Value for Money: Review of the SKILL Programme
Final Report

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ERNST & YOUNG

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1 Executive Summary

1.1 Introduction

The SKILL Programme was established in 2005 to develop support staff in health services . The target audience was 32,000 support staff and supervisors in the HSE, plus staff in similar roles in disability and voluntary organisations. It is a significant and ambitious programme with plans to train up to 4,000 staff each year. By the end of 2010, c. €59m had been spent on c. 10,600 participants(including active participants, graduates and drop outs post commencement).

The following points provide important context to the SKILL Programme:

- The SKILL Programme was introduced for support staff whose learning needs had traditionally not been prioritised
- It was based on the FETAC qualification system and supported by a competency framework
- The programme built on an existing Centres for Nursing and Midwifery Education (CNME) programme for Healthcare Assistants (HCAs), and this distinction between CNME and the rest of the programme remains in place
- Initially, the programme was offered to all potential participants on a "scatter-model" approach. A modification in 2007 saw the introdution of the "critical mass site" (CMS) approach which allows for a large number of staff members from selected focus sites to be put through the SKILL Programme
- The management of the programme is devolved, with different bodies coordinating grants and reporting to the SKILL office.

1.2 Approach

Ernst & Young (EY) was commissioned to examine the value for money (VFM) of the SKILL Programme. Specifically, we were asked to assess the impact of the SKILL Programme in terms of:

- The particular literacy needs of this group of staff
- Appropriateness of the education and training interventions provided through the SKILL Programme for staff who are returning to learning
- The impact of the education and training at individual and service levels i.e. the transfer of learning to the workplace
- Skill mix and up-skilling changes as a result
- Customer satisfaction
- Culture change impact on a learning organisation with knowledgeable workers where support staff and support service managers have equal opportunities to training interventions.

At the centre of this review is the question of programme effectiveness. Specifically, this means:

- Effectiveness (i.e.output/ outcome)- how well do the outputs achieve the required outcomes?

We also considered the following related questions:

- Efficiency (input/output)- what inputs are turned to outputs?, with a specific focus on the cost per graduate and the number of withdrawals
- Economy (cost/input)- can the activity be done at a lower cost?, which is within the efficiency chapter, looking specifically at the cost of training participants.

In taking forward this research, EY:

- Studied previous documentation relating to the SKILL Programme
- Developed an understanding of best practice in evaluating training activity, drawing on expertise within the firm
- Commissioned a data search of key information
- Read the written submissions sent from different participating organisations
- Carried out interviews with a broad range of stakeholders, including participants.

The bias of the evidence was towards organisations which had benefited most from the SKILL Programme, and so one outcome is an increased understanding of best practice.

One difficulty in taking forward this evaluation was in the availability of data. Some of the data that EY has requested has not been available, and other data which has been collected has been a challenge to source as it is held across various HSE functions and external bodies. Additionally, there is a lack of integration between these data systems.

1.3 Efficiency

In assessing the efficiency of the programme, EY looked at the cost of training participants, the cost per graduate and the cost per graduate who was able to transfer their learning to the workplace.

1.3.1 Cost per participant

When it was established, the SKILL Programme was intended to train 4,000 participants a year, albeit expectations early on forecast about 2,000 participants a year. The average cost of training a participant has been €5,559. HCAs are significantly more likely to participate on the programme than other groups. There are also variations between regions, with HSE South sending more participants than other regions and a high number of participants from the disability organisations.

On the basis of tuition costs (i.e. excluding backfill and other SKILL office overhead costs), costs of the training programme per participant are broadly similar to, or better than, private providers. However, there may be opportunities to drive improved value for money, including a focus on increasing average class size.

1.3.2 Cost per graduate

There is a significant proportion of withdrawals from the SKILL Programme, including people who register but withdraw before the class starts (1,679 on SKILLVEC and 229 on CNME). The cost of the SKILL Programme per graduate, over the life of the programme to 31 December, 2010, is €7,128[1] against a cost per participant of €5,559. 93% of HCAs who participate on the CNME programme have graduated, which compares favourably to the 28% withdrawal rate of HCAs on the SKILLVEC progamme. There are also variations of performance between employing organisations and training colleges in terms of the proportion of withdrawals. Older participants and porters are more likely to withdraw from the programme than other groups.

[1] Cost data and CNME participant data are as of 31 December, 2010. VEC participant data was provided to Ernst & Young on 13 December, 2010.

A further concern is the length of time participants are taking to graduate, with some taking more than one year. Of the VEC participants who graduated in 2010, 36% had taken more than one year to complete. This has an impact on employing organisations. They receive a one-off backfill payment of €3,500 from the HSE although the recent Comptroller and Auditor-General's report suggested that the average cost of replacing a SKILL particpant is €4,384[2]. As a further example, Cork University Hospital estimates that the shortfall in backfill funding for 2010/11 will amount to €23,663 or 13% of the total cost of backfilling/administration of the programme. The estimated cost is €180,163 against a fund of €156,500. This amounts to c. €600 per participant.

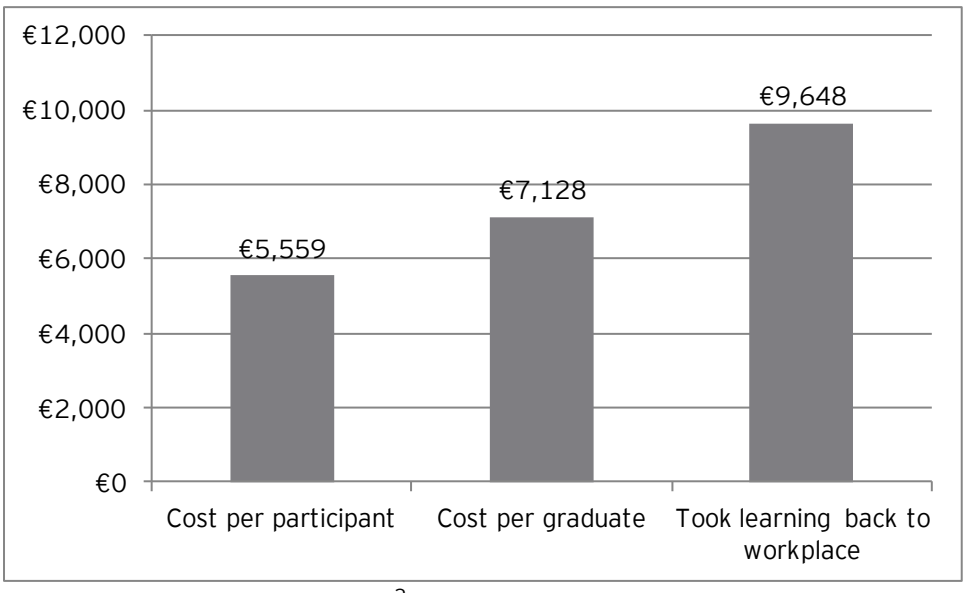
The shortfall in funding to cover backfill payment is a reflection of the commitment to the SKILL Programme as it identifies an additional cost which must be met by health service provider organisations (i.e. outside of the SKILL Programme budget).

1.3.3 Cost per participant who was able to transfer their learning to the workplace

A further test of value for money is whether the SKILL Programme is equipping participants to make a difference in the workplace and whether they are able to do so when they return. The 2008 Pearn Kandola Research identified that only 57.6% of participants agreed or strongly agreed with the statement that "Since completion of the SKILL Programme, I have been supported to transfer my learning back to work". Using that 57.6% figure, then the average cost per participant who has been able to transfer their learning back to the workplace is €9,648, against a cost per participant of €5,559.

The following chart compares the cost of the SKILL Programme per participant, the cost per graduate and the cost per participant who transferred their learning back to the workplace.

Chart 1.1: Cost of SKILL Programme per participant, cost per graduate and cost per participant who transferred their learning back to the workplace



Sources: CNME data and CDVEC[3] database. Pearn Kandola 2008 evaluation. Costs – see table 4.2

[2] Report of the Comptroller and Auditor General: Volume 2, September 2010, page497. Figure excludes employer PRSI.

[3] CDVEC refers to the City of Dublin VEC. SKILLVEC was a consortium of all the VECs in Ireland (external education provider). The CDVEC database captures data for all of the participants who studied through the VECs, UCD and St. Michael's House Open Training College (OTC).

1.4 Effectiveness

EY's study of the effectiveness of the Programme followed the specific terms of reference of the evaluation project.

1.4.1 Particular literacy needs of this group of staff

Adult literacy is a national concern. 4.7% of VEC participants were referred for literacy support (Level 3 or 4) following the Pre-Learning Assessment. Participation rates from grades (domestic/ household staff, catering staff) who are more likely to require literacy support is lower than participation rates of HCAs . Some 31 individuals have used the Level 3 qualification to move on to Level 4 and/or Level 5 and this demonstrates clear progress for those participants. Graduation at Level 5 is the core level and also its achievement indicates a standard of literacy which is appropriate to the various support roles. However, with overall participation rates still low (c. 10,600 participants to date), and with 276 Level 3 and Level 4 [4] participants (graduated/active) out of a HSE Whole Time Equivalents (WTE) staff cohort of c. 35,000 (excluding other eligible non HSE organisations), it is possible that many of the literacy issues are not identifiable.

1.4.2 Appropriateness of the education and training interventions provided through the SKILL Programme for staff who are returning to learning

The programme was developed to help support staff perform more effectively in their roles. There is an ongoing need for the programme at a macro level, based on an appreciation of the importance of support staff roles and the need to do them well. In addition, the link between the programme and FETAC qualifications is appropriate. Individuals benefit from the focus on their learning, particularly in terms of self-esteem and increased confidence. However, some feedback suggests that the greater flexibility about taking a few modules would make the course more attractive to some potential participants, particularly those with family commitments.

Feedback suggests that the course could be tailored more effectively to the workplace in some instances. Also, there is some feedback that the training could be more tailored to the needs of staff who support disabled people. CNMEs argue that their training package is more appropriate than the VEC training for HCAs, as it is site-based and delivered locally.

1.4.3 The impact of the education and training at individual and service levels i.e. the transfer of learning to the workplace

Trained staff return to the workplace with fresh enthusiasm and confidence, but there is inconsistency in the transfer of learning to the workplace. Some individuals return and their role is unchanged and they are unable to apply the learning from the programme. CMSs are more effective in transferring learning to the workplace because participants return as a group, but even here application is inconsistent. St Vincent's Hospital is an example of an organisation which has set up a mechanism to measure transfer of learning and to act on feedback. Where transfer of learning is achieved, there are examples of transformed organisational performance.

[4] While 575 staff were referred to Level 3 and Level 4 courses, only 276 have actually completed and/or are actively completing the courses.

1.4.4 Skill mix and up-skilling changes as a result

Performance appraisal systems are under developed in the Irish health system, and so it is not possible to use such data to assess if FETAC trained staff perform better than those without the same training. However, there is evidence that some organisations have been able to upskill their workforce. Firstly, some organisations are able to mandate Level 5 FETAC qualification for HCAs as an increasingly significant number have now been trained across the Irish health system. This approach recognises a defined level of education/competence and directly associates it with a level of care. Secondly, role changes have supported productivity improvements, both through enabling tasks to be carried out more quickly and through support staff taking on roles previously carried out by more qualified and therefore better paid staff. Thirdly, the SKILL Programme has supported role progression, with individuals changing roles, and this has opened up significant opportunities for them.

1.4.5 Patient/client satisfaction

There is no HSE organisation wide (or otherwise) data available to assess whether there has been a quantitative improvement in patient/client satisfaction. EY's assumption is that there will have been improvements in patient/client satisfaction through increased staff commitment and awareness, experienced in everyday patient or client interactions. However, the transformation in patient/client satisfaction is likely to be most apparent when the organisation as a whole commits to improved patient/client service, and uses the SKILL Programme as a lever to make this happen. There are examples of where this transformation has taken place, see section 5.5.

1.4.6 Culture change impact on a learning organisation

The evidence suggests that the SKILL Programme can make a difference to organisational performance, depending on the extent to which organisations invest in it. Generally, the SKILL Programme is not linked to corporate strategies, although this is less true for CMSs. EY carried out an analysis of CMS performance against a number of key indicators. There is a trend in that the CMSs are performing better than the national average, and that the CMSs with high take-up rates on the SKILL Programme are performing best of all. It is important to point out that there may not be a direct correlation between the SKILL Programme and improved performance against those indicators. A number of factors could have a role. However, there is evidence to suggest that those critical mass hospital sites are proving successful in improving performance, and that the SKILL Programme is part of their efforts to improve the organisation.

Table 1.2 Key indicators comparing critical mass site performance against the national average

Key Measure	National average	Critical Mass Site Annual Average (less than 5% take-up)	Critical Mass Site Annual Average (more than 5% take-up)
% Increase in Bed Days (2006-2009)	2%	0.9%	-11%
Increase/ Decrease in Absenteeism Rate among support staff (2009-2010)	0.13%	-1.91%	-4.42%
Increase/ Decrease Absenteeism Rate amongst OPCC staff (2009-2010)	0.85%	-1.49%	-4.05%
Increase/ Decrease in MRSA infection rate (2006-Q1/2 2010)	18%	-16.4%	-29.07%

Source: HSE

The following table sets out the individual performance of the CMSs with a take up of more than 5% (of eligible staff) on the SKILL Programme.

Table 1.3 Performance information for critical mass sites						
	Average Annual % uptake on SKILL Programme, including CNME	Composite take up over lifetime of SKILL Programme, including CNME	% Increase in Bed Days (2006-2009)	Increase/ Decrease in Absenteeism rate among general support staff (2006-2009)	Increase/ Decrease in Absenteeism amongst OPCC staff (2006-2009)	Increase/ Decrease in MRSA Infection Rate 2006-Q1/2 2010
St Columcille's Hospital	10%	51%	-5%	-10.93%	-15.11%	-47.60%
St James's Hospital	10%	48%	-3%	0.86%	-3.97%	-24.90%
Kerry General Hospital	8%	41%	-11%	-1.75%	-1.46%	-32.60%
Stewarts Care Ltd	8%	41%	No data	-3.12%	-2.23%	No data
St Vincent's University Hospital	8%	41%	-5%	-3.42%	1.60%	-26%
Central Remedial Clinic	8%	40%	No data	-3.79%	1.96%	No data
Monaghan General Hospital	8%	39%	-52%	-10.00%	-10.06%	-25%
Beaumont Hospital	7%	35%	8%	-2.90%	-6.78%	-22.20%
Midlands Regional Hospital Tullamore	6%	32%	-6%	-4.76%	-1.90%	-25.20%
Waterford Regional Hospital	6%	32%	-6%	-2.60%	3.66%	-8.60%
Brothers of Charity (Limerick Region)	6%	29%	No data	-4.42%	-2.59%	No data

Sources: (1) Participant data - CDVEC database and CNME data, and (2) Performance information - bed days, absenteeism and MRSA data provided by HSE.

Notes:

1. OPCC refers to the "Other Patient and Client Care" staff category.
2. The above sites were identified as critical mass sites with 5% or more staff take-up on the basis of the number of VEC participants. EY then added CNME participation figures to calculate the total take-up from those sites.
3. Uptake % calculated based on participant numbers (including participants who withdrew after commencement but excluding participants who withdrew prior to commencement) as a proportion of staff WTE. WTE data was provided by the HSE for 2006 – 2010. The 2010 WTE data is as of 31 October 2010.

Undoubtedly, the above are potential indicators but there are others. One such indicator is the hygiene score. HIQA hygiene reports cite SKILL participation as a positive indicator on hospital hygiene. Finally, some smaller organisations and with low participant rates emphasised the overall contribution of the SKILL Programme to their organisation.

1.4.7 Assessment against original objectives

The SKILL Programme established a number of supporting objectives, which are set out in the table below.

Table 1.4: Supporting objectives for the SKILL Programme	
Objectives	**Assessment- impact on participants**
Provide them with an opportunity to return to learning	**Achieved**
Enable them to update and extend their knowledge, skills and experience in order to make them more effective and efficient in the jobs they perform and consequently improving services to patients/ clinics	**Partially achieved, the issue is about the transfer of learning to the workplace**
Enhance their satisfaction and motivation in order that they may contribute more fully to the attainment of their organisation's mission	**Mostly achieved, motivation improved**
Develop areas of expertise to progress the "skill mix" requirements of the health services having regard to workforce and succession planning issues	**Partially achieved, with some organisations now mandating FETAC Level 5 qualification**
Assist them to reach their full potential	**Partially achieved, the issue is about the transfer of learning**
Guide them in their personal development and career planning	**Mainly achieved in terms of personal development, little evidence of systematic career development**
Provide greater clarity regarding their roles and functions	**Not achieved, with inconsistency around roles and functions even on the same site**
Enhance career opportunities	**Little/partial achievement, with inconsistent impact**
Up-skill to fulfil higher level duties where appropriate	**Partially achieved, with some limited impact**
Increase morale, mobility and flexibility	**Achieved. Morale improved for staff who have attended**
Acquire educational accreditation	**Achieved for graduates**

Our analysis is that the SKILL Programme demonstrates that it can achieve considerable individual and organisational benefit, although it does not do so in all instances. The challenge moving forward is to build on existing good practice to ensure that the programme functions effectively as a tool for organisational improvement.

1.5 Overall summary – principal conclusions

The SKILL Programme has achieved a significant amount in terms of supporting people in support roles to build their confidence and gain new skills. There are a number of inspiring examples of people whose lives have been transformed as a result of the learning which they received on the SKILL Programme. The overwhelming feedback is that participants have gained in skills and confidence and are more professional as a result of attending the programme.

However, while there is evidence that individuals are developing and learning from the SKILL Programme, there is no evident link in place between that learning and team functions, organisational performance and corporate strategy in all instances. Where that link is in place, the SKILL Programme would appear to contribute to improved performance, as evidenced by the fact that CMSs which have invested most in the programme are performing significantly above national averages. HIQA has also accepted that the training has an impact on hygiene assessments. Our analysis is that the SKILL Programme does not provide value for money and will not provide value for money until that link is in place in all instances. As one stakeholder commented to EY: "Training is not a panacea for systems failure".

One key indicator is that the average cost per participant of the programme is €5,559, but the average cost per participant who stated that they were able to transfer their learning back to the workplace is €9,756.

In addition, our research has identified concerns about the programme's efficiency, with a high number of participants withdrawing and 36% of VEC participants taking more than one year to graduate.

1.6 Recommendations

EY has identified areas of focus under three headings; management of the programme, efficiency and effectiveness. A high level road map is set out in Section 6.

Management of the programme

1. **Establish a VFM framework, linked to clear programme benefits and targets**, which can be tracked and reviewed at a programme and at an organisational level.
2. **Enhance the quality of data**, with a particular focus on data about the number of participants and relating to costs.
3. **Programme governance should be more integrated** i.e. the programme must be managed/delivered as one programme. CNMEs and VEC participants should not be managed as two unconnected participant streams. Any change in the model of training provision should not lose the experience built up to date. This integration should apply not only at a national level but also locally (e.g.in a hospital).
4. **Review the delivery model**. The HSE should review the delivery model and ensure that it manages the programme using a team with all of the requisite multidisciplinary skills. The governance and management of this programme requires a wide range of skills such as organisational, HR/training, programme management, contract management, governance, financial, etc.

Improving efficiency

5. **Keep all costs under review.** Maximise opportunities in procurement negotiations to incentivise greater efficiency and improved performance. The significant costs associated with backfilling mean, now more than ever, that it must be kept under review in order to assess if such costs can be reduced.
6. **A concerted effort should be made to increase the graduation rate**, focusing on reducing the number of withdrawals and increasing the proportion of participants who graduate within one year. There may be an opportunity to leverage SKILL training for clerical officer and grade IV (clerical) staff whose needs also merit consideration.

Improving effectiveness

7. **Organisations should also be prevented from sending staff members on the SKILL Programme unless there is a clear benefits plan in place** i.e. stronger organisational commitment must be part of programme management.
8. **Further efforts should be made to provide training which is as relevant as possible to the workplace** and consideration should be given to defining training programmes/ courses for non HCAs which may have less than 8 modules.
9. **There should be an increased focus on identifying participants who have low literacy levels.**

Finally, the HSE has an opportunity to use the reform of the SKILL Programme to raise core expectations of support staff and to drive through productivity and service quality improvements. A national drive could help organisations achieve maximum benefit from the programme, and would be linked to an increase in the participation rate on the SKILL Programme. The number of participants at c. 10,600 against c. 35,000 WTEs in the HSE is still low if this qualification is to become the norm for support staff.

2 Overview of the SKILL Programme

The SKILL Programme was established in 2005 to develop support staff in health services. The target audience was 32,000 support staff and supervisors in the HSE, plus staff in similar roles in disability and voluntary organisations.

The following points provide important context to the SKILL Programme:

- The SKILL Programme was introduced for support staff whose learning needs had traditionally not been prioritised
- It was based on the FETAC qualification system and supported by a competency framework
- The programme built on an existing CNME programme for HCAs, and this distinction between CNME and the rest of the programme remains in place
- Initially, the programme was offered to all potential participants on a "scatter-model" approach. A modification was taken in 2007 to introduce "critical mass sites", where a large number of staff members from specific sites are put through the SKILL Programme
- The management of the programme is devolved, with different bodies coordinating backfilling and reporting to the SKILL office.

2.1 Introduction to the SKILL Programme

The SKILL Programme was established in 2005 with the mission to 'educate, develop and train support staff in the health services to the optimum of their abilities in order to enhance their role in the quality of service to patients/clients'[5]. The target audience of the SKILL Programme is the 32,000 support staff and their line managers/supervisors in the Irish health service[6].

The SKILL Programme arises from, and is part of, a development and restructuring agreement between employer and union sides known as "Recognising and Respecting the Role" (2003). This has its origins in the parallel benchmarking process and applies only to the grades of staff covered by that agreement. This agreement was underpinned by the following four principles;

1. Quality of services
2. Standards/best practice
3. Key responsibilities of support staff and
4. Training and development of support staff.

The SKILL programme / initiative dealt with the fourth principle above.

To support the mission of SKILL, the SKILL Programme has set out its objectives as follows:

- Provide an opportunity to return to learning
- Update and extend knowledge, skills and to improve job efficiency and effectiveness and consequently improve services to patients/clients
- Enhance satisfaction and motivation in order to contribute more fully to the attainment of the organisational mission
- Develop areas of expertise to progress the "skill mix" requirements of the health services having regard to workforce and succession planning issues
- Assist in reaching full potential

[5] Activities and Achievements, The Story So Far, July 2009.

[6] Activities and Achievements, The Story So Far, July 2009.

- Guide personal development and career planning
- Provide greater clarity regarding their roles and functions
- Enhance career opportunities
- Up-skill to fulfil higher level duties where appropriate
- Increase morale, mobility and flexibility
- Acquire educational accreditation.

Source: Request for Tender SKILL Project, 13 April 2005.

While the SKILL Programme had a clear mission statement and set of objectives, specific performance metrics were not set to measure achievement against them. There was no VFM framework to assess the performance of the programme, although the programme recognised at the outset that there would be both individual and organisational benefits. Independent evaluators were commissioned by the SKILL initiative to evaluate the programme under three headings:

- operational (system readiness and external provider capacity to deliver programmes nationally) 2006
- behavioural (pre and post individual and line manager questionnaires 2006 – 2008), and
- business level evaluation (2008-2009) - the business level impact (return on investment) was to be considered for the critical mass sites.

The Department of Finance provided funding of €60m which covered a five-year period (2004-2008) and an ongoing further funding of €12m per annum linked to the consumer price index was agreed in 2009.

The 32,000 support staff in the Irish health service include HCAs, family support workers, therapy assistants, speech and language assistants, laboratory aides, household staff, catering staff, porters, laundry workers, general assistants as well as other support grades and their supervisors. In addition, the programme is open to staff at health-related voluntary organisations and disability organisations, so potentially around 40,000 people. A backfilling element was included so that organisations could release staff to attend.

There are over 500 participating organisations across Dublin Area Teaching Hospitals (DATH), Disability Federation of Ireland (DFI), Federation of Voluntary Health Bodies (FVHB), HSE Dublin North East (HSE DNE), HSE Mid-Leinster (HSE ML), HSE South, HSE West, National Federation of Voluntary Bodies (NFVB) and CNMEs (HSE).

The rest of the section sets out contextual points about the SKILL Programme.

2.2 Learning needs

The SKILL Programme was intended to support people in support roles whose learning needs had traditionally not been prioritised. This followed discussions with trade unions. As part of the development of the SKILL Programme, a comprehensive training and learning needs questionnaire, was completed by almost 4,000 staff in 2005. The results indicated that staff would consider participating in a SKILL Programme for the following reasons:

- develop new skills
- increase self-esteem and self-confidence
- pursue personal development
- acquire extra qualifications
- achieve career development.

Barriers to participating were perceived to be:

- lack of time
- apprehension about 'studying'
- fear of examinations

- nervousness about 'going back to the classroom'
- lack of confidence and low self-esteem
- concerns about the level of reading and writing ability that might be required.

2.3 FETAC qualification system and HSE competency framework

The SKILL Programme was based on the FETAC qualification system and supported by a competency framework. One of the underlying aims of the SKILL Programme is to ensure that participants acquire a recognised FETAC qualification. This is pitched at different levels:

- **Level 3 and Level 4:** These courses are pitched at people with low literacy levels. Level 4 has a particular focus on people for whom English is not their first language. All participants have to carry out a Pre-Learning Assessment (PLA) and where appropriate they are signposted to Level 3 or 4. Level 3 participants must complete three compulsory module and five out of eight job specific modules. Level 4 participants must complete four mandatory modules and four out of six job specific modules.
- **Level 5:** This is the core course for people in support staff roles. Participants must complete five core modules and three job-specific modules.
- **Level 6:** This is the course aimed at people in supervisor roles. Participants must complete seven core modules and one job-specific module.

A diagram setting out the SKILL Programme in more detail is at Appendix 1. A full list of the level 5 SKILL Programme job specific mandatory modules is set out in Appendix 2.

In addition, seven positions are available in degree programmes including a BA in Applied Social Studies (Disability) and a BA in Applied Management (Non-profit/ Human Services). Through the John F Kennedy Jr Institute for Worker Education Fellowships, 22 fellowships for academic study have been awarded. These amount to €1,500 and are funded equally by the SKILL Programme and the City University of New York.

The SKILL Programme is also linked to a competency framework. In late 2005, research was carried out to identify the skills and attributes which these staff needed to fulfil their roles and carry out their duties. SHL (Ireland) was commissioned to identify the most important management skills and attributes for support managers. The results of this research provided the foundation for the development of competency frameworks for support staff and managers.

2.4 Existing CNME programme for Healthcare Assistants

The SKILL Programme developed from an existing programme for HCAs. Some CNMEs were providing FETAC Level 5 Certificate in Healthcare Support, for HCAs, since the original pilot programmes in 2001. The SKILL Programme essentially mirrored this existing programme for new SKILLVEC participants, so with tutor support available for participants. Modules were developed with specific roles in mind. The training delivered through the CNME courses continued and was subsumed into the SKILL Programme.

Essentially the SKILL Programme has two streams:

- HCAs were trained (as before) through CNMEs. CNMEs serve the acute sector, the intellecutal and physical disability sectors as well as community services
- Other support staff (including some HCAs) were trained by external education providers who provided training offsite to a large number of sites – this latter approach was known as the 'scatter model' approach.

There are currently four training providers for the SKILL Programme:

1. The HSE CNME (internal education provider) i.e. Centres for Nursing and Midwifery Education. They are part of the Irish Health Service structure and as such are internal providers of the FETAC Level 5 (formally NCVA level 2) programmes for HCAs since 2001.
2. SKILLVEC is a consortium of all the VECs in Ireland (external education provider) led by the City of Dublin VEC. The VECs are local education authorities for each of the county councils and city corporations in Ireland. They provide 2nd level, further education and adult education programmes and services.
3. SKILLOTC (external education provider) which delivers two electives: Intellectual Disability Studies and Person Centred Focus to Disability.
4. SKILLUCD (external education provider) which delivers two electives: Diagnostic Imaging Department and Radiation Protection in Diagnostic Imaging Skills.

2.5 Critical mass sites

Pearn Kandola was engaged by the HSE in 2006 to evaluate the SKILL Programme. They performed evaluations across 2006 to 2009 at a behavioural level and at a business level to evaluate the impact of the SKILL Programme.

One key outcome from the Pearn Kandola research was that, from autumn 2007, SKILL has adopted a significant new approach referred to as the CMS approach. The CMS approach is operated in parallel to the 'scatter model' approach. The CMS approach aims to ensure that a large number of support staff and support service managers from one particular employer/ location go through the programme at the same time. A CMS is defined as:

> *'The representative number of support staff required in order for classification as critical mass site can be determined by ensuring that the proportion of key variables (i.e. support staff) in the sample (i.e. the numbers attending SKILL) reflects the proportion of key variables in the overall population of the site. An example will be used to illustrate this point:*
>
> *If a site had 1,000 staff members in total in the population and 200 of them are support staff, this means that proportion of support staff in the total population is 20%. Therefore, 20% of support staff should take part in SKILL in order to determine if the site can be classified as a critical mass site. Once the numbers of support staff have been determined, each site should ensure that the sample is in itself representative of the different categories of support staff within the support staff population.'* (Pearn Kandola, 2008)

There are 27 CMS, 21 of these are currently active with the remainder having completed the programme in September 2007 and 2008 (See Appendix 3 for a complete list of active and completed CMS).

2.6 Governance of the programme

The SKILL Programme is now managed centrally by the SKILL Programme team based in Dr. Steevens' Hospital, Dublin. It is positioned as part of the HSE Leadership Education and Training Division, HR Directorate. When the SKILL Programme was established, the office was staffed by a General Manager, two education and development specialists (1.5 WTEs) and two administration support staff.

The SKILL Steering Group members (now disbanded) comprised 14 members including a Chairperson, representatives of the unions (SIPTU, IMPACT, AGTWU), a representative from the Department of Finance, the Department of Health and Children, Federation of Voluntary Bodies, Disability Federation of Ireland, Health Services Executive Employers Agency, a large acute hospital, human resources/operations HSE and also a Local Health Manager HSE, a Hospital Network Manager HSE and an external consultant.

There appears to be some confusion in relation to the governance arrangements. The governance arrangements were set out in the SKILL Programme June 2005 governance document. A HSE Internal Audit report found that "On the basis of evidence available to Internal Audit, there is a lack of clarity and confusion among various parties, in relation to the governance and reporting arrangements of the SKILL programme. Notwithstanding the fact that the reporting and accountability lines set out in the June 2005 document lacked clarity and transparency, the non implementation of the governance and accountability lines, contained in the 2005 governance document, between the Corporate National HR Directorate, the Steering Group and the General Manager has resulted in the creation of a silo whereby the SKILL programme with a 5 year budget of €60m and €12m pa thereafter, and although part of the HSE's Corporate National HR Directorate, in effect did not report to that Directorate, and was not overseen by the Directorate, instead reporting to a Steering Group which did not, in reality, have a proper reporting line to the Corporate National HR Directorate."

The SKILL office makes use of the DFI, NFVB, HSE regions and NMPDU (Nursing and Midwifery Planning and Development Units)/CNMEs to manage and deliver the programme - these representative bodies/organisations manage the recruitment of participants, provide information on participant numbers to the SKILL office and calculate participant numbers (a manual process) to determine backfilling costs. These bodies also manage directly or oversee the payment of monies to the recipient bodies. Critical mass sites are different to the scatter model sites in that they have a direct reporting line to the SKILL office and are funded directly.

Each CMS and HSE region has a SKILL coordinator, who reports to the SKILL Programme team. SKILL coordinators in the HSE regions are part of the HR Performance and Development Unit and are not necessarily funded through SKILL.

While the role of the SKILL Coordinators may vary from organisation to organistion, the role of the SKILL coordinator would, generally, be to:

- communicate the existence of the programme to the eligible population in their site(s)
- facilitate briefing sessions on site to eligible participants
- work with line mangers in encouraging participants to enrol
- enrol participants
- identify relevant modules for each area
- liaise with the VEC and CNME (but principally VECs)
- set up the training schedule and agree location
- provide support to participants
- confirm participant numbers for backfilling payment purposes
- report to the SKILL Programme team.

Additionally, in relation to governance, we have noted the following:

1. The reporting from SKILL coordinators to the SKILL office is not structured/template driven.
2. Financial reporting is not comprehensive.
3. The management of the CNME component is not integrated with the management of the VEC participant stream.

General reporting

CMSs report to the SKILL office on a regular basis. EY understands that some sites would report monthly on progress, but there is no evidence of a formal reporting template for this purpose and template design seems to be at the discretion of the CMS. CMSs are, however, required to submit an annual proposal which requests baseline information including expected impact. Outside of this, the SKILL office would request data on an as need be basis. For non CMSs, reporting does not appear to be structured or template driven. We have no evidence that sites, critical or otherwise, have been reporting in a standard or structured manner over the life of the programme.

Financial reports

Financial governance of the programme is limited. Standard annual financial reports/summaries (actual, budget) by category of expenditure (backfilling, tuition costs etc) setting/sector are not available. If such reports are not readily available, it limits analysis of the programme. We have noted that the SKILL coordinators calculate the number of participants who qualify for backfilling payments. This requires manual intervention and, for example, in this case of VEC participants relies on the CDVEC database which was not designed for that purpose. In view of this process, it is possible that the number of VEC participants funded for backfilling costs (having completed 4 modules) may not be correct. We have noted that the HSE's Internal Audit team recently reported on SKILL backfilling[7].

Level of integration

The lack of integration between the CNMEs and the rest of SKILL is a real one, shown in a number of ways:

- Participant data is not recorded in the one database. Furthermore, each CNME maintains it own data.
- There was no CNME/ NMPDU representative on the national SKILL committee.
- With minor exceptions, there is little integration of the VEC and CNME streams at a local level. For example, generally it is not possible to identify one individual with total responsibility (i.e. VEC & CNME) for SKILL participants at a hospital level nor are there local (e.g. hospital) steering committees with oversight of the whole programme. Therefore, the level of integration at a national level would appear to be mirrored at a local level.
- Pearn Kandola evaluation reports do not appear to have included CNME participants explicitly.
- A further difference is that backfilling costs for CNMEs are paid in one instalment whereas payments relating to those on SKILLVEC are made in two equal instalments.

Conclusion

Our overall conclusion is that the governance of the programme is devolved and there is a lack of central control.

[7] The scope of the audit covers an assessment of controls, on a sample basis, of backfill claims and payments during the period 2007 - 2009.

3 EY's approach

EY was commissioned to assess the value for money of the SKILL Programme. In taking forward this research, EY:

- Studied previous documentation relating to the SKILL Programme
- Developed an understanding of best practice in evaluating training activity, drawing on expertise within the firm
- Commissioned a data search of key information
- Reviewed the written submissions sent from different participating organisations
- Carried out interviews with a broad range of stakeholders.

The bias of the evidence was towards organisations which had benefited most from the SKILL Programme, and so one outcome is an increased understanding of best practice.

One difficulty in taking forward this evaluation was in the availability of data. Some of the data that EY has requested has not been available, and other data which has been collected from HSE data sources has been a challenge to source as it is held across various HSE functions and external bodies. Additionally, there is a lack of integration between these data systems.

3.1 Terms of Reference of this Review

The terms of reference for this project are to assess the impact of the SKILL Programme in terms of:

- The particular literacy needs of this group of staff
- Appropriateness of the education and training interventions provided through the SKILL Programme for staff who are returning to learning
- The impact of the education and training at individual and service levels i.e. the transfer of learning to the workplace
- Skill mix and up-skilling changes as a result
- Customer satisfaction
- Culture change impact on a learning organisation with knowledgeable workers where support staff and support service managers have equal opportunities to training interventions.

EY is aware of the Comptroller and Auditor General's report (2010) into the SKILL Programme and of the HSE internal audit reports. This study is not intended to duplicate those reports, and does not assess financial controls and/or compliance with expenses/procurement policy.

3.2 EY's Approach

EY's approach was designed to assess the effectiveness and the efficiency of the programme against a Value for Money Framework which considered the following questions:

- Economy (cost/input)- can the activity be done at a lower cost?, which is within the efficiency section, looking specifically at the cost of training participants
- Efficiency (input/output)- what inputs are turned to outputs?, with a specific focus on the cost per graduate and the number of withdrawals
- Effectiveness (output/outcome)- how well do the outputs achieve the required outcomes?, which is covered through the effectiveness section.

The Value for Money assessment was carried out by performing the following steps:

1. Study of previous documentation on the programme; a detailed log was established with 30 documents. This included:

   - descriptions of the SKILL Programme
   - previous evaluations of the programme, such as the Pearn Kandola attitudinal work
   - other studies such as "Best Practices for supporting Health Care Assistants to increase participation in direct care" by the University of Leeds School of Healthcare and the "National Review of the Role of the HCAs Assistant in Ireland" by the HSE/ SKILL Programme
   - literacy studies such as "a cost benefit analysis of adult literacy training" by the National Adult Literacy Agency.

2. Study of best practice in HR evaluations; wider material was researched on the effective evaluation of training activity, which drew on the broader expertise available within EY. One of the main themes from this research was the importance of securing organisational as well as individual benefit from investment in training:

   - An interview with Donald Kirkpatrick in November 2010 on evaluation of training, posted by Annie Hayes in "The Training cycle". Donald Kirkpatrick identified the need for results, which demonstrated the impact on the business of the learner's performance.
   - Value of Learning: From Return on Investment to Return on Expectation" by Valerie Anderson, commissioned by the UK CIPD in 2007. Valerie Anderson's study interviewees described the development of what can be termed return on expectation (ROE) measures of the value of learning. This involves focusing on establishing 'up front' the anticipated benefits of learning interventions or investments with key stakeholders, and then assessing the extent to which the anticipated benefits have been realised.

3. Data search; data was sought from the HSE to establish essential background information such as:

   - costs of the training activity
   - number of participants.

   Other data included success or performance measures for the critical mass sites (CMSs) for key indicators such as absenteeism and MRSA infection rates. These measures could be compared to national average data.

   In assessing the data, we examined SKILL take-up levels by participants across a wide range of organisations/ sites in order to assess the impact on organisations at different levels of (training) maturity.

4. Study of written submissions; EY received 77 written submissions, which were assembled into a log. The overwhelming majority were from CMSs. The written submissions varied from personal testimonies to detailed evaluation studies. In some instances, follow-up submissions were provided where further information had been sought.

5. Structured interviews were carried out to seek a broad range of views. A detailed script was prepared for each interview. Amongst others, interviews included:

   - SKILL coordinators at HSE sites, including St James's Hospital and Cork University Hospital
   - Representatives from Nursing and Midwifery Practice Development Unit (NMPDU)/ Centres for Nursing and Midwifery Education (CNME)
   - Participants and non-participants at the Irish Blood Transfusion Service
   - Nursing managers at St James's Hospital and at Clonakilty Community Hospital
   - Representatives of disability organisations such as Stewarts Care Ltd, the Donegal

Centre for Independent Living and the Irish Wheelchair Association
- Representatives of the National Federation of Voluntary Bodies
- Education providers at City of Dublin Vocational Education Committee (CDVEC), Open Training College (OTC) and University College Dublin (UCD)
- Representatives of the IMPACT, SIPTU and UNITE trade unions.

We are very grateful to the individuals and organisations who have prepared submissions and met with us. We recognise their commitment and professionalism, and also their belief that the underlying objectives of the SKILL Programme are deeply worthwhile.

Inevitably, the people who we have spoken to and involved are key stakeholders in the SKILL Programme, who have a deep commitment to making the programme work. We have not spoken to the individuals who did not gain from the programme apart from some non-participants at one CMS.

Apart from CMSs, and despite our requests, we have not received a single submission from the HSE regions. This makes it difficult to assess the impact of the programme on HSE organisations which are not CMSs.

The evidence we have seen is oriented towards the good practice examples which organisations have shared with us. This evidence provides powerful insights into the potential benefits of the SKILL Programme, if that good practice can be shared effectively across the country.

3.3 Concerns about data

In preparing this report, we have encountered concerns over the data. Some of the data that EY has requested has not been available, and other data which has been collected has been a challenge to source as it is held across various HSE functions and external bodies. Additionally, there is a lack of integration between these data systems.

Participant data

For example, the SKILL office does not have a composite database to keep track of the total number of participants. It has relied on a number of other sources- the CDVEC database and ad hoc information collected on an as need be basis from the NMPDU/ CNMEs. To be clear, this means that the SKILL office does not have an integrated database with essential information to manage and analyse how the programme is working.

Financial data

Financial data collection has also been difficult. Maintaining readily accessible financial data is a prerequisite for programme management and analysis. While we have sourced relevant data, we have not secured data in an appropriate format for analysis e.g. EY has not identified a financial summary of SKILL Programme expenditure under all of the relevant categories of expenditure such as backfilling, tuition costs for CNMEs, etc. Instead, we has been consistently referred by the SKILL office to other sources such as HSE internal audit and the Comptroller and Auditor General. The Comptroller and Auditor General's analysis indicated that internal training costs fluctuated throughout the programme. Therefore, EY has sought to separate the backfilling costs from the other internal (CNME tuition) costs. This has not been possible and indeed after many conversations, we have been directed to the heads of finance for the HSE regions. This suggests that financial analysis was not uppermost in the governance of the project.

Performance data/metrics

The collection of hospital or organisational (potential) performance indicators such as MRSA statistics, absenteeism, accidents, injuries, hygiene scores, client satisfaction has been most challenging and largely not available for some of the sectors/settings which benefit from SKILL training. There are two issues. One, the information is often not collected (e.g.client satisfaction data was not collected for the period under review), and, two, even where data is available, it has to be sourced from many disparate HSE functions (e.g.BIU, HR, CNMEs, Health Protection Surveillance Centre) and external (e.g.HIQA) data sources before any analysis can be conducted i.e. data sources are not integrated/coordinated.

3.4 Document structure

In the rest of the document,

- **Section 4** assesses the efficiency of the programme
- **Section 5** assesses the effectiveness of the programme
- **Section 6** sets out our recommendations.

4 Efficiency

Efficency relates to the ratio of inputs to outputs. In the context of this study, inputs are costs/ funding and outputs are participants/ graduates. The effectiveness of the quality of graduates and their input on their organisation is assessed in Chapter 5.

The SKILL Programme has spent €59m since 2003/04 and has supported about 10,600 participants.

The programme has trained fewer participants than envisaged when it was set up, and this has efficiency implications. There may be opportunities to use procurement negotiations to secure improved value for money from providers, and this could include measures to incentivise provider performance.

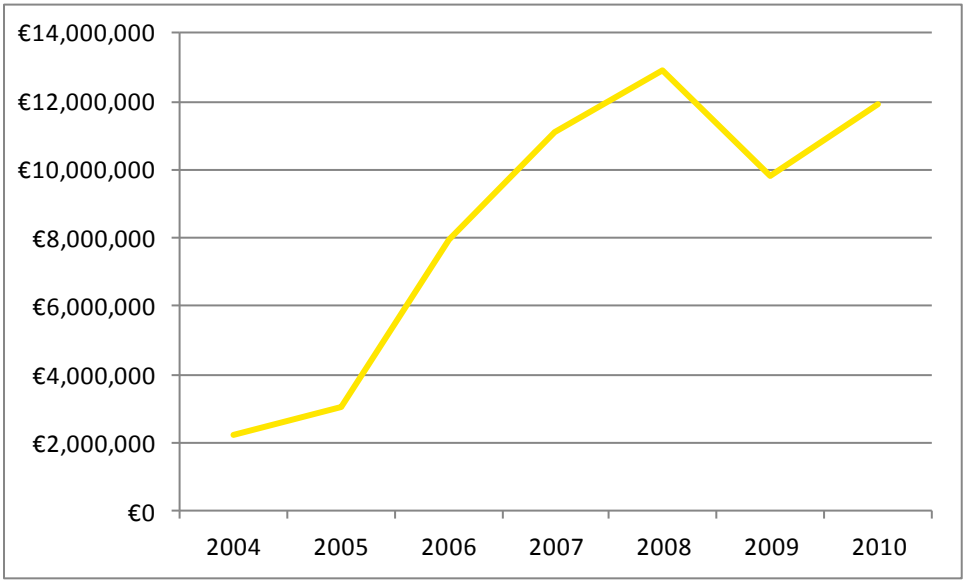
On average, 78% of participants graduate. In addition, a large number withdraw before the course starts. This is an area of focus for efficiency. A related point is the number of participants who take more than one year to complete the programme, and this has resource implications for the employing organisation which receives a one-off backfill payment,

A Pearn Kandola evaluation suggested that only 57.6% of participants were able to transfer their learning to the workplace, and this also has efficiency implications. In conclusion, the cost of the SKILL Programme per participant is €5,559, the cost per graduate is €7,128 (see Section 4.4)and the cost per participant who was able to transfer their learning to the workplace is €9,648 (see Section 4.5).

4.1 Overview of costs

In total, the SKILL Programme has spent €59m since 2004. The following chart demonstrates year to year expenditure over the lifetime of the programme.

Chart 4.1: Year on Year expenditure on the SKILL Programme since its inception



Sources: Date for 2004-2009 was taken from the Report of the Comptroller and Auditor General, Volume 2, Accounts of the Public Services 2009. This table is based on information provided by HSE Internal Audit. 2010 expenditure data provided directly to EY by the HSE SKILL office.

The profile of spending is set out in the following table.

Table 4.2: Expenditure on the SKILL Programme since its inception								
Expenditure Classification	2004 €000	2005 €000	2006 €000	2007 €000	2008 €000	2009 €000	2010 €000	Total €000
External Training Cost	-	8	1,133	5,239	4,923	4,430	4,253	19,986
Internal Training Cost	2,088	2,474	6,147	5,142	7,166	5,009	7,568	35,594
Grants	50[a]	-	250	250	250	250[b]	33[e]	1,083
Reimbursements [c]	3	-	25	92	228	-	-	348
Other Costs [d]	100	573	387	365	339	132	57	1,953
Total	2,241	3,055	7,942	11,088	12,906	9,821	11,911	58,964

Sources: Report of the Comptroller and Auditor General, Volume 2, Accounts of the Public Services 2009. Table based on data provided by the HSE Internal Audit. 2010 expenditure data provided directly to EY by the HSE SKILL office.

Notes:
a. According to the HSEA records, the grants of €50,000 in 2004 was paid to SIPTU
b. The grant paid in 2009 was €208,200. An amount of €41,800 advanced for other purposes in 2008 was treated as satisfying part of the 2009 grant
c. Some of the payments referred to as "reimbursements" could be considered as payments made pursuant to further funding applications. For convenience, they are aggregated with amounts paid as reimbursements of expenses
d. Includes expenditure on SKILL office operations, consultancy, advertising, Kennedy Fellowships, SKILL Grant Scheme, travel and subsistence, hotels, conferences and taxis
e. This figure refers to a grant scheme for returning to education. Similar grants in 2004-09 are covered either in Reimbursements or Other Costs.

The expenditure above relates to the following:

External training: This relates to educational expenditure for the VEC providers; so CDVEC, UCD and the OTC.

Internal training: The SKILL Programme provides a grant to employers in respect of each participant (currently €3,500). The internal "backfilling" costs amount to approximately twice the cost of the training activity. The cost of delivering SKILL training internally through the Centres for Nursing and Midwifery Education (€1,554 per participant) is also included in this category of "internal training" cost.

Grants: This relates to the following:
- Funding given by the Department of Health and Children and the Office of Health Management for the provision of training to frontline supervisors in the health services, paid to the University of Limerick via SIPTU
- Grants in relation to costs associated with research and development in industrial relations and human resource management programmes / research to identify management skills and attributes for support services.

Reimbursement and other costs: Includes reimbursement of expenses, payments made following further funding applications, as well as expenditure on SKILL office operations, consultancy, advertising, travel and subsistence.

Note on internal training costs

We noted from our review of costs above that internal training costs increased by 148% between 2005 and 2006 and they increased by 39% between 2007 and 2008. This is in spite of the fact that CNME participant numbers fell by 2.45% between the academic years 2004/05 and 2005/06 and participant numbers fell by 17.4% between years 2006/07 and 2007/08. Using internal cost data provided by the SKILL office we were able to analyse the increase in funding awarded to particular HSE regions:

1. Increase from 2005 to 2006:
   - Increase of €1,313,596 in the funding given to HSE West
   - Increase of €1,681,470 in funding designated as "HSE Corporate"
   - Increase of €306,550 in funding awarded to HSE Dublin mid-Leinster.

2. Increase from 2007 to 2008:
   - €189,306 awarded to Eastern Regional Health Authority in 2008, nil given in 2007
   - Increase of €695,318 in funding provided to HSE South
   - Increase of €139,977 in funding provided to HSE West
   - Increase of €476,356 in funding awarded to HSE Dublin mid-Leinster
   - Funding of €408,817 given to HSE NMPDU Palmerstown in 2008, nil given in 2007.

We were unable to analyse these variances any further and contacted the SKILL office to obtain explanations for the increase in these specific areas of funding in the years concerned. The SKILL office had not provided us with any explanations on these movements at the time of issuance of this report. While this is presumably related to the timing of backfilling costs, we have not seen any definitive explanation.

4.2 Number of participants on the programme

When it was established, the SKILL Programme was intended to train up to 4,000 participants a year, albeit expectations early in the life of the programme envisaged about 2,000 participants per annum. The average cost of training a participant has been €5,559 (2004 to 2010) which is higher than might be expected. HCAs are significantly more likely to participate on the programme than other groups. There are also variations,between regions, with HSE South sending more participants than other regions and a high number of participants from the disability organisations.

4.2.1 Participation rates against original expectations

Originally, the SKILL Programme was set up to address the learning needs and aspirations of 32,000 supervisors and support staff in the health service by training circa 4,000 participants per annum. In reality, the number of participants being trained annually was significantly lower, demonstrated in the following charts. 5,796 participants commenced the programme through the VECs.

Table 4.3: SKILL participants commencing each year through VEC and their outcomes						
Description/Year	2006	2007	2008	2009	2010	Total
Active	177	202	341	523	1,435	2,678
Dropped out after commencing	174	111	84	53	22	444
Graduated	754	775	702	431	1	2,663
Active, due to graduate in 2011	1	1	3	6	-	11
Total	**1,106**	**1,089**	**1,130**	**1,013**	**1,458**	**5,796**

Source: CDVEC database[8]. CDVEC data in this report is based on data received as at 13 December, 2010, unless otherwise noted.

Note: This table excludes 1,679 people (registered) who withdrew before the course began.

In addition, 4,811 participants commenced the programme through the CNMEs.

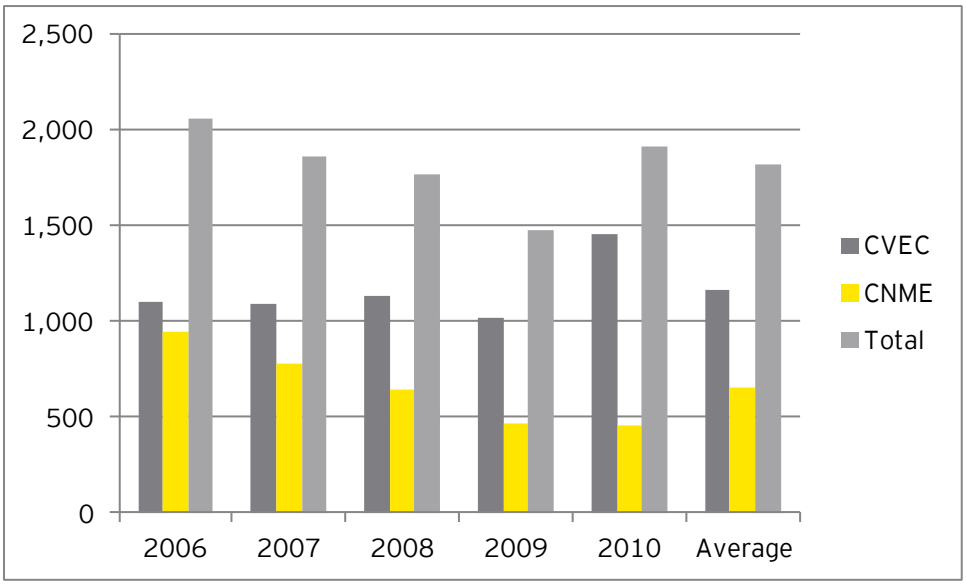
Table 4.4: CNME skill participants commencing each year								
Region/Year	2003-4	2004-5	2005-6	2006-7	2007-8	2008-9	2009-10	Total
Midlands	25	80	72	76	51	35	16	355
Dublin North	107	132	140	139	106	74	60	758
Dublin South	139	181	192	136	158	56	90	952
North East	25	53	49	53	50	35	35	300
West	51	99	108	69	36	52	43	458
MidWest	57	68	58	34	33	29	38	317
Cork and Kerry	31	110	84	74	57	55	46	457
North West	75	137	144	122	94	73	77	722
South East	42	112	102	72	55	56	53	492
Total	**552**	**972**	**949**	**775**	**640**	**465**	**458**	**4,811**

Source: CNME data, based on data received as at 24 January, 2011

In total, CDVEC and CNME data combined suggests about 10,600 have been participants of the SKILL Programme. The following chart suggests that annual take-up is about 2,000 participants a year.

[8] CDVEC developed a database to keep a record of all VEC participants.

Chart 4.5: Annual take-up (number of participants) on the SKILL Programme



Sources: CDVEC database and CNME data

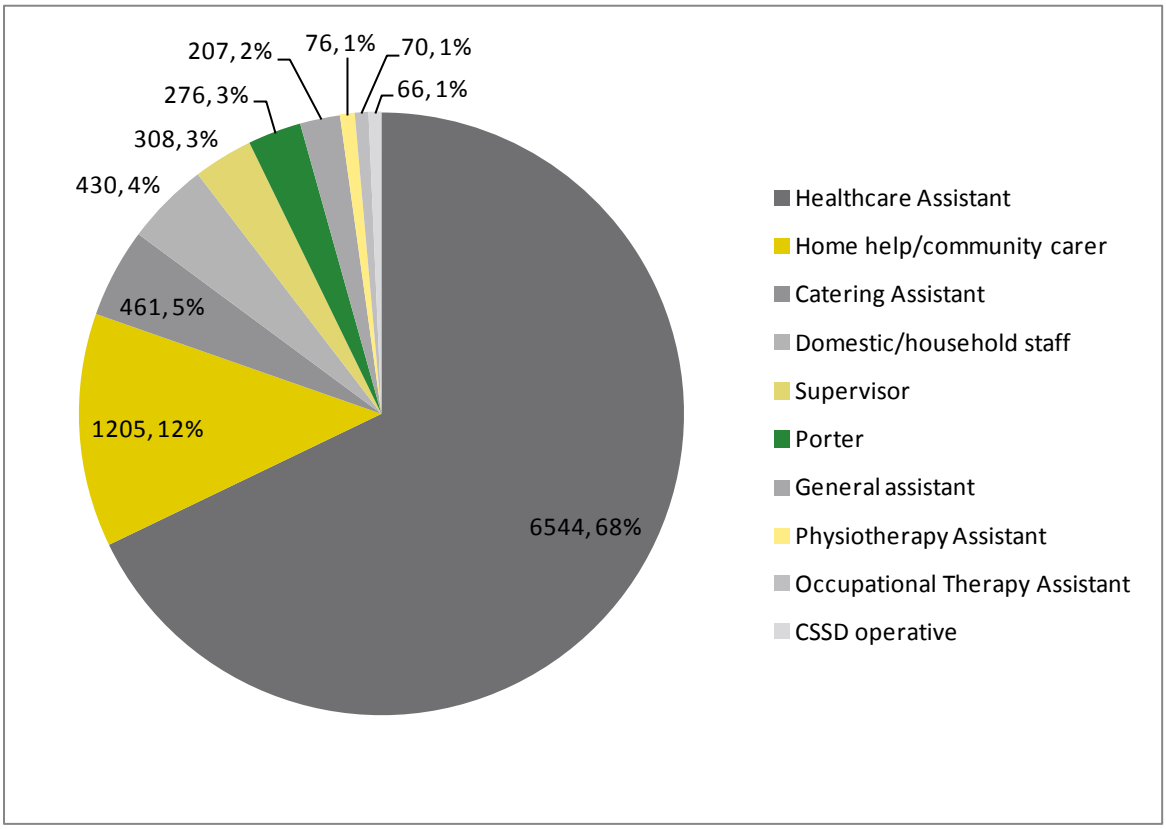
Note: For the purposes of this chart, 2009/10 CNME data was taken as 2010, and so on through the last five years.

Taken as a whole across the lifetime of the programme, the cost of the programme per participant is €5,559. The original expectation was to train 4,000 participants a year, which was probably unrealistic within an annual budget of c. €12m. EY's assessment is that over the lifetime of the programme to date, backfilling costs average about €3,000, with training costs €1,500-€1,800. This would suggest that the average cost per participant, taking account of additional expenses, might be expected to be around €5,000-€5,300, which in turn suggests that the cost of the programme per participant is around 5%-10% more than might have been expected.

4.2.2 Variations in participation rates

The following chart sets out the breakdown of SKILL participants by grade, pulling together the CNME and CDVEC data.

Chart 4.6: Breakdown of SKILL participants by grade



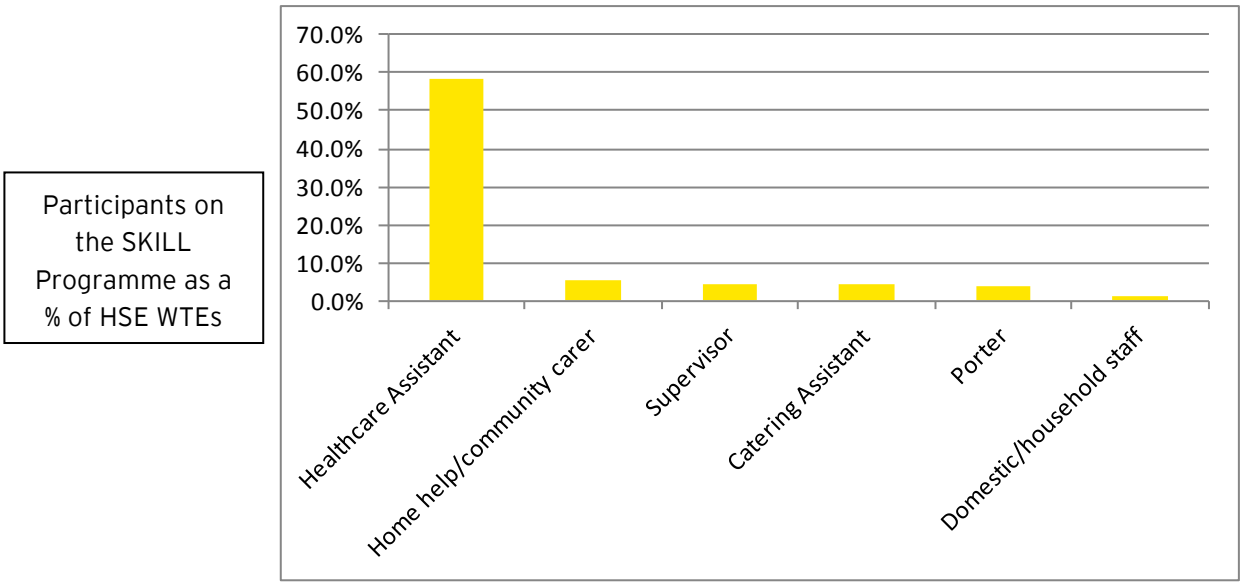
Sources: CDVEC database and CNME data

Note: This includes people who dropped out before commencement.

This demonstrates clearly that HCAs represent two thirds of the SKILL Programme participants. With home helps and community carers, who perform similar roles to HCAs outside of the hospital setting, those two groups represent 80% of the SKILL participants. The remaining roles represent 20% of participants between them.

A further indicator of the weighting of the programme is the number of participants as a proportion of HSE WTEs for the grade. The following chart provides this information for grades with more than 250 participants on the SKILL Programme. It demonstrates the greater importance of the programme to HCAs than to other groups.

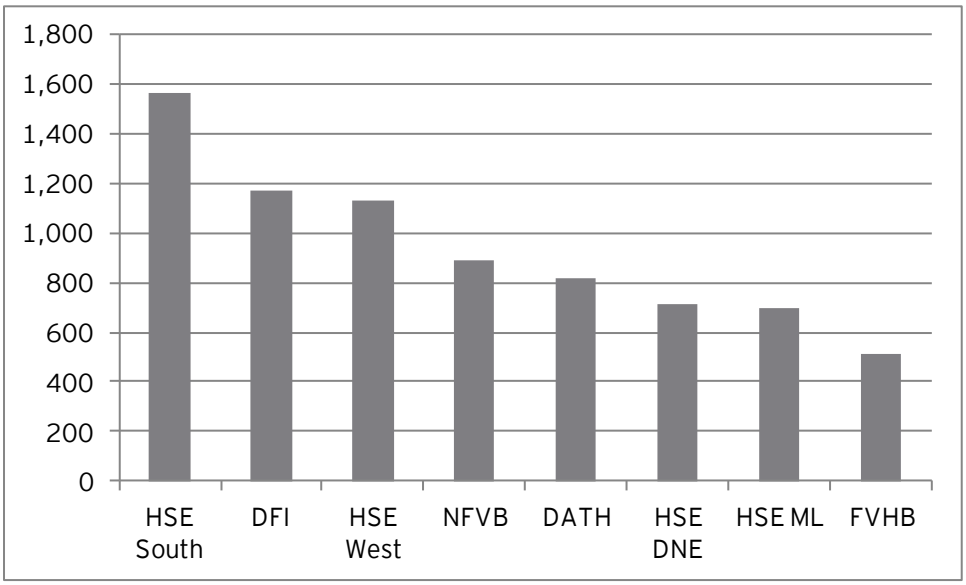
Chart 4.7: SKILL participants as a proportion of HSE WTEs, for the six eligible grades with the largest number of HSE WTEs



Sources: CDVEC database and CNME data, HSE workforce data

A second point of comparison is in the breakdown of participants between the organisations. This is demonstrated in the following chart.

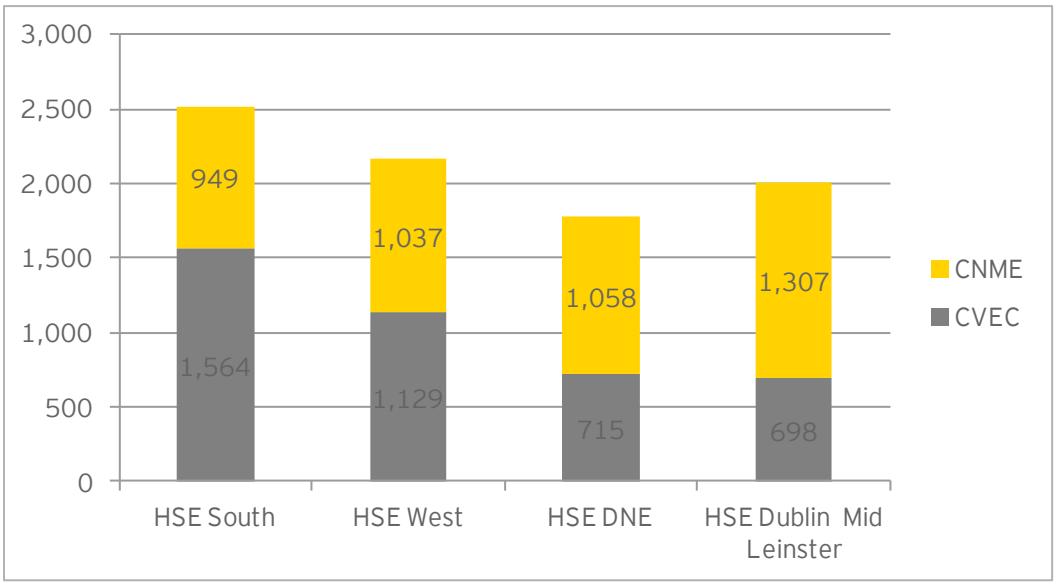
Chart 4.8: Number of SKILL VEC participants from different organisations



Source: CDVEC database

The following chart also shows the number of SKILL participants in each region, which suggests that there has been a much higher take-up in HSE South than elsewhere. The data suggests that the difference between the South and other regions is the greater numbers of participants attending the VEC programme.

Chart 4.9: Number of SKILL participants 2006-2010 in each region, split between CNME and VEC participants

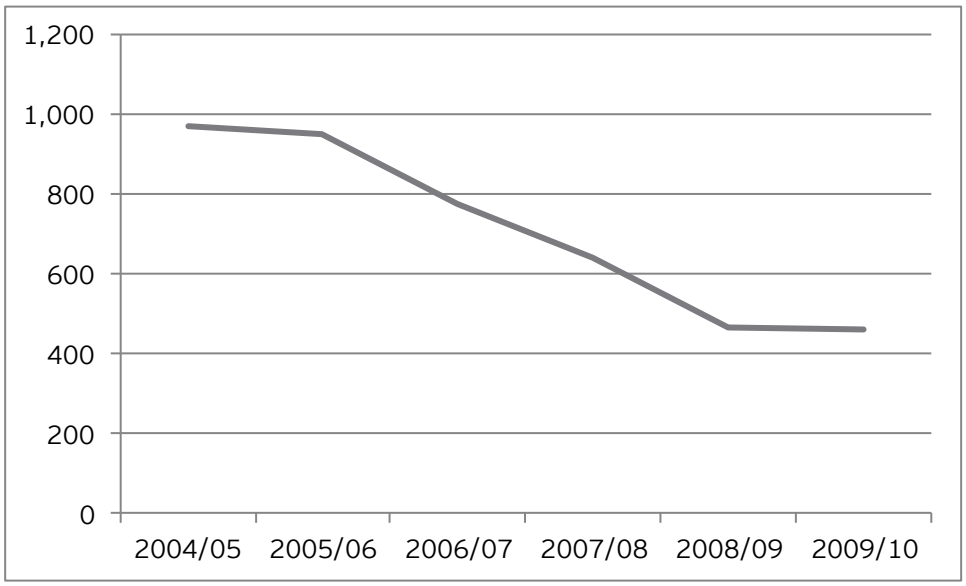


Sources: CDVEC database and CNME data

Note: These participants include participants from disability and voluntary organisations. CNME information was provided as nine regions which were then grouped as: **South,** Cork and Kerry, South East; **West,** North West, West, Mid West; **Dublin NE,** Dublin North, North East; **Dublin Mid Leinster,** Midlands, Dublin South.

One interesting point is that the number of CNME participants has declined significantly in recent years. This is shown in the following chart.

Chart 4.10: Number of CNME participants by year



Source: CNME data

A final point of analysis is gender participation rates. Analysis of the VEC participant data[9] suggests that 78% of participants were women. Information is not available on the gender breakdown within particular roles, which is needed to assess whether men or women are under-represented.

4.3 Value for money considerations

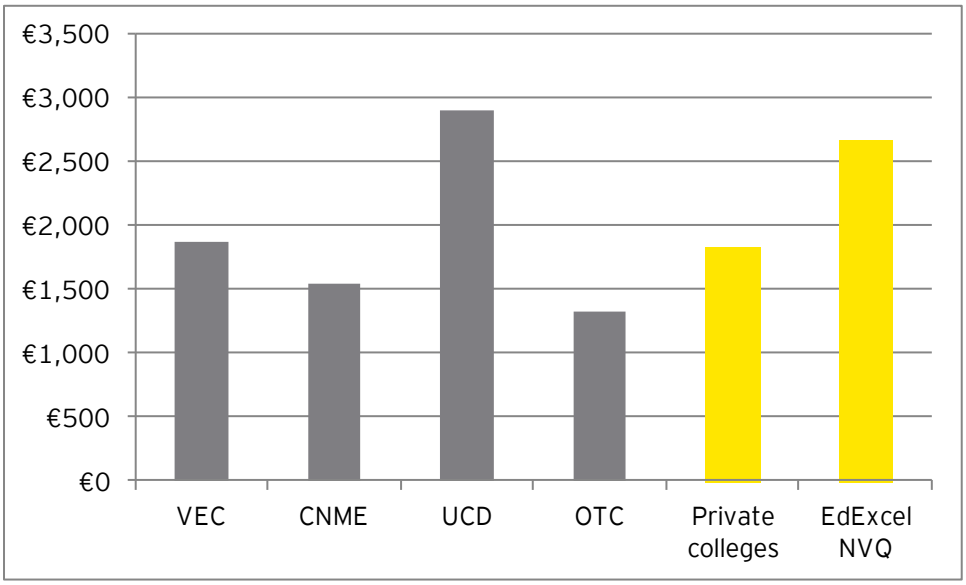
Costs of the training programme participant are broadly similar to, or better than, private providers. An efficiency concern is that classes are not always filled. There may be opportunities to challenge providers who have a lower proportion of their participants achieving distinctions or merits in their examinations.

4.3.1 Benchmarking costs

One area to explore is whether contracts with providers are securing value for money. It is difficult to assess whether full efficiency has been secured from the contracts without a detailed study. However, the Report of the Comptroller and Auditor General stated that "no evidence was available to my staff of how tenders were evaluated and selected to provide the training"[10]. Procurement, by its nature, provides opportunities to ensure value for money and to incentivise performance.

In order to measure the value for money in relation to education providers we undertook a benchmarking exercise. Benchmarking costs is an important aspect of an assessment of the training activity. EY researched the costs of providing similar training from private providers and benchmarked these against the costs of the main SKILL providers. The following chart illustrates the variances in cost across these private providers.

Chart 4.11: Tuition cost per participant of the main SKILL providers, benchmarked against equivalent private college costs



Sources: Contracts with City of Dublin VEC, OTC and UCD; SKILL Programme for CNME costs, internet research on EdExcel (UK) NVQ with cost converted into €s
Note: Some organisations, such as UCD and OTC, provide two modules only. Costs were extrapolated on the basis of eight modules.

[9] CDVEC data. This includes participants who dropped out before the course began.
[10] Report of the Comptroller and Auditor General, September 2010.

Note on private college costs:
UCD costs are significantly higher than the other providers' costs, which can be partly ascribed to the use of specialist radiography equipment which are expensive to run. Private college costs are an average of one similar Level 5 and one similar Level 6 course run through private colleges (the courses have mostly the same modules but some module content can vary from the more specific HSE tailored modules in the SKILL Programme). Fees are on a per student basis and so these private college costs are expected to be higher due to lack of economies of scale.

In order to facilitate comparison with private college costs, the VEC cost above includes only module training/delivery costs associated with running the SKILL Programme and excludes significant costs associated with pre-learning assessment, module production and preparation, project co-ordination and tuition delivery. These costs are excluded as these are considered to be costs specifically related to the SKILL Programme which would not be included on the same scale in the fees of equivalent private college courses.

The figures for private colleges were obtained on an individual basis. Private college costs above have been deflated to 2007 levels using the "Miscellaneous Goods and Services" CPI on the CSO website (as the VEC, OTC and UCD contract costs were agreed and signed in 2007). EdExcel training costs are the costs of a UK NVQ (National Vocational Qualification) programme at Level 3 and 4 in Social Care, which is broadly equivalent to Level 5 FETAC. The training programme covers three core units and one specialist unit and lasts two years.

A number of conclusions can be drawn from Chart 4.11.

- Firstly, there is some variation between the costs of the different SKILL providers. OTC training costs are lower than the other organisations, with UCD costs highest.
- CNME average costs are slightly lower than the VECs.
- As a related point, UCD has identified concerns about the administrative costs associated with the SKILL Programme. They report that the procedures are bureaucratic, particularly in sub-contracting to a university to grant the FETAC certificate because UCD is not a FETAC accredited body. UCD has signalled that it is not prepared to continue with current arrangements, but would be willing to continue under a different arrangement.

Separately, the private sector costs are broadly equivalent to the costs of the SKILL providers, and in some instances are higher. However, the private sector costs are estimated on the basis of an individual subscription. With economies of scale, it could be possible to establish a greater differential between the costs of SKILL providers and private sector costs.

4.3.2 Class size/attendance

A further concern is to ensure that all courses have a full complement of participants. The Report of the Comptroller and Auditor General into the SKILL Programme in September 2010 carried out a study of one hundred module delivery sheets. It was noted that 55 modules had an attendance of 15 or more, 45 modules had an attendance of less than 15 with 25 of these with 10 attendees or less. The report noted that this has value for money implications.

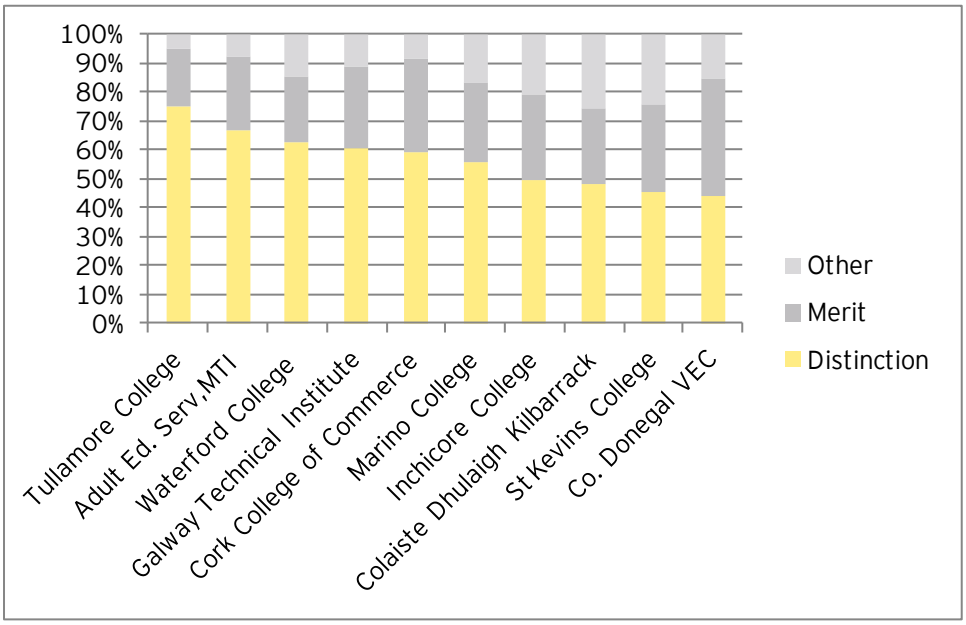
As a related point, the Comptroller and Auditor General cross-checked 25 module delivery sheets against the related database. 72% of the sample did not reconcile with the attendance figures. Consistent with this analysis, CDVEC data provided by the SKILL office for 2009/10 which indicates a class average size of 13.75.

We understand that the HSE is looking at different costing/ pricing structures and risk sharing arrangements for the education providers for the next phase of the SKILL Programme. This is welcome if it has the necessary incentives and registration efficiency to maximise each individual class size.

4.3.3 Proportion of graduates who achieve distinctions and merits

A further measure of performance is the proportion of participants obtaining distinctions and merits. The following chart shows that there is variation in performance between the different colleges.

Chart 4.12: Proportions of VEC participants obtaining Distinctions and Merits, broken down by the ten most popular colleges



Source: CDVEC, 14 December, 2010 (VEC data on grades achieved for students who reached exam stage)

Note: To achieve a distinction, a participant must obtain a grade of 80% or more in their final examination. A merit is awarded when a grade of 65-79% is obtained, and a pass is awarded when a grade of 50-64% is obtained. Other in this context means pass, or that the participant did not complete.

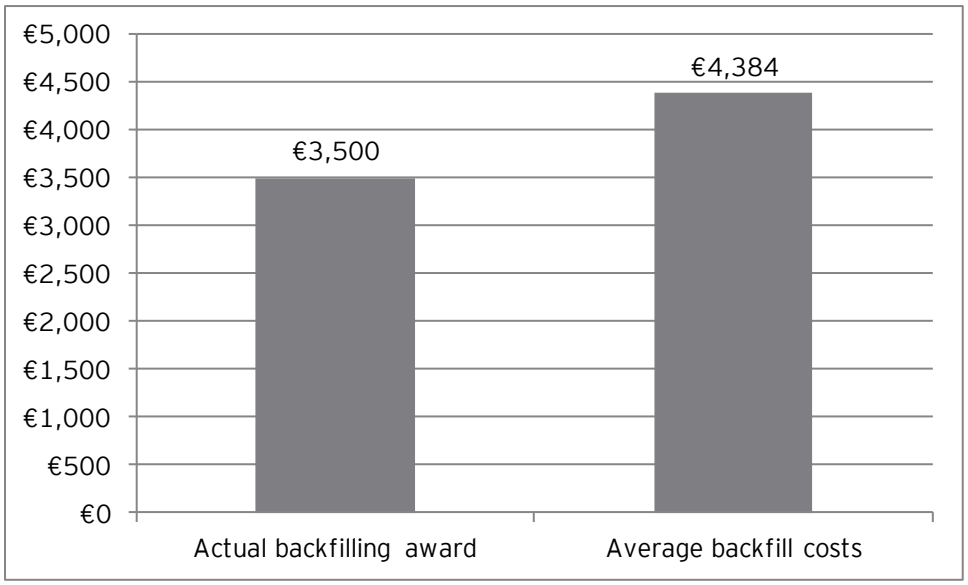
One option moving forward might be to introduce contractual levers to reward colleges with higher numbers of distinctions.

4.3.4 Backfilling

Backfilling is an important element of the progamme. It is evident that it has helped to get a level of buy-in from participating organisations. Feedback suggests that some employing organisations are becoming reluctant to release staff for the SKILL Programme as they have to meet the additional costs beyond the backfilling grant, and manage the disruption to the activity.

The cost of backfilling is significant. Employers are given a flat rate payment of €3,500 per participant which is, generally, fully paid in year 1. The Report of the Comptroller and Auditor General estimated that the full replacement costs associated with release of staff is €4,384 excluding PRSI paid by employer.

Chart 4.13: Average estimated backfilling cost vs. actual current backfilling payment award



Sources: Average estimated backfilling cost: C&AG report (2009). Current backfill payment: HSE

The additional costs to be borne by the participating site/organisation is evident in the following example. Our analysis confirms that there is an additional cost to the service providers which must be considered. The fact that service providers are willing to release staff and meet part of the backfill costs demonstrates a commitment to the programme.

Case Study - Cork University Hospital Backfilling Example

Cork University Hospital estimate that the shortfall in funding for 2010/11 will amount to €23,663 or 13% of the total cost of backfilling/administration of the programme. The estimated cost is €180,163 against a fund of €156,500. These costs are based on the following assumptions:

- The above backfill costs are inclusive of Employers PRSI of 10.75%. All relief staff are paid a flat rate of pay. This is assumed to be the average rate of pay for all staff except porters and housekeeping staff where the actual relief pool rate is applied. The relief pool is generally made up of students.
- The costing in relation to the SKILL Coordinator is based on 50% of salary costs (inclusive of Employer PRSI) for the period February to December 2010.
- The total number of working days that require backfill is 32 days per participant (8 hours per day).

The average shortfall per person (based on 39 participants)is €607. The cost of subvention ranges from c. €400 in the case of porters/housekeeping to over €750 in the case of HCAs.

Source: Cork University Hospital

While backfilling payments are an important element, it is unusual to have such a significant financial support mechanism in place. The significant costs associated with backfilling mean, now more than ever, that it must be kept under review in order to assess if such costs can be reduced.

There are a number of factors which should be considered in this respect:

1. The Public Service Agreement 2010 – 2014 (Croke Park Agreement) specifically refers to:
   - "achieving a more productive match between staffing and service activity levels across the working day/week/year while safeguarding quality and clinical performance;

- further developing and utilising the skills of all health professionals through the introduction of expanded roles…"

2. There may be an opportunity to redesign or reduce the number of modules, particularly, for non HCAs programme.
3. Furthermore, in time, organisations may be in a position to require core/common modules to have been completed before entering the HSE/service providers with the result that any additional or supplementary modules required in order to perform a specific role would require less backfilling.

All of these considerations or developments could lead to a lessening in the need for backfilling and a consequent cost saving to the programme nationally albeit such considerations need to be carefully balanced against the impact on participant demand and organisational commitment.

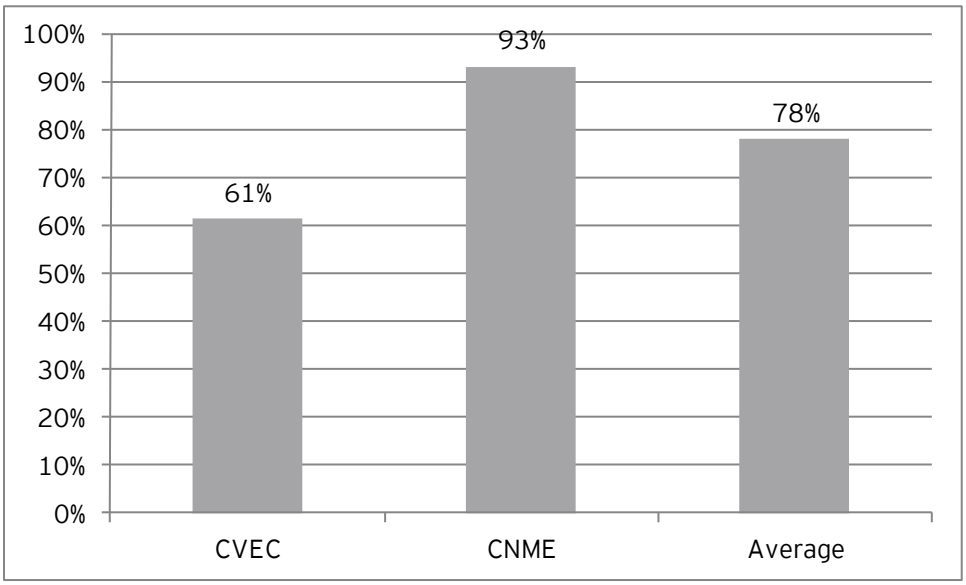
4.4 Proportion of participants who graduate

The cost of the SKILL Programme per graduate is €7,128 against a cost per participant of €5,559. 93% of HCAs who participate on the CNME programme have graduated, which compares favourably to the 28% withdrawal rate of HCAs on the CDVEC progamme. There are also variations of performance between employing organisations and training colleges in terms of the proportion of withdrawals. Older participants and porters are more likely to withdraw from the programme than other groups.

A further concern is the length of time participants are taking to graduate, with some taking more than one year. Of the VEC participants who graduated in 2010, 36% had taken more than one year to complete. This has an impact on employing organisations. They receive a one-off backfill payment of €3,500 from the HSE although analysis suggests that the average cost of replacing a SKILL particpant is well over €4,000.

The graduation rate is one important indicator of the effectiveness of the SKILL Programme. The following chart shows the proportion of VEC and CNME participants who graduated.

Chart 4.14 Proportion of participants who graduate

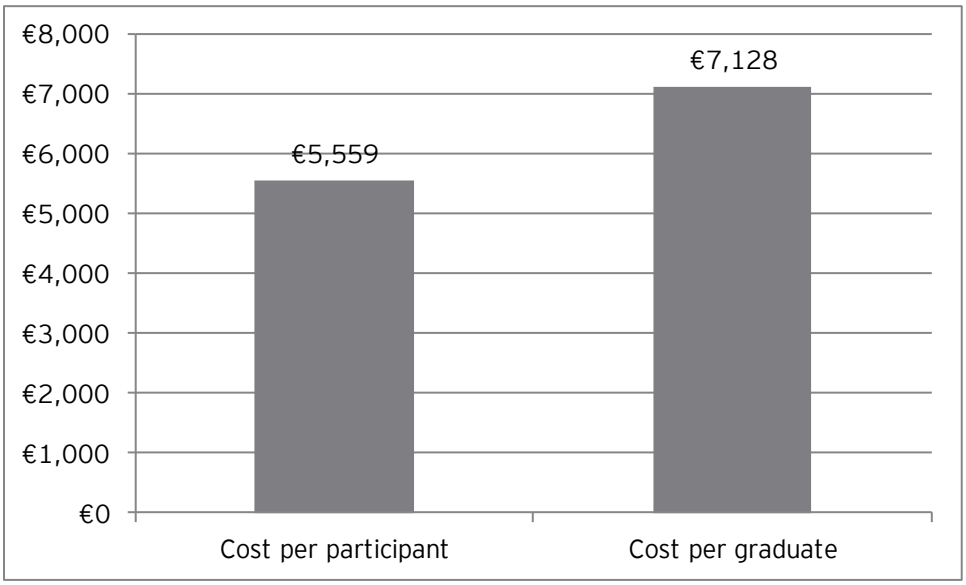


Sources: CDVEC database and CNME data

Note: CDVEC numbers do not include 2010 participants, as only 1 person had graduated from that intake at the time the figures were prepared.

An important point is that 28% of VEC HCAs have withdrawn[11] from the programme, which compares with the 93% CNME graduation rate. This would suggest that the CNME programme is more efficient than the VECs in getting people through the programme. The cost of the SKILL Programme per graduate is 28% higher than the cost per participant[12], as shown in the following chart. The number of participants is greater than the number of graduates which explains why the cost per participant and per graduate are different.

Chart 4.15: Cost of the SKILL Programme per participant and per graduate over the lifetime of the programme



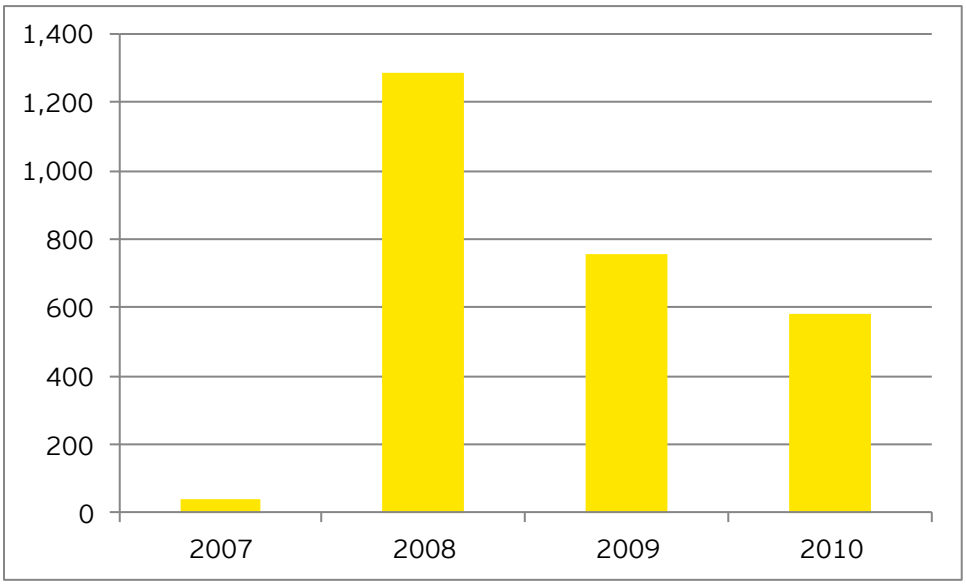
Sources: CDVEC and CNME databases**.** Overall costs taken from table 4.2. Proportion of graduates of participants taken from average figure used in chart 4.14.

We examined the number of VEC participants graduating annually, firstly taking figures supplied by the CDVEC. There was a soar in the graduation numbers from 2007 to 2008. The greatest number of graduations was in 2008. Graduation numbers have declined steadily since then.

[11] CDVEC data.

[12] Cost data and CNME participant data are as of 31 December, 2010. VEC participant data was provided on 13 December, 2010.

Chart 4.16: Graduation numbers by year



Source: CDVEC database

Of this number, the number of Level 6 graduates is 275 out of a total of 7,146 SKILL graduates, suggesting Level 6 graduates account for about 3.8% of the total. 186 of the 275 Level 6 graduates are described as supervisors with an additional 21 described as HCAs. A year by year breakdown of graduates has not been provided for CNME graduates.

4.4.1 Withdrawal rates

One area of concern is the number of people who signed up to the programme but withdrew before it started. Figures provided from the VEC database suggest that 1,679 people registered for the SKILL Programme but did not begin their studies. This is a very significant figure of 22.4% of VEC registrants. The CNME equivalent is 4.8%. Taking the overall external costs of the SKILL Programme over the number of participants, (i.e. an average external cost per actual participant of €3,448), the cost attributable to 1,679 non participants could potentially equate to €5.79m. This cost is indicative as the actual cost will depend on the structure of each provider's arrangement and actual number who registered yet failed to show up and whether those non-participants were replaced by others. Not only is there an actual cost but there is an opportunity cost of the value foregone as it is a missed opportunity to train more people.

Furthermore, the CNME data provided to EY indicates that 338 people withdrew either before or after course commencement. At a training cost rate of €1,554 per participant, this amounts to a potential loss/cost of c. €525k.

One simple illustration is in data provided by the OTC, which reflects the withdrawals in relation to the two job specific intellectual disability mandatory modules.

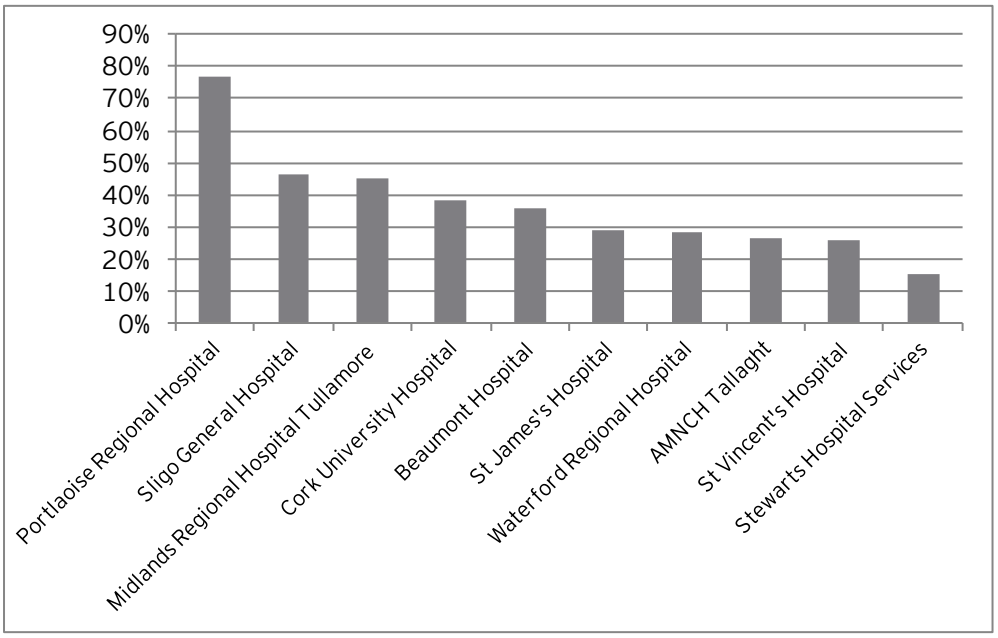
Table 4.17: OTC withdrawal prior to commencement		
Number students registered	1,816	Confirmed to OTC within days of commencement
Number completed (2 modules) to Nov 2010	1,322	Have been through the FETAC process
Number completing (still in system)	313	Includes 180 that did not attend initial workshop but returned to later workshop and are still in the system completing
Number withdrawn	181	Represents 10% of the number registered

Source: OTC, 9 December 2010

On the basis that 10% of those registered failed to show, this represents a loss to the HSE of €26,133 (€144 per student which is the variable charge applied by the OTC) based on the variable delivery cost (i.e. excludes fixed cost) as per OTC/ HSE agreed costing structure i.e. the OTC will be paid irrespective of whether the participants show.

It is important to identify differences in performance in withdrawal rates. The following chart shows the proportion of participants who withdrew by the participating organisation and includes those who dropped out pre and post commencement.

Chart 4.18 Withdrawal rates by participating organisation

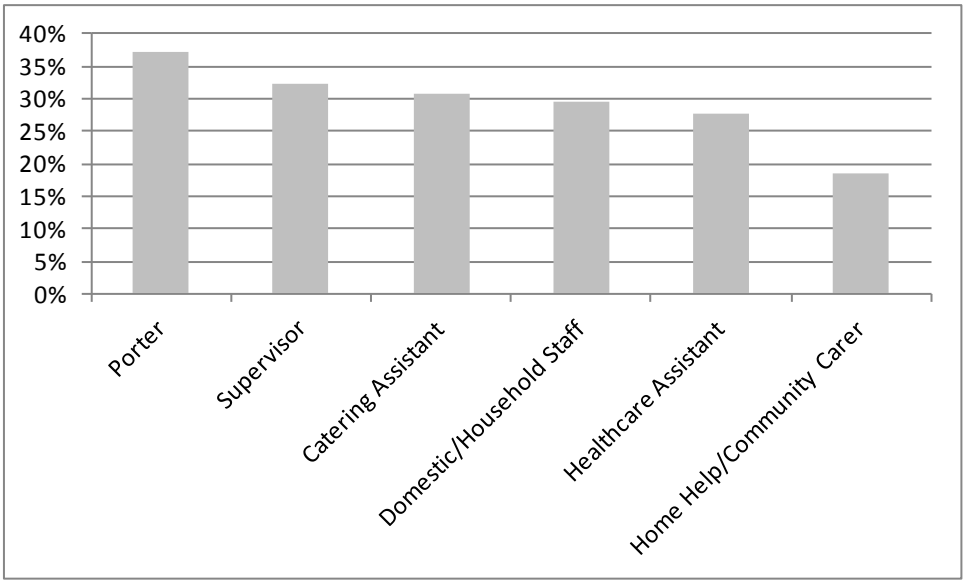


Source: CDVEC database

Note: The above is a summary of the top 10 participating organisations for which WTE information was available.

In addition to the 1,679 VEC participants who dropped out before commencement, 444 dropped out post commencement. An analysis of VEC withdrawals by grades showed high number of withdrawals (pre/post commencement), for some groups, such as laundry assistants and porters. This chart excludes groups such as laundry assistant/ operatives, where participation rates were relatively low.

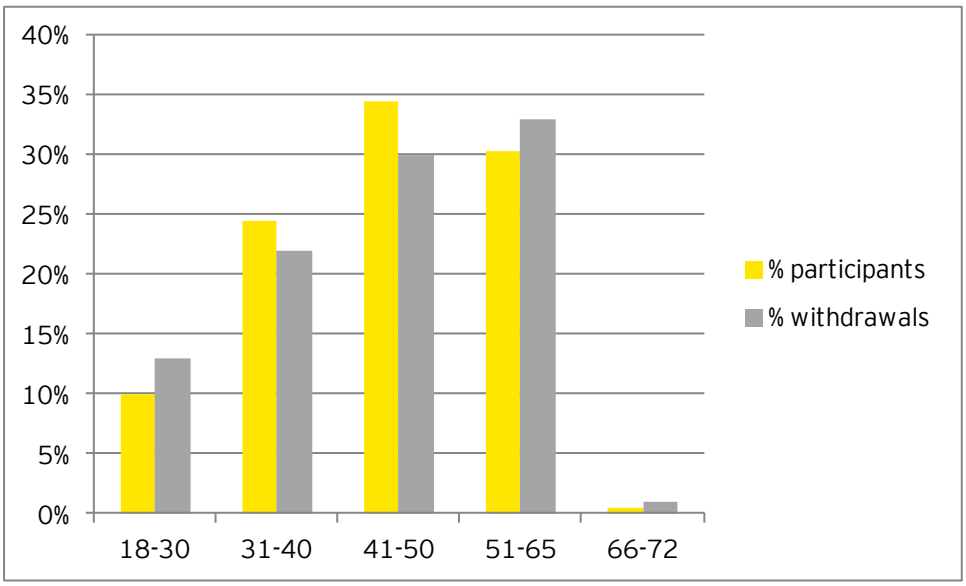
Chart 4.19: Proportion of VEC withdrawal rates by grades, focusing on grades with the highest number of participants



Source: CDVEC database

A second analysis compared VEC withdrawal rates and participation rates by age group. This demonstrates that older participants and younger participants are proportionately more likely to withdraw than participants in their 30s and 40s.

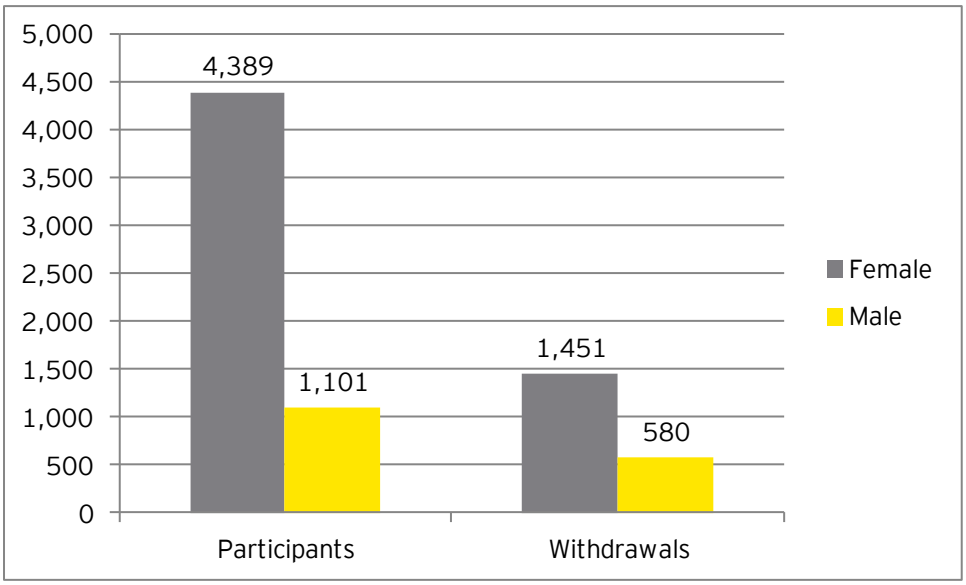
Chart 4.20: Proportion of VEC withdrawal and participation rates by age group



Source: CDVEC database

A third analysis looked at participation rates by gender. The following chart sets out participation and withdrawal rates by gender on the VEC programme. 43% of male participants and 33% of female participants withdrew from the programme.

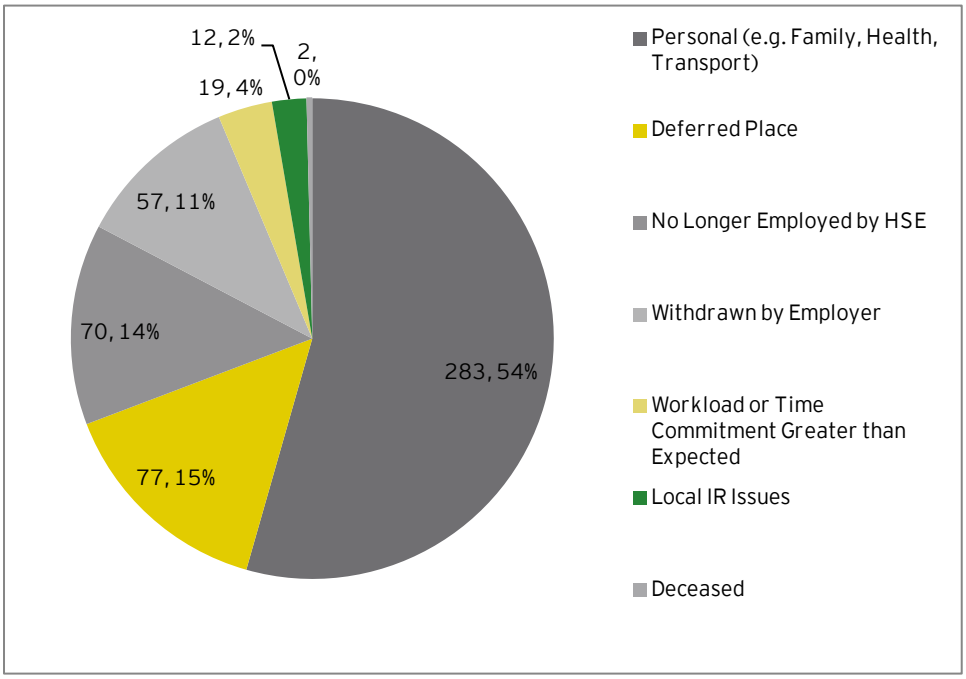
Chart 4.21: Number of female and male VEC participants and withdrawals



Source: CDVEC database

The chart below identifies the reasons for withdrawal of VEC HCA participants. 69%, more than two-thirds, left the SKILL Programme either because of family commitments, workload pressures or because the employer withdrew them. 54% cited personal reasons.

Chart 4.22: HCAs Assistant withdrawals and reasons for withdrawal



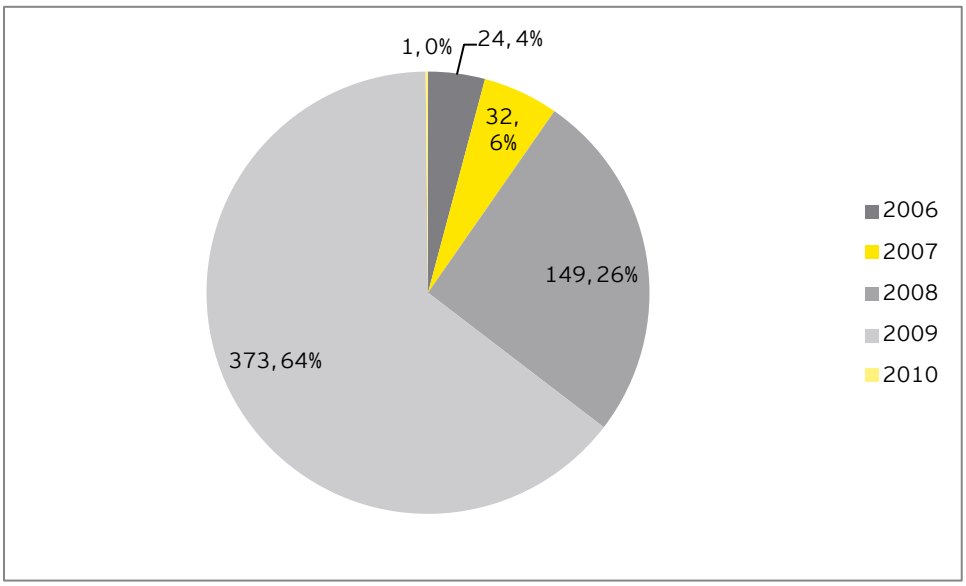
Source: CDVEC database

In conclusion therefore, there is scope to drive up the efficiency of the programme through cutting down on the withdrawal rates. A significant number of participants register on the course but do not take up their place. VEC participants are more likely to withdraw than CNME participants. There is also evidence of variations in withdrawal rates between the participating organisations and between educational providers.

4.4.2 Length of time taken to complete courses

A further area of focus in reducing the cost of the programme per graduate is the length of time participants take to graduate. The following chart sets out, for the people who graduated through FETAC (VEC) in November 2010, the year in which they started the course.

Chart 4.23: Participants who graduated in 2010 and their year of commencement



Source: CDVEC , 22 December, 2010

The fact that 36% of participants take longer than one year has significant implications from a financial point of view for the employing organisation. If a participant takes longer than one year, then backfilling costs (from the health provider's perspective) will also arise in years when no backfilling payment is due. Therefore, reducing the time taken to complete the course would reduce the overall cost of the programme.

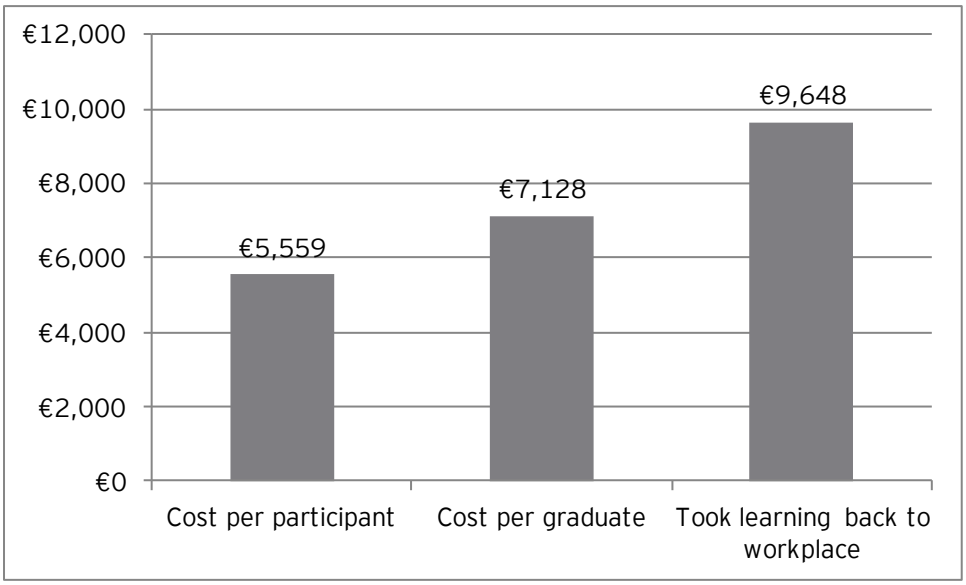
4.5 Efficiency conclusions

In conclusion, there are a number of important indicators which suggest that the efficiency of the SKILL Programme can be improved, in terms of the cost per participant and the cost per graduate.

One further assessment of efficiency is the number of participants who were able to transfer their learning to the workplace. The 2008 Pearn Kandola Research identified that only 57.6% of participants agreed or strongly agreed with the statement that "Since completion of the SKILL Programme, I have been supported to transfer my learning back to work". Using that 57.6% figure, then the average cost per participant who has been able to transfer their learning back to the workplace is €9,648, against a cost per participant of €5,559.

The following chart compares the cost of the SKILL Programme per participant, the cost per graduate and the cost per participant who transferred their learning back to the workplace.

Chart 4.24: Cost of SKILL Programme per participant, cost per graduate and cost per participant who transferred their learning back to the workplace



Sources: CNME data and CDVEC database. Transfer of Learning - Pearn Kandola 2008 evaluation. Costs - see table 4.2

There is a 74% difference in the cost per participant and the cost per participant who took their learning back to the workplace.

In addition to the c. 35,000 support staff in the HSE, we have noted that there is another 11,800 staff who are graded as clerical officer and grade IV (clerical). We understand that this group of staff would not, generally, have post leaving certificate qualifications. This group of staff do not have access to Level 6 training. While the needs of such staff merit consideration, there may be an efficiency gain to be made if such staff could also leverage the SKILL training programme. While we have not studied the clerical roles in detail, it would appear that the general modules (e.g. Communications and Introduction to IT & Computer Applications) of the Level 6 course may also be relevant to their job roles.

5 Effectiveness

This chapter assesses the effectiveness of the SKILL Programme against core terms of reference:

- The particular literacy needs of this group of staff
- Appropriateness of the education and training interventions provided through the SKILL Programme for staff who are returning to learning
- The impact of the education and training at individual and service levels i.e. the transfer of learning to the workplace
- Skill mix and up-skilling changes as a result
- Customer satisfaction
- Culture change impact on a learning organisation with knowledgeable workers where support staff and support service managers have equal opportunities to training interventions.

Each term of reference is addressed in turn.

Overriding points are that the SKILL Programme makes a significant difference to the self-esteem, confidence and professionalism of the individuals who participate. There is not evidence that this learning has been transferred back to the workplace in a systematic way.

However, where an organisation invests in the SKILL Programme, there appears to be evidence of improved operational performance. CMSs demonstrate improved performance against key indicators compared to the national average, and CMSs with highest participation rates generally report the most significant performance improvements.

It is important to point out that there may not be a direct correlation between the SKILL Programme and improved performance against those indicators. A number of factors could have a role. However, there is evidence to suggest that those critical mass hospital sites are proving successful in improving performance, and that the SKILL Programme is part of their efforts to improve the organisation.

5.1 Particular literacy needs of the group

Adult literacy is a national concern. 4.7% of VEC participants were referred for literacy support (Level 3 or 4) following the Pre-Learning Assessment. Participation rates from grades (domestic/ household staff, catering staff) who are more likely to require literacy support is lower than participation rates of HCAs.

Some individuals are using Level 3 qualification to move on to Level 4 and Level 5 and this demonstrates clear progress for those participants. Graduation at Level 5 is the core level and also its achievement indicates a standard of literacy. However, with overall participation rates still low (c. 10,600 participants to date), and with 276 Level 3 and Level 4 participants (graduated/active) out of a HSE WTE staff cohort of c. 35,000 (excluding other eligible non HSE organisations), it is possible that many of the literacy issues are not identifiable.

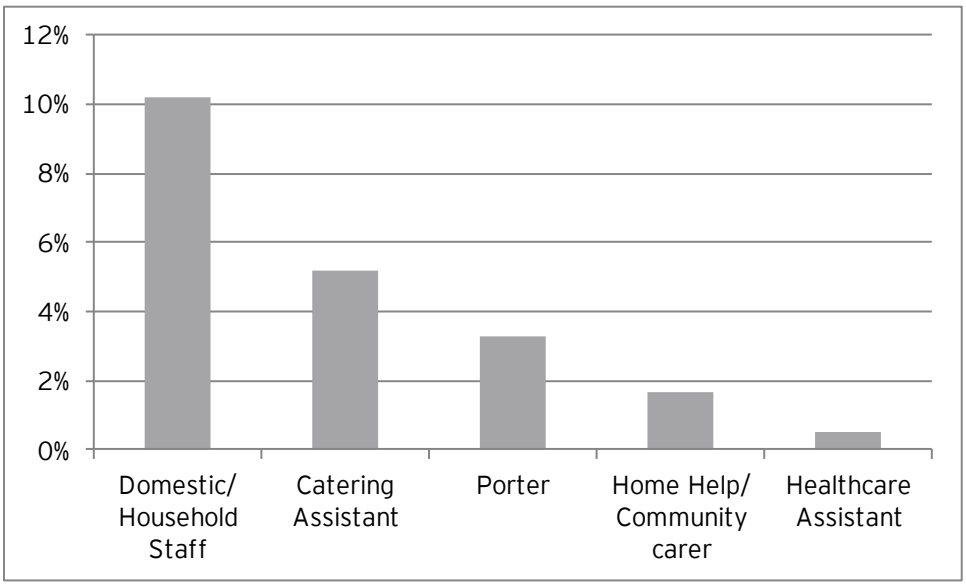
Adult literacy is a national issue. The 1995 International Literature Survey identified that a significant number of the Irish population have problems with basic tasks in literacy and numeracy. This survey classed about 25% of the population with Level 1 literacy capabilities (the lowest in a five-part scale) in respect of document, prose and quantitative literacy.

National research[13] suggests that increasing literacy has an important impact on the individual's economic potential. This cost benefit analysis of adult literacy training suggested that on average the income gain for working trainees from each increase in NFQ (National Framework of Qualifications) level was €3,810 per annum.

A Pre-Learning Assessment is carried out on eligible participants. This ensures that staff with low levels of literacy; i.e. without FETAC Level 3; are identified and supported. Stakeholders report that people with low levels of literacy are invited to apply, and that barriers are not placed in their way.

575 people were referred after the PLA to a Level 3 or Level 4 course. This amounts to 4.7% of all participants who registered for the programme[14]. EY carried out an analysis by grade of the proportion of participants through the VEC programme who required a Level 3 intervention. This is set out in the following chart.

Chart 5.1: Proportion of participants who required a Level 3 intervention, by grade



Source: CDVEC, 16 December, 2010

One key point is that participation rates for those groups where someone is more likely to require literacy support is relatively low. For example, the participation rate for domestic staff is 1.5% of HSE WTEs, the participation rate for porters is 3.9% of HSE WTEs, the participation rate for caterers is 4.5% of HSE WTEs and the participation rate for home helps/ community carers is 5.5%.

One concern is that many organisations we have spoken to reported that they place people on the SKILL training course through seeking volunteers. Working from the basis that people with low literacy levels are likely to be more insecure about formal education, it is possible to suggest that this group are less likely to volunteer. SIPTU reported to EY that they provide literacy training to their members on an anonymous basis. They suggested that some efforts be made to provide anonymity to participants on the Level 3 course.

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13 A cost benefit analysis of adult literacy training, Research report, March 2009, by the National Adult Literacy Agency.

14 The number includes all those who registered including staff who withdrew before the course began. Source: CDVEC, 13 December, 2010.

A small number of staff are using Level 3 and Level 4 qualifications to progress further – this indicates progression in terms of literacy.

Table 5.2: Progression of participants through Levels 3 and Level 4 to Level 5			
Role	**Level 3 and Level 4**	**Level 4 and Level 5**	**Level 3 and Level 5**
Catering Assistant (ID Sector)	1		
Catering Assistant, etc	4	5	2
Domestic/ Household Staff, etc	7	7	2
HCA (Non-SKILL VEC)	1	3	
HCA, etc	6	6	3
Home Help/ Community Carer	1	1	
Porter	1		2
General Assistant		1	1
Physiotherapy Assistant		1	
Total	**21**	**25**	**10**

Source: CDVEC database, 16 December, 2010

5.2 Appropriateness of the education and training interventions provided through the SKILL Programme for Staff, who are returning to learning

The programme was developed to help support staff perform more effectively in their roles. There is an ongoing need for the programme at a macro level, based on an appreciation of the importance of support staff roles and the need to do them well. In addition, the link between the programme and FETAC qualifications is appropriate. Individuals benefit from the focus on their learning, particularly in terms of self-esteem and increased confidence. However, some feedback suggests that the greater flexibility about taking a few modules would make the course more attractive to some potential participants, particularly those with family commitments.

Feedback suggests that the course could be tailored more effectively to the workplace in some instances. There is some feedback that the training could be more tailored to the needs of staff who support people with disabilities. CNMEs argue that their hospital based training package is more appropriate than the VEC training for HCAs.

5.2.1 Programme need

In terms of the history and development of the SKILL Programme, the programme was developed out of an identified specific training and competence need for support staff in health services. We have noted the skill needs assessment (a large survey of 4,000 staff) and the competency profiles developed by the Office of Health Management. This work and the existence of the health skills training through CNMEs which predates the commencement of the SKILL Programme are evidence of the detailed work on which the SKILL Programme was founded.

Therefore, there was an identifiable need for such a programme at a macro level. This need extended to the acute and community sectors, and in time other groups such as those represented

by DFI were included in mid 2006. Organisations such as the Donegal Centre for Independent Living have pointed out to EY that they would not be equipped to provide staff with training opportunities on this scale without central support.

Stakeholders expressed strong views that the programme was needed because the work of support staff is important and should be done well. A Director of Nursing, who had insisted that all her HCAs attended the programme, stated that "caring for people demands competency". One trade union representative emphasised the importance of support staff in delivering patient care, giving the example of the role that catering staff played in helping patients recover through providing nutritious food.

Furthermore, there is broad agreement that the development of Level 5 and 6 training with the majority of those to be trained at Level 5 was a laudable objective, and that the programme was pitched at the right level (i.e. FETAC Level 5 and 6) which is generally appropriate for those in this target work group who are returning to education. Levels 3 and 4 were provided for those who needed more support and the level of referrals (575 to date) which is running at 4.7% (of participants) is evidence of the need for such additional supports.

5.2.2 Appropriateness of interventions for individuals

The mere fact that the participants education is being taken seriously and that they are valued by the organisation is arguably the most important aspect of the SKILL package. 65% of the SKILL VEC participants[15] are aged 40 and above and this group will have been out of the education system for at least 20 years. The SKILL Programme supports a group of staff who, in the words of a trade union representative, have traditionally been considered as "second-class citizens".

Consistent feedback suggests that the growth in self-esteem and self-confidence is possibly the biggest single benefit of the SKILL Programme.

> *"My confidence has grown over the course of the experience. My graduation was a great day, I am the first member of my family to graduate, all the family turned up and cheered me on, it felt great."*
>
> Participant feedback, from disability organisation
>
> *"Now I won't always think of me as only being a mum"*
>
> Participant poem as part of the Communications module, Waterford Regional Hospital

The Pearn Kandola research[16] asked SKILL participants at Level 5 a series of attitudinal questions. 84% of participants and 100% of line managers agreed or strongly agreed with the two statements that:

- "Since completion of SKILL, I am more confident about doing my work"
- "SKILL has given my staff members the opportunity to learn new knowledge and skills that they would not have learned otherwise"

However, there is feedback, including from SKILL coordinators and from non-participants, that the course could be more attractive if a flexible approach was adopted for some. In this model, participants would have the option of studying a few modules rather than all eight. This could be

[15] CDVEC database.

[16] Pearn Kandola: HSE Skill Project Long-term Evaluation: Report on the Scatter Model Behavioural Level Evaluation, May 2008.

more attractive to participants with less confidence about returning to the workplace and to participants with family commitments.

The same Pearn Kandola research made also examined Level 6 and stated that "the findings for Level 6 show that based on how the participants rated themselves there has been an improvement in approximately 50% to 90% of the behavioural indicators for 5 of the competencies: Analysis and Decision Making; Quality and Customer Focus; Planning, Organising and Prioritising; Communicating and Influencing, and Motivating, Developing and Empowering. Of the remaining 5 competencies, there was only a significant improvement in 20% or less of the behavioural indicators across each competency." However, the report also concludes that "further review of these high-lighted that this may be due to participants rating themselves as effective on most of the behaviours prior to the programme". Interestingly, the report concludes that "between 76% and 84% of participants reported increased motivation, confidence and commitment at work following completion of SKILL".

5.2.3 Need for the programme at a specific role level

The programme has to cater for a broad range of roles from HCAs to household staff to porters and across a diverse mix of organisations – teaching hospitals, acute hospitals, voluntary bodies, disability groups (physical and intellectual), community and primary care settings .

Our research suggests that there is broad agreement that an 8 module course as currently designed is appropriate for HCAs. We have some concerns about a programme which trains HCAs through two different routes i.e. HCAs can be trained in both the CNMEs and the VECs. The two models of training were described in section 3.

In terms of the specific learning, participants on the SKILL Programme cover five core modules:

- Communication
- Teamworking/ Building effective working relationships
- Health and Safety
- Personal development, including caring for and valuing self
- Procedures, Legislation, Quality.

The 2008 Pearn Kandola research[17] suggested that, in all five core modules, participants and line managers identified between a 95% and 99% likelihood of significant improvement in the participant's performance. Notwithstanding that, we have identified some concerns about the need for an 8 module programme for all of the non HCA categories. This point may have added relevance when one considers the low levels of programme up take to date, set out in section 4.2.

An issue has been raised about the relative merits of training HCAs by the SKILLVEC programme as opposed to through the CNME. Some CNMEs noted HCAs trained by SKILLVEC would not be allowed to perform certain activities (e.g. taking blood pressure) that CNME trained participants would after their training. The CNME/health service provider would reassess the SKILLVEC participants and make sure they have adequate training before allowing them to use these new skills. The CNMEs believe their training is superior as the participants' work experience was far more practical and realistic. The CNMEs also noted that training is provided by qualified nurses in the CNMEs whereas the VEC tutor may not have a medical background.

[17] Pearn Kandola: HSE Skill Project Long-term Evaluation: Report on the Scatter Model Behavioural Level Evaluation, May 2008.

A CNME noted the training takes place over 5 weeks in a block release format which they believed was better than one day a week as done by SKILLVEC. They believed five intensive weeks was better and more could be learnt and retained. The block release was deemed to be particularly successful in CMS centres as a greater number of trained HCAs were being released back onto the wards at once which aided the potential impact of the training.

> *'…I had 19 HCAs achieving their FETAC Level 5 award at once. They all heard the same thing and came back at the same time. They worked together so supported each other in making a change…'*
>
> CNME interviewee

The CNME have submitted a business case for the CNME to increase their capacity in order to train all HCAs and other support staff. This business case was submitted to the SKILL Programme in March 2009 with the intention of it been considered prior to the tendering process in early 2010.

More generally, there have been concerns expressed about whether learning can be applied in the workplace. In some instances, there has been feedback that staff have been trained to carry out tasks which they have not been able then to perform when they return. For example, some staff have been trained as HCAs but did not subsequently work as HCAs.

There is a widely held view that the programme as initially developed focused more on the acute sector. For example, more than 30 organisations from the NFVB have chosen not to participate. Related to this, there is an ongoing concern as to whether the SKILL Programme could be more effective through tailoring courses to the needs of the individual and their organisation. For example:

- A 2008 report on the participation of DFI member organisations in the SKILL Project[18] stated that: "Participants report that while they are gaining in knowledge, much of the course delivery reflects a medical model and overlooks the social and community models".
- Feedback suggests that communication modules could be more sensitive to communicating with people with intellectual disabilities.
- Another stakeholder argued that the communication needs of catering staff who deal mainly with colleagues and a porter who has to deal with patients are completely different. This is an argument for putting groups of people from similar professions together as much as possible.
- Where an organisation is able to tailor the bespoke modules to its needs, then it makes a significant difference. For example, the Blood Transfusion Service has developed a bespoke module around venipuncture which enables care assistants to take blood from donors.

This genuine concern has resulted in a review of in terms of their contextualisation and fit for all groups, particularly those from the disability sectors. It is too early to assess impact as the "contextualised" modules are being run for the first time in the academic year 2010/11.

[18] "The Skill Experience: A report on the participation of DFI Member organisations in the Skill project" by Winifred Jeffers.

5.3 The impact of the education and training at individual and service levels i.e. transfer of learning to the workplace

Individuals return to the workplace with fresh enthusiasm and confidence, but there is inconsistency in the transfer of learning to the workplace. Some individuals return and their role is unchanged and they are unable to apply the learning from the programme. CMSs are more effective in transferring learning to the workplace because participants return as a group, but even here application is inconsistent. St Vincent's Hospital is an example of an organisation which has set up a mechanism to measure transfer of learning and to act on feedback. Where transfer of learning is achieved, there are examples of transformed organisational performance.

Team members return back from SKILL with fresh enthusiasm and enhanced self-confidence. One returning participant described himself to us as "100% more professional". This is supported by a submission from Waterford Regional Hospital, which is a CMS. It has demonstrated improvement in a number of workforce indicators which map broadly to "professionalism" between November 2008 and February 2010:

- Absenteeism among HCAs fell from 8.45% to 7.6% and from 8.4% to 8% among general support staff
- Compliance with hand hygiene standards rose from 77% to 80% among general support staff and HCAs
- Compliance with uniform policy increased by 5% for general support staff and HCAs
- Compliance with photo ID policy increased by 10% for general support staff and HCAs.

Staff renewed confidence and commitment can result in new ideas and service improvements:

"I suggested that staff provide face cloths daily for patients instead of weekly… because of the risk of infection. This suggestion was passed at the meeting and introduced. This resulted in a feeling of accomplishment for me… FETAC has provided me with the knowledge and confidence to do this".

Practice Exemplar 3- Acute Hospital, quoted in the National Review of the Role of the Healthcare Assistant in Ireland

Feedback, including that from trade unions, is that there is most benefit when team members are encouraged to transform working practices when they return. Donegal Centre for Independent Living (DCIL) has sent 35 out of 140 personal assistants (HCA equivalent) on the SKILL Programme. In its written submission to this review, it reported that: "this Project has brought DCIL to another level. It has encouraged and awakened potential in our staff who may have never been offered such opportunities before."

There are also examples of where the FETAC course has been used to support the transformation of a team.

A ward in St James's Hospital developed new practices using the Team Based Performance Management (TBPM) tool, with the ultimate aim of reducing patient length of stay. The improved skills of the HCAs were fundamental to this transformation. The concept was to "utilise their knowledge and skills, enhance their job efficiency and effectiveness, and allow them to optimise their ability to enhance their role in the quality of service to patients". Key changes to procedure included changes to the shifts of HCAs and asking HCAs to attend shift handover.

There is inevitable disaffection when a participant returns from SKILL and is not able to make the same difference to the way that the team works.

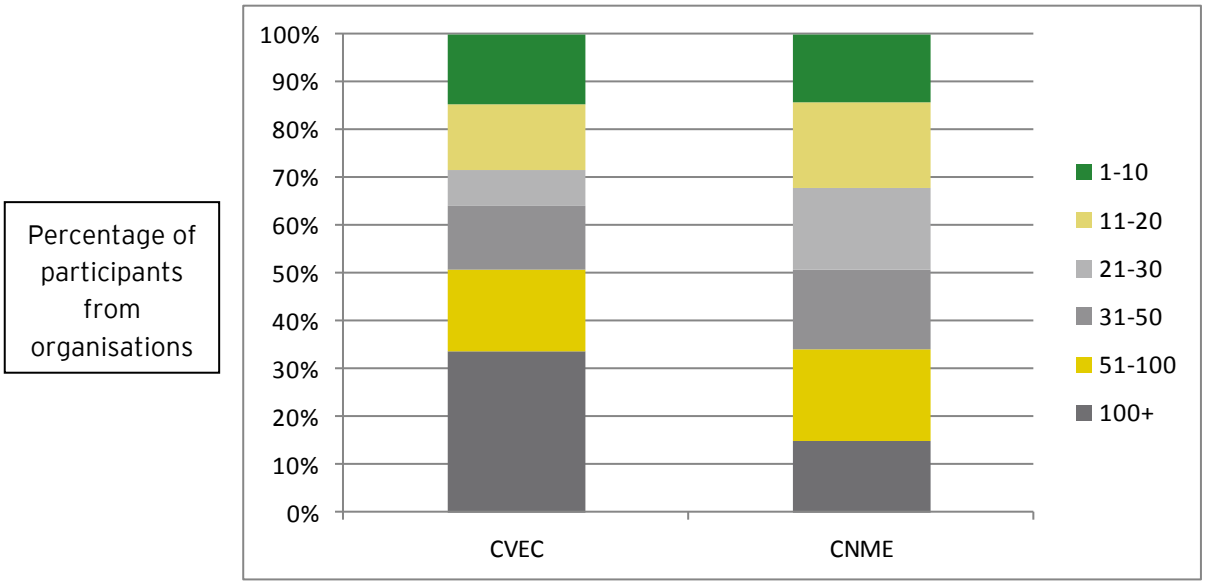
> *"I was asked to complete the fluid balance chart as this was one of the new clinical skills I had studied and passed at the Level 5 FETAC course offered by the HSE. However this didn't come to pass. When I discussed this with the Nurse Director, she stated that even though I was qualified to the level of a care assistant I was still employed as a home help by the HSE and therefore not in a position to use my newly acquired clinical skills. Currently there are no care assistant positions available in the community. The fact that I couldn't use the skills I had acquired impacted this situation as it took a lot of time and effort for me to do this course plus it cost the HSE financially. I don't think a person should be asked to do a course if there are no positions available when qualified. When knowledge is not put into practice a person can de-skill very quickly".*
>
> Practice Exemplar 4- Home help/ Community, quoted in National Review of the Role of the Healthcare Assistant in Ireland

The National Review of the Role of the Healthcare Assistant in Ireland in 2008 noted that 64.07% of HCAs surveyed stated that their role had not changed since the completion of the course.

Similarly, the 2008 Pearn Kandola research identified that only 57.6% of participants agreed or strongly agreed with the statement that "Since completion of the SKILL Programme, I have been supported to transfer my learning back to work" and only 46.5% agreed or strongly agreed with the statement that "SKILL has given me the opportunity to take on new tasks/ activities at work".

The introduction and further development of the CMSs has been a step forward in driving up the benefit for the individual and the organisation when they return to the workplace. The following chart demonstrates that about 50% of VEC participants come from an organisation, which has had more than 50 VEC participants, although this bias towards organisations with more participants is less apparent for CNME participants.

Chart 5.3: Proportion of participants by the number of participants from their employing organisation



Sources: CDVEC database and CNME data

However, even in the larger or critical mass sites, the individual is not able to transfer their learning to the workplace on every occasion. A nursing manager at a CMS, with experience in the English NHS, reported that some participants are not able to develop their roles or change practices if they return to a particular ward. This is extremely demotivating. Her recommendation was that in these cases there was little added value from the staff member attending the course.

As a linked point, UCD has fed back that about 80% of the HCAs from the radiation therapy and diagnostic imagery modules report that their working practices have not changed since they took the course. UCD confirmed that a large number of those participants came from CMSs.

EY's concern is that there are not systematic processes in place in all instances to ensure that learning from the SKILL Programme is deployed in the workplace for organisational benefit. As one stakeholders commented to EY: "Training is not a panacea for systems failure".

There are however positive examples which should be used to spread best practice elsewhere. Many of the CMSs are now starting to develop transfer of learning assessment/ audit tools and to complete their own evaluations.

An example of good practice is St Vincent's Hospital which carried out a detailed review of students and line managers in February 2010. The survey identified that 80% of participants felt that they learned a lot and gave examples of how they transferred the learning back to the workplace. 60% of line managers felt that the SKILL Programme was a success, with the remaining 40% feeling that the students did benefit but that the transfer of learning in the workplace could be improved in some areas.

An example of a recommendation from the review was:

"Infection Prevention and Control was rated very highly by both participants and their line managers. This suggests that the Infection Control module was a huge success and everyone is focused on improving infection control within the Hospital. Line managers may like to build on this through their departmental initiative for example, a suggestion box for Infection Control or an Infection Control theme week rolled out by SKILL students."

5.4 Skill mix and upskilling changes as a result

Performance appraisal systems are under developed in the health systems, and so it is not possible to use such data to assess if FETAC trained staff perform better than those without training. However, there is evidence that some organisations have been able to upskill their workforce. Firstly, some organisations are able to mandate Level 5 FETAC qualification for HCAs as an increasingly significant number have been trained across the Irish health system. Those organisations which have mandated Level 5 have linked training to competence on the job. Secondly, role changes have supported productivity improvements, both through enabling tasks to be carried out more quickly and through support staff taking on roles previously carried out by more qualified and therefore better paid staff. Thirdly, the SKILL Programme has supported role progression, with individuals changing roles, and this has opened up significant opportunities for them.

5.4.1 Performance Appraisal

One difficulty with assessment of the SKILL Programme is the under development of performance appraisal at an individual and team level in the health systems. There are no ratings to assess if FETAC trained staff perform better than those without training.

5.4.2 Mandating FETAC Level 5 for Healthcare Assistant roles

There are a number of ways in which organisations are benefiting from the SKILL Programme to improve the skills of the workforce. One approach is taken by St James's Hospital in Dublin and Clonakilty Community Care to establish FETAC Level 5 as the core basic level of HCA grades. The proposal by St James's to become a CMS included a number of revised job descriptions. The fact that those organisations can now mandate Level 5 FETAC in new recruitment is a positive indicator for the SKILL Programme, in that they believe that enough people now have that level of qualification for this position to be sustainable and that the qualification is regarded as a basic level of competence.

The crucial aspect is that HCAs are able to apply new roles and work in different ways when they return to work after completion of the course. A study of best practice by the University of Leeds[19], commissioned by the SKILL Programme in 2009, stated that:

"In some sites there remain traditional job descriptions for HCAs, (some of which are more reminiscent of ward attendants) that do not reflect the new skills that the HCA has acquired therefore making it difficult for HCAs to be supported to implement their new skills."

5.4.3 Enabling SKILL participants to take on enhanced roles

A further aspect of the SKILL Programme is that it can enable people to take on enhanced roles. This brings significant benefits to the organisation in terms of productivity, both in terms of carrying out tasks more efficiently and through support staff carrying out roles previously carried out by more senior and therefore more highly paid staff.

There are examples of an explicit link between the SKILL Programme and organisational productivity, though this is not evident in all instances.

- An example is the Irish Blood Transfusion Service in Cork which trained 18 out of 25 HCAs to carry out venipuncture through the SKILL Programme. This has transformed the role of those staff. It has also supported a productivity shift to take blood from 25 people in an hour as opposed to 15 previously[20], which is an example of an organisation using the SKILL Programme to improve a key performance indicator.

- St James's Hospital has reinvented the HCA role in some wards by giving more responsibilities to the HCA which would have been performed by the nurses previously in order to free doctor time and help comply with the European Working Time Directive. This was facilitated by the SKILL Programme as the SKILL Programme equipped the HCAs with the skills to perform these new responsibilities. Also, at St James's Hospital, some porters are now asked to help prepare the operating theatre as well as bring the patient on the trolley.

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19 Best practices for supporting Health Care Assistants to increase participation in direct care: An independent evaluation report by Gayle Garland and Ben Totterdell, School of Healthcare, University of Leeds, September 2009.

20 Irish Blood Transfusion Service.

Table 5.4: Roles which moved within the organisation in order to help compliance with the European Working Time Directive		
Function	**Previously carried out by**	**Now carried out by**
Clean furniture	HCA	Household Assistants
Stock up soaps/ paper towels	HCA	Household Assistants
Record observations	Staff Nurse	HCA
Record fluid intake/ output	Staff Nurse	HCA
Record weight/ height	Staff Nurse	HCA
Perform urinanalysis	Staff Nurse	HCA
Phlebotomoy (drawing blood)	Doctor	Staff Nurse
Cannulation (delivering or removing fluid)	Doctor	Staff Nurse

Source: St James's Hospital

This would bring the role of the HCA more in line with the English NHS. The NHS Careers website lists the core functions of HCAs as:

- washing and dressing
- feeding
- helping people to mobilise
- toileting
- bed making
- generally assisting with patients overall comfort
- monitoring patient conditions by taking temperatures, pulse, respirations and weight.

Interestingly, even at St James's, only 32% of FETAC HCA participants record and report vital signs/weight/height/urinalysis and document same.

However, there are some barriers to be overcome if roles are to change. The University of Leeds study identified a concern among some nursing staff with HCAs taking on enhanced roles, and recommended that a concerted effort be made to overcome this:

"In some areas there remains an attitude of protectionism, where nurses are reluctant to let go of direct care activities, especially the observations, for fear of accountability, or simply as a resistance to change. In sites where a concerted effort is made to educate and inform nurses about the training, competence assessment and accountability, protectionism is less evident."

A further complicating factor is when some HCAs are trained to take on enhanced roles and when others are not. This has an impact on team morale, in that the staff who haven't attended feel that they have a reduced role and are less valued as a result. It also complicates workplace organisation and introduces inconsistency in the level of care provided.

The University of Leeds study notes the possibility of introducing different staffing levels within the HCA grade:

"Some HCAs suggested that there should be a different job description for those that have completed the programme, emphasising direct care while those who have not participated focus on indirect care."

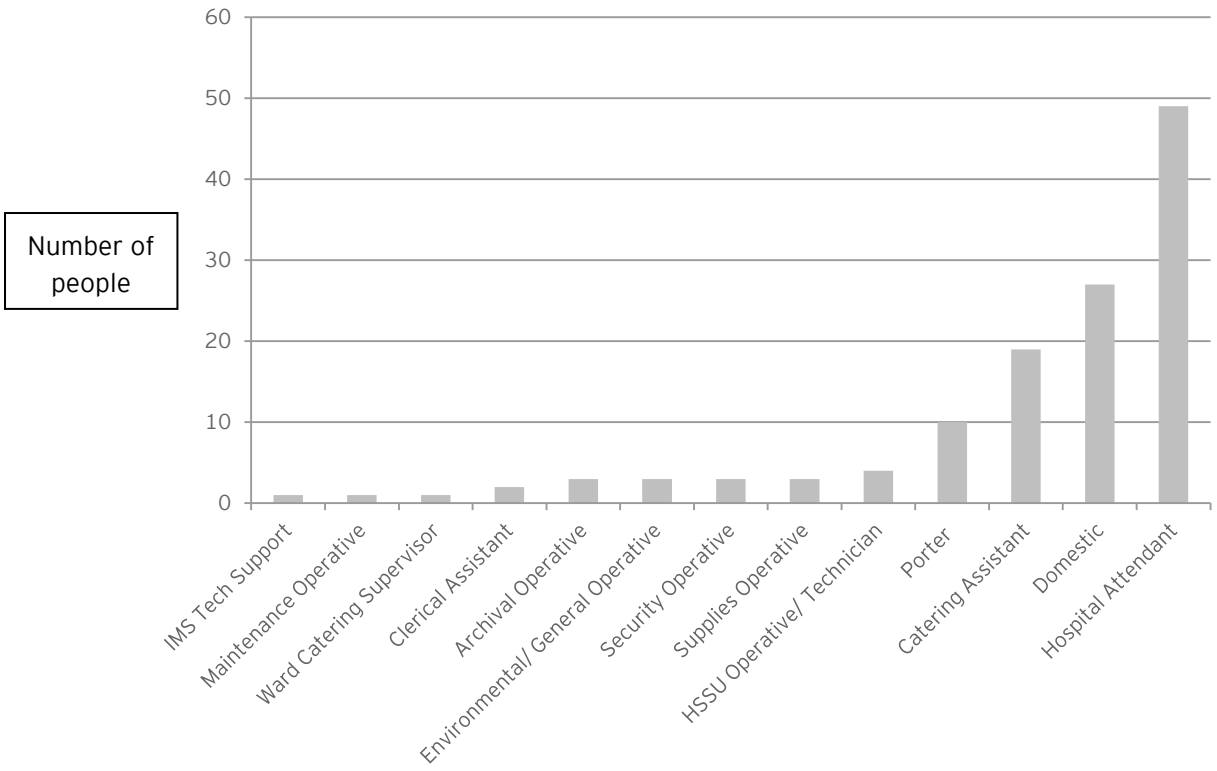
5.4.4 Opportunities for personal progression

The second aspect of career development is the opportunity for personal progression. An important point is that achieving FETAC Level 5 competence in one discipline means that a participant can move to another area. This establishes a broader health and social care benefit, looking beyond the focus of a single organisation.

Achieving the FETAC Level 5 qualification therefore opens new opportunities for individuals to take on different roles. St James's Hospital in Dublin is an outstanding example of where this has taken place. It provided information that 127 out of the 408 SKILL graduates had taken on new roles since graduating.

The following chart shows the roles that those individuals have moved from:

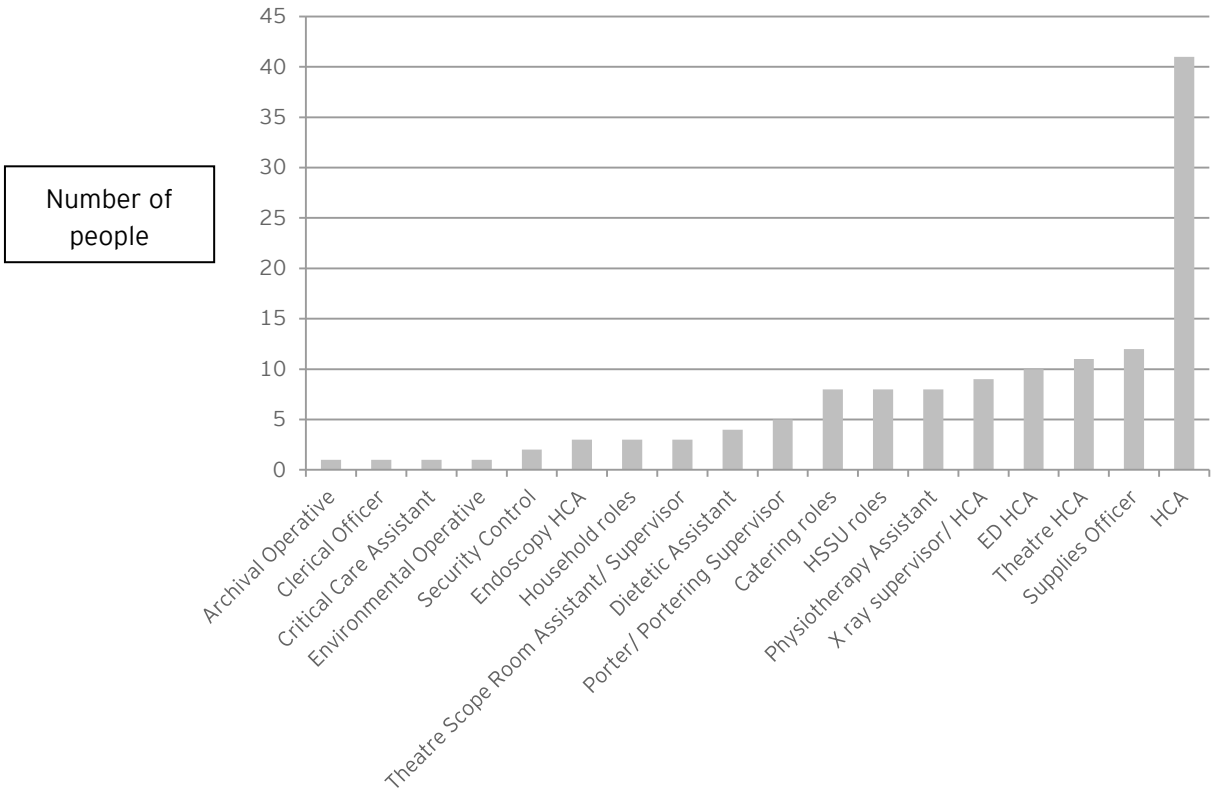
Chart 5.5: Roles that staff at St James's held prior to SKILL training, where they have subsequently changed roles



Source: St James's Hospital

The following chart shows the posts that those people moved to.

Chart 5.6: New roles taken up by St James's Hospital staff after attending SKILL training



Source: St James's Hospital

St James's Hospital therefore provides evidence of people moving into HCAs posts from other roles. For example, 18 domestic staff and 10 catering staff moved into HCA posts. This demonstrates that the SKILL Programme can raise ambitions and expectations of staff, who then want to fulfill a different role in the organisation. Some of the individual stories are clearly life-changing.

"I previously worked as an Environmental Operative in the Environmental Services Department in St James's Hospital. My role consisted of removing all clinical, general and recyclable waste materials from the hospital. I was also required to drive a tractor and road sweeper from time to time. On the 1st of November 2010, I started my new job as a Healthcare Assistant in the Theatre Department. This move would not have been achievable had I not completed the FETAC Level 5 course."

In addition, the University of Leeds study noted the desire of some FETAC participants to link the course to broader career progression:

"There were suggestions for exploring Senior Healthcare Assistant roles that would include supervisory responsibility, or the option for specialisation such as theatre technician, dialysis technician, or orthopaedic technician (applying and removing casts and splints)."

In addition, some participants who we interviewed stated that they would like to progress to FETAC Level 6 and that this is not currently possible for them. Career progression is important in the

context of life-long learning and it is important to link the SKILL Programme explicitly to broader progression.

While there is no evidence that it is commonplace, there are examples of individuals who have acquired Level 5 qualifications and then progressed to a higher role within the organisation.

> *"After a year of learning the (FETAC) course came to an end and this left me with a feeling of anticlimax so I needed further learning and my confidence was high as this course made me believe in myself. I enrolled and successfully completed a Certificate in Safety and Health at Work in UCD, Dublin. I would not have been eligible to attend this without FETAC. I then decided to use my recent academic achievement and applied, was successful in my application for the full time post of Manual Handling Coordinator in one of Ireland's largest academic teaching hospitals."*

Some managers have expressed concern about the cost of the SKILL Programme in filling the participant's role when they are on training and of the participant seeking a new role when they return. Chart 5.5 and 5.6 provide evidence of participants moving roles within an organisation, but there are instances of participants moving organisations. One HR director in the disability sector estimated that staff turnover for his organisation in 2005 was in the order of 10%-12% per annum whereas in 2010 it was in the order of 3%-5%. While we do not know how many of those trained left the health service, it is always a programme risk that trained staff use their new skills in other health organisations and potentially outside of the health sector. Our research has also shown that 14% of those HCAs (based on CDVEC data) who withdrew from the VEC course did so because they no longer worked for the HSE. On this basis it is possible that some proportion, may be 15%+ of graduates are no longer in the health service.

5.5 Patient/client satisfaction

There is no data available to assess whether there has been a quantitative improvement in patient/client satisfaction. EY's assumption is that there will have been improvement in patient/client satisfaction through increased staff commitment and awareness, experienced in everyday patient interactions. However, the transformation in patient/client satisfaction is likely to be most apparent when the organisation as a whole commits to improved patient/client service,and uses the SKILL Programme as a lever to make this happen. There are examples of where this transformation has taken place.

Jan Carlson, the former Chief Executive of SAS, said that his organisation had "50,000 moments of truth" every day in client interactions. Similarly, our strong assumption is that 10,600 members of staff returning with improved communication skills, increased self-confidence and a wider awareness of their work environment has had an important impact on the workplace.

Anecdotal examples of those "moments of truth" include:

- Care Assistants at one charity teaching clients to cook, taking them swimming and supporting their independence in other ways
- HCAs at a large hospital volunteering to take patients on short walks to assist their rehabilitation.

However, the impact on the organisation is enhanced when these initiatives are encouraged and form part of a broader organisational transformation. The point is that if, to paraphrase Jan Carlson, there are 50,000 moments of truth, then improved patient/client satisfaction must be felt across those 50,000 moments and not just through individual actions. An example of this sort of transformation is in the submission from Sligo Centre for Independent Living:

> *"The participants on this programme have given the organisation more qualified skilled staff which can be confidently placed with any service user in any care setting. The benefits are twofold, i.e. the PA feels more confident and appreciated for the work that they do and the service user feels more comfortable and secure giving direction to the PA regarding service provision".*

Unfortunately data on patient satisfaction has not been available to benchmark the CMS patient/client satisfaction against other sites to identify whether it led to service improvements. Establishing this benchmark data should be a priority for HSE. Our hypothesis is that the SKILL Programme provides an opportunity to drive up patient/client satisfaction, but it must be linked to organisational change and not dependent on individuals acting on their own initiative.

5.6 Culture change impact on a "learning organisation" with knowledgeable workers where support service staff and support service managers have equal opportunities to training interventions

The evidence suggests that the SKILL Programme can make a difference to organisational performance, depending on the extent to which organisations invest in it. Generally, the SKILL Programme is not linked to corporate strategies, although this is less true for CMSs.

EY carried out an analysis of CMS performance against key indicators. There is a trend in that the CMSs are performing better than the national average, and that the CMSs with high take-up rates on the SKILL Programme are performing best of all. It is important to point out that there may not be a direct correlation between the SKILL Programme and improved performance against those indicators. A number of factors could have a role. However, there is evidence to suggest that those critical mass hospital sites are proving successful in improving performance, and that the SKILL Programme is part of their efforts to improve the organisation.

HIQA hygiene reports cite SKILL participation as a positive indicator on hospital hygiene. Finally, some smaller organisations emphasised the overall contribution of the SKILL Programme to their organisation.

A crucial test for the effectiveness of the SKILL Programme is whether the sponsoring organisation is more effective as a result. Generally, the SKILL Programme is not linked to corporate strategies, although this is less true for CMSs.

As part of this review, EY looked at a range of possible performance measures and compared the national average change against the CMS hospitals. A distinction was made between the CMS with less than 5% annual average take-up and CMS with more than 5% average annual take-up. Take up refers to the percentage of staff from eligible grades who have joined the programme.

Table 5.7: Key indicators comparing critical mass site performance against the national average

Key Measure	National average	Critical Mass Site Annual Average (less than 5% take-up)	Critical Mass Site Annual Average (more than 5% take-up)
% Increase in Bed Days (2006-2009)	2%	0.9%	-11%
Increase/ Decrease in Absenteeism Rate among support staff (2009-2010)	0.13%	-1.91%	-4.42%
Increase/ Decrease Absenteeism Rate amongst OPCC staff (2009-2010)	0.85%	-1.49%	-4.05%
Increase/ Decrease in MRSA infection rate (2006-Q1/2 2010)	18%	-16.4%	-29.07%

Source: HSE

There is a trend in that the CMSs are performing better than the national average, and that the CMSs with high take-up rates on the SKILL Programme are generally performing best of all. It is important to point out that there may not be a direct correlation between the SKILL Programme and improved performance against those indicators. A number of factors could have a role. However, there is evidence to suggest that those critical mass hospital sites are proving successful in improving performance, and that the SKILL Programme is part of their efforts to improve the organisation.

The following table sets out the performance of the CMSs with a take up of more than 5% on the SKILL Programme.

Table 5.8 Performance information about the critical mass sites with 5% or more take up on the SKILL Programme

Site/Key Measure	Average Annual % uptake on SKILL Programme, including CNME	Composite take up over lifetime of SKILL Programme, including CNME	% Increase in Bed Days (2006-2009)	Increase/ Decrease in Absenteeism rate among general support staff (2006-2009)	Increase/ Decrease in Absenteeism amongst OPCC staff (2006-2009)	Increase/ Decrease in MRSA Infection Rate 2006-Q1/2 2010
St Columcille's Hospital	10%	51%	-5%	-10.93%	-15.11%	-47.60%
St James's Hospital	10%	48%	-3%	0.86%	-3.97%	-24.90%
Kerry General Hospital	8%	41%	-11%	-1.75%	-1.46%	-32.60%
Stewarts Care Ltd	8%	41%	No data	-3.12%	-2.23%	No data
St Vincent's University Hospital	8%	41%	-5%	-3.42%	1.60%	-26%
Central Remedial Clinic	8%	40%	No data	-3.79%	1.96%	No data
Monaghan General Hospital	8%	39%	-52%	-10.00%	-10.06%	-25%
Beaumont Hospital	7%	35%	8%	-2.90%	-6.78%	-22.20%
Midlands Regional Hospital Tullamore	6%	32%	-6%	-4.76%	-1.90%	-25.20%
Waterford Regional Hospital	6%	32%	-6%	-2.60%	3.66%	-8.60%
Brothers of Charity (Limerick Region)	6%	29%	No data	-4.42%	-2.59%	No data

Sources: (1) Participant data - CDVEC database and CNME data, and (2) Performance information - bed days, absenteeism and MRSA data provided by HSE

Notes:

1. OPCC refers to the "Other Patient and Client Care" staff which is defined as personnel who provide direct client care and assist or free medical, nursing and health care professionals to perform their clinical duties. General support staff (including maintenance and technical Staff) is defined as personnel who provide non-front line support, maintenance, technical, catering or domestic duties.
2. The above sites were identified as critical mass sites with 5% or more staff take-up on the basis of the number of VEC participants. EY then added CNME participation figures to calculate the total take-up from those sites.
3. Uptake % calculated based on participant numbers (including participants who withdrew after commencement but excluding participants who withdrew prior to commencement) as a proportion of staff WTE.

Our assessment is that the impact of the programme will be most apparent when participation rates are high and there is greater organisational commitment from service providers to drive change and efficiency through the upskilling of staff. Some interviewees have suggested that having the majority of staff trained, 50% or more, is an important target in driving real organisation change.

Moreover, in some aspects of performance FETAC is recognised by external bodies as making a difference. We reviewed the HIQA reviews for 51 acute hospitals in Ireland for 2007 and 2008. Reference to FETAC/SKILLs was made at least once in 22 of the hospital reviews in 2007 and in 15 of the hospital reviews in 2008. Of the 22 hospital reviews in which reference was made to FETAC/SKILL in 2007, 12 of the hospitals showed improved hygiene/training scores in 2008, 3 showed disimproved hygiene/training scores and 6 showed no change in hygiene/training scores (for one hospital no review was performed by HIQA in 2008). We also examined, for the 11 critical mass sites listed in the table above, all of the hygiene scores which are available to EY for 2007 and 2008. We found that 2 recorded an improvement, 3 recorded no change, 2 recorded a disimprovement. We do not have data for other 3 sites. While the analysis of the critical mass sites is inconclusive, the positive impact of the FETAC course on hygiene in the acute system is acknowledged by HIQA.

An effort was also made to ascertain what the impact was on smaller organisations, such as disability groups. Again, there are examples of good practice.

The Catholic Institute for Deaf People (CIDP) provided a submission about the impact of the SKILL Programme on its residential care facilities:

"The residence for vulnerable Deaf and Blind adults has its objectives set in 2007 and has been reviewed independently in 2008 and 2010. The outcome from the 2008 review was 65% (of objectives met) and from the 2010 review is 85% (of objectives met) … One aspect of this improvement relates to the training of staff. This is the reason the Skills training is so important to our organisation. Many of the staff initially employed were not trained in how to deliver a professional service and the SKILLs training is providing certain aspects of this development. The training has improved the confidence of the staff trained, has resulted in the staff demanding more from their line managers resulting in better outcomes for residents."

5.7 Summary of effectiveness assessment

When the SKILL Programme was established, its overall objective was "to educate, develop and train support staff in the health services to the optimum of their abilities in order to enhance their role in the quality of services to patients/ clients". Our analysis suggests that the SKILL Programme has been effective in educating, developing and training support staff, but that the enhancement of their role in delivering services is not always apparent.

The SKILL Programme established a number of supporting objectives, which are set out in the table below.

Table 5.9: Supporting objectives for the SKILL Programme	
Objectives	**Assessment**
Provide them with an opportunity to return to learning	**Achieved**
Enable them to update and extend their knowledge, skills and experience in order to make them more effective and efficient in the jobs they perform and consequently improving services to patients/ clinics	**Partially achieved, the issue is about transfer of learning to workplace**
Enhance their satisfaction and motivation in order that they may contribute more fully to the attainment of their organisation's mission	**Mostly achieved, motivation improved**
Develop areas of expertise to progress the "skill mix" requirements of the health services having regard to workforce and succession planning issues	**Partially achieved, with some organisations now mandating FETAC Level 5 qualification**
Assist them to reach their full potential	**Partially achieved, the issue is about transfer of learning**
Guide them in their personal development and career planning	**Mainly achieved in terms of personal development, little evidence of systematic career development**
Provide greater clarity regarding their roles and functions	**Not achieved, with inconsistency around roles and functions even on the same site**
Enhance career opportunities	**Little/partial achievement, with inconsistent impact**
Up-skill to fulfil higher level duties where appropriate	**Partially achieved, with some limited impact**
Increase morale, mobility and flexibility	**Achieved. Morale improved for staff who have attended**
Acquire educational accreditation	**Achieved for graduates**

Our analysis is that the SKILL Programme demonstrates that it can achieve considerable individual and organisational benefit, although it does not do so in all instances. The challenge moving forward is to build on existing good practice to ensure that the programme functions effectively at an individual level and as a tool for organisational improvement.

6 Recommendations

The SKILL Programme has helped individual participants in building up their confidence and providing new skills. However, there is not clear evidence of a link to improved organisational performance in all instances, and the SKILL Programme will not achieve value for money until that link is always in place.

This concluding section makes a number of recommendations:

1. **Establish a VFM framework, linked to clear programme benefits and targets**, which can be tracked and reviewed at a programme and at an organisational level.
2. **Enhance the quality of data**, with a particular focus on data about the number of participants and relating to costs.
3. **Programme governance should be more integrated** i.e. the programme must be managed/delivered as one programme. CNMEs and VEC participants should not be managed as two unconnected participant streams. Any change in the model of training provision should not lose the experience built up to date. This integration should apply not only at a national level but also locally (e.g.in a hospital).
4. **Review the delivery model**. The HSE should review the delivery model and ensure that it manages the programme using a team with all of the requisite multidisciplinary skills. The governance and management of this programme requires a wide range of skills such as organisational, HR/training, programme management, contract management, governance, financial, etc.
5. **Keep all costs under review.** Maximise opportunities in procurement negotiations to incentivise greater efficiency and improved performance. The significant costs associated with backfilling indicate that it must be kept under review in order to assess if such costs can be reduced.
6. **A concerted effort should be made to increase the graduation rate**, focusing on reducing the number of withdrawals and increasing the proportion of participants who graduate within one year. There may be an opportunity to leverage SKILL training for clerical officer and grade IV (clerical) staff whose needs also merit consideration.
7. **Organisations should also be prevented from sending staff members on the SKILL Programme unless there is a clear benefits plan in place** i.e. stronger organisational commitment must be part of programme management.
8. **Further efforts should be made to provide training which is as relevant as possible to the workplace** and consideration should be given to defining training programmes/ courses for non HCAs which may have less than 8 modules.
9. **There should be an increased focus on identifying participants who have low literacy levels**.

Finally, the HSE has an opportunity to use the reform of the SKILL Programme to raise core expectations of support staff and to drive through productivity and service quality improvements. A national drive could help organisations achieve maximum benefit from the programme, and would be linked to an increase in the participation rate on the SKILL Programme. The number of participants (including active participants, graduates and drop outs post commencement) at c. 10,600 against c. 35,000 WTEs in the HSE is still low if this qualification is to become the norm for support staff.

6.1 Overview

The SKILL Programme has achieved a significant amount in terms of supporting people in support roles to build their confidence and gain new skills.

There are a number of inspiring examples of people whose lives have been transformed as a result of the learning which they received on the SKILL Programme. The overwhelming feedback is that

participants have gained in skills and confidence and are more professional as a result of attending the programme.

However, while there is evidence that individuals are developing and learning from the SKILL Programme, there is no evident link in place between that learning and team functions, organisational performance and corporate strategy in all instances. Where that link is in place, the SKILL Programme would appear to contribute to improved performance, as evidenced by the fact that CMSs which have invested most in the programme are performing significantly above national averages. HIQA has also accepted that the training has an impact on hygiene assessments.
Our analysis is that the SKILL Programme does not provide value for money and will not provide value for money until that link is in place in all instances. One key indicator is that the average cost per participant of the programme is €5,559, but the average cost per participant who stated that they were able to transfer their learning back to the workplace is €9,756.

In addition, our research has identified concerns about the programme's efficiency, with a high number of participants withdrawing and 36% of VEC participants taking more than one year to graduate.

EY has identified areas of focus under three headings; management of the programme, efficiency and effectiveness.

6.2 Management of the Programme

The following recommendations relate to the management of the programme:

1. Establish a VFM framework, linked to clear programme benefits and targets

The national programme should establish a VFM framework which addresses issues of economy, efficiency and effectiveness. The VFM framework should be linked to clear benefits which would be applicable at a national and organisational level.

The benefits or impact of the SKILL Programme should be measured against the following indicators:

- Proportion of SKILL participants out of potential participants, identified by role/sector/setting/region
- Proportion of withdrawals
- Proportion of participants who graduate within one year
- SKILL participant performance appraisal grades, compared with non-participants
- Cost per participant, graduate and participant who was able to transfer their learning back to the workplace
- Clear identification of changed roles before and after the programme, linked to improvements to productivity and client service
- Proportion of participants and line managers who agree or strongly agree with the statement that the participant is more effective after the course
- Proportion of participants and line managers who agree or strongly agree with the statement that the participant has an enhanced role after the course
- Clear identification of changed job descriptions before and after the programme, linked to efficiency
- Identification of productivity savings linked to those changes, and other benefits. Performance over time against key performance indicators, such as MRSA infections and staff absenteeism need to be defined. Performance should be monitored at a team and at an organisational level
- Performance over time on customer satisfaction, where baselines should be established.

The national programme should work with participating organisations to embed best practice.

2. Enhance the quality of data associated with the Programme

One concern through this evaluation has been the quality and availability of data relating to the programme. A review of data arrangements should be carried out to establish clear reporting structures, with the intention of having single and agreed records of:

- Financial inputs (funding, expenditure profiles). Cost data must also be readily available in a prescribed annual format.
- Staff input (such as management time – SKILL office and in health provider settings),
- Participant data/outputs, such as:
    - new and active participants
    - the number of graduates and grade on the course
    - the number of withdrawals
    - profiles for those three groups by job role, age, sex, years of experience, modules taken, setting/sector etc. Similar data should be available for non-participants.

Outcome data is more challenging to collect but essential for a VFM framework. Outcome data refers to the impact of the training on the individual's role and on the organisation measured through performance indicators (covering staff, patient/client and clinical) such as staff absenteeism, staff turnover, patient/client satisfaction data, performance appraisal scores, hygiene scores, reportable incidents, MRSA infections, complaints, etc.

3. Programme governance should be more integrated i.e. CNMEs and VEC participants should not be managed as two unconnected participant streams

The programme must be managed as one programme. This should apply both at a national level and at local level (e.g. in a hospital). The current model largely focuses on SKILLVEC and leaves the operation of CNME training for HCAs to the CNMEs. If the HSE wishes to run two parallel tracks for the HCA grade (presumably to boost the number trained or to assist redeployment), then the least it should do is ensure that the outputs from the VEC course are accepted by the CNMEs. We are not convinced of the logic of have two methods of training HCAs (and where graduation rates differ).

4. Review the delivery model

The governance and management of this programme requires a wide range of skills such as organisational, HR/training, programme management, contract management, governance, financial, marketing, database management/development, stakeholder engagement and management. Given the significant scale of the programme, its strategic importance and evident weaknesses in programme governance, the HSE should review the delivery model and ensure that it manages the programme using a team with all of the requisite skills.

6.3 Improving efficiency

The following recommendations relate to improving efficiency. The most effective underlying measure of success is the cost of the programme per effective graduate:

5. Keep costs under review

Procurement negotiations provide opportunities to negotiate improved value for money. This can include the cost of training each participant, but it should also include incentives to maximise class sizes. A further measure is to incentivise providers to equip participants to perform strongly in the FETAC examinations.

Backfilling payments are an important element of the programme. However, it is unusual to have such a significant financial support mechanism in place. While backfilling is an area which requires very careful and balanced consideration, the current budgetary pressures and envisaged work

practice flexibility documented in the Croke Park Agreement, amongst other factors, suggest that it must be kept under review in order to assess if such costs can be reduced.

6. A concerted effort should be made to increase the graduation rate

All parties, including the SKILL Programme, the employing organisations, trade unions, education providers and the individuals themselves should work together to develop an action plan to: i) reduce the withdrawal rate from the programme and ii) to increase the proportion of participants who graduate within one year. We have also noted that the CNME graduation rate is 93%, whereas 28% of CDVEC HCAs have withdrawn from the programme.

One option is to consider some limited flexibility, in that some participants may be able to study a smaller number of modules over a two year period and to agree this in advance (see also recommendation 8). This could be more attractive to participants with lower levels of confidence, and also to some participants with family responsibilities. Backfill arrangements would obviously be reconsidered with this approach.

The issues of withdrawal and of the time taken to study should be considered moving forward. We have noted also that while there is a need to consider the training/educational requirments of clerical officer and grade IV (clerical) staff, there may be an opportunity to leverage SKILL training in this regard. Consideration should be given to SKILL as a model to cater for the needs of other staff groups. Training is important for creating standards for staff, whether support or administrative, and to creating opportunities for career progression.

6.4 Improving effectiveness

The following recommendations relate to improving effectiveness. The most effective underlying measures of success are the proportion of participants who have been able to transfer their learning to the workplace and key organisational performance indicators.

7. Organisations should be prevented from sending staff members on the SKILL Programme unless there is a clear benefits plan in place

One of the main conclusions from this evaluation is that there must be a clear link between the SKILL Programme and organisational performance. The SKILL Programme should work with participating organisations to identify clear roles for SKILL graduates, and to link this to organisational productivity or client or patient service improvements. Measures should be put in place to track progress.

One option to be considered is whether this should take place as a national drive, to set out national expectations of key roles linked to FETAC qualifications, and to establish different grading structures for people who have not met those levels.

The national SKILL office must insist on a clear benefits plan. Organisations benefiting from SKILL must show commitment to the programme by demonstrating how they see SKILL playing a role in the context of national priorities and in terms of their own local corporate/business plan. National priorities are set in the National Service Plan 2011 which sets out the type and volume of service the HSE will provide directly, and through a range of agencies funded by the HSE. The priorities for 2011 are to:

- "Maintain the levels of service provided in 2010
- Deliver the cost reduction and restructuring programmes to enable the maintenance of these service levels on a total reduced budget basis of €962m (€683m net)
- Seek to ensure the delivery of high quality and safe services

- Accelerate our reform programme to reconfigure core services and in line with our strategy, deliver an appropriate balance between hospital and community services as well as best care models in childcare, disability, mental health and older person's services, and
- Implement the national clinical change programmes and new service developments."

One further consideration may be to ensure that organisational tools and survey/audit methods are used on all SKILL sites in order to assist the transfer of learning in these organisations.

8. Further efforts should be made to provide training which is as relevant as possible to the workplace

Organisations who send participants on the SKILL Programme should be expected to take an active role and work with providers in shaping the design of the training, particularly the non-core modules. This includes disability and voluntary organisations, who should be encouraged to work together to develop modules.

9. There should be an increased focus on identifying participants who have low literacy levels

The SKILL Programme, employing organisations, trade unions and education providers should work together to support people with low literacy levels to participate in the SKILL Programme. This could include an initiative to recruit people from grades which have had relatively low take-up so far.

6.5 National expectations about support staff roles

As the recommendations are addressed, and the management of the programme is strenghtened, then the potential is there within the SKILL Programme to make a significant contribution across the HSE and disability and voluntary organisations.

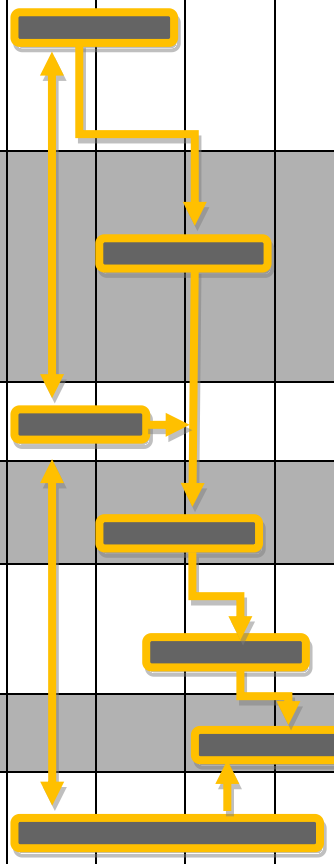
A decision should be be made about whether the expectations implicit within FETAC Level 5 should be established as the core standard across HSE and care organisations. There is a strong argument that it should be, made forcefully by a Director of Nursing that: "caring for people demands competency".

Stakeholders, including the HR Director at a large teaching hospital, recognise the potential benefits of the SKILL Programme around role re-design, but argue that changes, particularly/ most specifically in relation to HCAs, should be driven centrally at a national level. HSE should consider carefully whether to place a national focus on role re-design, to improve productivity and service quality, and to raise further SKILL participation rates to 50 % and beyond. This would assist organisations as they seek to establish maximum organisational benefit from the programme.

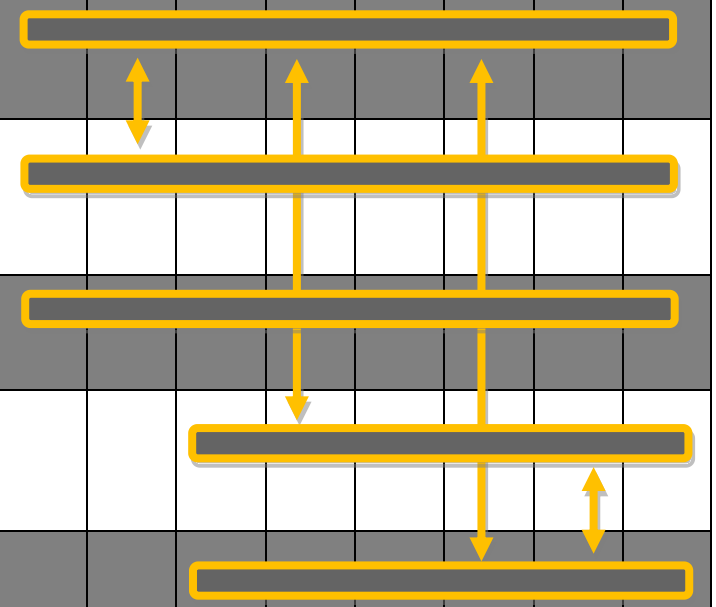
6.6 High Level Roadmap for the Future

Below, we set out a high level roadmap.

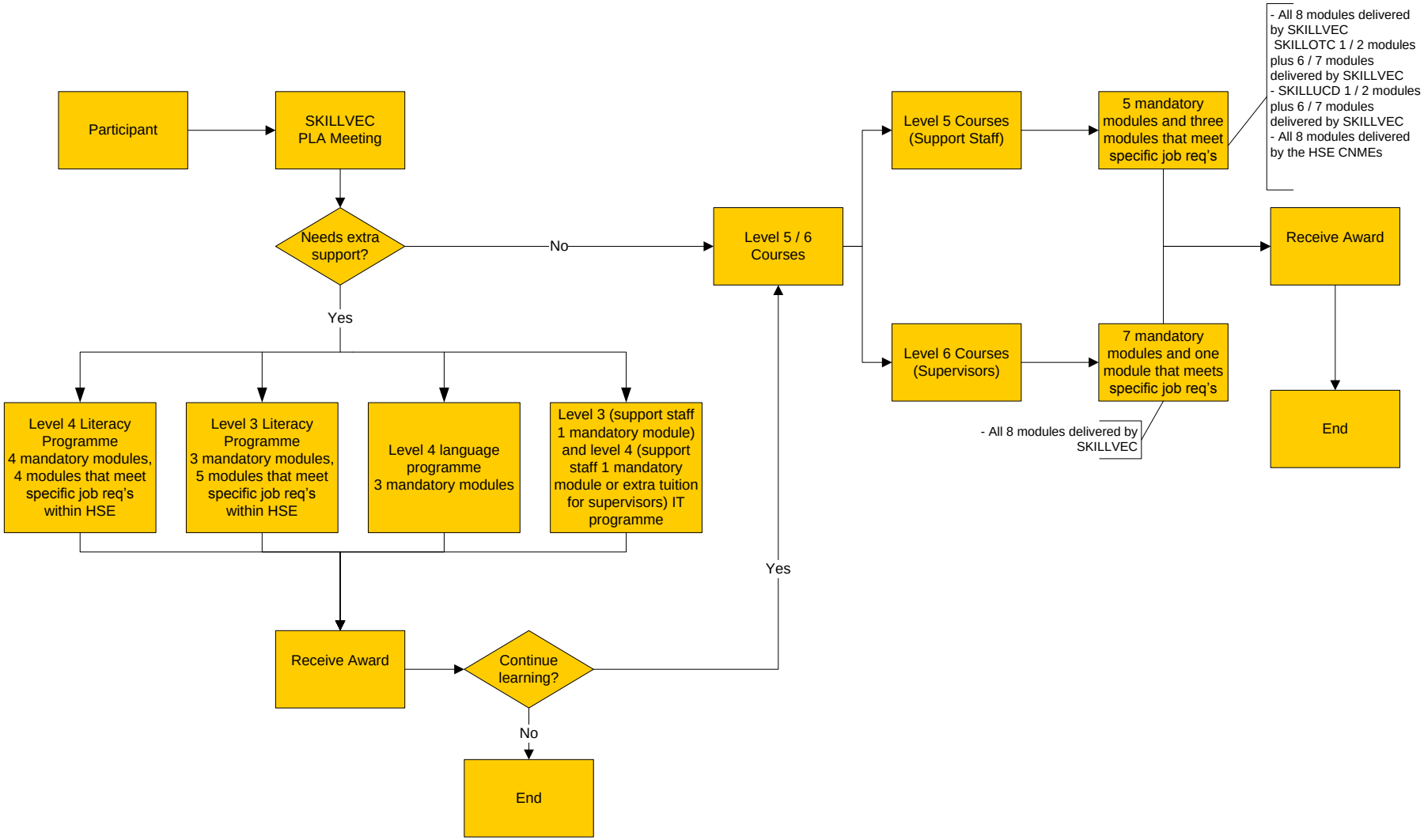
	Months											
Rebuilding the Foundations (Design & Develop)	1	2	3	4	5	6	7	8	9	10	11	12
Establish a VFM framework, linked to clear programme benefits and targets, which can be tracked and reviewed at a programme and at an organisational level. ▶ Define VFM framework (inputs/outputs/outcomes). ▶ Define the process for securing approval as a participating organisation i.e. programme expectations and benefits. ▶ Define data requirements (nationally within HSE, locally from health providers). ▶ Define ongoing reporting requirements (national, local). ▶ Define annual SKILL office planning needs. ▶ Define annual plan process for participating organisations.												
Enhance the quality of data, with a particular focus on data about the number of participants and relating to costs. An integrated database is required. ▶ Financial data ○ Define accounting requirements. ○ Organise HSE accounting knowledge and input to maintain accounting records and reports in appropriate format. ▶ Create an integrated database to capture participant (education) data i.e. number of participants, number of graduates, etc. ▶ Organise systems to maintain a performance data/metrics (indicators) database.												
Redesign national programme governance and review delivery model ▶ Define SKILL leadership team (ensure link to CNME programme)/ review delivery model. ▶ Ensure clear reporting line and accountability for the programme.												
Develop materials to support integration and management of the programme at a local level ▶ Develop programme management/steering committee materials for local use. ▶ Develop audit/organisational commitment tools.												
Procure service providers ▶ Maximise procurement opportunities (to meet the needs of an integrated and more organisationally focused programme). ▶ Education provider(s) will need to engage more with health providers as part of contract execution.												
Develop and launch new marketing literature ▶ Develop new material to reflect the refocused programme. ▶ Launch the material.												
Consider all other findings in this report and plan for implementation as appropriate ▶ Should the programme be mandatory? ▶ Can clerical staff avail of the programme? ▶ How might backfill costs be reduced? ▶ Are all 8 modules required for all support staff?												



	Months											
Execute (Deliver)	1	2	3	4	5	6	7	8	9	10	11	12
Organisations should also be prevented from sending staff members on the SKILL Programme unless there is a clear benefits plan in place ▶ SKILL must engage with organisations which will be required to demonstrate the impact of SKILL and ensure that it is aligned with HSE strategy/local business plans. ▶ Use SKILL to help deliver change in terms of support staff role definition.												
A concerted effort should be made to increase the graduation rate ▶ Higher level of engagement with participant group to identify those at risk of dropping out and/or taking too long to complete the programme. ▶ There may be an opportunity to leverage SKILL training for clerical officer and grade IV (clerical) staff.												
Keep all costs under review ▶ Monitor all cost categories – review variations over time. ▶ Reassess backfill.												
Further efforts should be made to provide training which is as relevant as possible to the workplace ▶ Consider if an 8 module course is required for all support staff. ▶ Work with health providers to tailor modules.												
There should be an increased focus on identifying participants who have low literacy levels. ▶ SKILL should actively work with organisations to identify potential programme participants with low levels of literacy.												



Appendix 1: A flow-chart description of the journey for SKILL participants



Appendix 2: Job specific mandatory modules (Level 5)

Job Title	Module Description
Catering Assistant / Catering Attendant / Catering Domestic	Any three of: ▶ Food Hygiene ▶ Food Preparation & Service ▶ Nutrition ▶ Occupational 1st Aid ▶ Peer Mentoring ▶ Personal Effectiveness in the Workplace ▶ Stock Control & Materials Systems
Craft-Persons Mate / Groundsman / Maintenance Operative / Semi-skilled Person	▶ Personal Effectiveness in the Workplace ▶ Stock Control & Materials Systems
CSSD Operative	▶ Cleaning & Decontamination Practice ▶ Sterilisation & High Level Disinfection Practice
Dietetics Assistant	▶ Dietetics *(only for those who are in the role of Dietetic Assistant) ▶ Nutrition
Domestic/Household Staff / House-keeping Assistant / Wardsmaid	▶ Health Related Cleaning Skills
Family Support Worker	▶ Family Support Skills
Family Support Worker in the Intellectual Disability sector	▶ Family Support Skills ▶ Person Centred Focus to Disability (OTC Module)
General Assistant	▶ Care Skills
General Assistant in the Intellectual Disability sector	▶ Care Skills ▶ Person Centred Focus to Disability (OTC Module)
HCA/Care Assistant in the Intellectual Disability sector	▶ Intellectual Disability Studies (OTC Module) ▶ Person Centred Focus to Disability (OTC Module)
Home Help/Community Carer	▶ Care of the Older Person ▶ Care Skills
Home Support Worker in the Intellectual Disability sector	▶ Care Skills ▶ Person Centred Focus to Disability (OTC Module)
Household Staff in the Intellectual Disability sector	▶ Health Related Cleaning Skills ▶ Person Centred Focus to Disability (OTC Module)
Laboratory Aide	▶ Health Related Cleaning Skills ▶ Laboratory Techniques
Laundry Assistant / Laundry Operative	▶ Laundry Skills
Laundry Assistant / Laundry Operative in the Intellectual Disability sector	▶ Laundry Skills
Maintenance Operative / Semi-skilled Person / Craft-Persons Mate / Groundsman in the Intellectual Disability sector	▶ Person Centred Focus to Disability (OTC Module) ▶ Stock Control & Materials Systems
Occupational Therapy Assistant	▶ Occupational Therapy Assistant Practice ▶ Occupational Therapy Assistant Theory
Physiotherapy Assistant	▶ Physiotherapy Assistant Practice ▶ Physiotherapy Assistant Theory
Porter (Including Laundry Porter/Driver, Catering Porter/Driver, Post-Mortem Orderly, Post-Mortem Porter, Mortuary Attendant)	▶ Stock Control & Materials Systems

Seamstress	▶ Laundry Skills ▶ Stock Control & Materials Systems
Speech and Language Therapy Assistant	▶ Speech & Language Therapy Assistant Practice ▶ Speech & Language Therapy Assistant Theory
Support Staff who are part of the National Nursing Home Training and Quality Initiative	▶ Care of the Older Person
Support Staff working in IBTS (Irish Blood Transfusion Service)	▶ Donation Venepuncture *(only for employees of the IBTS) ▶ Donor Screening *(only for employees of the IBTS)
Support Staff working in Radiography Department	▶ Diagnostic Imaging Department (UCD Module) ▶ Radiation Protection in Diagnostic Imaging Skills (UCD Module)
Theatre Attendant / Theatre Porter	Any three of: ▶ Diagnostic Imaging Department (UCD Module) ▶ Health Related Cleaning Skills ▶ Operating Department Care Skills ▶ Peer Mentoring ▶ Personal Effectiveness in the Workplace ▶ Stock Control & Materials Systems
Therapy Assistant in the Intellectual Disability sector	The appropriate Mandatory Module(s) in the relevant Therapy Assistant section (in the non-ID sector). Any one/two of: ▶ Intellectual Disability Studies (OTC Module) ▶ Person Centred Focus to Disability (OTC Module)

Appendix 3: Critical mass sites

List of active Critical Mass Sites:

Site	Commencement Date
Mercy Hospital Cork	October 2010
St James's Hospital	September 2010
Adelaide, Meath and National Children's Hospital	September 2010
St Vincent's University Hospital	September 2010
St Columcille's Hospital	September 2010
Stewarts Care Ltd	September 2010
Kerry General Hospital	May 2010
Waterford Regional Hospital	March 2010
Nestling Home Support Workers Project, Dundalk	September 09 (PT/2yrs) September 2010 (PT/2yrs)
Clonakilty Community Hospital and 4 other community hospitals	May 2010
Carlow/Kilkenny Community Services	April 2010
Cork University Hospital	May 2010
South Tipperary Community Services	September 2010
Beaumont Hospital	September 2007
Brothers of Charity Limerick	September 2010
Disability Federation Ireland (DFI)	September 2007
Dublin North Central Ballymun Health Centre	September 2010
Fingal Home Care Dublin North	April 2010
Monaghan General Hospital	September 2009
St. Ita's Hospital Portrane	September 2010
Wexford Community Services	May 2008

List of completed Critical Mass Sites:

Site	Start Date	CMS Years
Baltinglass District Hospital	September 2007	2
St Vincent's Hospital,Athy	September 2007	2
Cherry Orchard Hospital	September 2007	3
IBTS	September 2007	3
HSE Procurement	September 2008	2
Wexford Community Care Home Help	September 2008	2

Appendix 4: List of submissions

EY received 77 submissions from the following individuals or organisations which were considered while preparing this report.

Individual	Role	Organisation
DATHs		
Amy Carswell	SKILL Project Manager	Adelaide and Meath Hospital, incorporating the National Children's Hospital
Deirdre Donoghue	SKILL Programme coordinator	Beaumont Hospital
Jennifer Shaw (née Fanning)	SKILL Project coordinator	St Vincent's Hospital
Ken Hardy	HR Director	St James's Hospital
John McPhillips	HR Director	St Vincent's Hospital
Una Healy	SKILL Project Coordinator	St James's Hospital, Dublin
DFI		
		Mayo Centre for Independent Living
		Muscular Dystrophy Ireland
		Roscommon Disability Support Group
Shane Bradley	Training and Support Coordinator	Donegal Centre for Independent Living
Nigel Brander	Acting Manager	Kilkenny Centre for Independent Living
Bernadette Byrne		Anne Sullivan Centre
Deirdre Fahey		Mayo Centre for Independent Living
Tamara Gormley	Development Worker	Sligo Centre for Independent Living
Kate Kearney	Chief Executive	Enable Ireland
Grainne McGovern		St Mary's Institute for the Blind
Liam O'Dwyer	Chief Executive	Catholic Institute for Deaf People
Carol Rogan	Training Manager	Acquired Brain Injury Ireland
Gerry Sharvin	Training Department	Irish Wheelchair Association
Caroline Whelan	Head of Human Resources	Cheshire Ireland
Gerry Whelan	HR Director	Irish Wheelchair Association
HSE		
Martina Hutchison	Skill Coordinator	Cork University Hospital
Nollaig Barry	Acting Staff Officer	Kerry General Hospital
Cliona Rafter	Skill Coordinator	Waterford Regional Hospital
Barbara McMahon	Coordinator for SKILL Programme	Carlow/Kilkenny Community Care
NFVB		
Susan O'Brien	Skill Coordinator	Stewarts Care Ltd
Gillian Sexton	Human Resource Training and Development Coordinator	National Federation of Voluntary Bodies

Appendix 5: List of interviews

Organisation/ Hospital	Interviewee
Centre for Nursing and Midwifery Education, CUH	Eileen Kelly
City of Dublin Vocational Education Committee (CDVEC)	Jacinta Stewart, Kay Cullinan, Evan Buckley, Jackie Nunan, Brenda O'Mara and Paul Kennedy
Clonakilty Community Hospital	Carol McCann
Cork University Hospital	Annemarie Byrne and Martina Hutchison
Disability Federation of Ireland	Martin Naughton and Cathy McGrath
Donegal Centre of Independent Living	Shane Bradley
ESRI	Professor Philip O'Connell
HSE, Nursing and Midwifery Planning and Development Unit, HSE	Patrick Glackin
HSE South	Martina Walshe
HSE SKILL office	Ann Judge, Ann Smyth and Caroline O'Regan
IMPACT	Gerry Dolan
Irish Blood Transfusion Service (at St Finbarr's Hospital, Cork)	Paul Casey, Lisa Arnold, Georgina Evans, Collette Bark, Anne Lee and Patrick Kenneally
Irish Wheelchair Association	Gerry Phelan
National Federation of Voluntary Bodies	Jillian Sexton
SIPTU	Paul Bell
St. James's Hospital	Ken Hardy , Una Healy , Catherine Deegan. Catherine Tobin, Valerie Larkin
St. Michael's House Open Training College (OTC)	Karen Finnerty, Aine Melinn, Claire Hopkins
St. Vincent's University Hospital	John McPhilips & Louise Doyle
Stewarts Care Ltd	Susan O'Brien, Ingrid McGovern and Jennifer Par
UCD	Dr Mark McEntee
UNITE	Walter Cullen

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