Submission

to

European Commission

on

Green Paper on

Workforce for Health

31st March 2009

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1 Introduction

1.1 SIPTU

The Services, Industrial, Professional and Technical Union (SIPTU) represents over 200,000 Irish workers from virtually every category of employment across almost every sector of the Irish economy. SIPTU provides the expertise, experience and back-up services necessary to assist workers in their dealings with employers, government and industrial relations institutions.

In recent years SIPTU has also played a pivotal role in the contribution made by the trade union movement to the success of the Irish economy while at the same time securing real improvements in living standards through increases in pay in the workplace and greater social provision in the community.

SIPTU represents approximately 40,000 staff in the Irish Health Service.

1.2 Purpose of this submission

This submission has been prepared in response to a request for contributions to the consultation process relating to the Green Paper on the European Workforce for Health. The purpose of the submission is to identify issues of relevance to the members of SIPTU in the Irish health sector, which should be considered for further development in the context of the Commissions Green Paper.

1.3 The Irish health demographic

The census of the population of Ireland carried out by the Irish Central statistics office in 2006 recorded a total population of 4,239,848. This represented a population growth of 8.2% over the previous census in 2002. It was the largest population growth rate in Europe over the preceding ten year period. In his paper titled "Health status in Ireland: challenges for the future", Dr Patrick Doorley, National Director of Population Health, Irish Health Service Executive, states -

> *"The greatest percentage increase has been in the 50-59 age group. The increase of 24.9% in those of 80+ years is important in the delivery of health services. As the population ages, chronic diseases will increase and we will need to further develop community-based health services so that people can continue to live in their own communities".*

He goes on to say -

> *"Population projections from the CSO suggest that our population will continue to grow and could reach 5.8 million by 2036. Figure 3 shows the expected change in the population by age group. Of particular interest is the projected growth in the 45-64 and 65+ age groups. Health service developments will need to take the changing population structure into account."*

[Available at http://www.hse.ie/eng/HSE_FactFile/FactFile_PDFs/Other_FactFile_PDFs/PopHealth/Health%20Status%20in%20Ireland%20Challenges%20for%20the%20Future.pdf]

Dr Doorley identifies nine areas which should be population health priorities for the Irish HSE

1. Increasing the emphasis on primary care and health promotion.
2. Freeing up the hospital care system.
3. Ensuring integrated care is provided in the right place, at the right time.
4. Improving health outcomes.
5. Improving quality & safety.
6. Promoting equity as a strong value in the health system.
7. Developing services based on 'identified need' and evidence.
8. Measuring investment returns.
9. Improving user participation and empowerment.

It is clear that a combination of items 1, 2, 3 and 9 would have a significant impact on developing care in the community, if properly promoted, funded and resourced by national and EU agencies. These areas should get specific priority and consideration in the follow up discussions to the European Commission Green Paper on the European Workforce for Health.

2 Workforce demographic - throughput of staff

The green paper acknowledges a significant problem with the demographic of an aging doctor and nursing cohort throughout Europe. This problem has manifested itself most recently in Ireland with the problem of reducing the hours worked by non-consultant hospital doctors to below the legal threshold stipulated in EU workplace regulations. Due to the relatively high hours historically worked by junior doctors, the increasing demand for health services and the insufficient supply of newly trained doctors to balance those requirements, considerable strain is being placed on this critical human resource within the health service. It also places additional strain on nursing and health care assistants who work alongside the junior doctors.

There is an urgent need to rethink the health care delivery model to ensure a greater balance in the application of the multi skilled resources available across the full spectrum of staff making up health care delivery teams.

In 1997 the Irish government allocated €3.5 billion to the Health service. In 2009 the allocation was €14.79 billion (see www.hse.ie). Over the same period (1996 to 2009) the Irish population increased from 3.62 million to 4.5 million people. In spite of a near quadrupling (X 4) of funding against a population increase of one third (X 0.33), there are increasing problems with accessing services, increased waiting times and over-stretched service providers.

It is SIPTU's view that there has been an over-emphasis on growing the numbers of the more highly specialised service providers (consultants, doctors and nurses) at the expense of investing in the general support service grades which will tend to spend most one to one time with patients, attending to basic needs which don't require the detailed medical skills of their more specialised colleagues. There is a need to re-examine the care delivery model so that support grades such as Health Care Assistants (HCAs) are up skilled to continue to provide for the basic needs of

patients but also so that they can attend to basic medical needs within their competence and ability.

3 Shortage of nurses.

The shortage of qualified nurses in Ireland is a well documented and acknowledged problem. This has been evidenced by the need to recruit nurses in relatively large numbers over the last five years from outside the EU. While very positive progress has been made on developing training programmes for health care assistants (e.g. the Securing Knowledge Intra Lifelong Learning (SKILL) project), there is still a lack of urgency to optimise both the staff pool available and to up skill those staff for the maximum benefit of patients.

The lead time for training nurses is four years, excluding the time required for additional training to pursue a specialist nursing discipline. The HCA training programme through the SKILL project requires one year, and can qualify staff to provide significant support for nurses and free up their time for more focused application of their specialised medical skills. This highlights the need to review the care team delivery model and the optimum use of staff within that model. Improved layering of the support staff in the model would significantly help to alleviate the workload of professional medical staff and ultimately provide a better care solution for the patients.

In May 2007, the National Implementation Body in Ireland was asked to adjudicate on a dispute involving the reduction of the working week for nurses from 39 to 35 hours. As part of their adjudication, they established a commission to review how this could be achieved. (see http://193.178.1.117/index.asp?locID=564&docID=3430).

SIPTU made a comprehensive submission to this commission, to overcome the shortage of nurses in the Irish health care system. The submission included ideas for developing a clearly integrated healthcare delivery team involving a more rigorously qualified and regulated cohort of health care assistant grades (HCAs). An executive summary of the submission is set out in Appendix 1 to this document.

4 Aging doctor and nurse cohort

The green paper identifies the aging cohort of doctors and nurses as a latent problem for the health services. The underlying problem seems to be an inadequate supply of new graduates to these roles, resulting in increased workloads for those remaining. There is also a pattern of early retirement and burn out in the caring professions due to the pressures of the working environment.

As the population grows and expectations of care increase, there is a clear requirement to increase the number of care staff available to meet patient's needs. This provides an opportunity to reassess the mix of staff on the care teams providing support to patients. Figure 1 below provides a general model of how care teams are generally structured at present.

Under this model, the support structure available to the professional consultant, doctor and nursing grades has a limited scope of action, both in terms of the numbers of staff available and the medical and care skills available to them to carry out their support function.

Health Care Delivery Team - Current Clinical relationships

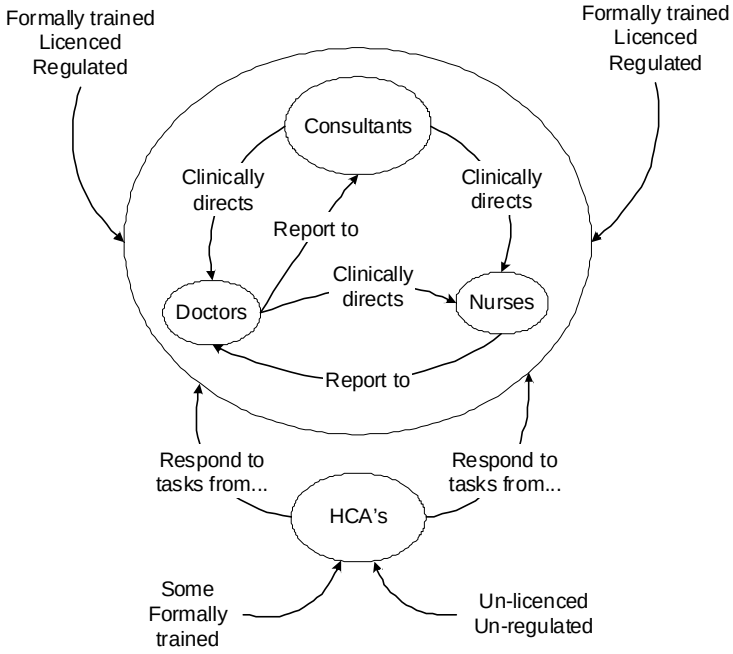

Figure 1

Figure 2 below provides an alternative perspective on how the care team model could be structured.

Health Care Delivery Team - Proposed Clinical relationships

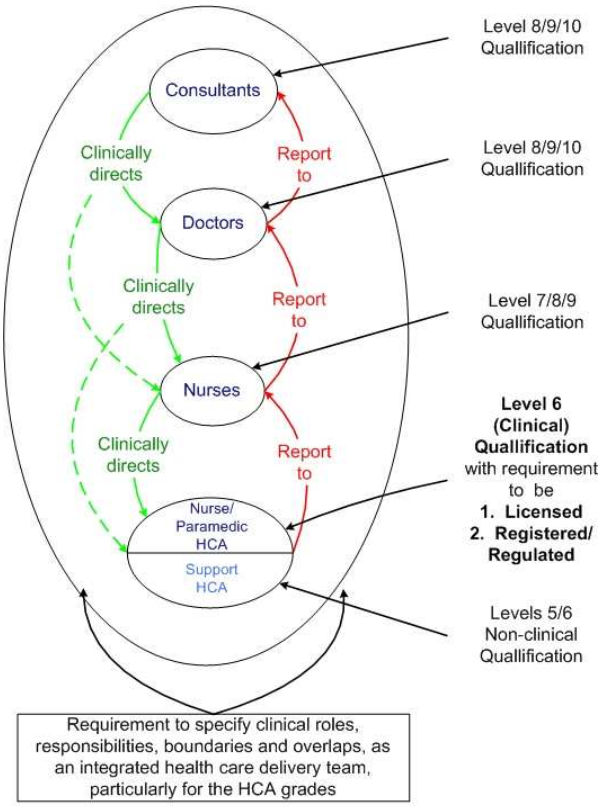

Figure 2

Under the model in figure 2, health care assistant grades would be developed as a layered group, with an incremental range of both care and medical expertise to complement those of the medical staff. This approach would enable a more balanced distribution of workload across a care team to ensure each team member is applying their time and expertise in the most effective way possible to meet the specific needs of their patients.

Note: the levels (5/6/7/etc) referred are from the National Framework of Qualifications, as established by the National Qualifications Authority of Ireland.

See Appendix 1 for a more detailed expression of this concept.

5 Monitoring workforce indicators.

SIPTU shares the view expressed in the green paper of the need for improved monitoring of workforce indicators on the through put of staff in the health services. The trade unions in the health sector could provide valuable support in carrying out this monitoring function.

There is a mutual interest between health service employers and unions representing staff to ensure that any adverse trends in staff movements are identified as early as possible and corrective action taken. This would help to maintain the optimum levels of care for patients and also prevent over stretching of human resources in the event of unexpectedly high numbers leaving the care professions.

Detailed proposals should be developed jointly with the trade unions representing staff to engage in this workforce monitoring function.

6 Workforce diversity

In recent years there has been a significant increase in the effort and resources being provided for developing care in the community schemes. This approach to providing health care has many advantages for patients in terms of minimising disruption from their daily routines and minimising costs while away from their home environment.

The care in the community services are primarily founded on the expertise of the public health nurse. This category of nurse is highly skilled and experienced and should be supported by public health care assistants, in the same way that hospital nurses have HCAs to support the delivery of in-hospital patient care.

There is both a need for and an opportunity to initiate a trans European support programme to develop this field as a specific area of expertise, with public health nurses taking the lead in delivering care in the community, supported by a specifically trained and resourced cohort of care support staff to meet the day to day needs of convalescing patients in community based settings. This category of support staff would provide the same type of support as health care assistants (HCAs) in a hospital setting.

7 Attracting the next generation

Service planning for future health care delivery needs to take account of where the next generation of professional and support staff will come from. The role of health care staff is vocational in nature and needs to be fostered from an early age within the education system.

Over the last ten years, the Irish second level education system introduced two innovative approaches to the senior cycle of second level education - Transition year and the Leaving Cert Applied. Both of these programmes are aimed at providing school goers in the 15/ 16 age group with basic experience of working in a range of environments of their choosing. This helps personal development and

exposes the students to a greater range of work areas in which they may find future fulfilment.

A specific drive should be undertaken to encourage engagement with the health services as part of these two programmes. This could increase the potential interest from a wider range of students in pursuing a career in the health service area.

8 "Observatory on the health workforce".

The green paper proposes an idea for developing an observatory on the health sector workforce (page 8). This concept has many positive aspects and should be developed across the EU.

It is essential that inputs to such an observatory, along with processing and actioning of data within the observatory, should be handled on a joint stakeholder basis. Trade unions should have a central role to play in specifying, establishing and running such an entity.

Trade unions could bring a practical, hands-on knowledge of conditions at the leading edge of health care delivery to this type of observatory and could play an active part in formulating policies and action plans for early response to any adverse trends observed.

This approach would bring considerable benefits to patients, staff and employers, in their efforts to provide the best possible service with the resources available to the health service providers in Europe.

Appendix 1 - Executive summary from SIPTU submission to Nursing hours commission.

Three options to solve the 35 hour problem for nurses.

1. Hire more nurses to spread the existing workload.

2. Streamline the work practices of nurses to reduce their effective outputs to patients by approximately 10% (i.e. identify approximately 10% of nurses work which is redundant and can be fully dispensed with)

3. Redefine the core work of the nurse, in the context of a whole health care delivery team, and

> **a. identify and delegate non-clinical activities of their work to non-nursing staff**
>
> **b. define specific clinical activities which can be delegated to suitably trained, qualified and certified to practice non-nursing staff, who have a direct reporting relationship to a clinical nurse manager or registered nurse.**

This submission advances the case for 3 above.

Essence of the proposal

- Set the national policy to use HCAs as an integral part of the health care delivery team.
- Define the boundaries of responsibilities for members of the HCDT, with emphasis on the HCAs general versus clinical care scope of activities.
- Design a FETAC Level 6 training programme for HCAs, to add to and compliment the existing FETAC Level 5 programmes.
- Designate a Nursing/ Paramedic HCA, holding a Level 6 (clinical care qualification), to streamline the full integration of the HCA into the operation HCDT.
- Formally establish the Nursing/ Paramedic HCA grade as the first step on the nursing career path.
    - Nursing/ Paramedic HCA
    - registered nurse/midwife;
    - clinical nurse or midwife specialist (CNS) - equivalent to ward sister level; and
    - advanced nurse or midwife practitioner (ANP) - equivalent to middle nursing and midwifery management level.

- Establish a register, under Section 30 of the Nurses Act 1985, to regulate the HCA grades when involved in any form of clinical care.
- Implement the proposal system wide on a planned structured basis.

Supporting evidence

"Effective utilisation of professional skills of nurses and midwives (2001)" working group report.

Section 2.5 of the report sets out a synopsis of the views expressed by nurses and existing HCAs.

"The collective views of both nurses/midwives and health care assistants are outlined as:

- *Health care assistants are essential to the efficient functioning of the health services*
- *Health care assistants are an integral part of the health care team*
- *Health care assistants are most appropriately positioned within the supervisory remit of the nursing and midwifery function*
- *Inclusive mechanisms for communication are required to ensure that health care assistants receive appropriate information*
- *There is also substantial evidence to support the employment of health care assistants within certain specialist areas of nursing"*

National Pilot Programme for the Education of Health Care Assistants (4)

The following findings in the report (page 5) are particularly relevant in the context of the case being made in this submission:

- *"Nursing staff working alongside trained HCAs and patients receiving care from trained HCAs in maternity and theatre wards felt that the role of the HCA focuses on supporting qualified members of nursing staff in the clinical setting.*
- *Nursing staff working alongside trained HCAs within the clinical setting felt that they allowed nursing staff to spend more time with patients.*
- *Nursing staff expressed overall satisfaction with the standard of work and level of expertise from trained HCAs.*

The overall majority of health care agencies (92.9%, n=65) felt that the role of the trained HCA was to assist and support qualified nursing staff."

Supervision, accountability and delegation of activities to support workers.

A UK collaborative paper on this topic, which is fundamental to the use and suprevision of HCAs, provides a strong argument for the development and full integration of the HCA, as a means of freeing up the time of the other professional staff on the HCDT. (page 23 of SIPTU submission).

National review of the Role of Healthcare Assistants in Ireland.

The review provides a detailed, evidence based case for greater clarity and consistency of the HCA role, full integration of the HCA into the clinical care team and continued development of the educational provision for on-going professional development of HCAs. (page 25 of SIPTU submission)

Benefits of this proposal

- **Benefits to patients**

The development of the Nursing/Paramedic HCA as proposed would ensure a consistent level of care for patients, to an agreed national standard which was fully regulated, based on clarity of the HCA role whilst remaining under the direct supervision of a qualified nurse.

- **Benefits to other staff**

Due to agreed training and qualification standards in clinical care provision, there would be significantly greater clarity and consistency on the scope of activities which could be delegated to and carried out by HCAs across all nursing disciplines.

- **Benefits of a better (career) structure**

Under these proposals, HCAs would have greater clarity on the scope of their role, particularly in relation to the provision of clinical care to patients. They would also have greater clarity on their place within the HCDT.

Registering Nursing/Paramedic HCAs on a national register would provide greater protection for both staff and patients through a more regulated approach for front line staff directly engaged in one-to-one delivery of patient care services.

- **Personal and professional development**

Maintenance of professional care standards would be a pre-requisite of joining and remaining on a fitness to practice register. This would require and enable HCAs to ensure personal and professional development, which would be beneficial to patients and all other members of the HCDT.

Summary and conclusion

Notwithstanding the progress and normalisation of a previously ad hoc working grade, there is still a significant level of difference of utilisation of HCAs across the Health Service. The extent to which HCAs are deployed for direct patient care activities varies significantly and is as much dependent on the disposition of individual supervising nurses as it is on the qualifications or ability of the HCAs themselves.

A number of reviews of progress on the development of the HCA grade in Ireland have recognised the importance of the role for patient care, the progress on

developing the role and the benefits which accrue to patients when HCAs are deployed as part of the patient care team.

A number of reports on HCAs, particularly in the UK, have highlighted the need to improve the consistency of training and development for HCAs and the benefits for patients and Nurses of integrating these staff more fully into the health care delivery team. They have also emphasised the need to continue the direct supervisory relationship between Nurses and HCAs.

In the context of reducing the Nursing week to 35 hours per week, this submission proposes the following:

- HCAs should be identified with two strata - Support HCAs and Nursing/Paramedic HCAs. Support HCAs should continue to be trained to FETAC Level 5 and 6 and deployed as at present. **Nursing/Paramedic HCAs should be specifically qualified in particular clinical care activities to FETAC Level 6**, to enable them to work as full members of the health care delivery team.

- While both strata would be qualified at Levels 5 and 6 on the NQF, the Nursing/Paramedic HCAs would have to undergo specific training in clinical care techniques and would have to qualify at Level 6 before being enabled to practice in the particular Nurse/Paramedic HCA role.

- Nursing/Paramedic HCAs should have a specified range of clinical care activities, which would be common to patient care within any of the Nursing specialisms, and which they were specifically qualified to carry out. These should continue to be directly supervised by a nurse or nurse manager, but should be an integral part of the HCAs role within the HCDT, rather than being exclusively dependent on specific delegation from individual nurses.

- To ensure the highest level of consistency and safety of patient care provided by HCAs, Section 30 of the Nurses Act 1985 should be used to establish a Nursing/Paramedic HCA register in line with the existing Nurses register. The role should continue to operate under the direct supervision of a qualified nurse but the scope of clinical care activities should be made more consistent through the prescribed training provided, the qualification achieved and regulation through maintenance of a fitness to practice register.

- Through this clearer definition of the HCAs scope of clinical and support care delivery, there would be a structured, regulated and practical operational basis on which nurses hours could be reduced to 35 hours per week, while ensuring that the clinical and support care needs of patients were being fully provided for within a regulated and well managed health care delivery team setting.