

- Deliver a new Child and Youth Mental Health Service to replace CAMHS and provide integrated early intervention services for children and young people to the age of 25,
- Ensure a consistent transition between youth and adult mental health services to prevent any young person falling through the cracks,
- Support general adult mental health services to ensure early intervention where conditions arise after the age of 25,
- Expand access to Jigsaw and primary care mental health services to deliver equitable access across the state,
- Deliver universal counselling in primary care,
- Invest in specialist dual diagnosis mental health teams for ADHD, intellectual disabilities, eating disorders, psychosis, and addiction,
- Develop comprehensive out-of-hours, crisis intervention, and emergency mental health care services to ensure 24/7 access, and implement a No Wrong Door policy for dual diagnosis,
- Fast track professional regulation of counselling, psychotherapy, and psychology with CORU,
- Develop inpatient perinatal services at St Vincent's University Hospital and the new National Maternity Hospital site,
- Expedite the development of a new IT system for CAMHS,
- Underpin service expansion with strategic workforce planning.

7. Improve Social Care

- Invest in personal assistance, home support, housing adaptation grants, healthy age-friendly homes, rural public transport, and social outlets such as community centres and day care services,
- Implement a comprehensive social care policy to support independent living and social participation,
- Enact Adult Safeguarding legislation, establish a safeguarding authority, and appoint a Chief Social Worker in the HSE,
- Provide for a legal right of entry to any designated care centre for relevant social workers and social care professionals,
- Provide for a care partners scheme for future public health emergencies similar to the scheme in place in the north,
- Ensure full implementation of the recommendations of the Nursing Home Expert Panel and the Final Report of the Oireachtas Special Committee on Covid-19 Response,
- Establish the Commission on Care and the statutory home care scheme to future-proof the model of care for older people,
- Implement Sinn Féin's Charter for Family Carers,
- Address recruitment and retention barriers which are hampering home care and social care services, such as the absence of a mandatory living wage for such workers.

8. Disability Services

- Fund a 10-year investment programme to provide for unmet and future need,
- Prioritise children's disability services to deliver timely assessment and care from a young age,
- Support family carers as outlined in our Charter for Family Carers,
- Continuously engage with people with disabilities, their families, and the disability advocacy and services sector to ensure services are being sufficiently resourced and are accessible to service users,
- Ensure integration of community care, mental health, and disability services to provide holistic care for people with disabilities and mental health conditions, and deliver the full complement of specialist Child and Adolescent Mental Health Service Intellectual Disability teams as per Sharing the Vision,
- Review the Disability Act and disability services to deliver timely access for people with disabilities,
- Implement an Autism Empowerment Strategy,
- Invest in adequate independent living, respite care, and personal assistance services,
- Ratify the Optional Protocol of the UNCRPD.

9. Addiction and Recovery

- Initiate an unprecedented investment in community addiction and recovery to boost inpatient capacity, return historic funding to local and regional taskforces, and implement a "No Wrong Door" policy for dual diagnosis,
- Waive assessment fees for access to addiction services,
- Employ additional community development and family support workers in each taskforce area,
- Fund further research into gambling prevalence and behaviours and fully implement a Gambling Regulation Bill,
- Deliver multi-disciplinary neuro-rehabilitation teams and managed clinical rehabilitation networks which will work with community sector services to ensure state-wide coverage for substance-related brain injury,
- Work across Government to support drug and alcohol misuse educational programmes in schools, recovery-inclusive programmes in sport, social inclusion and Traveller community-specific projects, and equip frontline services and the Gardaí to focus on harm reduction in communities,
- Establish a Consultatory Working Group of people with lived experience of addiction to consult on, and influence, relevant policy,
- Support a whole-family approach to addiction services and work to end the postcode lottery delivery of family support services.

10. Targeted Strategies and all-Island Healthcare

10.1. All Island Healthcare

- Plan health services on the basis of the population health needs of the island,
- Enable all-island collaboration, cooperation, and integration,
- Maximise use of all-island healthcare capacity to tackle waiting lists,
- Commission new research into existing and potential cross-border and all-island health and social care collaboration.

10.2. Cancer

- Deliver sustained improvements in cancer services through multi-annual funding of Health Regions to improve access to screening, rapid access clinics, and radiation therapy,
- Reduce costs for cancer patients by capping and reducing car parking charges, expanding medical card coverage, and reducing the cost of medicines, prescription charges, and the Drug Payment Scheme threshold,
- Prioritise preventive measures to reduce cancer incidence rates,
- Provide funding certainty to cancer care and support centres through a standardised funding arrangement via the National Cancer Control Programme.

10.3. Cardiovascular and Respiratory Health

- Invest in the National Stroke Strategy to improve stroke services in hospitals and the community, including rehabilitation services,
- Complete and publish the National Review of Specialist Cardiac Services and ensure services are properly evaluated on an all-island basis,
- Implement a comprehensive Cardiovascular and Respiratory Health Policy which improves access to community-based prevention and rehabilitation services, hospital-based services, and education and research.

10.4. Rare Diseases and Genomics

- Urgently complete and publish a review of the outdated National Rare Disease Plan 2014-2018,
- Develop an all-island rare disease and genomics strategy,
- Review approval, pricing, and reimbursement arrangements for orphan medicines.

10.5. Women's Healthcare

- Develop a structured care programme for women's healthcare in primary care, including sexual and reproductive health, menopause, mental health, social inclusion, and community-based gynaecology,
- Develop access to secondary and tertiary gynaecological services and invest in community-based gynaecology services,
- Invest in health and social care supports for survivors of abuse and domestic violence,
- Set new targets for the Maternity Strategy to reflect advancements in best practice over recent years,
- Conduct a geospatial analysis of abortion services, invest in local and regional women's health hubs, and repeal the three-day wait,
- Improve access to IVF,
- Invest in cancer screening to improve early diagnosis rates,
- Deliver a fit-for-purpose new National Maternity Hospital,
- Investment in expanding midwife-led units and community midwifery services.

10.6. Children and Youth

- Target investment in healthcare for children across hospital care, disability services, mental health services, and primary and community care to reduce waiting lists for children's services,
- Reduce the cost of healthcare and medicines for children,
- Invest in access to sports and healthy activities,
- Ensure appropriate supports which address the non-medical cost of caring for a sick child,
- Establish a new, fit for purpose Child and Youth Mental Health Service,
- Fully resource Children's Disability Network Teams,
- Ensure that no child is waiting longer than the Sláintecare wait times for appointments, scans, and surgeries.

10.7. LGBT+ Healthcare

- Develop a new national sexual health strategy to address long waiting lists for PrEP and reduce rates of STIs and HIV,
- Implement a new model of care for the holistic care of transgender people based on the ongoing review which is being conducted by healthcare professionals.

10.8. Mesh Injury

- Advance an inquiry into mesh use and injury,
- Ensure the availability of full removal services where possible,
- Take further actions to support survivors through investment in public diagnostic capacity, raising eligibility thresholds for medical cards, providing appropriate aftercare devised with mesh-injured people, and providing as local a service as is possible for the full removal of mesh implants where sought,
- Recognise the harm caused by mesh and the hurt caused by denial and delays in acting on emerging evidence and survivor's lived experiences.

10.9. Climate and Health

- Implement a multiannual investment strategy for the HSE Climate Action Strategy,
- Complete an energy review of HSE capital stock to inform a programme of retrofitting,
- Mandate all Health Regions to develop Health and Climate Change Action Plans and ensure adequate climate-related resourcing of Public Health units,
- Increase funding for research and development for climate action and research,
- Ensure that new builds in the health sector are built to high energy standards.

10.10. Medicines Supply and Management

- Ensure cost-effective and efficient management and supply of medicines through maximal use of generics and by encouraging the strategic development of domestic supply of certain products,
- Review pricing arrangements for commonly out-of-stock medicine and ensure that a rapid licensing process for substitute products is in place,
- Review the approvals processes for medicines to address blockages, streamline the approval process, and bring approval timelines in line with the EU average,
- Ensure that where fair pricing has been agreed that resources are not an obstacle to the provision of or reimbursement for such medicines through the public system.

SF

Introduction

Réamhrá

Introduction

The health service is challenged by growing waiting lists, longer waiting times, legacy equipment, an under supply of key workers, and low morale, and has been held back by unambitious planning and glacial pace reform. Almost every aspect of the health system is attempting to muddle through with no overarching strategic plan. Nearly one-and-a-half million people are languishing on waiting lists across the island and the average emergency department wait is half-a-day. Meanwhile, vast amounts of care worth billions of euros has been outsourced or handed over entirely to for-profit private healthcare. This is just the tip of the iceberg, and major structural reform and a re-orientation of care into the community is needed.

Sinn Féin has a plan to tackle waiting lists and deliver a National Health Service for Ireland. We would bring an urgency to fixing healthcare and delivering better services across the island. We would underpin our plans with strategic workforce planning to ensure a sustainable supply of frontline workers which is planned for the population health needs of our island. We would make use of fiscal surpluses to catch up on a lost decade of underinvestment in healthcare which has left our health service creaking. We would reform the National Treatment Purchase Fund into Oifig an Chomliosta, which would implement and oversee our proposed integrated waiting list management system in addition to enhanced functions around waiting list auditing, transparency, and reducing outsourcing.

The Sláintecare Report provided the high-level principles and objectives for creating a national health service with universal entitlements in the south. The Bengoa report provided solutions for modernising and improving the health service in the north. Both reports focussed on delivering integrated care, ending silos, and reducing barriers. Sinn Féin is committed to implementing both of these important reports on an all-island scale. But real reform requires the political system to go far beyond reports and recommendations. It requires ambition, long-term planning, and structured investment. We would build towards an all-island NHS to make best use of resources north and south. We would coordinate care delivery across Health Regions and Health and Social Care Trusts to realise accessible, affordable healthcare for all.

This document focusses on the key priorities and policies which are needed to deliver real change. Its purpose is to build on the more than three years of engagement which I have led as Sinn Féin spokesperson on Health. With this document I will embark on an extensive round of consultation with clients, workers, and service providers across the health and social care sector north and south, east and west. This document is written to enable these conversations on the specifics, to learn and develop ideas, rather than setting out to be prescriptive on all solutions from the outset. I will spend the coming months engaging with stakeholders, clinicians, officials, patients, advocates, and academic experts as we finalise the most serious plan yet to deliver a health service that works for all. This is to ensure that our policies are stress-tested and meet the wide-ranging needs of the sector. This work will inform our manifesto and ensure it is realistic, credible, and deliverable as well as appropriately costed.

The document sets out major challenges and key proposals across my ten priorities:

- **Improve affordability and deliver universal health,**
- **Reduce wait times and improve access to hospital,**
- **Deliver more care in the community: "Right Care in the Right Place at the Right Time,"**
- **Train, recruit, and retain more healthcare professionals,**
- **Deliver reform and accountability,**
- **Address the mental health crisis,**
- **Recognise the importance of social care,**
- **Respect the rights of people with disabilities,**
- **Tackle addiction and resource recovery,**
- **Improve health outcomes through targeted strategies and all-island healthcare.**

Year 1 funding and multi-year measures were outlined in our Alternative Budget for 2023. Last year, we set out proposals totalling €1.1 billion in new measures in 2023. This was comprised of €657.7 million in current expenditure measures and an additional €461.6 million in capital or one-off spending. This will be further elaborated on in our Alternative Budget for 2024 and our proposals will be of a similar magnitude.[1] The full costings and planned implementation of multi-annual measures will be outlined in our manifesto.

Sinn Féin wants to lead the next Government. We want to hit the ground running with a plan for healthcare that is ambitious but also realistic, practical, and deliverable. We do not pretend to have all of the answers but know that the answers are already out there. Those working on the front line and patients using services know what is needed. To reduce waiting times and deliver an all-island NHS, we need a comprehensive, multi-annual plan which addresses capacity, processes, workforce planning, and resourcing in a coherent, strategic, and joined up way.

This process will form the basis of the fully costed Health plan which we will set out in our manifesto and which we would implement if given the chance to be in Government.

David Cullinane

David Cullinane TD
Sinn Féin spokesperson on Health

1 At time of print, Sinn Féin's Alternative Budget for Health was due for publication in mid-September 2023.

Réamhrá

Tá an seirbhís sláinte faoi bhrú ag liostaí feithimh atá ag fás, agaí feithimh níos faide, treallamh oidhreachta, easpa oibrithe bunriachtanacha, agus lagmhisneach, agus coimeádta siar toisc pleanáil gan uailmhian agus leasú fadálach. Tá beagnach gach gné den chóras sláinte ag déanamh iarracht teacht tríd ar bhealach éigean gan aon mhórphlean straitéiseach. Timpeall milliúin go leith duine atá ag fulaingt ar liostaí feithimh fud fad an oileáin agus leathlá le fanacht ar an mheán i rannóga éigeandála. Ag an am céanna, tá an iliomad cúraim, ar luach na billiúin euro, curtha amach ar chonradh nó tugtha ina iomlán don éarnáil bhrabúis sláinte príobháideach. Ní anseo ach an ceann caol den deacracht, agus tá leasú mór struchtúrach agus atreorú cúraim i dtreo lár an phobail ag teastáil.

Tá plean ag Sinn Féin chun dul i ngleic leis na liostaí feithimh agus Seirbhís Náisiúnta Sláinte chur i bhfeidhm in Éirinn. Bheadh práinn i gceist againn agus muid ag iarraidh an cúram sláinte a dheisiú agus seirbhísí níos fearr a sholáthair fud fad an oileáin. Bheadh pleanáil straitéiseach don lucht oibre chun a soláthar inbhuanaithe a chinntiú do oibrithe sa líne thosaigh ina bhunús dár gcuid pleananna, bunaithe ar riachtanais sláinte dhaonra an oileáin. Bhainfeadh muid leas as na barrachais fioscach chun beir suas leis an deich mbliana caite amú toisc gearrinfheistíocht sa chúram sláinte atá tar éis ár seirbhís sláinte a fhágáil ina praiseach. Leasfadh muid an Ciste Náisiúnta um Cheannach Cóireála isteach in Oifig an Chomhliosta, rud a riarfadh agus a dhéanfadh maoirsiú ar ár gcóras bainistíochta comhtháite do liostaí feithimh chomh maith le feidhmeanna feabhsaithe maidir le iniúchóireacht ar liostaí feithimh, trédhearcacht agus seachfhoinsiú a lahgdú.

Thug an Tuarascáil Sláintecare ardphrionsabail agus aidhmeanna dúinn chun seirbhís náisiúnta sláinte a chruthú le teidlíochtaí uilíocha ó dheas. Thug tuarascáil Bengoa réitithe dúinn chun an seirbhís sláinte a thabhairt suas chun dáta agus a fheabhsú ó thuaidh. Bhí an dá tuarascáil dírithe ar chúram comhtháite a sheachadadh agus bacanna a laghdú. Tá Sinn Féin tiomanta i dtreo an dá tuarascáil tábhachtacha seo a chur i bhfeidhm ar scála uile-oileánda. Ní mór don chóras polaitiúil dul i bhfad chun tosaigh ar tuarascálacha agus moltaí áfach chun fíorleasú a bhaint amach. Teastaíonn uailmhian, pleanáil fadtréimhseach, agus infheistiú straitéiseach. D'oibreodh muid i dtreo NHS uile-oileánda a thógáil chun an méid agus is féidir a bhaint ó áiseanna thuaidh agus theas. Dhéanfadh muid comhordanú ar sheachadadh chúraim trasna na Réigiúin Sláinte agus na hIontaobhais Sláinte agus Cúraim Sóisialaigh go léir chun cúram sláinte inrochtanach agus inacmhainneach a chruthú do chách.

Díríonn an doiciméid seo ar na príomhthosaíochtaí agus polasaithe atá ag teastáil chun fíorathrú a chur i bhfeidhm. An fáth atá leis ná chun tógáil anuas ar an os cionn trí bliain caite agam chun teagmháil a stiúradh mar urlabhraí Sláinte Shinn Féin. Sa cháipéis seo, rachaidh mé i gcomhairle cuimsitheach le cliaint, oibrithe, agus soláthraí seirbhíse i ngach chearn den chúram sláinte agus sóisialaigh thuaidh agus theas, thoir agus thiar. Tá an doiciméid scríofa ar mhaitheas leis na comhráití seo ar na mionrudaí, chun foghlaim agus smaointe a fhorbairt, in áit a bheith forordaitheach maidir leis na réitithe go léir ó thús. Sna míonna amach romhainn, rachaidh mé i dteagmháil le páirtithe leasmhara, cliniceoirí, oifigigh, othair, abhcóidí, agus saineolaithe acadúla agus an plean is dáiríri riamh maidir le seirbhís sláinte a sheachadadh chun feidhmiú do gach uile duine a thabhairt chun críche. Sa chaoi seo, cinnteoidh muid go bhfuil na polasaithe againn tástálaithe faoi strus agus go ndéanann siad freastal ar riachtanais fairsing an éarnála. Tabharfaidh an obair seo eolas dúinn dár chlár chun a chinntiú go bhfuil sé réalaíoch, inchreidte agus insheachadta chomh maith le bheith costáilte mar is cóir.

Leagtar amach sa doiciméid seo mórdhúshláin agus príomh moltaí trasna an deich tosaíochtaí atá agam:

- **Inacmhainneacht a fheabhsú agus sláinte uilíoch a sheachadadh,**
- **Agaí feithimh a laghdú agus rochtain a fheabhsú ar an ospidéal,**
- **Níos mó cúram a sholáthar sa phobal: "An Cúram Ceart san Áit Cheart ag an Am Ceart,"**
- **Níos mó gairmí cúram sláinte a oiliúint, a earcú, agus a choimeád,**
- **Leasú agus freagracht a chur i bhfeidhm,**
- **Dul i ngleic leis an ngéarchéim meabharshláinte,**
- **Tábhacht an cúraim sóisialaigh a aithint,**
- **Meas a theaspáint do chearta na ndaoine faoi mhíchumais,**
- **Dul i ngleic leis an andúil agus téarnamh a mhaoiniú,**
- **Torthaí sláinte a fheabhsú trí sraitéis dírithe agus cúram sláinte uile-oileánda.**

Leagadh amach maoiniú Bliain a 1 agus beartais ilbhlianta inár mBuiséad Malartach don bhliain 2023. Anuraidh, leag muid amach moltaí de luach €1.1 billiúin iomlán i mbeartais nua i 2023. San áireamh anseo bhí €657.7 milliúin i mbeartais caiteachais reatha agus €461.6 milliúin breise i gcaiteachas caipitil nó aon-uaire. Déanfaidh muid tuilleadh cur síos air seo inár mBuiséad Malartach don bhliain 2024 agus beidh na moltaí againn ar thomhas den chineál ceanna.[2] Beidh an costáil iomlán agus an cur i bhfeidhm molta do na beartais ilbhlianta leagtha amach sa chlár againn.

Teastaíonn ó Shinn Féin a bheith i gceannas ar an gcéad Rialtas eile. Ba mhian linn tús maith a dhéanamh le plean don chúram sláinte atá uailmhianach, ach freisin atá réalaíoch, praiticiúil, agus insheachadta. Ní ag ligint orainn go bhfuil na freagraí go léir againn atáimid, ach tá a fhios againn go bhfuil na freagraí ar fáil cheana féin. Tuigeann iad siúd atá ag obair sa líne thosaigh agus othair ag baint úsáid as seirbhísí cad atá ag teastáil. Chun agaí feithimh a laghdú agus NHS uile-oileánda a sheachadadh, teastaíonn plean cuimsitheach ilbhlianta a dhéanann freastal ar chumas, próisis, pleanáil don lucht oibre, agus maoiniú ar bhealach atá ciallmhar, straitéiseach agus comhtháite.

Beidh an próiseas seo mar bhunús don phlean Sláinte, go hiomlán costáilte, a leagfaidh muid amach inár gclár agus a chuirfeadh muid i bhfeidhm dá dtabharfar an deis dúinn bheith i Rialtas.

David Cullinane

David Cullinane TD

Urlabhraí Sláinte Shinn Féin

2 Agus é seo á gcur i gcló, bhíodar ag súil go bhfoilseofar Buiséad Malartach Shinn Féin don Sláinte i lár mí Mheán Fómhair 2023.

PRIORITY 1

Improve Affordability and Deliver Universal Healthcare and an Irish NHS

1. Improve Affordability and Deliver Universal Healthcare and an Irish NHS

Healthcare is a human right. Upfront charges penalise those who can afford them least. On the path to universal healthcare, Sinn Féin would tackle the two major barriers to timely care: unfair charges and waiting lists. We would improve affordability and accessibility. Our ambition is to deliver a comprehensive all-island Irish national health service that is free at the point of use, delivers services on the basis of need, and which delivers the care you need when and where you need it.

Achieving this goal will take time. The health service is under immense pressure and creaking under the strain of a lost decade of underinvestment. Some measures can be implemented immediately or over a short period, while others, such as universal GP care, will take time and good planning to build up the sufficient capacity. Recognising the need to expand entitlements incrementally, we propose to agree a roadmap, which we refer to as 'a keystone agreement,' with the various professions in the sector to achieve universal healthcare over a defined period. This would set out the measures which are necessary for implementing universal healthcare and set out a timeframe for reaching this goal.

1.1 Reduce the Cost of Healthcare

Many unfair charges exist across the health system. Households without a medical card must pay up to €80 a month for access to medicines which are covered under the Drug Payment Scheme. For medical card holders, prescription charges are still charged at up to €10 a month for over 70s and up to €15 a month for people under 70. These can be considerable fees for individuals and families with multiple chronic illnesses which are not covered under the long-term illness scheme, or where one or both parents are out of work due to illness or care responsibilities. In many instances, there are delays in adding medicines to the reimbursement list, for a variety of reasons, which piles additional costs onto patients. For families and older people experiencing financial hardship, these charges can add unnecessary and avoidable pressure. To ensure that all health and social care is affordable, we would end unfair charges which force workers and families to make decisions about whether they access care or not. We propose to do this through a single integrated health benefits scheme which we term '*Sláintecard*.' This is discussed further in the next section.

Long waiting times for public healthcare are pushing patients into the costly private sector. As of April 2023, more than 500,000 people are waiting longer than the Sláintecare targets of 12 weeks for an outpatient appointment and 10 weeks for an inpatient appointment.[3] That is more than 55% of patients who are on waiting lists, and it is inevitable that the vast majority of the remainder will exceed theses target wait times before they get an appointment. There are also lengthy wait times for access to diagnostic scans such as MRIs, CT scans, and ultrasounds. More than 230,000 people are on waiting lists for scans which is delaying access to further care.[4] More than 130,000 of them are waiting longer than 3 months. When faced with these waits, it is no wonder that approximately half of the population has some form of private health insurance. Yet, even where someone has health insurance or a medical card, there can still be many additional costs for scans, additional appointments, medication, and a variety of fees. When faced with these waits, even for potential cancers and potentially life-threatening conditions, and the anxiety which

3 National Treatment Purchase Fund, May 2023.
4 PQ 20900/23.

this will cause, people will often choose to be seen in the private sector. For those who cannot afford this, they are faced with extremely long waiting lists for access to care or the unenviable burden of healthcare-related debt.

Some aspects of health and social care, such as social care, home support, and long-term residential care, are provided, in the main, by the private sector. Much of this care is provided directly by private services but there are also extensive outsourcing arrangements in place within the public health service. Many people avail of these services through the HSE or schemes such as Fair Deal (the nursing home support scheme). This over-reliance on the private sector has inhibited long-term planning across the sector and has held back wages. Consequently, these sectors are faced with a severe shortage of workers. Governments have not acted as they have seen these as problems for 'the market,' rather than the State, to address. As a result, there are more than 6,000 people on home support waiting lists.[5] The nursing home support scheme places obligations on those who avail of it which are not congruent with universal healthcare. While in principle it appears fair, as fees are then based on the value of a person's assets and thus takes into account, to a degree, one's ability to pay, in reality this can impose a significant burden on a person's family.

The cost of being sick extends beyond the upfront cost of health or social care. As referenced above, such charges, even those as minor as €10 a month, can place a significant burden on people who are experiencing financial hardship. Whether that is being sick yourself or having a sick child or parent and the additional caring responsibilities this brings, people often work less or fall out of employment altogether. This has wider social and financial consequences which have been exacerbated by the housing and cost of living crisis and inflation. The cost of being sick must be further examined to ensure that our social protection and social care systems are sufficiently robust to support families experiencing financial hardship as a result of ill-health.

Inevitably, reducing barriers to accessing care may unveil the true scale of demand across the population which is now unencumbered by financial obstacles. This will present challenges, underlining the need for strategic capacity and workforce planning to underpin the delivery of universal healthcare.

To make health and social care affordable, we must not only remove upfront costs and charges for public services and for the wide range of independent primary care services (which provide the vast majority of general practice medicine and dentistry, among other care services), but we must also improve the performance of the public health service to reduce the need for going private. Private insurance should not provide beneficial access to public services and private practice needs to be removed from public hospitals.

1.2 Deliver Universal Healthcare and an Irish NHS

Sinn Féin's ambition is to deliver a comprehensive national health service that is free at the point of use, delivers services on the basis of equity and need, not ability to pay, and which performs at a level that diminishes the need for private health insurance to get the care you need when you need it. A core commitment of ours is to remove private healthcare from public hospitals to maximise the use of public capacity for the treatment of public patients. We would end the two-tier system in our hospitals.

Sinn Féin propose to expand eligibility for free and subsidised care on the basis of income

5 PQ 20894/23.

over two terms in Government. To lock this plan in place, we propose to agree a roadmap, which we refer to as 'a keystone agreement,' with the various professions in the sector to achieve universal healthcare over a defined period. This would set out the measures which are necessary for implementing universal healthcare and set out a timeframe for reaching this goal.

KEYSTONE AGREEMENT ON UNIVERSAL HEALTHCARE

Sinn Féin are proposing a 'keystone' agreement on universal healthcare. This agreement would involve representatives of stakeholder professions and would set out the path to universal healthcare.

A keystone is the central stone at the summit of an arch which locks the whole together. In policy terms, it is the central aspect on which a system depends.

In theory, the direction of travel is agreed. All political parties are signed up to Sláintecare, and all trade unions have expressed their support for this model of healthcare delivery. However, the precise measures required to implement Sláintecare have never been fleshed out. The staging posts have not been identified, nor have the conditions for reaching our destination.

We believe that the iterative approach to reform has stalled and undermined the delivery of universal healthcare. Every change requires a fresh negotiation, and the implementation of agreements often descends into further bargaining.

While a keystone agreement would not remove the need for iterative bargaining as conditions change and new challenges arise, it would set out an agreed roadmap underpinned by timeframes and clear funding commitments to reach our end goal.

We believe that a genuinely collaborative approach, matched by political will, will deliver the change which is needed to break the gridlock, fix the health service, and deliver a National Health Service for Ireland.

Sinn Féin propose to implement an income-based single integrated health benefits scheme designed to reduce upfront costs as we build up capacity for universal healthcare, to be known as the *Sláintecard*. We acknowledge that such a scheme would be complex and require dynamic new IT systems which are not presently budgeted for and which are difficult to cost. However, there are leaders in this field internationally and we understand that the Department of Health and HSE will soon publish a new IT strategy. It is our view that this should scope such a scheme. Cooperation across the HSE, as the registrar of births and deaths, the Department of Social Protection, as the Department responsible for the Public Services Card and PPSNs, and the Department of Health, as the lead Department, would be essential in developing and implementing this scheme successfully.

THE *SLÁINTECARD* SINGLE INTEGRATED HEALTH BENEFITS SCHEME

Sinn Féin are proposing to integrate all health and social care benefits, eligibilities, subsidies, discounts, and entitlements under a single scheme to be known as the *Sláintecard* Single Integrated Health Benefits Scheme. These are currently split across medical card, GP visit cards, the long term illness scheme, the drugs payment scheme, various CHO-level optometry schemes, the dental treatment scheme, various PRSI benefits, and more.

Entitlements would be incrementally expanded through the scheme to achieve universal healthcare within a decade. Varying levels of eligibility would be based on standardised income cohorts, and we would expand entitlements as capacity allows by raising qualifying thresholds.

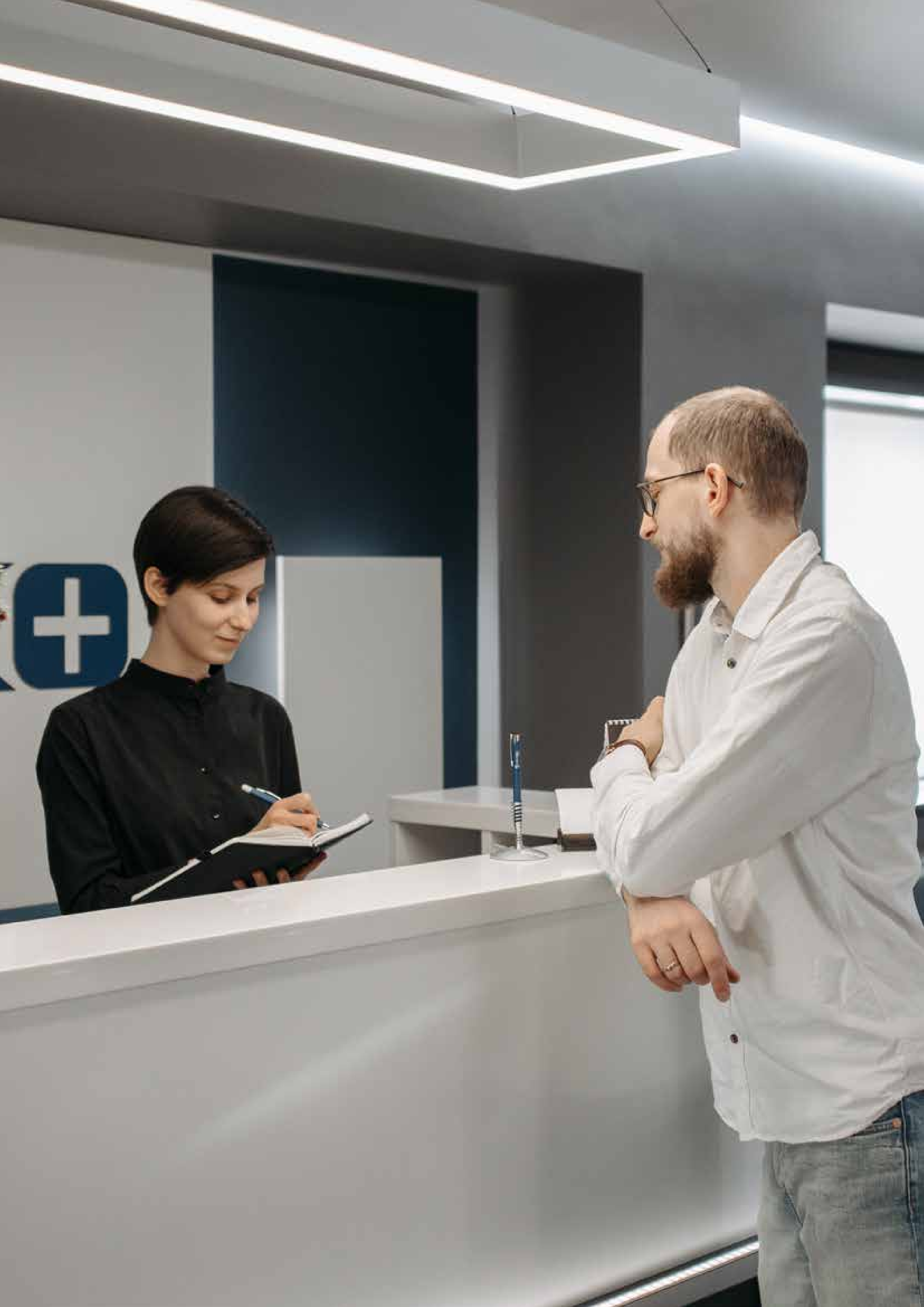
The scheme would empower individuals with full knowledge of their health and social care entitlements, including PRSI benefits, subsidies, and tax refunds. This scheme would allow for greater transparency on an individual's entitlements and ensure that every taxpayer has a fair level of entitlements. It would also provide a mechanism for integrating healthcare systems across relevant providers and would be governed by all appropriate data protection regulations.

A core aspect of universal healthcare is free GP care and access to medicines on referral. An argument commonly put forward against introducing free GP care for all is that the increase in demand will overwhelm practices. While GPs are struggling under current demand for their services, the trade-off is that those who can least afford it go without. This burden falls on workers and families whose incomes are too high to qualify for medical and GP cards but too low to regularly pay for health services. On the path to universal healthcare, eligibility for free and subsidised healthcare should be expanded on the basis of income under a single integrated health benefits scheme. The end goal must be a free-at-the-point-of-use health service.

As with general practice medicine, access to dental care comes with a host of often very large fees. Dental insurance generally does not cover the full cost of root canals, extractions, crowns, and other care. Medical card patients have access only to a limited set of treatments under the Dental Treatment Services Scheme. They are faced with significant difficulties in finding a dentist who is operating the scheme. Despite there being nearly 1,500 dentists officially on the scheme as recently as 2019, the number of dentists actively claiming under the scheme had dropped to 634 by December 2022.[6]

As discussed previously, the cost of medicines under existing schemes, and especially for patients who may fall outside of subsidy schemes, can present major difficulties for individuals and families. Universal healthcare must address the cost of medicines. This is a major cost and, as such, the State must ensure that cost-saving measures, such as the use of generic products, are maximised. The enforcement of price reductions, and such measures as agreed under the Framework Agreements for the Supply and Pricing

6 PQ 15956/23.



of Medicines, will be a critical component in achieving universal healthcare. Sinn Féin are conscious that, in the context of global supply shortages, the State must also be reasonably flexible where there is a strategic supply imperative. At the same time, there is a social obligation on manufacturers to provide medicines at reasonable costs. As discussed later, Sinn Féin propose to prioritise the production of commonly undersupplied medicines in the State where possible and cost-effective. A strategic approach is required to ensure an unbroken supply of much needed medicines while also keeping a lid on the ballooning pharmaceuticals budget.

1.3 Key Priorities for Affordability and Universal Healthcare

As we move to universal healthcare, Sinn Féin proposes to:

- **End unfair charges, reduce the Drug Payment Scheme threshold, and increase eligibility thresholds for Medical Cards and GP visit cards on the path to universal healthcare,**
- **Establish a single integrated health benefits scheme to be known as *Sláintecard*,**
- **End the two-tier health service and remove private healthcare from our hospitals,**
- **Deliver free GP and primary care under the terms of a keystone agreement on universal healthcare,**
- **Diminish the need to 'go private' by investing in the public health service to improve timely access and reduce waiting times,**
- **Review financial hardship supports available through our social protection and social care systems to ensure they are sufficiently robust to support families experiencing financial hardship as a result of ill-health,**
- **Plan healthcare on the basis of the whole island to leverage the critical mass of the population, provide seamless care in the border region, and prepare for an all-island NHS.**

PRIORITY 2

Reduce Wait Times and Improve Access to Hospital

2. Reduce Wait Times and Improve Access to Hospital

Accessibility is the biggest challenge facing the health service. Shortcomings in primary care and community-based care have heaped a major burden onto hospitals. This has manifested as extreme waiting lists, long emergency department waits, high volumes of cancellations, long delays, and over pressurized work environments. A lack of long-term planning, and delays in capital delivery, have held the health service back. Hospitals are overcrowded and understaffed. Sinn Féin propose a major short-term investment to address existing built infrastructure deficits, such as beds and diagnostic equipment. We also propose a long-term population-based approach to planning for our healthcare and workforce needs. Significant and sustained investment in built infrastructure, equipment, and the workforce is needed to make up for a lost decade and deliver the Sláintecare wait time targets.

2.1 Bed Capacity

Our hospitals are overcrowded and have been for many years. Before Fine Gael came to power in February 2011, there had only been rare instances of more than 500 patients on trolleys on any given day. In winter 2010/11, there were approximately 400 patients on trolleys or otherwise inappropriately admitted to hospital every day.[7] This peaked on the 5th of January at 569, which was significantly above average. The numbers trended down over the year and hovered around 300 a day in July 2011, ranging from 242 to 334.

Now, more than 10 years later, the situation is worse than ever. At the start of May 2023, there were 704 patients on trolleys. A new record was set on the 3rd of January 2023 when there were 931 patients on trolleys or otherwise inappropriately admitted to hospital. In July 2022, the number ranged from 372 to 540. The trolley scandal has become the year-round norm and is an ever present, severe threat to patient safety.

Hospitals are operating at dangerously unsafe levels of occupancy. The target level of occupancy is 85%, which would provide for surge capacity and safe staffing levels. In July 2022, the lowest point of the year, 88.5% of acute inpatient beds were occupied, and average occupancy reached 95.5% in November before scheduled care activity was reduced to make room for the winter surge.[8] Only four hospitals operated at below 85% occupancy throughout 2022. Eight hospitals operated at above 100% capacity throughout the month of December, and seven of these operated at above 100% capacity year-round on an annualised average. The data for all hospitals is illustrated by quarter in table 1.

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7 ED Trolley Watch/Ward Watch Figures below for 31st August 2016 (inmo.ie).
8 PQ 2956/23.

Table 1. **Occupancy Levels across public hospitals, 2022**

	Q1	Q2	Q3	Q4	Average
St. Vincent's UH	108%	108%	107%	107%	107%
UH Limerick	108%	109%	103%	105%	106%
Tallaght UH	105%	105%	104%	109%	106%
Sligo UH	101%	103%	101%	105%	102%
Mayo UH	90%	100%	105%	112%	102%
St. Luke's Kilkenny	96%	102%	98%	109%	101%
Connolly Hospital	100%	99%	102%	103%	101%
Galway UH	98%	95%	97%	106%	99%
Mercy UH	98%	97%	96%	99%	97%
Tipperary UH	98%	95%	91%	97%	95%
Beaumont Hospital	94%	96%	95%	97%	95%
MRH Mullingar	90%	95%	96%	97%	95%
UH Waterford	97%	92%	92%	96%	94%
St. James's Hospital	88%	92%	93%	93%	92%
CHI at Crumlin	90%	87%	88%	97%	90%
Roscommon UH	87%	92%	91%	89%	90%
Cork UH	88%	89%	89%	91%	90%
Our Lady of Lourdes Hospital	91%	87%	87%	91%	89%
St. Columcille's Hospital	93%	87%	88%	88%	89%
MRH Tullamore	91%	87%	87%	89%	88%
Wexford General Hospital	87%	82%	89%	96%	88%
UH Kerry	84%	91%	88%	90%	88%
Our Lady's Hospital Navan	92%	86%	83%	88%	87%
Portiuncula University Hospital	89%	84%	86%	89%	87%
Mater Misericordiae UH	86%	87%	87%	88%	87%
Letterkenny UH	83%	82%	88%	93%	86%
St. Michael's Hospital	85%	73%	86%	94%	85%
CHI at Temple St	87%	79%	81%	91%	84%
Cavan General Hospital	79%	80%	81%	84%	81%
MRH Portlaoise	81%	75%	73%	76%	76%
Naas General Hospital	84%	73%	72%	66%	74%
CHI at Tallaght	68%	61%	60%	85%	69%

The consequences of this level of occupancy are manifold. It causes difficulties for patient management and patient flow, disrupts the ability of hospitals to group patients by medical specialty (which causes further inefficiencies), places additional multiplicative burdens on staff, causes delays in accessing scans or operating theatres, creates severe risks of cross-infection and diminishes a hospital's ability to manage infectious diseases (such as Covid-19, the flu, and other common hospital-acquired infections), among other challenges. For patients, this manifests primarily in two ways: long waits in hospital for admission, scans, and procedures, and cancellations of scheduled care to make room for surges in emergency care.

The 2018 health service capacity review estimated a requirement for between 2,100 and 5,800 acute inpatient beds by 2031, depending on the level of reform. It identified an immediate deficit of 1,260 beds. The 2016 bed baseline was 10,500. By February 2020, the health service had 11,165 available beds. By February 2023, there were 11,831. On these figures, approximately 1,330 beds have been reliably added to the system, only surpassing the original deficit by 71. Tables 2 and 3 illustrate the scale of bed requirements out to 2031 and the resulting deficit.

Table 2. **No Reform bed need**

	Baseline	Reality	Needed	Deficit
2018	10,500		11,760	1,260
2020	+665	11,165	12,517	1,352
2023	+1,331	11,831	13,652	1,821
2031			16,300	

Table 3. **High Reform bed need**

	Baseline	Reality	Needed	Deficit
2018	10,500		11,760	1,260
2020	+665	11,165	11,900	735
2023	+1,331	11,831	12,110	279
2031			12,600	

But by these figures, and not accounting for the unexpected population growth in recent years, there is a deficit of at least 279 beds today. Even with the full delivery of the 1,228 beds promised by the Minister in Budget 2021 and Budget 2022, of which only 970 were delivered by March 2023, there would still be a deficit of more than 20 beds.[9]

Of course, we know that there has not been a high level of reform and recent ESRI estimations have estimated a deficit of 1,000 beds this year and an ongoing need of 330 beds a year thereafter.[10] These estimates are based on an appraisal of the Capacity Review, the National Development Plan, earlier ESRI research, and new demographic data. On such

9 PQ 12395/23.

10 McQuinn, K., C. O'Toole, W. Disch, E. Kenny and E. Shiel, (2023). Quarterly Economic Commentary, Spring 2023, ESRI Forecasting Series, Dublin: ESRI, https://doi.org/10.26504/qec2023spr.

estimates, there may be a need for up to 3,600 additional acute inpatient beds by 2031. This may vary depending on the level of actual reform and the impact this may have on hospital occupancy levels. The delivery of these beds must be front ended over the coming years to address the existing deficit. However, it will be unsuccessful even if delivered if not underpinned by a robust strategic workforce plan.

The Minister for Health has said that the 2018 capacity review "probably underestimates fairly significantly the number needed" but that "coming up to Covid, we were on track for the annual increase in beds called for in the 2018 review. We are now well ahead of that."11 Given that key performance indicators on occupancy levels, delayed discharges, and other metrics have been readily available to the Minister, the Department of Health, and the HSE for every month of every year since 2018, it is hard to believe that there could ever have been any certainty that aiming for the minimum target was the right strategy. While the capacity review likely has underestimated bed need, primarily due to greater than expected population growth, it cannot be argued that the capacity review's lower-bound estimates are the fault which has led to record overcrowding. The political choice made time and again at Government level was to not take a realistic approach to investment in the health service in line with the higher estimates. Instead, successive Ministers for Health and for Public Expenditure and Reform have ignored all of the indicators which showed that they were underinvesting in the health service. This attitude must change and these indicators must be taken seriously at the highest level if the health service is going to be turned around.

In addition, operational changes are needed to increase the utilisation of existing capacity. Most importantly, the health service needs to move to a normalised 7-day week. Hospitals could not sustainably operate at full capacity 7 days a week if asked to do so tomorrow due to, in part, a lack of staff, but in particular a lack of supporting capacity and beds in hospitals and in the community. Consultants often make decisions which then take days to implement due to a lack of capacity. This situation is wasting potential for optimising utilisation of existing capacity across operating theatres and diagnostic and other equipment, which could be used at a higher intensity if the supporting infrastructure was in place. In addition to extra staff, such reforms would also require changes to contracts to permit rostering of normal hours across 6 and 7 days.

While a review of the capacity review is welcome, it is not needed to start getting things right. The health service urgently needs a multi-annual capacity expansion plan based on what we know today. Government must then front-up the investment and revise National Development Plan allocations in line with this need. If it is found to be insufficient following a review of the 2018 review, it should be adjusted accordingly. The health service will not get out of this crisis without a responsive, rolling investment plan.

2.2 Wait Times in Emergency Departments

Presentations at emergency departments have risen by 3% since 2019 while admissions rose by 4%. In the first quarter of 2019, there were 339,806 attendances and 89,791 admissions.[12] This represents an admission rate of just 26.4%. This rose to 351,000 in the first quarter of 2023, with 93,308 admissions (for an admission rate of 26.6%).[13] The admission rate for over 75s fell slightly from 55% in 2019 to 53% in 2022, while the total

11 Stephen Donnelly TD, Oral Response to PQ 17405/23, 20 April 2023 (https://www.oireachtas.ie/en/debates/debate/dail/2023-04-20/speech/16/).
12 PQ 20866/23.
13 PQ 20866/23.

number of people aged over 75 attending at emergency departments increased from 41,591 to 48,368.

The average emergency department wait for a patient who was admitted to hospital in 2022 was 10.7 hours. In the first quarter, the average wait has risen from 10.2 hours in 2019 to 11.6 hours in 2022, and to 11.7 hours in 2023.[14] This was highest, in all years, in Tallaght University Hospital where the average wait was 22.8 hours in the first quarter of 2023, up from 16.1 hours in 2019. Only 56% of people were admitted within the target time of 6 hours, one-in-four waited longer than 9 hours, and 5% had to wait longer than 24 hours.[15] For over 75s, 12% had to wait over 24 hours.

Table 4. **Average wait time to admission from Emergency Departments, all patients**

Provider	Q1 2019	Q1 2023
Tallaght University Hospital	16.1	22.8
St. Vincent's University Hospital	12.3	19.3
Mercy University Hospital	17.3	18.9
Mater Misericordiae University Hospital	17.6	18.3
Naas General Hospital	15.1	17.3
Cork University Hospital	10.4	17.0
St. James's Hospital	13.5	16.8
Beaumont Hospital	14.6	16.3
Children's Health Ireland	7.5	13.3
Sligo University Hospital	8.2	12.6
UH Kerry	13.1	12.5
Connolly Hospital	12.5	11.5
Wexford General Hospital	6.2	10.9
Galway University Hospitals	12.5	10.6
Our Lady of Lourdes Hospital	10.1	10.5
Our Lady's Hospital Navan	6.1	10.1
UH Limerick	11.8	9.7
Cavan General Hospital	8.0	9.2
MRH Portlaoise	13.4	9.0
MRH Mullingar	6.2	8.8
MRH Tullamore	13.3	8.6
Letterkenny University Hospital	7.3	8.5
UH Waterford	14.3	8.3
Mayo University Hospital	5.4	8.2
Portiuncula University Hospital	6.3	6.7
Tipperary University Hospital	5.5	6.6
St. Michael's Hospital	5.4	5.8
St. Luke's General Hospital Kilkenny	1.7	3.6
State-wide average	**10.2**	**11.7**

14 PQ 20865/23.
15 PQ 20866/23.

Cork University Hospital and Mercy University Hospital, also in Cork, have consistently performed poorly, particularly for older patients aged over 75. The average wait for a patient aged over 75 for admission through Cork University Hospital's emergency department in the first quarter of 2023 was 27.4 hours.[16]

Table 5. **Average wait time to admission from Emergency Departments, over 75s**

Provider	Q1 2019	Q1 2023
Cork University Hospital	14.0	27.4
St. Vincent's University Hospital	15.6	25.3
Naas General Hospital	19.3	20.9
Mater Misericordiae University Hospital	19.6	20.2
Tallaght University Hospital	14.6	19.7
Mercy University Hospital	16.2	19.0
Beaumont Hospital	16.5	17.2
UH Kerry	18.1	16.7
Galway University Hospitals	17.7	15.1
Our Lady of Lourdes Hospital	12.1	14.1
Wexford General Hospital	7.4	13.9
Sligo University Hospital	8.9	13.9
Cavan General Hospital	9.8	13.4
UH Limerick	17.2	12.5
St. James's Hospital	12.6	12.4
Connolly Hospital	15.4	11.8
Letterkenny University Hospital	8.7	11.7
MRH Mullingar	7.1	10.6
UH Waterford	21.4	10.2
Mayo University Hospital	6.0	9.9
Our Lady's Hospital Navan	6.2	9.6
MRH Tullamore	15.2	8.6
MRH Portlaoise	11.2	8.4
Tipperary University Hospital	6.5	8.1
Portiuncula University Hospital	7.5	7.9
St. Michael's Hospital	5.8	5.9
St. Luke's General Hospital Kilkenny	2.1	4.6
State-wide average	**12.2**	**13.8**

Emergency department overcrowding creates serious difficulties for hospitals. Often, the only immediate solution available to a hospital manager is to cancel elective surgeries to free up beds for emergency patients. More than 85,000 hospital appointments have been cancelled so far this year, including more than 24,000 in April alone.[17] Overburdened hospitals are backed up with patients waiting for scans and surgeries. A significant driver of patients' long waiting times in emergency departments, and one which also lengthens

16 PQ 20865/23.
17 PQ 20870/23.

their stay in hospital once admitted, is access to diagnostic scans. Prioritisation of scans for emergency patients, which is necessary in the moment, is further driving up waiting times for scheduled scans. Many hospitals simply do not have enough equipment and there is a significant shortage of radiologists. However, much of the equipment in use across the health service is old and out-dated. Many hospitals have said that if they had the funds to upgrade their equipment, they could significantly improve their throughput without a need for more staff or more machines.

The health service is shifting the burden of overcrowded emergency departments onto waiting lists by cancelling scans and procedures on a regular basis and at an increasing rate. The consequences are longer waiting times and delays to patient care, driving a vicious cycle of long waits, overcrowding, and cancellations. This has severe consequences for waiting lists and is preventing any significant reduction in the totality of hospital waiting lists. This is exacerbated by delays on the other end of hospital stays which result in people staying in hospital longer than is necessary.

2.3 Waiting Lists for Hospital Care

As of Summer 2023, there are more than 880,000 patients on hospital waiting lists including more than 100,000 children and young people.[18] This is up by nearly 20,000 so far this year. There were 461,864 patients on lists when the National Treatment Purchase Fund (NTPF) began collating figures in 2014. Orthopaedics, ophthalmology, ENT, urology, cardiology, and gynaecology are particularly challenged and faced the most severe waiting list growth rates in the period up to the pandemic, as covered in our policy document 'Tackling Hospital Waiting Lists.'[19]

Nearly 500,000 people are waiting longer than the Sláintecare targets of 12 weeks for an outpatient appointment and 10 weeks for an inpatient appointment.[20] That is more than 50% of patients who are on waiting lists, and it is inevitable that the vast majority of the remainder will exceed theses target wait times before they get an appointment.

Table 6. **Patients waiting over targets, July 2023**

	Total
Outpatient	431,126
Inpatient/Day Case	50,105
Gastrointestinal Scope	10,093
Total	**491,324**

The Minister for Health has now launched two, single-year, short-term waiting list plans. The first plan, for 2022, fell far short of its target of an 18% reduction. Core inpatient and outpatient waiting lists were reduced by only 4% in 2022, and overall lists by just 1%. This has already been reversed in the year-to-date. Similar plans which have relied on outsourcing to private practice, private diagnostic services, and more intensive use of existing resources have been tried in the past and have failed in the medium- and long-term.

While these are necessary components in the short-term, and more effective use of existing public capacity is necessary, these plans will not succeed in the medium- and long-term, if

18 National Treatment Purchase Fund, May 2023.
19 Sinn Féin, (2021), Tackling Hospital Waiting Lists.
20 National Treatment Purchase Fund, May 2023.

even in the short-term. They are not underpinned by multi-annual investment frameworks which are necessary to ensure lasting and sustainable capacity-building.

2.3.1 Elective centres and surgical hubs

Protected capacity for scheduled care is needed. The physical separation of planned and unplanned (emergency) care was a major recommendation in the Sláintecare report.

The Government have decided to advance three major elective centres in Cork, Galway, and Dublin. The site has yet to be selected for Dublin. The Minister has also decided to invest in six surgical hubs for day-case surgeries. These will be delivered in advance of regional elective centres and will be attached to model 4 hospitals in Galway, Cork, Waterford, Limerick, and two in Dublin. Sites have yet to be finalised for the Limerick and north Dublin hubs. Rapid delivery of these projects is essential and they should be seen as an opportunity to test and streamline the capital approval process for strategic health infrastructure.

A major concern about three regional centres is that specialist consultants and nurses who provide these services will be pulled into Cork, Galway, and Dublin, to the detriment of the mid-west, south-east, and north-west. The decision to invest in surgical hubs and ensure that each major hospital will continue to have local capacity is an important recognition of the need for balanced development. Regional centres and local hubs need to be utilised to reduce waiting lists and reduce our reliance on the private sector.

2.4 Access to Diagnostic Scans

There are also lengthy wait times for access to diagnostic scans such as MRIs, CT scans, and ultrasounds. More than 230,000 people are on waiting lists for scans which is delaying access to further care.[21] More than 130,000 of them are waiting longer than 3 months. When faced with these waits, even for potential cancers and potentially life-threatening conditions, and the anxiety which this will cause, people who can afford it will often choose to purchase a scan from the private sector. Others will go into debt to get access to basic healthcare.

Table 7. **Diagnostic scan waiting lists Quarter 1 2023**

	0-3 months	3-6 months	6-12 months	12-18 months	18+ months	Total
CT	28,558	12,538	11,339	4,925	8,663	66,023
MRI	23,072	12,008	11,792	5,925	12,228	65,025
US	41,012	15,994	13,500	4,788	7,366	82,660
VUS	4,074	2,356	2,656	1,348	6,064	16,498
Grand Total	**96,716**	**42,896**	**39,287**	**16,986**	**34,321**	**230,206**

Delays in accessing scans is also a major driver of delays in emergency departments. Legacy equipment is also hindering the performance of the health service.

Access to diagnostic scans on referral from a community GP has been a very important development which has helped to reduce the strain on hospital services and support

21 PQ 20900/23; data for Q2 2023 was unavailable at time of print.

admission avoidance. However, this has relied on outsourcing to private services. Much more needs to be done to further reduce waiting lists for scans, including investment in public capacity,

2.5 Patient Management and Discharge to Community Care

Several hospitals have improved their performance to reduce emergency department waits. Waterford University Hospital, for example, reduced its average wait by 6 hours from 14.3 to 8.3 hours. St Luke's Hospital in Kilkenny has had the lowest average wait time for several years. Despite an increase since 2019, the average wait in the first quarter of 2023 was just 3.6 hours.

This has been achieved through the application of best practice in patient management and a zero tolerance for patients on trolleys. Blockages throughout the system must be cleared and best practice must be applied across all sites.

The first challenge is to reduce overall attendances and delays from overcrowding through timely referrals to diagnostic scans or out of the emergency department for patients who need a different service, such as to a medical assessment unit, local injury unit, or to primary and community care services such as GP, pharmacy, or physiotherapy.

The second is to ensure the availability of beds for patients who need to be admitted, without relying on wholesale cancellation of elective surgeries. Without expanding capacity, this can only be achieved if the average length of stay in hospital is reduced to the minimum necessary time. Table 8 illustrates how the impact of delayed discharges has only been reduced 3.4% since 2019 and still resulted in over 50,000 bed days lost in the first quarter of this year.

Table 8. **Delayed transfers of care (DToC) and bed days lost (BDL), Q1 2019-2023**[22]

	2019		2022		2023	
	DToC	**BDL**	**DToC**	**BDL**	**DToC**	**BDL**
St. James's Hospital	223	6,398	202	5,862	201	5,792
Cork University Hospital	86	2,484	135	3,708	169	4,095
St. Vincent's University Hospital	114	3,243	104	2,936	148	3,917
Tallaght University Hospital	129	3,355	115	3,571	132	3,874
Mater Misericordiae University Hospital	147	3,814	143	3691	151	3,778
Our Lady of Lourdes Hospital	122	4,134	135	4,232	78	2,590
UH Waterford	52	1,295	27	8,93	85	2,530
Galway University Hospitals	60	1,696	59	1,445	70	2,170
National Rehabilitation Hospital	-	-	33	889	51	1,684
Mercy University Hospital	53	1,618	54	1,628	59	1,677
Letterkenny University Hospital	33	913	53	1,255	59	1,485
St. Michael's Hospital	39	878	46	1,248	45	1,466
Beaumont Hospital	163	5,420	95	2,187	57	1,459
UH Kerry	29	846	60	1,714	45	1,458
UH Limerick	36	936	59	1,346	66	1,418
Naas General Hospital	48	1,457	25	1,020	39	1,171
Mayo University Hospital	31	875	32	1,131	30	983
Sligo University Hospital	22	480	28	911	25	951
St. Luke's General Hospital Kilkenny	49	1,376	31	849	33	908
Connolly Hospital	101	2,718	14	404	27	696
MRH Portlaoise	12	312	22	511	18	671
Portiuncula University Hospital	12	308	15	522	16	595
Wexford General Hospital	57	1695	29	862	19	573
Tipperary University Hospital	26	639	-	-	24	535
Our Lady's Hospital Navan	16	523	14	390	10	508
Children's Health Ireland	13	353	19	654	17	467
MRH Tullamore	27	821	24	689	15	428
Bantry General Hospital	17	496	25	741	11	367
Roscommon University Hospital	3	115	9	285	7	325
South Infirmary Victoria University Hospital	11	253	9	193	11	324
St. Columcille's Hospital	36	1,147	64	1,526	13	321
Nenagh Hospital	9	202	19	496	9	278
National Orthopaedic Hospital Cappagh	17	592	5	150	7	271
Cavan General Hospital	24	743	20	424	13	259
Ennis Hospital	1	49	8	397	9	222
St. John's Hospital Limerick	4	81	11	231	7	216
St. Luke's Radiation Oncology Network	-	-	4	103	1	60
Mallow General Hospital	1	26	0	13	0	37
MRH Mullingar	2	57	2	72	2	29
Total	**1,825**	**52,348**	**1,784**	**50,091**	**1,779**	**50,588**

22 PQ 20873/23.

Patient flow within and out of hospitals can be achieved if we support senior decision makers. Often, the call is for “more senior decisions makers,” i.e., consultant doctors, which is certainly part of the solution. There is ample anecdotal evidence of delayed discharges occurring over weekends when the number of consultants on duty or on call is significantly reduced. This was improved during the deep winter crisis out of severe necessity, and more recently over the June bank holiday weekend, but these improvements need to be sustained by long-term changes to work practices and, critically, in staffing levels. The new consultant contract will assist with this. The aim should be getting hospitals working at consistent levels 7 days a week and ensuring that they are sufficiently staffed and supported by community recovery capacity to do this.

Grouping patients in specialty-based medical wards is one method of improving patient flow, quality of care, and patient experience, and decreasing length of stay, which has been successful deployed in some hospitals. The basic premise is that patients with similar conditions or requiring supervision and treatment by certain medical and nursing specialists, are grouped to reduce the length of time it takes a doctor or nurse to find them. Keeping patients close to their clinicians, and keeping these clinicians close to one another, increases the efficiency with which clinicians can work. It also improves the learning environment and reduces risks to patient safety. There is also potential for a greater decision-making role for “non-consultant” doctors, such as registrars, and senior nursing staff, once supported by appropriate clinical governance frameworks and protocols. However, it must be recognised that we have too few consultant-level doctors and the solution is not to dump consultant-level decisions on lower paid, and differently trained, staff.

A common frustration among healthcare professionals is that many of the decisions which consultants make are held up by a lack of capacity elsewhere in the system, whether that is delays in scans or assessments or a lack of community transitional care beds or home support. Access to community-based transitional care, that is “step-down” or recovery beds, can significantly improve hospital performance by reducing delayed discharges. It is essential to improving performance that every patient who is admitted to hospital has a discharge plan, based on their likely length of stay, which includes planned access to a reserved recovery bed. Delays in accessing such beds, which provide for lower levels of care and can be closer to home, causes extremely costly delays in hospitals.

HSE Health Regions and the integration of care management will help to improve coordination across acute and community services. Hospitals and local managers also need to be provided with funding to access step-down care, such as in nursing homes, where it is available and appropriate. In the medium- and long-term, we need to build public capacity across community rehabilitation and transitional care and home-based care, supported by links to GPs and wider primary and community services.

2.5.1 Transitional Care and Hospital Networks

Major investment and reform of community services is needed to support the improvements we want to see in hospitals. Shifting care out of major acute hospitals into the community and sub-acute inpatient care facilities is an essential component of Sláintecare reforms. There are thousands of delayed discharges from hospital every year due to a failure to plan and align community services with hospital need. This is a significant contributor to the trolley crisis.

A functioning network of hospitals and community facilities, planned to prioritise care closer to home, will enable higher quality care while also improving the performance of our hospitals. Such facilities would provide rehabilitation and reablement care and time for recovery until a person can be cared for in the home. Our preference is to build public capacity. While we build public capacity, we propose to resource the HSE to lease appropriate surplus capacity in the private sector, such as in nursing homes. We would reduce funding for outsourcing in this area as public capacity is developed.

Model 2 hospitals in Cork and the mid-west played a major role during the winter surge in 2022/23. We need to examine the ability and desirability of such hospitals providing surge capacity and space to discharge patients requiring lower levels of care. There may be ideally placed to provide a limited service at certain points in the year, or a more substantial service year-round, and could play a role in the provision of urgent and scheduled acute and community services.

Medical assessment units and local or minor injury units are an integral aspect of the urgent care system. If utilised correctly, and made accessible through greater opening hours and awareness, they can take significant pressure off of emergency departments and ensure quicker access to appropriate care. To facilitate greater access to direct more patients to the appropriate care setting, opening hours and the spread of such units should be reviewed as part of a comprehensive review of emergency and urgent care capacity.

The role and spread model 2 and 3 hospitals should be reviewed to ensure an appropriate provision of centres of excellence and safe emergency departments. The provision of emergency, urgent, and rehabilitative care should be planned on the basis of population and geographic spread. The upgrading of hospitals, building of new hospitals, and reorganisation of services across existing model 2 hospitals should be examined. There should be a root-and-branch review of emergency and urgent care provision.

2.6 Pre-Hospital Emergency Care and Ambulance Services

A person's experience with the health service often starts with a paramedic, first responder, or in an ambulance. The National Ambulance Service (NAS) handled 384,000 emergency and urgent callouts in 2022 and facilitated 22,000 inter-hospital transfers.[23]

Table 9. **Percentage of Clinical Status 1 (ECHO) incidents responded to within 19 minutes, Q1 2019 – 2023**[24]

	Q1 2019	Q1 2022	Q1 2023
Statewide	**79%**	**72%**	**75%**
North Leinster	85%	76%	78%
DFB	81%	77%	78%
South	72%	65%	73%
West	74%	68%	70%

Table 10. **Percentage of Clinical Status 1 (DELTA) incidents responded to within 19 minutes, Q1 2019 – 2023**[25]

	Q1 2019	Q1 2022	Q1 2023
Statewide	**55%**	**42%**	**45%**
North Leinster	60%	47%	49%
DFB	44%	33%	37%
South	56%	37%	43%
West	58%	47%	49%

NAS response times to ECHO and DELTA callouts, which relate to life threatening cardiac and respiratory and life threatening non-cardiac/respiratory, respectively, have been getting worse. 80% of these callouts should be responded to within 19 minutes. Performance improved slightly in the first quarter of this year, but it remains far below target. This is a risk for patient safety. Patients with other conditions which are not deemed life threatening have been left waiting hours for an ambulance, and there has been anecdotal evidence of severe conditions worsening due to these waits.

Table 11. **Average response times, 2019-2023**[26]

	2019	2020	2021	2022	2023 (YTD)
National	**00:18**	**00:19**	**00:24**	**00:27**	**00:23**
North Leinster	00:17	00:19	00:22	00:26	00:22
Southern	00:20	00:21	00:27	00:21	00:26
Western	00:18	00:18	00:22	00:18	00:22

NAS performance is at significant risk of deteriorating further due to understaffing, which would further increase risk for patients. The NAS spent more than €18.5 million on overtime in 2021, and more than 1,200 employees were recorded as having worked

23 HSE National Service Plan 2023.
24 PQ 20886/23.
25 PQ 20886/23.
26 PQ 20886/23.

overtime on average every month. The NAS workforce review found a need for an additional 2,160 net additional whole-time equivalent staff by the end of 2026. That is a doubling of the NAS staff from its current base of 2,140. It says that without a substantial increase in the number of paramedics the NAS will have insufficient resources to respond to the projected demand and as a result, 19-minute performance would be considerably less than 40%.

The NAS had only 209 new staff start with then in 2022, of which 181 were patient and clinical care staff. Since 2019, the NAS College has commenced training for just 472 new recruits to the paramedic programme, less than 160 a year. The degree programme is 3 years long. There is no ready supply of paramedics in the State, and the Ambulance Service must train most of its recruits. There have also been substantive complaints made to the Joint Oireachtas Committee on Health that the NAS' recruitment process has unfairly disadvantaged paramedics who were trained by another body, particularly those trained outside the state. At this rate, the NAS will fall far short of their own targets in their strategic plan.

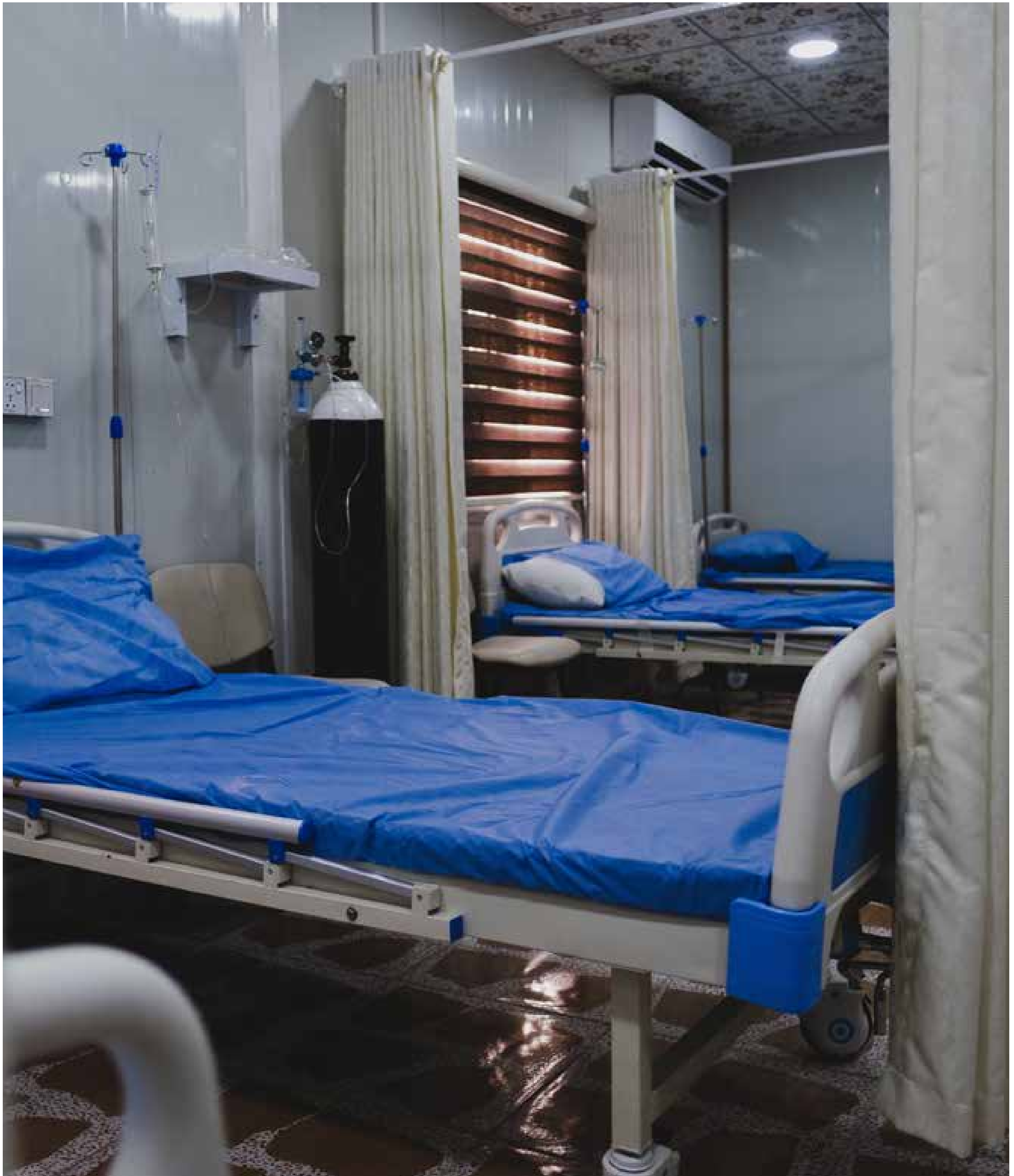
Table 12. **Ambulance turnaround time against target by hospital, Q1 2023**[27]

	Less than 30 minutes	30+ minutes
Kerry University Hospital	7%	93%
Letterkenny General Hospital	8%	92%
Sligo General Hospital	8%	91%
Mercy University Hospital	10%	90%
Mayo General Hospital	10%	90%
Portiuncula General Hospital	11%	89%
St Luke's Hospital Kilkenny	12%	87%
University Hospital Galway	12%	87%
Cork University Hospital	13%	87%
St Vincent's Hospital	13%	87%
South Tipperary General	18%	82%
Mullingar Regional Hospital	19%	81%
Tullamore General Hospital	19%	81%
Portlaoise General Hospital	21%	79%
Waterford University Hospital	22%	78%
Naas General Hospital	23%	77%
Wexford General Hospital	23%	77%
Lourdes Hospital Drogheda	24%	76%
University Hospital Limerick	25%	75%
Cavan General Hospital	27%	73%
Bantry General Hospital	27%	73%
St Michaels Dun Laoghaire	28%	72%
Tallaght Hospital	28%	72%
Beaumont Hospital	33%	67%
Connolly Memorial Hospital	34%	66%
Mater Hospital Dublin	36%	64%
St James Hospital	40%	60%
Crumlin Children's Hospital	50%	50%
Our Lady's Navan	50%	50%
Coombe Maternity Hospital	57%	43%
National Maternity Hospital	60%	40%
Temple St Children's Hospital	61%	39%
Rotunda Maternity Hospital	69%	32%
Tallaght Paediatric Hospital	72%	28%

27 PQ 20888/23.

The NAS will also play a crucial role in community service reforms in the coming years to assist alternative care pathway development, pilot projects, and boosting community-based emergency care. These measures would assist in tackling emergency department overcrowding by ensuring patients are directed and have access to the most appropriate service.

The poor performance of some hospitals, due to a lack of readily available beds, is hindering the ambulance service's performance. As illustrated in table 12, there are significant delays at many hospitals. Ambulances should be able to transfer patient care into hospitals rapidly but in many cases they are left waiting for over an hour to do so.



2.7 Key Priorities to Tackle Hospital Wait Times

To address deficits in our hospitals, Sinn Féin proposes to:

- **Invest, on the basis of ESRI projections, in at least 2,000 additional hospital beds and 1,500 community-based care beds over a term in Government,**
- **Continually develop capacity to meet expanding need on the basis of expected population increases and demographic shifts, ranging from 300 to 500 additional beds every year,**
- **Prioritise the development of regional elective centres and hospital-adjacent surgical hubs to deliver protected surgical capacity,**
- **Support senior decision makers to implement their decisions through rapid, targeted investment and strategic planning,**
- **Take a zero-tolerance approach to hospital trolleys,**
- **Implement best practice patient management across all sites,**
- **Work with healthcare workers to deliver a seven-day health service,**
- **Modernise hospital- and community-based diagnostic capacity to reduce waits for scans and decrease reliance on the private sector,**
- **Underpin service expansion with strategic workforce planning and substantially increase training places,**
- **Legislate for safe staffing levels and engage with workers to improve retention,**
- **Engage with Irish-trained healthcare professionals working abroad to bring healthcare workers home, and engage with those who have returned to learn from their experience abroad,**
- **Improve collaboration across hospitals and primary care and community services to reduce presentations and speed up discharges,**
- **Better support out-of-hours GP and late pharmacies to provide alternatives to emergency departments,**
- **Invest in community-based intermediate care to reduce admission to hospital and speed up discharges from hospital,**
- **Conduct a population-based review of emergency and urgent care services,**
- **Review the role and spread of model 2 and 3 hospitals to identify areas which are underserved or where lower acuity hospitals can fill service gaps or alleviate overcrowding,**
- **Streamline management through Health Regions and simplify processes for planning, designing, and funding of large strategic infrastructure developments to deliver a rapid expansion of capacity and improve value for money and efficiency,**
- **Resource the ambulance service to implement its strategic workforce plan and deliver a safer and more responsive service.**

PRIORITY 3

Deliver More Care in the Community: “Right Care in the Right Place at the Right Time”

3. Deliver more care in the Community: "Right Care in the Right Place at the Right Time"

A major burden has been placed on hospitals by a consistent failure to invest in primary and community care. Reorienting care to the community and addressing the lack of alternative care pathways, home care, and out-of-hours care is not just about resource efficiency. Delivering "right care, right place, right time" reforms are about improving health outcomes and early intervention opportunities, which in turn will reduce pressures on the rest of the system. Early intervention is not only significantly more cost effective than hospital care; it also substantially improves quality of life. It is necessary to build a better and larger primary and community care system to reduce pressure on hospitals, improve value-for-money, and improve health outcomes. This must be supported by investment across the range of primary care professions and integrating care delivery into groups of multi-disciplinary teams which serve defined and aligned populations.

3.1 Primary and Community Care and General Medical Practice

Primary care practitioners, particularly GPs, are responsible for the long-term care of a population. They are an anchor for continuity of care. The primary care system must support regular and quality access to clinicians with whom patients can build trust and familiarity. Community healthcare networks and the variety of multi-disciplinary primary care teams must be fully developed to provide that access close to home. In parallel, primary care must also provide access to urgent care services and seamless referrals to specialist services.

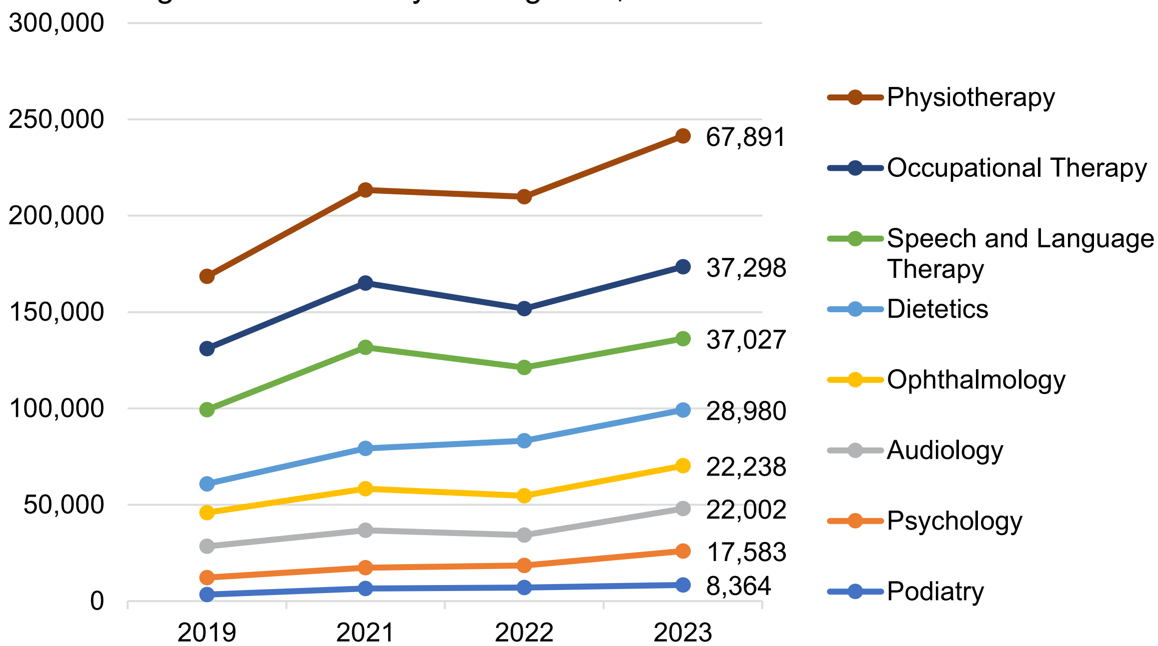


Figure 1. Community Waiting Lists, Q1 2019 - Q1 2023

Community care waiting lists have risen dramatically since Covid-19. In March 2019, there were 168,000 people on waiting lists for primary and community services. By the end of March 2023 there were 241,000.[28] 71% of these people are on waiting lists for physiotherapy, occupational therapy, speech and language therapy. While only 29% of people are on waiting lists for ophthalmology, audiology, psychology, and podiatry, there are acute pressures on these services as well. There are a further 18,000 children on

28 PQ 20892/23

specialist disability service waiting lists and 4,500 on child and adolescent mental health service waiting lists.

The biggest failure of Government health policy over the last twenty years has been the disregard for primary care staffing. We have been training far too few GPs, community nurses, and allied health and social care professionals to provide a proactive primary health system. As a result, waiting times for access to a GP have increased and the general availability of GPs has decreased. Many communities go without easy access to a GP or rely on a sole GP providing extraordinary services far beyond reasonable expectation.

The Competition and Consumer Protection Commission's 2010 study on General Medical Practitioners found:

> ***"[A] number of restrictions on competition among GPs in Ireland … made it difficult for newly established GPs to set up in practice … public and private patients had fewer GP practices to choose from [and so] GP practices were under less pressure to compete on price for private patients or to be innovative in the services they provide."***[29]

More than a decade later and despite moderate efforts to improve the situation, many of these concerns remain.

As noted by the Irish College of General Practitioners, only 1-in-5 GPs are open to taking new public patients and 1-in-4 are open to taking new private patients. A significant number of these doctors, several hundred, do not have a public General Medical Services (GMS) contract. Many of them only see private patients. Increasingly GPs are employed by partnership and corporate practices which hold the GMS contract(s). It remains difficult for new GPs to establish their practice and there are increasing wait times for access to GPs. Sinn Féin propose to give certainty to new and locum GPs through a public employment option.

According to the Medical Council's Medical Workforce Intelligence Report 2021, there were 4,461 GPs clinically active and working in Ireland.[30] There are also 206 community health doctors and 190 public health doctors. An estimated 1-in-4 of these doctors are aged over 60.[31] It is estimated that 5,650 GPs are needed to deliver universal free GP care by 2028.[32]

According to the latest data from the HSE, 30% of Enhanced Community Care (ECC) posts are vacant.[33] 94 of 96 Community Healthcare Networks (CHN), 23 of 30 Community Specialist Teams (CSTs) for Older People, and 24 of 30 CSTs for Chronic Disease Management are in operation. The ECC programme has embedded private provision of diagnostic scan services for GPs rather than building public capacity. CHNs must prove to be more than a rearranging of the deck chairs. Each CHN will need to provide services to a population of c. 50,000 people across several primary care teams while working with GPs and other specialist teams.

The Health Service Capacity Review 2018 estimated a need for 500 additional practice nurses and 700 additional public health nurses. We need to train significantly more health

29 Competition and Consumer Protection Commission, (2010), Report on General Medical Practitioners.
30 Medical Council, (2022), Medical Workforce Intelligence Report.
31 ICGP, (2022), ICGP Pre-Budget Submission 2023.
32 HSE National Doctors Training and Planning, (2020), Demand for Medical Consultants and Specialists to 2028 and the Training Pipeline to Meet Demand: A High-Level Stakeholder Informed Analysis, p. 23.
33 HSE, (2023), Enhanced Community Care Programme Technical Briefing to the Joint Oireachtas Committee on Health, 14 June 2023.

care workers. This must include a major expansion in training posts for allied health and social care professionals, especially physiotherapists, psychologists, occupational therapists, and speech and language therapists.

The provision of general medical services needs to be modernised. Sinn Féin is open to reviewing the terms of the GMS contract as part of an agreed framework for achieving universal healthcare. Many professions are seeking modifications and revisions to contracts and the new systems required for the delivery of universal healthcare will necessitate modernisation of working arrangements.

In the immediate term, we propose to fund an expansion of GP staffing, including nursing and management support, through existing GMS contracts. This would be contingent on a keystone agreement which would underpin the delivery of universal healthcare and transition to the *Sláintecard* scheme, as outlined in section 1.2. We propose to establish a Working Group on the Future of Primary Care to establish the immediate and ongoing needs of GPs as well as nurses, physiotherapists, pharmacists, psychologists, and other primary care professionals.

We propose to develop public primary care services to include publicly employed GPs. Publicly employed GPs would initially provide out-of-hours cover and general medical services in underserved areas and could provide general locum support and leave cover. We would initially develop a pilot scheme before rolling out these services across the state.

In the absence of accessible public services, Sinn Féin propose to temporarily fund access to trusted private disability and mental health services to ease long waiting times. This community care access fund would be available on a temporary basis only and until public services are responsive to children's needs in a timely manner. Private sector outsourcing has never been a sustainable or cost-effective method of reducing wait times and as such public capacity would remain our priority.

We need to significantly increase the number of healthcare professionals in training. As one example, GP training places need to be increased to 450 to develop services and account for retirements. We have outlined a strategy for increasing healthcare undergraduate places in our Alternative Budgets.

3.2 Community Pharmacy

Community pharmacy can play a much larger role in the provision of health services. Sinn Féin has long supported a greater role for community pharmacists in minor illnesses and ailments, chronic disease management, and medicines management. Community pharmacy can also play a role in preventive healthcare such as hypertension blood pressure checks. Expanding the scope of practice for community pharmacy would be a priority for Sinn Féin, as well as deepening integration of community pharmacy with wider health services.

Sinn Féin is open to a significant review of the scope, funding, and terms and conditions of community pharmacy with a view towards implementing our *Sláintecard* scheme. The minor ailments scheme would enable people to attend their local pharmacist for assessment and treatment for a number of specified ailments rather than initially having to attend the GP to obtain a prescription. Coverage would initially be for medical card holders and would be extended incrementally on the basis of income.

Many professions are seeking modifications and revisions to contracts and the new systems required for the delivery of universal healthcare will necessitate modernisation of working arrangements. Sinn Féin would establish a Working Group on the Future of Primary Care to set in place a keystone agreement for the delivery of universal healthcare.

In seeking to remove pressure from GPs Sinn Féin would work with GPs, pharmacists, relevant regulators, and patient advocates to improve access to over-the-counter medicines where appropriate. We await the output of the Expert Taskforce on the expansion of the role of pharmacists. We propose to appoint a Chief Pharmaceutical Officer at the Department of Health responsible for workforce planning, medicines supply and management, and related matters,

We are also conscious of inconsistent implementation of existing dispensing protocols, such as the reported concerns around codeine sales.[34] We would empower the pharmacy regulator, the Pharmaceutical Society of Ireland, to conduct more extensive no-notice checks and inspections to ensure public confidence in dispensing protocols. Pharmacists can also play an enhanced role during medicine shortages if we empower them through serious shortage protocols. These would enable pharmacists to substitute certain prescription medicines for similar products during a shortage without the need to consult a GP (who will inevitably issue a prescription which suits the pharmacy's stock of medicines). We would appoint a chief pharmacy officer at the Department of Health with responsibility for developing and overseeing pharmacy and pharmaceutical policy.

3.3 Oral Health Services

Publicly funded access to dental care was devastatingly slashed during the recession, with overall public funding dropping by more than 50% as a result of cuts to the Dental Treatment Benefit Scheme (DTBS) and the Dental Treatment Services Scheme (DTSS). This has led to a significant abandonment of the Dental Treatment Services Scheme, which was severely limited until some changes were made last year. According to the Irish Dental Association, 80% of dentists who are still on the public Dental Treatment Service Scheme are not taking new public patients. According to HSE data, there were just c. 650 dentists actively claiming under the scheme at the end of 2022.[35]

Similarly, the public dental service has struggled to secure adequate funding. Dental screening in schools and oral health services for children have not been developed as they should be, and HSE dental clinics have become a rarity. The HSE is also responsible for dental treatment under general anaesthesia for people with special needs. These services are patchy at best and waiting lists are unacceptably long.

The HSE Orthodontic Service is limited to those children with the most severe and complex orthodontic treatment needs. Waiting lists stood at over 10,000 at the end of quarter 1 2023.[36] More than 7,000 of these children are waiting over a year, and more than 2,300 children are waiting over 4 years for access to care.

Sinn Féin has proposed a significant increase in the number of training posts for dentists and a return to public provision of general dental services, starting with underserved communities, to address the shortcomings in service provision.

34 McMorrow, C., (2023), 'Inside Ireland's widespread reliance on codeine medicines,' ***RTÉ***, 12 April 2023, (rte.ie).
35 PQ 20907/23.
36 PQ 20908/23.

3.4 Preventive and Proactive Healthcare

The ideal health system, expressed as “delivering the right care in the right place at the right time,” is one where as many diseases as possible are prevented or caught early, where chronic conditions are managed locally, and where there are no unreasonable delays to the care a person needs. However, it is essential that healthcare goes beyond detection and responding to conditions at early stages. We must also enable healthier behaviours and address personal physiological, social, and economic contributors to ill-health.

A proactive approach to healthcare prioritises access to primary care to enable early diagnosis and intervention. This should be done through timely access, regular check-ups, condition monitoring and chronic disease management, and a close relationship between primary care clinicians and their patients. Targeted programmes are needed to support independent healthy living and prevent, or react quickly to, injuries such as fractures. A variety of initiatives have been devised to support proactive healthcare under the Healthy Ireland and Enhanced Community Care programmes but these need to be further developed.

Responsibility for preventive and proactive healthcare is shared across the individual and their primary care clinicians, wider society, and the regulatory state. The state plays a pivotal role in creating an enabling environment for healthy living. The state is responsible for access to sports and exercise facilities, physical and nutrition education, air quality, healthy eating, public health monitoring and planning, immunisation and awareness, food regulations, advertising rules, public transport and active travel, housing and environment standards, and screening services. Our environment has a significant impact on our health, with air pollution and damp being significant causes of childhood illnesses. It is not a coincidence that asthma and obesity rates are higher among children from lower income backgrounds. Public health policy, and the level of Government commitment to enabling healthy living conditions and tackling health inequalities, has a significant effect on health outcomes across all ages.

Sinn Féin would prioritise robust primary care services to deliver the most cost-effective and life-enhancing care possible. Strategies such as for Cardiovascular Health and Cancer should prioritise community-based access to care at appropriate levels. Services should be planned on a population health basis, accounting for identified needs of certain groups such as older people. This would significantly reduce the burden on hospitals and enable a more sustainable health service.

3.5 Transitional Care in the Community

There are thousands of delayed discharges from hospital every year due to a failure to plan and align community services with hospital need. This is a significant contributor to the trolley crisis. Along with increasing hospital capacity, we must also ensure optimal use of bed space.

Shifting care out of acute hospitals and towards community-based short-term sub-acute inpatient care facilities is an essential component of Sláintecare reforms. A functioning network of hospitals and community facilities, planned to prioritise care closer to home, will enable higher quality care while also improving the performance of our hospitals. Such facilities would provide rehabilitation and reablement care and time for recovery until a person can be cared for in the home.

Our preference is to build public capacity. While we build public capacity, we propose to resource the HSE to lease appropriate surplus capacity in the private sector, such as in nursing homes. We would reduce funding for outsourcing in this area as public capacity is developed.

3.6 Home and Residential Care

3.6.1 Home Care and Aging in Place

A fundamental principle behind Sláintecare is that more care should be delivered in the home, and that older people should be facilitated to remain at home for longer. Residential care should continue to exist for those who need and want it, but the priority should be to develop homecare and shift care to the home. The nature and level of care delivered in the home and in nursing homes must change to facilitate this.

There is significant unmet demand for home support. Waiting lists for home support increased by 40% from 4,615 people at the end of March 2019 to 6,439 at end of March 2023. There was shortfall of more than 2,500,000 home support hours in 2022. As a result, there were more than 1,600 delayed discharges from hospital in 2022 which were attributable to the shortage of home carers and healthcare assistants. The 2018 Health Service Capacity Review, which was conducted based on lower population growth estimates than transpired, forecasted a minimum 120% increase in demand for home support from 2016 to 2031 but this has already been reached and is expected to grow further.

There has been a significant over-reliance on the private sector to provide home care. 62% of home care is delivered by non-HSE provider while only 38% of home support services delivered directly by the HSE. This amounted to over €400m in 2021 being paid to non-HSE providers of home care.

Sectoral employment standards are a significant issue for recruitment and retention of home care workers. The Strategic Workforce Advisory Group on Home Carers and Nursing Home Healthcare Assistants found that a failure to guarantee hours, provide payment for travel and subsistence, the lack of a mandatory living wage or standardised pay grades, and other areas of dispute between workers and employers are the cause of labour shortage in the sector.

Sinn Féin has proposed a sectoral industrial relations solution for pay and conditions to provide a basic floor with standards sufficient to attract and retain workers in the home care and nursing home sector. This could take the form of an Employment Regulation Order. We must make home care an attractive career option and provide training opportunities. We would prioritise direct public sector service provision in the sector. Additional public funding should be linked to the promotion of better terms and conditions for the workforce in the sector and only for the portion of services which are provided on behalf of the State.

Sinn Féin proposes to modernise the home support scheme and legislate for a statutory home support scheme to deliver higher complexity care in the home. We would expedite the Health (Amendment) (Licensing of Professional Home Support Providers) Bill and new regulations for providers of home support services. We would implement the recommendations of the Strategic Workforce Advisory Group on Home Carers and Nursing Home Healthcare Assistants across recruitment, pay and conditions, barriers to employment, training and professional development, and sectoral reform.

We would prioritise the development of public home care services. Working with stakeholders we would develop training opportunities and career prospects for carers and carers with an advanced skillset, and develop a greater role for nurses, physiotherapists, and allied health and social care professionals in delivering higher quality care in the home. We would ensure more regular and holistic reviews of the health and care needs of persons receiving home support to ensure that they are in receipt of the type, quality, and intensity of care which they need. We would ensure that supports for housing adaptations, healthy age friendly homes and aging in place are increased to support older people retain their independence.

In relation to ongoing private service provision, we would modernise the tendering and funding model for providers of home care to prevent a race-to-the-bottom in costs and quality. This would be underpinned by an industrial relations solution focussed on improving employment standards in the sector. We would ensure a level playing field, high care standards, and fair remuneration for workers.

3.6.2 Long Term Residential Care

The majority of long-term residential nursing home care is delivered by the private and voluntary sectors. There are about 32,000 nursing home beds in Ireland.[37] 84% (26,600) are provided by the private and voluntary sector, with the remaining 16% (5,200) being public. The private and voluntary sector has increased its share of capacity from 78% (22,500) in 2014. The number of public beds has decreased by 16% since 2014 by 1,000 beds from 6,200.

Recent cost of living and economic pressures have put a significant strain on many nursing homes, particularly smaller community and family-run nursing homes and nursing homes which provide complex care. Since 2020, there have been 34 private and voluntary nursing home closures which have resulted in a loss of 1002 beds. Nursing homes are considering leaving the Fair Deal scheme and contend it is not providing sustainable funding. Many nursing homes report having surplus capacity which could be used to provide step up and step-down transitional care. Nursing homes face significant difficulties in recruiting and retaining experienced staff.

As the population grows and ages, with the number of people aged over 85 set to double in the next two decades, and as more care is delivered in the home, the health profile of nursing home residents will tend to be older and more complex. This is likely to further increase staffing and cost pressures in the sector, and a strategic plan is urgently needed to ensure that older people are receiving the care they need where they want to receive it.

Sinn Féin propose to reset the balance in the share of care in favour of public provision. We would develop public capacity, starting by returning the number of public beds to 6,200. Sinn Féin would address the viability of loss-making nursing homes through a review of the Fair Deal pricing mechanism. We would ensure that resources for care are allocated on the basis of a resident's individual care needs.

We would deliver a collective pay arrangement for workers in the nursing home sector to ensure a living wage and proper remuneration for public work. The translation of such minimum standards into fees for public services would be resolved through the review

37 Nursing Homes Ireland, (2023), Challenges for Nursing Homes in the Provision of Older Persons Care: Private and Voluntary Nursing Home Sector, p. 16.

of the funding mechanism. This review of public funding arrangements would provide better pay and conditions for workers, higher quality of care for residents, and maintain viability in the sector while ensuring value for money as we develop public capacity. Where, thereafter, nursing homes are resolved to close, we would ensure that the HSE can step in to acquire that capacity, where appropriate. Additional public funding should be linked to the promotion of better terms and conditions for the workforce in the sector and only for the portion of services which are provided on behalf of the State.

There must be transparency and closure for families who are still grieving the tragedy which unfolded in nursing homes during the pandemic. Many families have been denied answers. We would advance an inquiry into the handling of Covid-19 in residential care homes to ensure that transparency is delivered and that unnecessary isolation and substandard care is not repeated. Access to family support and social care practitioners must always be supported. We propose to enhance oversight of the residential care sector through a safeguarding authority. We would ensure full implementation of the recommendations of the Nursing Home Expert Panel and the Final Report of the Oireachtas Special Committee on Covid-19 Response. We would legislate to apply the framework for safe staffing and skills mix across all public healthcare facilities and those which are providing services on behalf of the State.

3.7 Neurorehabilitation

Community neuro-rehabilitation teams (CNRT) play a vital role in supporting the recovery of patients with neurological conditions. They are essential to preventing or managing acquired disabilities. They provide a range of clinical services, from physiotherapy to neuro-psychology, and include speech and language therapy, occupational therapy, and social work. CNRTs should work with regionalised specialist post-hospital rehabilitation services and the National Rehabilitation Hospital to deliver more care in the community and avoid unnecessary admissions to inpatient units. The work of CNRTs must be supported by ongoing access for patients to primary care and local condition management and recovery services for patients in the longer-term.

The delivery of CNRTs is tied to the delivery of managed clinical rehabilitation networks (MCRN). The current service is resourced at approximately half the level it requires, and an additional €12,000,000 is needed to fully resource the service. According to the Neurological Alliance of Ireland, only 15% of neurological patients have access to these teams as only two of the four-to-five teams which are currently resourced are providing full services.

Sinn Féin would put in motion a plan to deliver these services in full. It is clear that a comprehensive workforce plan is needed to ensure the delivery of full services. This must start with the proper resourcing of each team to ensure that posts are available to attract relevant specialists into under-served areas as they become available. The health service and higher education institutes should be tasked with ensuring there are sufficient training places for specialist programmes.

The benefits of this programme are very clear. It is estimated that up to 42,000 hospital bed days could be saved annually if patients can be discharged to a community neurorehabilitation team. Combined with other capacity saving measures which place more care in the community, this would go a long way to freeing up capacity in hospitals to reduce overcrowding.

3.8 Eye Care

It is estimated that 1-in-5 children will have an eye problem and sight deterioration should be caught as early as possible. Public eye-care in Ireland starts with a school screening. This involves every child aged 5-6 undergoing a vision screening carried out by public health nurses. Children requiring further attention are referred to HSE eye care services where they can face lengthy waits. Access to services is highly variable and many children missed the school screening due to COVID. This means that there is a significant cohort of school children whose vision difficulties may be undiagnosed. Delays in providing glasses to children can negatively affect their development.

Table. 13. **Assessment of Eye Care Cover by Community Health Office Area**[38]

CHO	Over 8s eye-care scheme in place	Fee Cover	Glasses
1	No	No	€150 allowance available
2	Scheme in place in all areas	Up to €22.51	€51.82 basic allowance and €150 for larger diagnoses
3	In some areas and at certain times, backlogs are sent out to Optometrists.	Up to €22.51	€51.82 allowance available
4	In some areas and at certain times, backlogs are sent out to Optometrists.	Up to €22.51	€51.82 allowance available
5	In some areas and at certain times, backlogs are sent out to Optometrists.	Up to €22.51	Information not available / clear
6	No	No	No
7	Over 8's discharged	No	Local voucher system in place
8	In some areas and at certain times, backlogs are sent out to Optometrists.	No	No
9	Over 8s scheme in place	No	€51.82 basic allowance and €150 for larger diagnoses

State support for access to eye care for children aged 8 to 16 is patchy despite commitments to assist this cohort. This is a critical period for intervention to reduce vision difficulties and eye problems which did not emerge at a younger age or which were missed. Some Community Health Organisations have introduced an 'Over-8's community ophthalmic scheme.' This unstandardised approach has resulted in a postcode lottery for services, as illustrated in table 13. This data was compiled by Optometry Ireland from CHOs which responded to their queries and by surveying the experiences of Optometry Ireland members in each CHO which did not.

There are significant waiting lists for eye surgery, such as for cataracts. In part this is due to a poor use of resources. The HSE has recognised that a significant amount of eye

38 Compiled by Optometry Ireland.

care which is currently delivered in hospitals could be delivered in the community and in primary care. This could free up capacity for specialist diagnostics and treatments. The National Clinical Programme for Ophthalmology and the Primary Care Eye Services Review Group were established to develop and implement the new model of care. Bespoke arrangements for post-cataract care in the community by optometrists have helped to improve cataract waiting lists in Sligo and Letterkenny.

Sinn Féin is proposing a functional and standardised eye care programme to cover children aged 0-16 and to improve the availability of care through optometrists. We would include levels of cover in our *Sláintecard* scheme to ensure that all families can avail of assistance anywhere in the State. We would invest in early intervention through primary care optometry for the benefit of children's lifelong development. We would leverage all ready capacity to reorient care and reduce waiting lists.

3.9 Audiology

There are more than 300,000 adults in Ireland with acquired hearing loss.[39] According to Chime, the National Charity for Deafness and Hearing Loss, the vast majority of people with hearing loss or deterioration do not seek intervention or a hearing test. The Irish Longitudinal Study on Ageing (TILDA) has found as few as only one-in-five older people with hearing loss have hearing aids while it has been reported that we prescribe hearing aids at less than half the rate of the UK per head of population.[40] Untreated hearing loss is a contributor to

39 Chime, (2022), Hearing Loss Survey (chime.ie).
40 Chime, (2020), A Fair Deal for Deaf and Hard of Hearing People (chime.ie).

dementia and depression, with as many as 50,000 older people affected by hearing loss-related depression. It can also contribute to physical injury and avoidable ill-health.

The HSE provides approximately 20% of hearing aids to children and adults while 80% is provided through the private sector. Approximately 50% of people avail of the PRSI hearing aid grant while 30% pay the full cost of hearing aids.

We are proposing to develop a national hearing plan to ensure that people receive appropriate hearing supports throughout their lives. This is part of our commitment to taking practical and cost-effective measures which can improve people's quality of lives and reduce accidents and hospitalisations.

3.10 Key Priorities to Deliver more Care in the Community

To improve the re-orient care to the community and improve early intervention opportunities, Sinn Féin proposes to:

- **Target investment in a decade of expanding primary care to deliver universal healthcare and expand multi-disciplinary primary care and community specialist teams, such as community neurorehabilitation teams, community specialist teams, chronic disease management teams, and community healthcare networks,**
- **Deliver a keystone agreement to underpin the delivery of universal healthcare and transition to the *Sláintecard* scheme,**
- **Establish a Working Group on the Future of Primary Care with relevant stakeholder professions to guide strategic investment and identify areas for deeper collaboration,**
- **Develop publicly employed GPs and launch a pilot scheme for out-of-hours and locum support,**
- **Increase the number of undergraduate, postgraduate, and advanced or specialist practice training places for primary care professions,**
- **Fund an expansion of primary care staffing around GPs, including nursing and administrative support, while developing salaried GP posts,**
- **Increase the use of nursing and advanced practice therapy grades across primary care services,**
- **Invest in a Pharmacy First approach to minor ailments and move appropriate care from GP practices to community pharmacy,**
- **Deepen the integration of pharmacy into primary care and preventive healthcare, ensure appropriate coverage for pharmacy and medicines costs under the *Sláintecard* scheme, legislate for serious shortage protocols and improve cooperation across GP and pharmacy,**
- **Appoint a Chief Pharmaceutical Officer at the Department of Health responsible for workforce planning, medicines supply and management, and related matters,**
- **Invest in universal oral and dental health cover for children while re-building the public dental service and review the existing dental schemes and care provision arrangements for public patients,**

- Better support hospitals by investing in community-based care, such as step-down facilities and home care, and improve access to public community-based diagnostic services,
- Reset the balance in the nursing home and home care sector and reverse privatisation by investing in public community nursing units and home care, return the number of public nursing home beds to 6,200, and reorient care into the home as much as possible to support independent living,
- Modernise the home support scheme and expedite the Health (Amendment) (Licensing of Professional Home Support Providers) Bill and new regulations for providers of home support to improve the quality and availability of home care,
- Ensure a living wage and appropriate travel remuneration to address recruitment and retention challenges in home care and the nursing home sector, and implement the recommendations of the Strategic Workforce Advisory Group on Home Carers and Nursing Home Healthcare Assistants across recruitment, pay and conditions, barriers to employment, training and professional development, and sectoral reform,
- Link additional public funding for nursing homes to the promotion of better terms and conditions for the workforce for the portion of services which are provided on behalf of the State,
- Revise care and funding arrangements for the nursing home and home care sectors to ensure sustainability as care is reoriented to the home and utilise appropriate surplus capacity in nursing homes for transitional care,
- Recognise the importance of preventive healthcare, early intervention, regular scheduled access, and integrated health and social care services to increasing health and quality of life and reducing the general disease burden,
- Take a whole of Government approach to preventive healthcare and invest across education, sports and exercise, housing, transport, healthcare, and more to improve health outcomes,
- Improve access to eye care including a standardised 0-16 eye care scheme, delivery of more post-cataract care through optometrists,
- Implement a national hearing plan to ensure that people receive appropriate hearing supports throughout their lives and improve access to hearing aids,
- Ensure cohesion and seamless collaboration across primary, community, and acute service providers through modernise IT systems and equipment, such as digital patient records,
- Advance an inquiry into the handling of Covid-19 in residential care homes and deliver transparency for bereaved families,
- Legislate to apply the framework for safe staffing and skills mix across all public healthcare facilities and those which are providing services on behalf of the State.

PRIORITY
4

Towards a sustainable, skilled and diverse health sector workforce

4. Towards a sustainable, skilled and diverse health sector workforce

Successive governments have failed to look ahead and plan to train, recruit, and retain enough healthcare workers to safely and fully staff the health service. The consequences of this are clear to see in the long waits, outdated contracts, understaffing, and major burnout across the workforce. We need a fresh approach to proactively planning the development of the healthcare workforce joined up across the health and further and higher education sectors. Healthcare will continue to be an evolving professional field. Expanding care in the community and changing the delivery of care in acute hospitals will necessitate changes in the way we interact with healthcare, and the way healthcare professionals work.

It is important that, in planning and developing the health workforce, we take a rounded, multi-disciplinary view of the needs of staff and patients. This will be essential to identifying areas for advanced training, specialisation, and increased interprofessional collaboration. A Sinn Féin government would establish a high-level group, including the Taoiseach and the Ministers for Health and Further and Higher Education, to implement a multi-annual health workforce strategy to cover training, recruitment, and retention.

4.1 Workforce Deficits

The HSE paid out €238 million in overtime payments in 2021 (Table 14).[41] These payments relate to more than 3 million hours of recorded overtime worked by medical professionals and more than 2 million hours worked by nurses, midwives, and healthcare assistants in 2021.[42] Overtime to other staff grades is included but represents a small portion of all payments. More than half of this was paid out to 9,000 medical/dental professionals. Non-consultant grade medical and dental grades worked 2.8 million of the 3 million medical/dental hours. Similarly, nurses and midwives and workers in 'patient and client care' (healthcare assistants, home helps, ambulance paramedics, and other care roles) racked up significant overtime bills. That is roughly the equivalent of 1,700 full-time doctors, more than 500 full-time nurses, and a similar number of healthcare assistants, who are missing across the system. This represents a 12% deficit in medical professionals at the end of 2021, the funding for which is already in the budget.[43]

This is placing an enormous strain on frontline healthcare workers to cover staffing gaps. The global shortage of healthcare workers is well documented, and it will only become more difficult to recruit internationally across all professions.

41 PQ 17516/22.
42 PQ 3985/22.
43 HSE, (2022), Health Service Personnel Census, July 2022: There were 12,113 medical/dental WTE at Dec 2021, an additional 1700 would bring posts to 13,800.

Table 14. **HSE Overtime Hours and Payments, 2016-2022**

Overtime Paid					
	2016 Full Yr	**2019 Full Yr**	**2020 Full Yr**	**2021 Full Yr**	**2022 Quarter 1**
Nursing/ Midwifery	€25,593,141	€30,895,397	€34,302,161	€42,898,228	€12,252,553
Management/ Admin	€2,754,072	€3,215,009	€6,381,027	€7,931,614	€1,755,355
General Support	€6,133,788	€7,124,409	€8,345,511	€8,977,185	€2,695,031
Health & Social Care Professionals	€2,127,650	€2,396,614	€3,872,790	€4,203,906	€990,250
Medical/ Dental	€84,046,122	€111,888,124	€123,229,958	€134,421,777	€39,403,614
Patient & Client Care	€25,428,043	€30,248,144	€32,515,182	€39,490,791	€10,967,897
Total	**€146,082,816**	**€185,767,697**	**€208,646,628**	**€237,923,500**	**€68,064,700**

No. of Employees					
	2016 Full Yr	**2019 Full Yr**	**2020 Full Yr**	**2021 Full Yr**	**2022 YTD March**
Nursing/ Midwifery	8,789	9,816	11,912	13,956	8,823
Management/ Admin	1,662	1,857	3,251	4,142	1,892
General Support	2,031	2,484	2,824	3,052	2,314
Health & Social Care Professionals	910	970	1,739	1,559	833
Medical/ Dental	6,340	7,703	8,323	9,003	5,905
Patient & Client Care	5,804	7,330	8,217	9,404	6,824
Total	**25,536**	**30,160**	**36,266**	**41,116**	**26,591**

The Medical Council's survey also affirms the findings of Irish Medical Organisation (IMO) research into 'Non-Consultant' Hospital Doctor (NCHD) working conditions. The Medical Council found that, of 7,500 NCHDs, 62% reported working more than 40 hours a week on average, and 29% reported working more than 48 hours. The IMO survey found that 100% of NCHDs were working beyond rostered hours; more than 50% were not paid for all of their hours; 96% were working in excess of 48-hour weeks; and many reported difficulties securing annual leave and study leave.[44] NCHD contracts and working conditions

44 Irish Medical Organisation Survey of Non-Consultant grade Hospital Doctors, June 2022.

are currently subject to a review by the National Taskforce on the NCHD Workforce which published an interim report in April 2023.[45]

The 2022 ESRI report 'Projections of Workforce Requirements for Public Acute Hospitals in Ireland, 2019-2035' sets out a projected need for 15,000 additional healthcare workers by 2035 in acute services.[46] The demand is likely to be similar in community services to deliver Sláintecare. However, there is no joined up projection of service requirements yet. The absence of this data complicates matters but it does not make evidence-based planning impossible.

To increase the number of medical specialists, for example, to the European norm we would need 40% more practicing doctors. That requires a significant expansion in medical training capacity from undergraduate to higher specialist level. It takes a decade to train a first-year student into a qualified GP. As such, we should be planning the growth and development of the health workforce with a long lead-in time.

Emigration of domestically trained healthcare professionals is a significant problem which many countries face, and Ireland is no different. Some entertain the idea of a work obligation, but the reality is that our graduates are emigrating due to both working and living conditions which are in the Government's control. Pressures at work from understaffing and the cost of housing are both contributing to emigration. Many would emigrate regardless, for a time, for work and life experience. This is a positive for our workforce, but their likelihood of coming home is impacted by their memory as much as by their prospects. Targeted retention and relocation policies and campaigns are needed, as well as improvements to the experience of young professionals in training.

The HSE is significantly reliant on migrant workers to fill gaps left by undersupply and emigration. The Medical Council has highlighted that two-thirds of first-time registrants with the Medical Council in 2021 were international graduates. Similarly, 62% of first-time registrants with the Nursing and Midwifery Board in 2021 were non-EU workers.[47] Migrant workers make a vital contribution to the health service, yet they face significant hurdles to working here. They can face lengthy delays getting visas and completing their registration. We must develop a sustainable domestic pipeline of healthcare graduates and address barriers for overseas recruitment and return, such as housing, to reduce our reliance on the highly competitive international labour market.

4.2 Strategic Workforce Planning

The Framework for Safe Staffing and Skills mix provides the scientific method for determining the number of nurses and healthcare assistants who should be on duty. It should be applied to every ward, emergency department, and relevant community settings, and placed on a statutory footing. It should also be mandatory to include safe staffing levels in the determination of the level of funding needed to maintain 'existing levels of service' each year.

A modern public health service will require updates to regulations and contracts for public work, such as public GP contracts and 5/6 or 5/7 rostering, and private work, such as treatment options, integration, and funding mechanisms. Many allied health and social care

45 National Taskforce on the NCHD Workforce, (2023), Interim Recommendations Report.
46 Keegan, C., Brick, A., García-Rodríguez, A., and Hill, L., (2022), 'Projections of Workforce Requirements for Public Acute Hospitals in Ireland, 2019-2035: A Regional Analysis based on the Hippocrates Model,' Research Series Number 147, July 2022.
47 INMO, (2022), INMO Pre-Budget Submission 2023, p. 12.

professions, such as psychologists, are still unregulated by CORU despite the legislative basis having been provided in the Health and Social Care Professionals Act 2005. There are also issues arising in other jurisdictions around unregulated new professions, such as Physician Associates, which will need to be addressed.

Occupational health and wellbeing are major concerns for many workers. Changing how the health service operates is an opportunity to embed a positive workplace culture. The Minister for Enterprise recently announced that a Health and Social Care Advisory Committee will be established within the Health and Safety Authority to address workplace safety issues. The high level of assaults against healthcare workers, particularly nurses, has been an unacceptable risk. Similarly, complaints regarding wellbeing, harassment, and bullying need to be addressed robustly. The Health and Safety Authority will need to be properly resourced to tackle issues within the HSE. The HSE needs to be held accountable for improving standards.

In achieving the substantial increase in staffing levels which is needed to deliver accessible and universal healthcare, the recruitment processes in the health service will need to be decentralised. The implementation of regional health areas (HSE Health Regions) is an opportunity to do this, but the precise level at which these decisions should be made has yet to be worked out. It is our belief that frontline management is acutely aware of their staffing needs and should be supported, within budgetary frameworks and under the supervision of regional executive teams, to quickly recruit staff as needed.

A Sinn Féin Government would give a job guarantee to health graduates. We would place an obligation on the HSE to work with students in their final years to ensure timely entry to the workforce. Many graduates who would work for the HSE end up working elsewhere or abroad due to delays from the HSE's recruitment methods. An example of this is in clinical psychology, where trainee clinical psychologists in funded HSE posts are required to provide "payback" after the completion of their PhD for three years. However, "over the last five or more years due to difficulties with the process of getting approvals, the HSE have not been in a position to offer employment at the time of completion of their trainee contract in effect releasing them from their payback condition."[48] The HSE spent €35 million on training approximately 150 clinical psychologists between 2017 and 2021 and not a single one of these were given a job at the end of their training despite the huge demand for psychologists across the health service.

In addressing recruitment and retention issues, we must also account for cost-of-living pressures, such as the cost of housing, and financial incentives to work abroad. If we are to stem the bleed of our healthcare professionals abroad, we must provide the conditions for them to stay.

4.3 Key Priorities to Increase Training, Recruitment, and Retention

To develop the healthcare workforce, Sinn Féin proposes to:

- **Implement a multi-annual strategic workforce plan to meet rising demand and deliver universal healthcare, and develop this plan with healthcare workers, the health service, and higher education institutes to address short-, medium-, and long-term workforce challenges,**

48 PQ 37836/22, PQ 41046/22.

- Establish a high-level group, including the Taoiseach and the Ministers for Health and Further and Higher Education, to oversee implementation of a multi-annual health workforce strategy,
- Significantly increase undergraduate places, clinical placements, and post-graduate specialist training places,
- Legislate for safe staffing levels and fund staffing accordingly across wards, emergency services, community care, and long-term care,
- Give Irish-trained healthcare professionals a job guarantee, and mandate the HSE to work with them as they approach graduation to ensure timely placement into work,
- Engage with healthcare workers to improve retention, and engage with those who work or have worked abroad to improve the health service based on their experiences,
- Ensure that the HSE is supporting early career development and retention rather than leaving graduates waiting on panels.
- Engage with Irish-trained healthcare professionals working abroad to bring healthcare workers home,
- Tackle workplace pressures such as overcrowding, bullying and harassment, negative cultures, and high-pressure environments, increase security in hospital, and increase occupational healthcare supports to improve staff welfare and wellbeing,
- Work with allied health and social care professionals to address deficits in professional regulation, review career structures, enable AHSCPs to practice at the top of their licence, deploy more clinicians in advanced practice and specialist grades, and increase access to training including the use of assistant grades,
- Fully implement the Health and Social Care Professionals Act 2005 to ensure that all health and social care professions are regulated to the standard that workers and clients deserve, and that any new or emerging professions are regulated as a matter of priority,
- Fund the establishment of a Health and Social Care Advisory Committee in the Health and Safety Authority,
- Explore avenues for career progression for healthcare assistants, such as the Open University model in place in the north for training healthcare assistants up to degree nurses.

PRIORITY
5

Deliver Reform and Accountability

5. Deliver Reform and Accountability

5.1 Health Regions and Integrated Management

The current HSE management structure is top-heavy, misaligned, and stifling. Hospitals are planned across 6 regions while community services are planned across 9 areas. Specialist mental health and disability services are patchy and unintegrated. Capital, estates, and human resources functions are replicated across management layers, and there is a patchwork of leadership roles sprawling across the health service.

Regionalisation reforms must cut through the layers of bureaucracy and deliver streamlined, accountable management. There must be a clear delineation of responsibility for defined areas and care groups between minimal layers of management. Health Regions must be more than a rearranging of the deck chairs. It must involve real integration of management responsibilities. Spending decisions are not optimised and expenditure is overly concentrated on acute hospitals. This will continue to some extent while hospitals are de-leveraged and care is re-oriented to the community.

Health Regions need to be empowered to deliver this transformation. Health Regional executives must be accountable for community care, hospital care, and integration, and they should be empowered to make a real difference on the frontline. There must be a clear delineation of responsibility for defined areas and care groups between minimal layers of management.

Health Regions must be accountable for delivering efficiency improvements and value-for-money. As comparable, population-based units, their infrastructure, process, system, and workforce deficits should be identifiable in a meaningful way. Best practice should be identified and applied across other regions as appropriate.

Waiting list management reform should be delivered on a regional basis, with systems built to prioritise intra-region transfers of care before looking at inter-region transfers, with the exception of care requiring attention at a centre of excellence outside of the region. This is discussed further in section 5.2 and 5.3.

5.1.2 Forward Planning

Integrated Health Regions are key to planning the health service of tomorrow. Sinn Féin has proposed that responsibility and accountability for decision making for service planning and delivery, recruitment, and capital investment should be devolved to Health Regions.

We would give Health Regions multi-annual funding certainty to speed up the delivery of capital projects and address deficits in strategic infrastructure. We would mandate the use of standardised designs and reduce decision gates. Health Regions would be charged with developing multi-annual masterplans to ensure a pipeline of capacity to address future need on time and eliminate the widespread reliance on trolleys. It is essential that the capital process is streamlined and that Health Regions can rapidly develop capacity as appropriate. Major projects take far too long to deliver. This must be balanced against the need to avoid a repeat of the New Children's Hospital fiasco. We have discussed this previously in our policy report 'Report on Stakeholder Engagement: Understanding the Causes of Hospital Waiting Lists.'[49]

49 Sinn Féin, (2021), Report on Stakeholder Engagement: Understanding the Causes of Hospital Waiting Lists.

Health Regions must be in a position to collaborate with educational institutions on training capacity and in planning workforce supply. They should be expected to significantly improve working conditions and staff retention and given the leeway to do so. While the HSE centre would be accountable to Government on the overarching workforce strategy, Health Regions would play a key role in developing and implementing that strategy.

5.1.2 Reducing Outsourcing

A major priority for Sinn Féin is the reduction of waste in the health budget. There is far too much reliance on expensive agency staffing and management consultancy firms within the HSE. More than €2 billion has been spent on agency staff by the HSE in the last 5 years. Annual spending has risen from €330 million in 2018 to €620 million in 2022.[50] Spending on consultancy services, excluding IT consultancy, amounted to €44.7 million in 2020, and rose to €92.25 million in 2022. The HSE should be prioritising directly hired staff and in-house expertise, insofar as possible. This is essential for achieving value for money and building up expertise and experience in delivering on strategic priorities within the health service.

Sinn Féin are proposing the establishment of a time-limited working group to review the HSE's practices in these areas and make recommendations to reduce reliance on external services where it is cost effective. The health services should be less dependent on outsourcing in general, but especially so when it comes to frontline workers and strategic planning.

5.2 *Oifig an Chomhliosta*, a reimagined National Treatment Purchase Fund

Over the last twenty years, the National Treatment Purchase Fund has been embedded as a core institution of the health service. It has been used to facilitate private health care, and the health service has become far too reliant on NTPF outsourcing instead of proper planning to deliver sustainable reductions in waiting lists. Regional integration and digital transformation offer an opportunity to reimagine the NTPF.

Sinn Féin is proposing to establish *Oifig an Chomhliosta* to deliver an integrated waiting list management system, *An Comhliosta*, which prioritises public investment, reduces outsourcing over time, and delivers sustained reductions in waiting lists. We would incorporate the National Treatment Purchase Fund into this new statutory body with improved remit, oversight, and accountability. We have set out some of this reform already in our 2017 policy, Comhliosta, and in our soon-to-be published Health (Waiting Lists) Bill 2023.

This organisation would have responsibility for standards and transparency in waiting list management and would work proactively to reduce the number of long-waiters and develop public capacity alongside the HSE. A key responsibility of this organisation would be to maximise HSE 'in-sourcing' and make optimal use of the totality of healthcare capacity across the state. The organisation could play a key role in the development of integrated referral and waiting list systems. The organisation would continue many of its core functions, such as commissioning care for long waiters, working in collaboration with the HSE centre to maximise investment in the public sector.

The NTPF already publishes waiting lists for hospital appointments, but it does not produce

50 PQ 35093/23.

data on average or maximum wait times or emergency departments, which is published in the north by Health and Social Care Trust on https://online.hscni.net/my-waiting-times-ni/. Data is made accessible through an interactive map. Community care waiting lists are not routinely published in either jurisdiction, and there is little reliable data on waiting lists for GP appointments. While the HSC website is a model for transparency, it could be significantly improved upon.

Oifig an Chomhliosta would be mandated to consider the totality of healthcare infrastructure across the island and assist the HSE in developing appropriate service arrangements or develop appropriate arrangements itself. To sustainably reduce wait times, it is essential that we leverage the totality of capacity across the island in an optimal way. ***Oifig an Chomhliosta*** would also be responsible for the strategic relationship between the public and private sector in the short- and medium-term and will be mandated to pursue the most cost-effective approach to reducing waiting lists. This relationship is necessary due to the dominance of private service providers in certain areas, such as nursing home care, where we are a long way off building a public majority in the sector due to decades of policy decisions by establishment conservative parties.

5.2.1 An Comhliosta*, an Integrated Waiting List Management System*

Sinn Féin has looked to international best practice on waiting lists and we have proposed a new single, integrated hospital waiting list management system where people can

move from one hospital to another to reduce waiting times. We have called this system *An Comhliosta*, and previously published details in 2017.

Under the current system waiting lists vary drastically across our hospitals. Patients do not know where they stand on the list or how long they will be waiting. People waiting for similar procedures can wait different lengths of time depending on which hospital they have been referred to. We want to do away with that.

We would introduce a new IT system based on international best practice which would generate new maximum waiting times by transferring those on the list from hospitals that are struggling to meet demand to those that are in a better position to perform the procedure sooner.

Waiting lists would be integrated at a regional level, and there would be national integration for national centres of excellence, certain limited specialties, long term waiters, and the longest lists. Access to centres of excellence on an all-island basis, and the continued development of centres of excellence, is essential.

5.3 Digital Transformation

The success of integrated care hinges on digital transformation. Integrated digital systems for appointments, waiting lists, referrals, health records, disease registers, and prescribing are tools which should be available in a modern health system. The HSE is a decade behind the curve. The current digital health strategy is years out of date, and years more behind schedule. There has been a lack of ambition and no appetite for the radical change which is needed.

A new digital health strategy is needed to enhance the collection, use and sharing of health information for care and treatment, develop new infrastructure, ensure robust identity management, empower patients and clinicians with greater access to health information, and build trust in complex health information systems. Systems to implement our *Comhliosta* and *Sláintecard* policies are key priorities.

5.4 Oversight of Complaints and Adverse Incidents

There are many instances where patients and healthcare workers have felt unheard, dismissed, let down, or pushed away when making complaints about quality of care or conditions at work. Bias, whether real or perceived, is a major issue for the HSE. While the quality of care is generally quite high, trust in the HSE is quite low due to a lack of accountability and transparency.

Sinn Féin would prioritise independent complaints processes to improve trust in the complaints process. We would ensure the availability of professional patient advocacy. We would work with the HSE and across oversight authorities to deliver trust in the outcome of investigations. We would hold the HSE to account for culture change to improve the working environment.

The Minister for Enterprise recently announced that a Health and Social Care Advisory Committee will be established within the Health and Safety Authority to address workplace safety issues. The high level of assaults against healthcare workers, particularly nurses, has been an unacceptable risk. Similarly, complaints regarding wellbeing, harassment, and bullying need to be addressed robustly. The Health and

Safety Authority will need to be properly resourced to tackle issues within the HSE. The HSE needs to be held accountable for improving standards.

Sinn Féin would enact Adult Safeguarding legislation which include a legal authority responsible for investigating individual complaints. We are proposing to legislate for rights of entry in appropriate events of concern in keeping with risk and proportionality. We would increase resources and powers for safeguarding teams. The establishment of an independent safeguarding authority with an extensive remit has been strongly recommended by Safeguarding Ireland and we will implement a whole of Government approach.

Sinn Féin are proposing to improve HIQA's remit and powers to increase standards across healthcare facilities of all kinds. We would legislate for improvement notices as well as penal compliance notices to empower HIQA with a range of enforcement options before involving Court action. We would empower HIQA to ensure high standards related to safeguarding across health and social care.

5.5 Key Priorities for Reform and Accountability

To deliver reform and improve accountability, Sinn Féin proposes to:

- **Position the Minister for Health as a driver of reform and accountability,**
- **Streamline management through Health Regions and simplify processes for planning, designing, and funding of large strategic infrastructure developments to deliver a rapid expansion of capacity and improve value for money and efficiency,**
- **Establish Oifig an Chomhliosta to deliver an integrated waiting list management system which prioritises public investment, reduces outsourcing, and delivers sustained reductions in waiting lists. We would incorporate the National Treatment Purchase Fund into this new statutory body with improved remit, oversight, and accountability,**
- **Deliver modern IT systems such as electronic health records, integrated financial and care management systems, and an integrated waiting list management system to underpin new schemes such as the *Sláintecard* and improve efficiency in the health service,**
- **Invest in modern equipment to improve performance, efficiency, and patient outcomes across the health service,**
- **Develop independent complaints processes to improve trust in the outcome of investigations. We would hold HSE management to account for cultural change and resource the Health and Safety Authority to tackle workplace issues within the HSE**
- **Enact Adult Safeguarding legislation which include a legal authority responsible for investigating individual complaints. We would increase resources and powers for safeguarding teams and for HIQA.**

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PRIORITY 6

Address the Mental Health Crisis

6. Address the Mental Health Crisis

6.1 Mental Health Capacity, Waiting Lists, and Workforce Challenges

Mental health services are in crisis because of persistent underinvestment and a failure over decades to match promises with action. The burden of mental health difficulties, the levels of mortality and comorbidity associated with mental health conditions, and the impact on individuals, families, and communities will only be reduced with significant intervention and investment across mental health services. This must be joined up across the health sectors, with significant interconnectivity with primary care.

As many as three-quarters of adults with mental illness first experience symptoms before they are 25. It is therefore vital that we develop comprehensive and integrated mental health services for children, adolescents, and young adults which can maximise early intervention and continuity of care into adult life. It is essential that these services are fully and properly integrated with and across the primary care sector.

The 2006 mental health policy, A Vision for Change, was a good policy. Unfortunately, it was never adequately resourced. Its successor, Sharing the Vision, has faced the same fate. Government after Government have paid lip service to the need to resource and improve our mental health services but have never delivered. This has culminated in a damning report by the Mental Health Commission in 2023 which found significant and severe failings in the Child and Adolescent Mental Health Service.

Table 15. **Mental Health Inpatient Places**[51]

CHO Area	No. of Admissions	In-patient places	Inpatient Days
CHO 1	1,423	84	19,610
CHO 2	1,216	104	30,239
CHO 3	825	81	21,177
CHO 4	1,738	170	37,569
CHO 5	1,496	88	23,541
CHO 6	733	86	20,196
CHO 7	1,070	138	24,539
CHO 8	1,264	109	25,393
CHO 9	1,459	136	30,600
Total	**11,224**	**996**	**232,864**

There are currently 4,421 children and adolescents on waiting lists for mental health services.[52] The HSE's systems do not separately record the number waiting for an initial assessment, initial therapy, or further therapy, nor do they capture age range.

CAMHS waiting lists are worst in CHO Area 4 (Kerry, North Cork, North Lee, South Lee, and West Cork), CHO Area 6 (Wicklow and South East Dublin), and CHO Area 8 (Offaly, Longford, Westmeath, Louth, and Meath).

51 PQ 41246/22.
52 PQ 35305/23.

37.6% of children are waiting longer than 26 weeks on CAMHS waiting lists across nine CHO areas. 62.5% of those are in CHO area 4, 6 and 8.

Waiting lists are not collated for general adult mental health services as there is no significant backlog over 12 weeks[53], though an increase in usage would follow an expansion towards universal coverage.

There are also more than 19,000 people on primary care waiting lists for psychology, the vast majority of whom are children.[54] While the reversal of privatisation is a key objective, it is inexcusable to leave thousands of children waiting years for access to services while the public sector is fixed. It is currently not working, and these children are suffering. Time-limited funding should be made available for access to private community care to target the longest waiters on primary care, disability, mental health, and community waiting lists for urgent intervention. The current waiting lists offer no alternative but to purchase private capacity where it is available for urgent care, and it will take time to get the public service in order.

Out-of-hours, crisis intervention, and emergency mental health care services are also underdeveloped. 24/7 access is not consistent and emergency departments do not have enough consultant liaison psychiatrists. A serious plan is needed for out of hours, crisis, and emergency mental health services.

6.2 Primary Care Mental Health Services

Primary care should be the first port of call for young people, children and their families who are experiencing periods of mental ill-health. Multi-disciplinary primary care teams can appropriately and efficiently triage a person based on their care needs.

Mental health supports for young people aged 12-25 are also provided by Jigsaw. Jigsaw is majority funded by the HSE. In addition to in-person primary mental health care services, Jigsaw provides access to online supports. Jigsaw is one of the recognised entry points for referral into CAMHS for some teams, but referrals are not uniformly accepted in each CHO which is exacerbating the postcode lottery in healthcare.

There are inconsistent relationships between GP medical services, Jigsaw, and secondary and acute care services. Jigsaw is not sufficiently integrated into the wider primary care and youth health system. This can be improved through association with or direct employment of a GP, or through protocols and standards. In addition, similar linkages can be developed across HSE primary care and community services, CAMHs, Jigsaw, and specialist secondary and acute care services for early intervention, mood disorders, eating disorders, and substance use. All these services must be delivered across the state to tackle the postcode lottery. Integration of services within regional health areas is key to avoiding bottlenecks.

Where services are properly integrated and sufficiently staffed across primary and community care and specialist mental health and disability services, local teams can ensure patients are seen by the right healthcare professionals as quickly as possible.

Waiting times for primary and community mental health services are lengthy. For example, there are over 16,000 children waiting on a primary care psychology appointment with 6,000 waiting for longer than a year. Access to Jigsaw services varies largely due to staffing

53 PQ 35340/22.
54 PQ 35330.23.

and skills shortages and wait times can be up to 30 weeks in certain parts of the country

Approximately 400 additional counsellors and therapists are needed to provide for universal counselling in primary care, in addition to clinical governance and administrative supports.[55]

6.3 Child and Youth Mental Health Services

Youth mental health services are at breaking point. Mental health services and supports are overwhelmed by demand which has resulted in lengthy waiting lists. Waiting lists for Child and Adolescent Mental Health Services increased by 90% since 2020, with the number waiting over a year nearly trebling. The Government published 'A Vision for Change' in 2006 but failed to implement it. They published a watered-down version, 'Sharing the Vision,' in 2020 with less detail and no costings. Unsurprisingly, little progress has been made since and waiting lists continue to get worse.

Nearly 1-in-5 (18.5%) people in Ireland have a mental health condition, above the EU average of 17.3%. In a wider sense, young people have reported a decrease in their general wellbeing owing, in part, to the impact of Covid-19. If services are not accessible for young people, their general health and wellbeing will be adversely affected. For those in need of psychiatric help, the consequences of long waits can be devastating. Urgent, targeted, and well-planned action is needed to reduce wait times, expand services, and deliver early intervention for young people.

Current mental health services are not meeting the needs of young people. Waiting times are too long, and eligibility criteria are too narrow. 75% of mental health conditions are established by the age of 25, but young people aged 18-25 are not specifically targeted for early intervention. International best practice has shifted the focus to integrated, specialist youth mental health services which provide care for young people up to the age of 25. Early intervention is key to reducing the chance of lifelong ill-health, but that chance is passing young people by.

Table 16. **Waiting Lists for Child and Adolescent Mental Health Services**[56]

	Total	Up to 12 weeks	12 to 26 weeks	36 to 39 weeks	39 to 52 weeks	Over 52 weeks
Total	**4,490**	**1,839**	**896**	**566**	**437**	**752**
CHO 1	483	238	90	75	46	34
CHO 2	312	143	51	39	22	57
CHO 3	336	95	65	30	37	109
CHO 4	882	172	135	100	134	341
CHO 5	264	83	59	48	36	38
CHO 6	766	429	156	87	49	45
CHO 7	451	260	97	39	20	35
CHO 8	745	348	145	84	75	93
CHO 9	251	71	98	64	18	0

55 PQ 29859/22.
56 PQ 20898/23; figures valid at end Quarter 1 2023.

To develop a robust and practical policy for improving youth mental health services, Sinn Féin hosted a policy workshop with key stakeholders, facilitated by Orygen, a leading Australian centre of excellence in youth mental health. In our policy paper *Priorities for Change in Child and Youth Mental Health*, we set out what works and what does not work in our current mental health system, and proposals to fix it.

6.4 Key Priorities for Mental Health Care

To address the mental health crisis, Sinn Féin proposes to:

- **Deliver a new Child and Youth Mental Health Service to replace CAMHS and provide integrated early intervention services for children and young people to the age of 25,**
- **Ensure a consistent transition between youth and adult mental health services to prevent any young person falling through the cracks,**
- **Support general adult mental health services to ensure early intervention where conditions arise after the age of 25,**
- **Expand access to Jigsaw and primary care mental health services to deliver equitable access across the state,**
- **Deliver universal counselling in primary care,**
- **Invest in specialist dual diagnosis mental health teams for ADHD, intellectual disabilities, eating disorders, psychosis, and addiction,**
- **Develop comprehensive out-of-hours, crisis intervention, and emergency mental health care services to ensure 24/7 access, and implement a No Wrong Door policy for dual diagnosis,**
- **Fast track professional regulation of counselling, psychotherapy, and psychology with CORU,**
- **Develop inpatient perinatal services at St Vincent's University Hospital and the new National Maternity Hospital site,**
- **Expedite the development of a new IT system for CAMHS,**
- **Underpin service expansion with strategic workforce planning.**

PRIORITY 7

Recognise the Importance of Social Care

7. Recognise the Importance of Social Care

7.1 Social Care Policy

Most of the time when we talk about the health service or health care, we think of treatment, control or prevention of a disease, illness, injury or disability, and related care or aftercare. A person's health is about much more. Social care aims to provide planned services to individuals and groups with identified personal and social needs. Primarily, these are children and young people, elderly people, and people with disabilities.

Social care services are those which seek to enable independent living, insofar as possible in any given case, and the fullest possible participation of an individual with additional needs in their community and wider society. Social care seeks to tackle challenges such as loneliness, isolation, and underemployment which can cause and compound physical and mental health problems.

Social care is highly under-developed in Ireland due to a lack of State investment and Government policy. It has not been given the priority it warrants. Consequently, loneliness and isolation have been rising and exacerbated by the pandemic. The social effects of Covid-19 have left deep scars on many older people and continues to limit their social activities.

Recently, the CEO of the HSE has announced that he will appoint a chief social worker with direct and specific responsibility for safeguarding for older people and people with disabilities in the HSE's care (both in residential facilities and at home). This is a very welcome announcement and recognises that there has been a serious deficit in this regard heretofore.

Social care policy must aim to enhance adult safeguarding. There have been many horrific incidents uncovered over recent years in residential care facilities. Several HSE facilities have been exposed for extremely poor practice and governance. Poor governance does not exist only in the private sector. Not only is accountability needed in these circumstances, but real action must be taken to protect people at risk of neglect, coercion, and abuse.

Comprehensive adult safeguarding legislation is needed, as are additional powers for social workers and relevant social care professionals. An agency, separate from the HSE, must be empowered to oversee safeguarding policy and practice, and its remit must go beyond the public health service and into the private sector and the home. Sinn Féin propose to enact Adult Safeguarding legislation to provide the statutory basis for enhanced oversight and governance arrangements and give a legal right of entry to any designated care centre for relevant social workers and social care professionals.

Social care policy must recognise the importance, value, and cost effectiveness of the family carer. Family carers carry an immense burden and are often forgotten by the State. When they are remembered, they generally receive lip service but nothing more. Sinn Féin published a Charter for Family Carers in 2021 and we are committed to implementing the actions set out across social protection and access to services.[57]

There must be transparency and closure for families who are still grieving the tragedy which unfolded in nursing homes during the pandemic. Many families have been denied answers. We would advance an inquiry into the handling of Covid-19 in residential

57 Sinn Féin, (2021), A Charter for Family Carers (https://www.sinnfein.ie/contents/60511)

care homes to ensure that transparency is delivered and that unnecessary isolation and substandard care is not repeated. Access to family support, such as designated care partners and the use of pods, and access social care practitioners must always be supported. We would ensure full implementation of the recommendations of the Nursing Home Expert Panel and the Final Report of the Oireachtas Special Committee on Covid-19 Response.

Sinn Féin would support people with additional needs through compassionate social care services. We would invest in personal assistance, home support, housing adaptation grants, healthy age-friendly homes, rural public transport, and social outlets such as community centres and day care services.

We would implement a comprehensive social care policy to support independent living and the fullest possible social participation for people and groups with identified additional needs, including targeted funding to tackle loneliness and isolation, particularly among older people and people living alone,

Sinn Féin believes that people deserve to live in their own homes and that the state should support this through home support and adaptation grants. Long-term residential care should be available for those who want or need it. We would establish the Commission on Care and the statutory home care scheme to future-proof the model of care for older people.

7.2 Care for Older People

Sinn Féin is committed to empowering older people to live independently and building a health service that cares for us as we age. We would ensure that there are options for remaining at home, downsizing, or living in a community setting. We believe that people deserve to live in their own homes for as long as they can. Long-term residential care should be available for those who want or need it, but it should not be the default option. We would seek to reduce reliance on nursing homes and reorient care to support this.

The state should support older people to ‘age in place’ through home support and adaptation grants to ensure healthy age friendly homes. We would establish the Commission on Care and the statutory home care scheme to future-proof the model of care for older people. We would support family carers, as outlined in our Charter for Carers, and invest in day services for older people. We would support specific programmes for people with dementia which recognise the complexity of care, respect the dignity of the individual, and support the family to ensure their loved ones are cared for.

There is a severe shortage of nurses, healthcare assistants, and social workers in the community. This is presenting significant challenges for many older people and their families. The statutory home support scheme and the national home support office have been delayed significantly and the Government remains behind schedule. Approximately 35,000 home care hours per week are not being delivered, with more than 4,500 people with funding on waiting lists for a carer.

The root cause of this issue is sectoral employment standards. This is a position shared by the Department of Enterprise, Trade, and Employment, and the Department of Health.[58] The interdepartmental group found that a failure to guarantee hours, provide payment for

58 Mahon, B., (2022), ‘Work permits for home care sector refused due to lack of ‘guaranteed hours,’ *The Irish Times*, 15 August 2022.

travel and subsistence, the lack of a mandatory living wage or standardised pay grades, and other areas of dispute between workers and employers are the cause of labour shortage in the sector.

Sinn Féin has proposed a sectoral industrial relations solution for pay and conditions to provide a basic floor with standards sufficient to attract and retain workers in the home care sector. We must make home care an attractive career option and provide training opportunities. We would prioritise direct public sector service provision in the sector. The Government recently signalled it would move to require a living wage for home care workers who are providing a public service through the new home care tender. However, this commitment has been watered down as the Government will not fund home care workers' travel expenses, despite major travel expenses in rural areas, and have reduced the target output for home support hours by nearly two million hours in 2023.

We would prioritise the development of public home care and nursing home services. Working with stakeholders we would develop training opportunities and career prospects for carers and carers with an advanced skillset, and develop a greater role for nurses, physiotherapists, and allied health and social care professionals in delivering higher quality care in the home. We would ensure more regular and holistic reviews of the health and care needs of persons receiving home support to ensure that they are in receipt of the type, quality, and intensity of care which they need. We would ensure that supports

for housing adaptations, healthy age friendly homes and aging in place are increased to support older people retain their independence.

In relation to ongoing private service provision, we would modernise the tendering and funding model for providers of home care to prevent a race-to-the-bottom in costs and quality. This would be underpinned by an industrial relations solution focussed on improving employment standards in the sector. We would ensure a level playing field, high care standards, and fair remuneration for workers. Additional public funding should be linked to the promotion of better terms and conditions for the workforce in the sector for the portion of services which are provided on behalf of the State.

Key Priorities to Improve Social Care

To improve social care, Sinn Féin proposes to:

- **Invest in personal assistance, home support, housing adaptation grants, healthy age-friendly homes, rural public transport, and social outlets such as community centres and day care services,**
- **Implement a comprehensive social care policy to support independent living and the fullest possible social participation for people and groups with identified additional needs, including targeted funding to tackle loneliness and isolation, particularly among older people and people living alone,**
- **Enact Adult Safeguarding legislation, establish a safeguarding authority, and appoint a Chief Social Worker in the HSE,**
- **Provide for a legal right of entry to any designated care centre for relevant social workers and social care professionals,**
- **Provide for a care partners scheme for future public health emergencies similar to the scheme in place in the north,**
- **Ensure full implementation of the recommendations of the Nursing Home Expert Panel and the Final Report of the Oireachtas Special Committee on Covid-19 Response,**
- **Establish the Commission on Care and the statutory home care scheme to future-proof the model of care for older people,**
- **Implement Sinn Féin's Charter for Family Carers,**
- **Address recruitment and retention barriers which are hampering home care and social care services, such as the absence of a mandatory living wage for such workers,**
- **Fully implement the Health and Social Care Professionals Act 2005 to define and regulate health and social care professions to the standard that workers and clients deserve,**
- **Advance an inquiry into the handling of Covid-19 in residential care homes to ensure that unnecessary isolation is not repeated.**

PRIORITY 8

Respect the Rights of People with Disabilities

8. Respect the Rights of People with Disabilities

8.1 Disability Capacity Review

The Government published the Disability Capacity Review (DCR) in 2021. The DCR was to be supplemented with a Disability Action Plan 2022-2025. Nearly halfway into the timeframe for the first Disability Action Plan, there is still no multi-annual plan for funding disability services.

Responsibility for specialist disability services transferred from the Minister for Health to the Minister for Children, Equality, Disability, Integration, and Youth in 2023. Future budgets will fund disability services through the latter Department, but disability issues should still be a top concern for the Minister for Health. The Minister for Health is ultimately responsible for the HSE's performance and is still responsible for many services which people with disabilities use. The two Ministers should work closely together on ensuring that disability services are improving year on year.

The DCR laid out, in rough terms, a requirement of up to €1 billion to fully resource disability services by 2032. This needs to be taken a step further to lay out the real-term workforce and funding requirements. A multi-annual implementation plan is needed to deliver these services. Any serious plan for disability services must also address outstanding issues around worker compensation and entitlements across the sector.

The DCR set out the following estimates to meet demographic demand and unmet need:

- **3,900 residential places,**
- **De-congregation of the 2,000 people with intellectual disabilities living in congregated settings,**
- **7,400 adult day service places,**
- **20,000 additional respite care hours.**
- **In terms of funding, it projected high end estimates of:**
- **€550 million for residential services,**
- **€280 million for day services,**
- **€45 million for personal assistance and home support,**
- **€25 million for respite services, and**
- **€89 million for therapies and community services.**

The rights of people with disabilities were set out in the Disability Act 2005. This Act has provided some solid entitlements, such as the right to an assessment of need, but these have been undermined by a lack of services. The Disability Act should be reviewed with a view to modernising and strengthening the rights and protections for people with disabilities. The HSE must resume the annual reporting of aggregate and unmet need as required under section 13 of the Disability Act 2005. Ultimately this comes down to political will to deliver the capacity that is necessary.

8.2 Primary and Community Services

8% of the population have a disability to a great extent or a lot, and 14% have a disability

to some extent or a little.[59] For most people with disabilities, access to mainstream services can make a massive difference to their ability to participate in society.

The risk of acquired disabilities can be reduced by community and hospital-based neuro-rehabilitation services and through personal services, such as home support, which can help to reduce accidents and improve recovery.

There are, however, significant waiting periods for these services. Access to the National Rehabilitation Hospital can be difficult, community neuro-rehabilitation teams are severely underfunded, and waiting lists for home support and personal assistance hours are increasing.

There have also been complications for children with disabilities in accessing mental health services. The health service must ensure that integrated care plans are supported between children and adolescent's mental health (CAMHS) and disability services, ensuring no child is turned away due to complex multi-disciplinary care needs.

There is also a severe shortage in CAMHS intellectual disability teams. As per the previous official mental health policy, 'A Vision for Change,' we should have 16 CAMHS-Intellectual Disability Teams comprising 176 staff. However, we have just 4 teams with only 38 staff. This is less than one quarter of what is required.

8.3 Children's Disability Services

Early and ongoing intervention is key. While many people will only need access to mainstream primary care and therapy services, specialist services need to be available for those with moderate to severe or profound disabilities.

There are nearly 18,000 children on CDNT waiting lists with 10,000 waiting over a year for initial contact with their team. There are more than 6,000 children with an overdue assessment of need. Staffing levels for CDNTs are not regularly available due to IT deficits in disability services. IT deficits also mean that CDNTs cannot produce data on the average length of time that children are waiting to see them, or capture waiting list data for follow up appointments. This is not a picture of a health services which is delivering for people with disabilities.

Children deserve timely assessment and intervention to give them the best chance at success. Comprehensive workforce planning is needed to fully staff CDNTs and primary/community services. In the absence of accessible public services, Sinn Féin is proposing to temporarily fund access to trusted private psychology and therapy services. This community care access fund would be available on a temporary basis until public services are responsive to children's needs in a timely manner.

8.4 Supporting Independent Living

Personal Assistance Services provide people with the opportunity to exercise control and choice in their lives. In so doing, it enables people to be active participants within their families, communities, employment and society and therefore results in an overall improved quality of life. PA services are different to home support, and this distinction is important.

The Independent Living Movement considers that PA services are the direct, one-on-one

59 CSO, (2023), Census 2022.

support a disabled person requires to achieve the same range of self-determination, opportunities, and activities as a nondisabled person, both at home and away, in the community and not in isolation.

Home support, or home care, provides little flexibility or choice for the person who is being cared for. It is time-limited and consistent of prescribed activities related to care need. Intensive home support is required where a person has a complex disability and requires a high level of constant care to avoid severe distress or manage challenging behaviours.

While home support/care is valuable, to truly enable independent living the focus must be on the provision of full-time personal assistance hours. The DCR could not identify the need for PA hours up to 2031 but estimates a requirement of up to €45 million additional a year by 2032. This equates to approximately 1.9 million hours.

8.5 Respite Services

Respite and short break services play an essential role in supporting family carers and people with disabilities, yet three quarters of families get no respite at all. There is a significant level of unmet need. Less than 5,200 people receiving a respite service in 2022, despite there being an estimated 20,000 people or more with intellectual disabilities, physical and sensory disabilities, and autism living with family. Less people received respite services in 2022 than in 2018, when more than 6,300 families were in receipt of respite care.

Fewer than one in four people with an intellectual disability, living at home with their family, received any form of Health Service Executive-funded respite service in 2017. The overall level of service provided has decreased with only 120,000 overnight respite sessions provided in 2022 to 160,000 in 2019.

Recent closures of respite services in Cork, Wexford, Donegal, and other counties have left hundreds of families with children and adults with disabilities without essential respite care. The Government failed to halt the closures of respite care centres during and since the Covid-19 pandemic, and has failed to support the sector to train, retain, and expand its workforce and develop the sector. The Government has been over-reliant on agency staffing, which has driven a creeping privatisation of essential health and social care services, resulting in an unsustainable workforce with unpredictable availability.

Sinn Féin would work with stakeholders and service providers across the sector to address their immediate workforce and facility needs. In the short-term, we would leverage all existing capacity in the sector to support the re-opening of closed respite centres, maintain existing capacity in the sector, and prevent further closures. In the long-term, we would invest in respite capacity to meet rising need.

8.6 UNCRPD

The United Nations Convention on the Rights of People with Disabilities (UNCRPD) provides the international framework to promote, protect and ensure the rights of all people with disabilities and promotes equal rights in all areas of life.

Ireland ratified the UNCRPD in March 2018. However, the Irish Government failed to ratify the Optional Protocol to the UNCRPD. The immediate ratification of the Optional Protocol should be a priority to put in place the internationally agreed oversight

mechanism to ensure the Government is living up to the commitments contained in the UNCRPD.

8.6 Key Priorities for Disability Services

To improve disability services and respect the rights of people with disabilities, Sinn Féin proposes to:

- **Fund a 10-year investment programme to provide for unmet and future need,**
- **Prioritise children's disability services to deliver timely assessment and care from a young age and ensure a smooth transition from child to adult services,**
- **Invest in accessible community services and integrated care for people with disabilities,**
- **Support family carers as outlined in our Charter for Family Carers,**
- **Continuously engage with people with disabilities, their families, disabled person organisations, and the disability advocacy and services sector to ensure services are being sufficiently resourced and are accessible to service users,**
- **Ensure integration of community care, mental health, and disability services to provide holistic care for people with disabilities and mental health conditions, and deliver the full complement of specialist Child and Adolescent Mental Health Service Intellectual Disability teams as per Sharing the Vision,**
- **Review the Disability Act and disability services to deliver timely access for people with disabilities,**
- **Implement an Autism Empowerment Strategy,**
- **Invest in adequate independent living, respite care, and personal assistance services, and ensure much greater cooperation between the HSE and Local Authorities in the provision of housing and the supports needed to reside independently,**
- **Ratify the Optional Protocol of the UNCRPD.**

PRIORITY 9

Tackle Addiction and Resource Recovery

9. Tackle Addiction and Resource Recovery

9.1 Community Addiction and Recovery Services

Sinn Fein recognises that addiction can affect anyone. It can be very visible and public to the person and community such as with substances, or it can be hidden and undetected for lengthy periods of time such as with gambling. However, many of the contributing factors to addiction have their roots in poverty. Sinn Féin's guiding principle in our approach to addiction, and recovery, is that we must reduce the harmful impacts of addiction while empowering communities.

Sinn Féin believes that those working on the ground in the addiction and recovery sector and service users and their families are best placed to identify and resource programmes and initiatives that will benefit individuals and families in their local communities.

On average, 3 people a day die from alcohol related harm in this state. Out of 23 EU states, Ireland ranked 3rd in prevalence of high-risk opioid use among adults in 2022 at a rate of 6.18 per 1,000.[60] 14 states recorded a prevalence rate of less than 4 per 1,000. In 2019, Ireland ranked 5th in the EU for prevalence of heavy episodic drinking, which is associated with significant health consequences as well as higher risks of harmful drinking and addiction.[61] Harmful gambling is also a significant challenge, with more than 55,000 people engaged in harmful gambling behaviours according to the Gambling Awareness Trust.[62]

Recognising addiction as a harm to the wider community, and not only the individual, is at the core of Sinn Féin's approach to addiction. We will be there to support communities to recover from the harm addiction has caused to them. Community support services and networks are essential to helping people get back on the right track. Harm reduction must be the guiding principle behind humane, compassionate services which treat recovery from addiction as a health issue. We have listened to frontline workers and we know that the people on the ground, day in and day out, are the experts.

Sinn Féin believes that those working on the ground in the addiction and recovery sector are best placed to identify and resource programmes and initiatives that will benefit individuals and families in their local communities. Local and regional Drug and Alcohol Taskforces (DATFs) and local community initiatives are the backbone of addiction and recovery services. This localised expertise must be allowed, and funded, to respond proactively to emerging trends within communities.

Funding for DATFs has never returned to pre-recession levels. In 2010, DATFs received just shy of €31 million in state funding. In comparison, in 2022 DATFs received just €27.8 million. That is an 11% reduction on 13 years ago, despite the fact that levels of drug use have risen in the intervening period. Social pressures from the housing and cost of living crisis are likely to place additional pressure on services as they attempt to support recovery and reduce harm. We are proposing to restore this funding.

We are proposing to further support recovery services through an unprecedented investment in publicly owned, community operated rehabilitation and detoxification inpatient capacity. We have outlined in our Alternative Budgets how we will fund an

60 European Monitoring Centre for Drugs and Drug Addiction, 28 July 2022, Last year prevalence of high-risk opioid use among adults in Europe (https://www.emcdda.europa.eu/media-library/last-year-prevalence-high-risk-opioid-use-among-adults-europe_en)

61 Eurostat, (2021), Alcohol Consumption Statistics, (https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Alcohol_consumption_statistics) [Accessed 14 July 2023]

62 Kerr, A, O'Brennan, J., and Mendoza, L. V., (2021), Gambling Trends, Harms, and Responses: Ireland in an International Context

expansion of 40 short-stay rehab and recovery beds and 24 medical detox beds. We would further support people in recovery through a recovery-specific housing programme, inclusive of wraparound supports. The programme would start as a pilot scheme with 3 initial bases across the regions. Each person utilising these services would have access to an addiction counsellor and support worker. Providing wraparound, holistic services to those who have newly entered recovery will be at the core of this project. We would work with local authorities to ensure that those who enter treatment on HAP, or as a social housing tenant, retain security of tenure throughout this process.

Addiction often overlaps with mental health challenges and conditions, both as a cause and a consequence of addiction. Lip service has been paid to the need for services equipped to care for people with dual diagnoses, but this has never materialised. Sinn Féin would implement a "No Wrong Door" policy for people with a dual diagnosis and enable addiction and mental health services to deliver the care a person needs when they present to a service they trust.

Sinn Féin recognises that staff in addiction services are often overlooked and under supported. We note reports finding that those working in addiction had the 3rd highest levels of stress and burnout in the social care field after only child protection and adult mental health services.[63] We recognise that supervision is a key aspect in social work and social care in mental health fields, yet it is often overlooked in addiction services. Frontline workers need to be supported through supervision and counselling services to reduce burnout and the mental burden of managing trauma on a daily basis.

We recognise the potentially life-saving intervention that Naloxone offers to those in

63 Redmond, B., Guerin, S., and Nolan, B., (2015), The Retention of Social Workers in the Health Services: An Evidence-Based Assessment.

addiction, those utilising Opiod Substitute Treatments and those who are legally prescribed opiods. We would explore evidence-based approaches to the expansion of the availability of Naloxone to ensure that every person whose life could be save by this drug can access it.

Sinn Féin recognises that families are disproportionately and often unfairly placed with the burden of caring for and supporting an individual in active addiction and early recovery. This can have profound and often long-lasting impacts on family members from economic hardship to violence[64] and without support, this can increase the likelihood of addiction amongst children especially. Sinn Féin would work with existing Family Support Networks to ensure fair tender processes, we would increase funding through DATFs to ensure that a whole-family approach can be taken to addiction across the State, and we would ensure that families are given a secure position on consultation bodies such as the National Oversight Council.

Sinn Féin recognises that significant barriers exist to those in recovery and that we need to work at all levels of government, across this island, to remove these barriers. We believe that across the island, those on a recovery journey have rights and these rights must be respected. To this end, we would implement an All-Island Charter of Rights for those in Recovery.

9.2 Key Priorities for Addiction and Recovery Services

To tackle addiction and resource recovery, Sinn Féin proposes to:

- **Initiate an unprecedented investment in community addiction and recovery to boost inpatient capacity, return historic funding to local and regional taskforces, and implement a "No Wrong Door" policy for dual diagnosis,**
- **Waive assessment fees for access to addiction services,**
- **Employ additional community development and family support workers in each taskforce area,**
- **Fund further research into gambling prevalence and behaviours and fully implement a Gambling Regulation Bill,**
- **Deliver multi-disciplinary neuro-rehabilitation teams and managed clinical rehabilitation networks which will work with community sector services to ensure state-wide coverage for substance-related brain injury,**
- **Work across Government to support drug and alcohol misuse educational programmes in schools, recovery-inclusive programmes in sport, social inclusion and Traveller community-specific projects, and equip frontline services and the Gardaí to focus on harm reduction in communities,**
- **Establish a Consultatory Working Group of people with lived experience of addiction to consult on, and influence, relevant policy,**
- **Support a whole-family approach to addiction services and work to end the postcode lottery delivery of family support services.**

64 Csiernik, Rick. "Counseling for the family: The neglected aspect of addiction treatment in Canada." Journal of Social Work Practice in the Addictions 2.1 (2002): 79-92.

PRIORITY
10

Targeted Strategies and All-Ireland Healthcare

10. Targeted Strategies and All-Island Healthcare

10.1 All Island Healthcare

Ireland has a population of just 7 million people. Sinn Féin proposes to plan health services around the total population and health needs of the island to make best use of economies of scale. We would revise health strategies to ensure they are truly national in their focus and practical implementation.

The benefits of this approach have already been demonstrated in a number of important areas. Joint projects have been developed across radiotherapy, paediatric cardiac services, and cancer research. The all-island congenital heart disease network, based out of Dublin, Belfast, and regional clinics, is an exemplar in this regard and is regarded as highly successful. Notably, this was established under two DUP Minister for Health in the North, Edwin Poots MLA and Jim Wells MLA, in collaboration with their counterparts in the south.

Sinn Féin sees significant opportunities for people north and south in further collaboration in paediatric, cardiac, and cancer services and in the development of all-island genetic services. We would increase cross-border clinical cooperation and collaboration and enable the development of specialist services on an all-Ireland scale. A 2011 report, commissioned by the Centre for Cross-Border Studies, entitled *Unlocking the Potential of Cross-Border Hospital Planning on the Island of Ireland*, identified several further areas for cooperation such as cross-border services at the South West Acute Hospital in Enniskillen, and potential for further collaboration across paediatric cardiac services, acute mental health services, orthopaedic services, otolaryngology (Ear, Nose and Throat), and Cystic Fibrosis services. This report focussed solely on hospital-based care and is now more than 10 years old. Sinn Féin would commission a new report to examine progress since 2011 and identify areas for collaboration across a wider range of health and social care services, including the development of truly national centres of excellence based on the model provided by the all-island congenital health disease network.

We would seek to include northern health capacity in our integrated waiting list management system to reduce waits on both sides of the border. This would be proportionately funded, and we would anticipate that the increased purchasing power of a joint approach would improve value for money for taxpayers on both sides of the border. This partially operates in practice in relation to private capacity in the north, previously through the cross-border directive and now through the planned healthcare scheme.

Sinn Féin proposes to:

- **Plan health services on the basis of the population health needs of the island,**
- **Revise national strategies to ensure all-island planning,**
- **Enable all-island collaboration, cooperation, and integration,**
- **Maximise use of all-island healthcare capacity to tackle waiting lists,**
- **Commission new research into existing and potential cross-border and all-island health and social care collaboration.**

10.2 Cancer

Survival rates for cancer have increased dramatically over the last 30 years. Today, more than 60% of people survive at least 5 years after treatment and most do not die from cancer. Cancer does, however, remain the leading cause of death ahead of circulatory diseases. In 2022, 29% of deaths were attributable to cancer.[65] The burden of cancer across the population is likely to double by 2045, and half a million people will get cancer in the next ten years.

Covid-19 had a significant impact on cancer services. Possibly more than 2,600 cancers were undiagnosed during the period due to service disruption and people opting not to attend health services such as GPs. Cancer trials activity dropped 40% and screening was significant impacted.

There are significant delays in radiology which pre-date Covid. 250,000 people are on waiting lists for diagnostic scans for a range of conditions. Waits for urgent scans can take months. Patients with potential cancers are left waiting by the public system and many families must go private to be seen urgently. This is unacceptable.

According to analysis conducted by the Irish Cancer Society, there are significant challenges right across cancer services.[66] Only 4 National Cancer Strategy Key Performance Indicators were met in 2021, 28% of patients did not access radiotherapy in the recommended timeframe, 25% of patients were unable to access rapid access clinics in the recommended timeframe, and half of lung and prostate cancer patients did not access surgery in the recommended timeframe. Radiation therapy is facing significant staff burnout and low morale. Four radiation therapy machines are closed due to staffing shortages.

Preventing cancer is as important as identifying, responding, and treating it. Preventive healthcare has often been paid naught but lip service. Sinn Féin would include a specific focus on preventing cancer in the implementation of a comprehensive preventive healthcare strategy.

Cancer care and support centres play a major role in cancer recovery and survival. Similar to hospices, they are largely provided by not-for-profit groups rather than by the HSE. These services are essential, and their local link is invaluable. They rely on fundraising to fund core services. Funding arrangements are inconsistent across the State. A standardised funding scheme is required to ensure the sustainability of these essential services.

Sinn Féin proposes to:

- **Deliver sustained improvements in cancer services through multi-annual funding of Health Regions to improve access to screening, rapid access clinics, and radiation therapy,**
- **Reduce costs for cancer patients by capping and reducing car parking charges, expanding medical card coverage, and reducing the cost of medicines, prescription charges, and the Drug Payment Scheme threshold,**
- **Prioritise preventive measures to reduce cancer incidence rates,**
- **Provide funding certainty to cancer care and support centres through a standardised funding arrangement via the National Cancer Control Programme.**

65 CSO, (2023), Vital Statistics Yearly Summary 2022.
66 Irish Cancer Society, (2023), Pre Budget Submission 2024 (cancer.ie).

10.3 Cardiovascular and Respiratory health

In 2022, 27% of deaths were attributable to circulatory diseases and 10.5% to lung diseases.[67] 95% of these deaths were people aged 65 or older while 55% were younger than 85.

Sinn Féin has long made the case for a new and comprehensive cardiovascular and respiratory health policy to improve lifelong health and access to community services. This strategy would address the totality of need across cardiovascular and respiratory health. It would focus on prevention, improving acute care and access to life-saving treatments, post-event rehabilitation, and education and research. Our focus must be on reducing incidences of stroke and disease and on increasing access to quality care.

Community based services for prevention and rehabilitation are a major weakness. Many people, including survivors of horrific strokes, feel abandoned once discharged from hospital due to the lack of community services. There is insufficient access to blood pressure testing and other check-ups which can be completed by pharmacists, GPs, physiotherapists, or community-based diagnostic services such as echocardiograms.

The northwest and the southeast are particularly underserved in emergency cardiac care due to deficits in PPCI cover. For example, there is no 24/7 cover at University Hospital Waterford. The cardiac catheterization laboratories at UHW will only operate from 8 am to 8 pm, Monday to Friday. Serious cardiac or respiratory incidents outside of these hours are required to travel to Cork University Hospital, which is 125 kilometres from Waterford City.

A joined-up approach across Government is needed to tackle issues around weight and obesity, uncontrolled blood pressure, physical inactivity, air pollution, and unhealthy behaviours such as smoking, alcohol consumption, and drug use.

Sinn Féin proposes to:

- **Invest in the National Stroke Strategy to improve stroke services in hospitals and the community, including rehabilitation services,**
- **Complete and publish the National Review of Specialist Cardiac Services and ensure services are properly evaluated on an all-island basis,**
- **Implement a comprehensive Cardiovascular and Respiratory Health Policy which improves access to community-based prevention and rehabilitation services, hospital-based services, and education and research,**
- **Implement a comprehensive preventive healthcare policy, as discussed previously.**

67 CSO, (2023), Vital Statistics Yearly Summary 2022.

10.4 Rare Diseases and Genomics

Up to 6% of people in Ireland have a rare disease. People with rare diseases can face significant difficulties in accessing diagnoses or treatment due to the rarity of their conditions, unavailability of specialists, delays in approval for new medicines, obstacles in accessing orphan medicines, and, in some cases, a lack of knowledge, research, or appropriate diagnostic tools.

The Department of Health's Rare Disease Plan is severely out of date and was planned for implementation across 2014-2018. The Department is only now reviewing the outdated plan with a view to developing a revised National Rare Disease Plan. Sinn Féin would urgently complete and publish this review. It is essential that a comprehensive analysis is conducted to identify areas for urgent, medium-, and long-term action.

Cutting edge genomics and genetic services offer a significant opportunity to advance care for people with rare disease across the island. An all-island approach is particularly important due to the extremely small number of people with certain conditions.

Sinn Féin proposes to:

- **Urgently complete and publish a review of the outdated National Rare Disease Plan 2014-2018,**
- **Develop an all-island rare disease and genomics strategy,**
- **Review approval, pricing, and reimbursement arrangements for orphan medicines.**

10.5 Women's Healthcare

Healthcare in Ireland has failed women for decades. Under-diagnosis of a range of conditions is a particular problem for women due to outdated medical models which miss or misunderstand female symptoms. A significant blind spot for the health system has been menopause, despite its ubiquity, which has not been properly supported in primary care. Another example is ADHD which is "far more commonly diagnosed in boys in childhood, about five to one in most studies, in adulthood to a 1:1.6."[68] A lack of awareness among GPs of certain conditions and their symptoms, such as endometriosis, is a major challenge for many women. This is compounded by a lack of care pathways and the unintegrated nature of care records and waiting lists.

We have previously published a comprehensive set of policies on issues in women's healthcare in our policy documents 'Women's Voices in Menopause' (2022), 'Advancing Women's Healthcare' (2021), and 'A Vision for Women's Health' (2018) covering reproductive healthcare, sexual health, menopause, obstetrics and gynaecology, and cancer screening.

The major deficit in health services for women exists in primary care. Access to guidance, information and healthcare supports appropriate across life stages is limited due to the underdevelopment of services and under-training of clinicians. Sinn Féin has proposed the development of a Structured Care Programme in Women's Health in cooperation with primary care professions to improve primary care for women. This programme would:

Foster informed environments where women can speak freely with their healthcare professional,

Ensure doctors understand women's needs and concerns, ensuring comfortable engagement for the woman, and keeping doctors up to speed on gynaecological conditions (e.g., endometriosis) and the appropriate specialists for onward referral,

Develop access to guidance and products such as across contraception and HRT, identify and help with healthy eating and eating disorders,

Ensure GPs, pharmacists, and nurses are supported to support and empower women,

Develop comprehensive supports for survivors of abuse, domestic violence, and female genital mutilation.

Improvements have been made and progress should be recognised. The first Women's Health Action Plan, launched last March, was an important step towards rebalancing services. This has seen the commencement of the access to contraception scheme, the development of "see and treat" gynaecology clinics, and limited specialist menopause and endometriosis services. The Health (Assisted Human Reproduction) Bill will significant enhanced fertility treatments and supports and regulate surrogacy. The National Maternity Strategy is due to run to 2026. Compiled 7 years ago, this strategy needs to be reviewed and updated in a timely manner.

The Independent Review of abortion services has provided a series of recommendations for improving the operation of and access to those services. Its many complex recommendations must be worked through in a sensitive manner. Straight forward

68 Carr-Fanning, Kate, (2020), Understanding ADHD and its impact (adhdireland.ie)

recommendations such as to conduct a geospatial analysis of abortion services, invest in local and regional women's health hubs, and repeal the three-day wait, must be acted on quickly.

Sinn Féin proposes to:

- **Develop a structured care programme for women's healthcare in primary care, including sexual and reproductive health, menopause, mental health, social inclusion, and community-based gynaecology,**
- **Improve knowledge and awareness of female-specific symptoms and conditions and develop care pathways and community-based care for conditions such as endometriosis,**
- **Develop access to secondary and tertiary gynaecological services and invest in community-based gynaecology services,**
- **Invest in health and social care supports for survivors of abuse and domestic violence,**
- **Set new targets for the Maternity Strategy to reflect advancements in best practice over recent years,**
- **Conduct a geospatial analysis of abortion services, invest in local and regional women's health hubs, and repeal the three-day wait,**
- **Improve access to IVF,**
- **Invest in cancer screening to improve early diagnosis rates,**
- **Deliver a fit-for-purpose new National Maternity Hospital,**
- **Investment in expanding midwife-led units and community midwifery services.**

10.6 Children and Youth

Many of the most vulnerable children and young people in the State are being failed or let down by the State. Children with scoliosis and spina bifida must wait years for life-changing surgery which they were promised within four months. They are often delayed by waits for diagnostic scans or a lack of protected recovery beds. Children with moderate to severe disabilities or mental health conditions must wait years for assessments and months between appointments. The scandal of CAMHs is a horrifying indictment of successive Government's failures.

It is estimated that 1-in-4 children are overweight or obese and sports participation rates have fallen to just 44%. There are more than 100,000 children on hospital waiting lists, another 100,000 on community care waiting lists, more than 15,000 children waiting for initial contact with a specialist disability team, and more than 4,000 children waiting for specialist mental health services.

An area of particular concern which highlights how drastically the State is failing many children is the long waiting times for orthopaedic procedures for children with scoliosis and/or spina bifida. The recent Ombudsman report on 'Ivy' lays bare the painful reality of broken promises. Successive Ministers for Health have promised that children with scoliosis would not be waiting more than 4 months for life changing surgery, but waiting lists are now 25% larger than in 2020. There are currently 290 children with scoliosis waiting for spinal surgery, and we are still regularly hearing anecdotes of children travelling to Dublin and preparing for surgery only for the surgery to be cancelled. In several cases, children have faced two or more cancellations, and complex surgeries have regularly been postponed for weeks on end due to staffing and capacity shortages.

The new Children's Hospital is essential for improving access to life-changing care for children. The hospital should be a game-changer for children's health when opened, if it is fully staffed, but it is not without its own controversies. The fiasco of the Children's Hospital has been beset by delays and cost overruns. The Minister for Health has been absent from this debacle and has taken a back seat.

The health and wellbeing of children, young people, and future generations is a top priority for Sinn Féin. A Sinn Féin Minister for Health would be across the new Children's Hospital project and regularly holding the Development Board and Contractor to account for delays and overruns.

Sinn Féin proposes to:

- **Target investment in healthcare for children across hospital care, disability services, mental health services, and primary and community care to reduce waiting lists for children's services,**
- **Reduce the cost of healthcare and medicines for children,**
- **Invest in access to sports and healthy activities,**
- **Ensure appropriate supports which address the non-medical cost of caring for a sick child,**
- **Establish a new, fit for purpose Child and Youth Mental Health Service,**
- **Fully resource Children's Disability Network Teams,**
- **Ensure that no child is waiting longer than the Sláintecare wait times for appointments, scans, and surgeries.**

10.7 LGBT+ Healthcare

Sinn Féin wants to see a new national sexual health strategy that is comprehensive and evidence based. The development of this new strategy should include the voices of people who use sexual health services, healthcare professionals, service providers, and community organisations. The Government delay in developing a new strategy is unacceptable given the closure of sexual health services during the pandemic, long waiting lists for PrEP and persistent rates of STIs and HIV.

Sinn Féin have long supported calls for the development of an Irish AIDS Memorial and we look forward to its installation in the Phoenix Park in 2023. It will be a place to grieve, remember loss and give hope to the future.

Recently, the HSE announced that it is now reviewing the model of care to provide fully domestic services for the holistic care of transgender people. The new model of care must be based on a complete review of the National Gender Service, and domestic service gaps must not only be identified, but addressed with clear plans and timeframes. It is important for the full implementation of the new service that the HSE clearly outlines the existing deficits and the staffing requirements for delivering a full service.

It is vital that this new model of care for transgender healthcare places care in the community at the heart of services. Services need to be locally available and accessible through primary care services wherever possible and appropriate.

Sinn Féin proposes to:

- **Develop a new national sexual health strategy to address long waiting lists for PrEP and reduce rates of STIs and HIV,**
- **Implement a new model of care for the holistic care of transgender people based on the ongoing review which is being conducted by healthcare professionals.**

10.8 Mesh Injury

In 2020, the report of the Independent Medicines and Medical Devices Safety Review in Britain concluded that serious harm had been inflicted on people, predominantly women or children, across a series of serious failings in hormone pregnancy tests, pelvic mesh implants, and sodium valproate use during pregnancy. The Review recommended immediate restitution and required improvements in services.

Similar issues of foetal valproate syndrome and mesh injury occurred in Ireland. The Government has finally approved an inquiry into historical use of sodium valproate, but it has failed to make a practical impact on the lives of mesh injury survivors.

Mesh survivors presented their case to the Joint Oireachtas Committee on Health in July 2022. They spoke about the global scandal and painful legacy of mesh injury. There are various estimates of complication rates for pelvic mesh implants, ranging from 3% to 30%. Inconsistent and unreliable data, due to a lack of proper collection and understanding, has hampered survivors' efforts to be heard. The use of these implants has been restricted or banned in several countries due to a high number of severe negative outcomes, including in USA, Britain, Australia, and New Zealand. Complication rates are higher for the much larger prolapse meshes than incontinence tapes.

Mesh survivors are seeking a reliable service for full and safe removal of their implants. They contend that partial removal has, by and large, failed to address their pain, and that partial removal has damaged their prospects for full removal as the resulting scar tissue makes the mesh inaccessible and inoperable. As a result, they are left with only non-surgical treatments. Mesh survivors have had to travel abroad for full removal, where they can afford it.

Mesh injured women and men are seeking an assistance scheme to cover medical costs, diagnostic need, medications, primary care, GP visits, and acute services required because of the associated side effects of mesh. They require access to services locally rather than in the two mesh centres in Cork and Dublin as travel can be very painful and many cannot drive as a result. Survivors require urgent access to diagnostic scans to uncover the extent of the damage caused to them by mesh and have been let down by poor aftercare and ineffective treatments.

Sinn Féin proposes to:

- **Advance an inquiry into mesh use and injury,**
- **Ensure the availability of full removal services where possible,**
- **Take further actions to support survivors through investment in public diagnostic capacity, raising eligibility thresholds for medical cards, providing appropriate aftercare devised with mesh-injured people, and providing as local a service as is possible for the full removal of mesh implants where sought,**
- **Recognise the harm caused by mesh and the hurt caused by denial and delays in acting on emerging evidence and survivor's lived experiences.**

10.9 Climate and Health

The effects of climate change in Ireland are more apparent by the year. Even if global efforts succeed in averting the worst, the changes we are experiencing now will have health consequences into the future.

In Ireland, we are likely to experience an increase in heatwaves and flooding, greater exposure to food- and water-borne diseases, and an increase in respiratory diseases. A failure to act will result in a higher frequency of various diseases, including skin cancers and acute respiratory conditions.

To date, preparations in the health sector have been too slow. As a major organisation with a very large footprint, and the largest employer in the State, the HSE has significant obligations in fighting climate change and mitigating its consequences. It should also play a pioneering role in technology development and energy security.

The HSE has finally published a Climate Action Strategy, but it will not meet its obligations without an investment plan. The lack of urgency is evident as the HSE does not even maintain records on building energy ratings (BER) as it is not required to under the current legislation except when seeking to sell or lease. Just 28 of the HSE's top energy use buildings exceed a B3 rating, according to an analysis undertaken by the Irish Government Economic and Evaluation Service unit at the Department of Health.[69]

The sectoral emissions ceilings have set a 40% reduction target in energy use for commercial and public buildings, but this cannot be achieved without the basic baseline data being known. The HSE has spent just €28 million over the last 4 years on its energy and decarbonisation shallow retrofit work programme.[70] Half of this was spent in 2022, indicating that investment is ramping up but remains at a relatively low level.

The HSE has yet to develop costs for its climate action strategy. The HSE has stated that "10 representative healthcare sites" have been identified and "design teams have been engaged to progress designs … and to provide estimated associated costs" which "will be used to prepare an upscaled report with estimated costs for a large-scale energy renovation of the health estate."[71]

Sinn Féin proposes to:

- **Implement a multiannual investment strategy for the HSE Climate Action Strategy,**
- **Complete an energy review of HSE capital stock to inform a programme of retrofitting,**
- **Mandate all Health Regions to develop Health and Climate Change Action Plans and ensure adequate climate-related resourcing of Public Health units,**
- **Increase funding for research and development for climate action and research,**
- **Ensure that new builds in the health sector are built to high energy standards.**

69 IGEES, (2022), Spending Review 2022: Health Capital Investment in Ireland: An Analysis of Built Healthcare Infrastructure.
70 PQ 35159/23.
71 PQ 35159/23.

10.10 Medicines Supply and Management

There are many challenges facing patients in accessing medicines. Patients and advocates, particularly in the rare disease space, are frustrated by the length of time it takes a product to first be approved for market, and to then be approved for reimbursement through the public system. Irish patients wait longer than the EU average for new medicines to become available to them through the public system. This reflects the challenging nature of the approval process itself which can be highly bureaucratic and uncertain. Resource constraints, and the small size of our population, make this more difficult.

Expenditure on pharmaceuticals is expected to rise significantly in the coming years as our population ages. Every effort must be made to keep costs as low as possible. This requires tough negotiation on pricing, smart deals on supply, an ambitious switch to generic and lower cost products wherever possible, and strategic development of domestic supply.

Both new and old medicines are presenting supply challenges due to global shortages and increasing global demand. Demand for hormone replacement therapies is increasing rapidly, for example, and at the other end, there are challenges for older drugs with the viability of pricing based on costs from decades ago. These challenges are causing considerable concern of prolonged shortages.

The state should take a proactive approach to managing the supply of medicines. A strategic approach could improve access to clinical trials and high-tech products, supply and use of generic and low-margin products, and investment in strategic production as well as research and development.

Sinn Féin proposes to:

- **Ensure cost-effective and efficient management and supply of medicines through maximal use of generics and by encouraging the strategic development of domestic supply of certain products,**
- **Review pricing arrangements for commonly out-of-stock medicine and ensure that a rapid licensing process for substitute products is in place,**
- **Review the approvals processes for medicines to address blockages, streamline the approval process, and bring approval timelines in line with the EU average,**
- **Ensure that where fair pricing has been agreed that resources are not an obstacle to the provision of or reimbursement for such medicines through the public system.**

Appendix:

- Published Policy in Health and Social Care since 2020
- Alternative Budgets for 2023, 2022, and 2021
- Priorities for Change: Child and Youth Mental Health Service (2023)
- Report on stakeholder engagement: Understanding the causes of waiting lists (2022),
- Women's Voices in Menopause (2022)
- Tackling Hospital Waiting Lists (2021),
- Waiting List Experience Survey (2021)
- Quality Care for All: Standards and Accountability in Social Care (2021)
- Advancing Women's Healthcare (2021)
- Mental Health Emergency Policy (2021)
- Community Addiction & Recovery Strategy (2021)
- 26 County Gambling Strategy (2021)
- A Fresh Start for Cancer Care (2020)
- Protecting Ireland's Health (2020)

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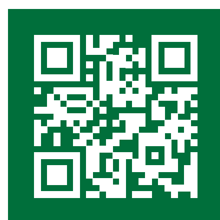

PRIORITIES FOR CHANGE IN HEALTH AND SOCIAL CARE

Consultation Document

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