

Joint Oireachtas Committee on Health

20th November 2019

11:15am Committee Room 3

SIPTU Health Division Presentation

Chairman and Members of the Committee,

1. On behalf of SIPTU, I confirm our appreciation at your invitation to meet with you today to discuss '*Workforce Planning for the Health Service*'. Firstly, I would like to introduce our delegation from the SIPTU Health Division to you: Paul Bell (Divisional Organiser), Michele Monahan (Honorary Vice-President) Kevin Figgis (Sector Organiser) and Marie Butler (Sector Organiser). Following my initial briefing, our team will be delighted to assist by answering your questions. If we are not able to answer any specific issues arising, we will endeavour to revert with any clarification necessary following the briefing today.

Introduction:

2. SIPTU Health Division represents approximately 45,000 health workers in Ireland. Our membership is based across the public health system, private healthcare and section 39 employers. Our Division organises in several sectors which include: Support Grades, Nursing & Midwifery, Health & Social Care Professionals, Health Care Assistants and the National Ambulance Service.
 - 2.1 Our Division represents members in all areas of the health service including Acute, Mental Health, Intellectual Disability and Care of the Older Person. In addition, SIPTU Health Division supports our members in all industrial relations aspects arising within the Hospital Groups and Community Health Organisation (CHO) areas.
 - 2.2 Our network of organising and support includes national representatives, local officials, shop stewards, activists and members. We are proud to represent these members.

Workforce Planning Definition:

3. In consideration of our presentation today, we note the following definitions of Workforce Planning which have been published previously.
 - 3.1 '*Workforce Planning is a core process of Human Resource Management which is shaped by the organisational strategy and ensures the right number of people with the right skills, in the right place, at the right time to deliver short- and long-term organisational objectives*'. [Department of Health, 2017]
 - 3.2 '*Without adequate skillsets where and when they are required, objectives cannot be achieved. Workforce Planning aims to draw together all of the various factors – including staffing, skills, learning and development, financial resources, succession planning – to develop a cohesive plan for the medium term*'. [Source – Department of Public Expenditure & Reform]
 - 3.3 '*A process in which an organisation attempts to estimate the demand for labour and evaluate the size, nature and sources of supply which will be required to meet that demand*'. (Reilly 1996)

Summary of Submission:

Funding Model

4. While our members note the principles of an effective Workforce Planning system, but most do not recognise it within their workplace. The health service is overcome with consistent funding issues which are apparent from one end of the year to the next. The current model of funding for our health service does not work and must change. If policies, such as SlainteCare have any chance to succeed, the model of funding approved for the health service must provide for the needs of the service and ensure it achieves *'the right number of people with the right skills, in the right place, at the right time to deliver short, medium and long-term organisational objectives'*
- 4.1 In our opinion, the current model of funding for our health service is destined to fail each year. Concerning Workforce Planning, the current model requires line managers to prepare plans for the needs of their service in the following year. When this is completed it is subject to various levels of scrutiny prior to it being submitted to senior HSE management. While we do not have an issue with oversight and scrutiny, which we accept is required, our concern remains that following the multi-layer overview by Senior HSE Management, Department of Health and Department of Public Expenditure & Reform officials, the final approved funding plan generally looks nothing like the original one submitted at department level. This results in a continuing battle playing out in each department where line managers are left struggling to provide for the ever expanding needs of service.
- 4.2 In order to achieve the full aims of SlainteCare, support for staff to develop and expand their roles are essential. There is distinct evidence SIPTU members embrace the development of their roles when supported through resources and funding. Examples such as the National Ambulance Service through the development of the role of Paramedic and Advanced Paramedic from the previously referred title of *'Ambulance Driver'* and the development of the role of Health Care Assistance are demonstrative of staff within the service embracing change and the upskilling of the role they provide. Equally within Health & Social Care Professionals, Radiographers have expanded their role to undertake cannulisation and administering of contrast in CT and Radiation Therapists have expanded their role to undertake duties formally assigned to Dosimetrists. The Committee will also be aware Nurses & Midwives have expanded their role to undertake a sharing of duties formally assigned to medical staff to ensure the most appropriate staff member undertakes responsibility of a task at any given time or day. These are just a few examples of change which have been undertaken to provide a better, more efficient service to the patient or service user.
- 4.3 We contend these examples, and there are more, demonstrate the willingness of staff to embrace greater responsibility, a pushing of boundaries and a new model for the provision of health care in Ireland. Unfortunately, our members argue a significant percentage of this responsibility is left on their shoulders only.
- 4.4 SIPTU members contend the focus of health management from National HSE, Department of Health and Department of Public Expenditure & reform is focussed almost entirely on cost reduction from day one of each year. This results in departments not receiving approval to recruit identified safe staffing levels and those in employment do not have guaranteed access to funding for postgraduate courses which are undeniably essential to the service provided. Our union argues there is something materially wrong in our model of health care when, for example, a department requires radiographers to upskill and undertake a postgraduate course in Ultrasound, but the members of staff is asked if they can provide the funding themselves.

Employment Recruitment System for Approval within HSE

5. The system of approval for the filling of vacancies or for submitting business cases for the replacement of new/existing posts is designed to frustrate and most importantly not do what is needed, fill vacancies.
- 5.1 Line managers and staff within the system are left totally demoralised at the extensive effort and repeated procedures required in order to fill vacancies for essential posts. Even where replacement of a post is approved, it is common that recruitment takes well over a year to complete. During this time, staff are left carrying the demand of the service all too often with insufficient staffing levels. This does not just affect the replacement of vacancies as it is the same procedure which also undermines the replacement of maternity leave etc. In such circumstances, it is commonplace the HSE may confirm replacement of a maternity leave literally weeks before the staff member is due to return to the workplace.
- 5.2 As a result, managers and staff have informed SIPTU they use the system for the replacement of posts without any expectation their application will be approved or when such approval will be received. The system of recruitment within the HSE is designed purposely to cause this frustration and is extremely damaging to our health service.
- 5.3 The current system of approval requires business cases to be submitted at multiple levels of the organisation. This results in a situation where staff, department level management, hospital and Group management can all agree on the need for the replacement of a post but national central management who are not connected in any direct way must provide final approval or else the position will not be recruited. This is very narrow minded and counter productive for the HSE as it results in the loss of eligible, qualified candidates for employment to the private sector and overseas opportunities. Evidence of the level of recruitment for our key grades over the past number of months and years is provided within the text of this presentation.
- 5.4 SIPTU contend the recruitment procedure within the HSE must be overhauled immediately. National Officials within the HSE and Department of Health refute there are instructions for a Recruitment Embargo, Freeze or Moratorium. While it would appear they are seeking to steer away from the stigma of these labels and their effects from the past, they are very much present in all their former aspects albeit under the disguise of business cases and multi-layer approval bureaucracy.
- 5.5 In contrast with the challenges of gaining approval for the filling of an accepted vacancy, it would appear expenditure on other expensive forms of employment, such as agency, are utilised as an alternative. We trust the committee will be aware the most recent costs associated with agency expenditure within the health service is in excess of €200 million in 2019. This includes a figure of over €60million on Health Care Assistants and €50million on nurses and midwives. The data also suggests our health service is purchasing in excess of 500,000 working hours this year to date through expensive agency arrangements rather than direct employment. SIPTU contend this method of refusing approval for recruitment but utilising hundreds of millions of euro on expensive external employment options must be revised.
- 5.6 The reality is many agency workers are employed in the same hospital or ward for years rather than the HSE deciding to recruit. Agency work may have a place in our health service for short term immediate or unexpected replacement. It cannot however be used as a replacement for direct employment for the filling of vital front-line health workers.

Right Person, Right Place, Right Time

6. Within this submission, we have highlighted some of the central principles required to successfully incorporate a concept of Workforce Planning within the health service. The modern day health service is a multi-grade team based approach. SIPTU believes the maintenance and development of this model will serve to benefit staff and patients alike.
- 6.1 We are acutely conscious of the cauldron which is faced by staff providing service each day and indeed those seeking to gain access to services from the outside. SIPTU argues it is crucially important for all stakeholders to work to change this experience for both staff and the service user. We believe a successful Workforce Planning model will assist and support the change required to achieve this.
- 6.2 There is no doubt staff want to provide their service in an environment which respects the dignity of all. SIPTU contend the principle of *'Right Person, Right Place, Right Time'* supports such an environment and presents an opportunity for staff to upskill and/or focus on duties and responsibilities which are cognisant of their qualification standards and professional registration.
- 6.3 We note the recent *'Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings in Adult Hospitals'* as launched by the Minister in 2018. We contend an examination of appropriate skill mix and safe staffing levels are crucial in all services provided to patients and service users. It is noted that some grades are suffering the effects of chronic understaffing and a restrictive labour market due to pressures from private sector and foreign employment opportunities. We argue there is merit in an appropriate examination, involving all stakeholders, to seek agreement on new methods of service provision which ensure the skillset, duties and responsibilities of graduate qualified staff are at the pinnacle of their qualification or registration and team or skill mix based approach is maximised to provide support. SIPTU believes such a model, while challenging on several fronts, will result in a changed environment for our members providing service and those who seek the benefit of it.

SlainteCare

7. Noting the significant focus on the development of the model of healthcare recommended within the SlainteCare report, it is appropriate that some brief comment is made within this submission.
- 7.1 SIPTU is acutely aware of the challenges currently being realised by our communities when faced with the realities of a two-tier health system and trying to access service. The last concern our citizens should have when faced with having to access healthcare is how much money they have to afford private treatment. This model breeds inequality and forces additional burden on the public system through longer waiting lists. Equally, we note that barriers to care in our communities are being realised now in areas never experienced before due to many towns and cities having insufficient medical doctors in general practice and the existing GP's being unable to cope with demand.
- 7.2 While there will be many challenges, we support the principles within the SlainteCare Report. Our union seeks the end of the bottleneck in our Emergency Departments and the never ending & ever expanding waiting lists, the development of community services and the urgent need for additional bed capacity.

- 7.3 However, we argue lessons must be learned from the existing failed model of service delivery if the prescribed future for healthcare in our country is to succeed. We must deliver opportunities for staff to develop and upskill. We must further enshrine the concept of multi-grade team based working which ensures the allocation of duties are assigned to the most appropriate person, at the right time, in the right place. We must support our staff through career opportunities and education supports to ensure the public health service is the first choice for health workers in our country.
- 7.4 Finally, SIPTU would like to convey our deep concern at the slow pace of progress concerning the necessary funding and supports for the advancement of SlainteCare. In our opinion, token funding is being afforded to this project currently to convey the optic that implementation is proceeding. We note €20million per year has been earmarked by the HSE and Government Departments to date which is insignificant to tackle the current challenges arising in funding the necessary actions to bring about real change. This point is made noting the identified funding required for the roll out of SlainteCare will be approximately €680million per year.

We thank you for your time. Within the remainder of this submission will be a brief outline on some key sectors for our union within the public health service in reference to Workforce Planning,

Health & Social Care Professionals:

8. SIPTU Health Division has negotiation rights for several Health & Social Care Professional Groups within the Health Service. The groups include Radiographers, Radiation Therapists, Phlebotomists and Laboratory Technicians. SIPTU also has many members in Clerical/Admin throughout the public health service including sole negotiation rights for these grades in many private healthcare providers.
- 8.1 For the purpose of this paper, we will provide a brief analysis below of Workforce related data concerning Radiographers and Radiation Therapists within the public health system below. (source HSE)
- 8.2 Radiographers and Radiation Therapists CORU register opened 31st October 2013. Compulsory annual registration/retention is a requirement as of this date. Grandparenting period ended on 31st October 2015.
- 8.3 Current HSE & Public Funded Employment WTE for all grades as of September 2019: 119,126 (Change from December 2018 +1,269)
- 8.4 Current HSE & Public Funded Employment WTE for Radiographers as of September 2019: 1,235 (Change from December 2018 +28)
- 8.5 Radiographers: Male (17.3%)/Female (82.7%)
Total Permanency – 94.5%
% Fulltime/Part-time – 73.4% (FT)/26.6% (PT)
- 8.6 Current HSE & Public Funded Employment WTE for Radiation Therapists as of September 2019: 192 (Change from December 2018 +0)
- 8.7 Radiation Therapists: Male (11%)/Female (89%)
Total Permanency – 89.5%
% Fulltime/Part-time – 77.6% (FT)/22.4% (PT)
- 8.8 Turnover rate: Overall for all grades – 6.4%. Health Professionals (other) 9.4%
- 8.9 Absenteeism rate: Overall for all grades – 4.6%. Health & Social Care Professionals 3.6%

Workforce Planning Challenges:

9. In the limited time available, it is very difficult to present a comprehensive paper to the Committee on the challenges concerning Workforce Planning arising within the above-mentioned professions. If deemed appropriate, we would welcome an opportunity of submitting a more detailed document for your consideration.
- 9.1 We note the key principle agreed by the Steering Group underpinning the framework “Working Together for Health” [Department of Health 2017] which stated: *‘Workforce Planning must be focused on identified current and future population health needs. It must consider what services will be required to meet the current and future health and social care needs of the population and plan, using a range of solutions, to have a workforce in place with the right skills, competencies and geographical distribution to deliver these services’.*
- 9.2 Unfortunately, our members within Radiography and Radiation Therapy have not experienced delivery of the key principles promised within the Framework for Health & Social Care Workforce Planning. Some of the key examples which underpin this position are as follows:
 - WTE numbers have not increased significantly since December 2018 (+28 rad) and (+0 rt). Increase since August 2019 (+4 rad) and (+6 rt). Health & Social Care Professionals (Other) since 2013 (-32)

- A National Radiographer Review has been underway with the HSE and Department of Health since 2015. This is independently chaired since 2017. Within the work of the review a country wide survey was undertaken, and a series of interviews were held with local hospital managers, line managers and shop stewards. The work of the review has to date identified several challenges including the following areas:
 - Lack of staff in key areas
 - Rostering gaps and inability to provide for extended day working due to staffing deficits. No additional staff to provide for 8-8 working.
 - Lack of resources
 - No funding for education
 - Rooms closed due to staffing deficits
 - No service extension due to staffing deficits
 - CT problematic due to effects of 2012 on-call pay cuts
 - Delays in NRS recruitment
 - Loss of highly trained staff to private sector
 - Demand for Advanced Practice in areas such as Ultrasound Reporting
 - Out of Hours activity increasing dramatically
 - Career Structure needs review
 - Role of Radiography Assistant needs review
 - National Equipment Replacement needs review as many radiographers are relying on equipment well beyond its sell by date.
 - Concerns relating to Over Prescribing of Diagnostic Tests

- Radiographers have experienced repeated events where new services and/or expansion of existing services are not accompanied by approval for recruitment of required staff. This has resulted in new services such as CT, MRI, Ultrasound or DEXA being funded, regularly through local community groups, but no staff being recruited or allocated to open the service. Invariably new equipment lies idle as a result.
- Most radiology departments have not had a service review for many years. This means the staffing profile assigned to the department may be totally out of sink with the existing service demand within the hospital. SIPTU has fought to have independent reviews undertaken of departments but we have met with some resistance from the HSE and Department of Health. An example where an independent review was undertaken was in University Hospital Kerry (UHK). This review was jointly undertaken by the HSE and SIPTU. Both sides agreed to accept the outcome on publication of the report. The independent report for UHK confirmed the department was staffed at 60% of the safe staffing level recommended by the Professional Body (Irish Institute of Radiography & Radiation Therapy IIRRT). Since the publication of the report in the summer of 2018, the HSE has only agreed to recruit a limited number of additional radiographers. The report recommended an increase of radiographers to 37wte from the existing 22wte. The HSE still has no workforce plan to recruit the balance of the workforce recommended and some local services have had to be cut as a result.
- Radiographers and Radiation Therapists can not access a central fund for education. This results in many examples where radiographers or radiation therapists fund their own education even though the skillset is a requirement and benefit to the health service. Across the country, our members apply for and are denied access to funding for Post-Graduate courses.

- There is no existing plan for Advanced Practice for Radiographers and Radiation Therapists. The benefit of the introduction of Advanced Practice should not be underestimated both in terms of cost saving and speed of access for the service user. Our members have repeatedly experienced barriers from the HSE and Department of Health with the proposed introduction of Advanced Practice.
- Extended Working Day was introduced for Radiographers in 2012 and Radiation Therapists in 2013. This initiative effectively failed due to the following issues: 1) no additional resources were provided despite the working day being extended by 1/3 and 2) no other grades of staff were required to work within an extended day in Radiology despite numerous grades working within the department during normal core hours.
- Changes to On-Call earnings in 2012 have had a detrimental effect on the provision of services in the intervening years. The dramatic changes to payments for On-Call have resulted in some sites finding it more difficult to sustain the provision of their service in areas such as CT.
- Recruitment and Retention of Radiographers and Radiation Therapists has been problematic due to the significant reduced salary rates when compared to other Health & Social Care Professions. This has been further exacerbated by the return of many allowances and indeed payment of new allowances/salary scales to other health specific grades over recent years.
- Recruitment and Retention of Radiographers and Radiation Therapists within the public sector has proven problematic due to the targeted campaigning by private sector and overseas employers. Commitment to signing on payments, retention bonuses and fee per scan on-call rates are common place and place the public health system with the difficulty of trying to attract staff with DPER restrictions.

9.3 In summary, our members contend an effective Workforce Plan for Radiology and Radiation Therapy must be based on securing and supporting the appropriate resources to provide for the needs of the service. The public sector must compete for the recruitment and retention of key qualified staff. It is not a guarantee and serious challenges are arising due to the significant restrictions being imposed.

Nursing & Midwifery

- 10 For the purpose of this paper, we will provide a brief analysis below of Workforce related data concerning Nurses and Midwives within the public health system below. (source HSE)
- 10.1 Nurses and Midwives are subject to annual retention through the NMBI register.
- 10.2 Current HSE & Public Funded Employment WTE for all grades as of September 2019: 119,126 (Change from December 2018 +1,269)
- 10.3 Current HSE & Public Funded Employment WTE for Nurses and Midwives as of September 2019: 37,843 (Change from December 2018 +199)
- 10.4 Current HSE WTE for Nurses and Midwives as of September 2019: 24,887 (Change from December 2018 +111)
- 10.5 Current Section 38 Hospitals WTE for Nurses and Midwives as of September 2019: 9,789 (Change from December 2018 +176)
- 10.6 Current Section 38 Voluntary Agencies WTE for Nurses and Midwives as of September 2019: 3,168 (Change from December 2018 -89)
- 10.7 Current Acute Services WTE for Nurses and Midwives as of September 2019: 22,944 (Change from December 2018 +354)
- 10.8 Current Community WTE for Nurses and Midwives as of September 2019: 14,700 (Change from December 2018 +161)
- 10.9 Current Children's Health Ireland WTE for Nurses and Midwives as of September 2019: 1,329 (Change from December 2018 +19)
- 10.10 Current Mental Health WTE for Nurses and Midwives as of September 2019: 4,779 (Change from December 2018 +12)
- 10.11 Nurses & Midwives: Male (9.2%)/Female (90.8%)
- 10.12 Total Permanency – 92.9%
- 10.13 % Fulltime/Part-time – 64.1% (FT)/35.9% (PT)
- 10.14 Turnover rate: Overall for all grades – 6.4%. Staff Nurse 7.3%
- 10.15 Absenteeism rate: Overall for all grades – 4.6%. Nurse & Midwifery 4.9%

Workforce Planning Challenges:

- 11 At the outset of this section, it is important to highlight that points already outlined as central factors for concern such as funding, replacement or approval of posts and pressures within the health service for demand of care are as prevalent for the nursing and midwifery workforce as the grades listed above. Equally, points made concerning SlainteCare are relevant to achieve the necessary change to provide real change to the experience of patients and staff alike.
- 11.1 SIPTU notes the significant ground achieved in the roll out of the Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings in Adult Hospitals. It is essential this policy has support through funding and delivery of recommendations.
- 11.2 SIPTU contends a similar multi-stakeholder exercise is warranted to achieve an agreed model for safe staffing in other areas of the health service. Real proposals for addressing key challenges in Mental Health are required given the deficit of nurses, the retirement crisis and the inability of the service to attract the recruitment of staff.
- 11.3 Supports are required to ensure the public health service is the option of choice of our nurse and midwife graduates. It is essential that appropriate mechanisms are in

place to ensure the growth of the nursing and midwifery workforce is achieved to meet the growing demands within the service.

11.4 SIPTU contends effective strategies are required to deliver the model of care which is deserved by our communities.

11.5 Significant action is required to change the environment which nurses, midwives and other front line staff face every day. The toxic nature of pressure within the system is not beneficial to those who provide care or seek to access it.

11.6 In Summary, on behalf of our members, SIPTU argues for the need to have agreed models of funded safe care for all disciplines and specialities within the nursing and midwifery workforce. The core challenges arising will not be addressed until appropriate strategies are supported and funded by the HSE, Department of Health and Department of Public Expenditure & Reform.

National Ambulance Service

- 12 Despite a significant increase in staffing levels in the National Ambulance Service in the last 10 years, problems persist whereby an increasingly skilled and professional workforce are delivering more extensive interventions and supports in our communities, but the workforce is not growing to keep pace with the demands of the service and the capabilities of the workforce.
- 12.1 According to figures cited by the Public Service Pay Commission in its Phase 2 2019 report, Whole Time Equivalents (WTEs) in the National Ambulance Service increased by 35% between 2008 and 2018. This increase coincided with a rapid expansion and development of the role of front-line ambulance professions and the work they could perform in the HSE.
- 12.2 The role, function and responsibilities of Emergency Medical Technicians (EMT's), Paramedics, Advanced Paramedics and the newly developed Community Paramedic have evolved substantially in this timeframe and the workforce now take on greater responsibility, clinical accountability, require a greater clinical skill set and a more developed knowledge base.
- 12.3 Previously, staffing arrangements on an ambulance largely consisted of a driver and an attendant or nurse. Training for the driver consisted of some basic first aid along with some driver training. Ambulance Professionals have continuously agreed to upskill and develop their role and they developed further with the establishment of the Pre-Hospital Emergency Care Council (PHECC) in 2000.
- 12.4 PHECC is an independent statutory agency with responsibility for standards, education and training in the field of pre-hospital emergency care in Ireland. PHECC developed a series of Clinical Practice Guidelines to which both PHECC registered practitioners and providers must work within. In 2005 PHECC set up a register for Advanced Paramedics and Paramedics. The NAS became an approved pre-hospital emergency care provider who only employ and allow PHECC registered practitioners to provide prehospital emergency care to patients.
- 12.5 PHECC are continuously developing more advanced Clinical Practice Guidelines which strive to meet best international practice and optimum prehospital care. As an example, the current 2017 CPG's allow the paramedic, once successfully up skilled, to administer 24 life saving drugs in addition to increased interventions, where in the not too distant past they operated at a level much lower than this consisting of 4 or 5 drugs with minimal interventions.
- 12.6 Presently clinical care within NAS is provided through the Intermediate Care Service, Emergency Ambulance Service, Aero Medical Service and the National Retrieval Service.
- 12.7 Alternative care models are being developed where the focus is switching towards providing the most appropriate response based on the patient's clinical need. A "see and treat" care pathway will be developed where hospital visits and stays will be reduced thereby freeing up much needed resources. The introduction of the Community Paramedic will further develop the "see and treat" model.
- 12.8 The future development of patient care provided through the National Ambulance Service is very positive. However, the delivery of such a plan requires the appropriate staffing levels.
- 12.9 The Capacity review, which the HSE accepted in 2016, identified a deficit of 461 staff for NAS which was to be addressed in a phased basis up until 2021.

While the NAS are working towards delivering much of those places, there are structural obstacles which they need to overcome to deliver not only on that figure by 2021 but to ensure they are able to cater for future service needs also.

- 12.10 For instance, recruits are trained through the National Ambulance Service training college. This training facility only has the capacity to train 110 new staff per year, including EMT's and Paramedics. Net, this training delivers circa 80 new staff members into the service each year. With that level of capacity, the NAS can not keep pace with demands to expand its service.
- 12.11 Should the NAS be able to train enough numbers, they face difficulties securing funding for their workforce plans, including delivering on agreements they have negotiated with the union. For instance, since 2013, SIPTU and the National Ambulance Service have been engaged on the need for the development of a patient transfer service provided by the Intermediate Care Service. While the primary function of this service is to safely transport patients to and from hospital settings to step down facilities, nursing homes, private homes etc thereby freeing hospital beds and facilitating a timely discharge from hospitals, the EMT's employed on the service also respond to certain categories of calls received through the National Emergencies Operations Centre of NAS, i.e. 999 calls.
- 12.12 Despite the commitments from NAS to continue to develop this service in line with demand, there are only 159 people in post as of October 2019. The number previously agreed between SIPTU and NAS in 2016 was for a further 150 people to join the service by 2018; this should have resulted in a total figure of 260 by end of 2018. Despite the NAS making applications through the estimates and workforce planning process, the Intermediate Care Service does not have approval for the numbers agreed with the unions to be in place. This is despite many millions of euro in HSE spending going to private ambulance firms in the corresponding years providing a service the HSE's own ICS can provide.
- 12.13 Similarly, the NAS and SIPTU reached a collective agreement in 2003 which included a ratio of supervisors to paramedics. To honour this agreement, the NAS would require funding for a further 54 LEMTS in 2019. They were not granted funding for these positions in their applications re workforce plans for 2019 and we wait to see if they will receive funding for 2020 either.

Health Care Assistants

- 13 In this section of our report, we will concentrate on the role of Health Care Assistants (HCA) and Health Care Support assistants (HCSA) (former Home Helps)¹ and will refer to five reports
- The Houses of the Oireachtas Committee on the Future of Healthcare Sláintecare Report = May 2017
 - Sláintecare Action Plan 2019
 - Review of Role and Function of Health Care Assistants – December 2018.
 - The report of the Maternity Health Care Assistant Group.
 - Integrated Care Programme for Older Persons

The Houses of the Oireachtas Committee on the Future of Healthcare Sláintecare Report = May 2017

- 13.1 The Committee's Terms of Reference state that: *The best health outcomes and value for money can be achieved by re-orientating the model of care towards primary and community care where most people's health needs can be met locally.*
- 13.2 It is noted that in the above report, that the role of the Health Care Assistant and Home Help (Health care support assistant) are referred to in the following paragraphs and indicates the need to recognise this staff group.

SPECIAL CARE SERVICES - Disability Services

- 13.3 Disability policy actively promotes living in the community and person-centred services for people with disabilities. In theory, people with disabilities should have priority access to a range of community care services, such as public health nurses, **home helps, personal assistance**, psychological services, speech and language therapy, occupational therapy, social work services, physiotherapy, day care and respite care.

Universal primary care - €266.6 million over first five years of the plan

- 13.4 The Primary Care – A New Direction (2001) policy proposed a primary care team model designed to cater for populations of 3-7,000 people. Apart from GPs, the team in this model includes **health care assistants, home helps**, nurses/midwives, an occupational therapist, a physiotherapist, speech and language therapists, social work and administrators and receptionists. Currently just 34% of the population with medical cards have access to these services.

ADDRESSING CRITICAL SERVICE DELIVERY CHALLENGES

¹ It would be SIPTU's position that this title should change to Community HCA. The inclusion of the word 'support' in the job title is to recognise that some people need basic 'housekeeping' supports. It is not the policy of the HSE to provide housekeeping, and staff in the community provide hands on patient care in much the same way as an HCA does in a residential or acute setting.

- 13.5 There are also significant possibilities for extending the roles of paramedics, public health nurses, **health care assistants**, community based clinical leads and allied health professionals to provide services in the community. This will require the building up of staff capacity and facilities outside of hospitals or in lower level hospitals.

Sláintecare Action Plan 2019

- 13.6 There is only one reference to Home Helps and no references to HCA's in the action plan, other than references to 'all staff' or healthcare 'staff', however it does state in the introduction to the Sláintecare Action Plan 2019 that

'it will be essential to engage with staff, staff representative bodies, and the wider stakeholder network, to find new ways of working to deliver expanded services and optimise the wealth of skills and knowledge inherent in our workforce.'

- 13.7 The action plan is centred on planning, building and supporting a health and social care workforce which can deliver on the Sláintecare reform programme, as well as initiatives which promote innovation, participation and the creation of a supportive work environment. The workforce planning

And in this regard, we make several observations.

Review of the role and responsibilities of Health Care Assistants – December 2018.

- 13.8 On 1st July 2019 the HSE launched the Review of the role and responsibilities of Health Care Assistants, undertaken by an independent chair at the request of the Department of Health.
- 13.9 This HCA review (2018) is the most recent in respect of Health Care assistants and identifies very clearly the significant and necessary development of this role in order to meet the health demands into the future. It is further recognised that many staff in our hospitals are now trained to a level that would allow them to perform an enhanced role in patient care.
- 13.10 This review sets out in chapter 14 (19) recommendations, from the HSE management review of data collection to models of care, skills mix, staffing levels, education and training and enhanced roles for HCA's as the role is developed. It also took under its remit the role of the Maternity Health Care assistant and the 12.5 of the report and developed a job description that will see Maternity HCAs develop an enhanced role.
- 13.11 The most immediate for our purposes is the 'establishment of a permanent national forum (PNF) for HCA's' (Recommendation no: 14 .7) which although assigned to an assistant national director of the HSE is yet to be resourced.
- 13.12 The HCA Permanent Forum would provide strong leadership in which to drive the national strategies for the full utilisation of HCA's and related grades and assist in the planning and delivery of services in an integrated way, and in this

- way meets the objectives of the Working group and would fit well within the planned development of a national framework for models of care
- 13.13 We have HCA's working in all services now. HSE staffing in HCA roles stood at 16.104 in February 2018. The HCA grade makes up 30% of the total number of support staff and is a significance group.
- 13.14 These staff are required to have QQ1 level 5 and monitor and promote a patient's well-being, through 10 key areas of patient centred care.
- Communicating
 - Breathing
 - Eating and Drinking
 - Intimate care and the elimination of waster
 - Controlling body temperature
 - Intimate care personal cleansing and dressing
 - Mobilising
 - **Death and Dying**
 - **Collaboration in other ward activities**
 - **Maintaining a safe environment.**
- 13.15 They work, as part of multidisciplinary teams in acute hospitals, maternity, community nursing homes, AHP support services, disability, Intellectual disability, psychiatric services, palliative care, mental health, rehabilitation services and also work in people's homes and residential settings.
- 13.16 To this end it is vitally important that the department of Health and the HSE fully endorse the role of HCA's in all their forms and seek to underpin their professional development, this will ensure it develops within its practice parameters and is not developed by the private sector who have no accountability in the setting of educational requirements or models of care.

Recommendations:

- 13.17 To this end we suggest that the Review of the roles and responsibilities of HCA is given full endorsement and that the support and the resources it needs are provided, so that this role can be developed along a cohesive and professional pathway.

Care Programme for Older Persons

- 13.18 The aim of the above supported in Slainte care, is to integrate, develop and implement integrated services and pathways for older people with complex health and social care needs, shifting the delivery of care away from acute hospitals towards community based, planned and coordinated care.
- 13.19 In Ireland there is a change in the profile of the population demographics for a variety of social and economic reasons. The demographic challenge facing the Irish health and social care system includes:-
1. People aged 65 and over comprise 12.7% of the population and use 53% of inpatient beds.
 2. People aged 85 and over represent 1.4% of population and use 13.5% of inpatient beds.

3. There will be 107,600 (17.3% increase) additional people aged 65 years and over by 2021
 4. There will be 15,200 additional people aged 85 years and over by 2021”
 5. 4.1% of the population provide unpaid care with the profile of carers aging (39% increase in over 75yrs).
 6. Patients over 75yrs spend 3 three times longer in ED than those aged 65 or less. Up to 40% of those waiting >24 hrs are >75.
 7. 50% of Acute Hospital delayed discharges require NHSS or a Home Care Package
 8. For Patients over 85 years, approximately 600 acute hospital presentations can be anticipated per 1,000 population.
- 13.20 The development of services in the community in particular with older persons, encouraged SIPTU who represent HCA, MTA, HCSA (Home Helps) care assistants in the community, to write to the Director General of the HSE requesting a high level group to be set up to conduct a review of the role support grade staff play in providing hands on patient care in community settings.

Recommendation

- 13.21 We suggest that there is an establishment of a higher-level group to conduct a comprehensive review of support staff providing patient care in the community. This fits in with the overall vision of Sláintecare in that it seeks to integrate and create multidisciplinary working teams and bring care as close to people’s homes as possible.
- 13.22 We believe the absence of a report into the role that support staff provide in patient care, leaves a gap of knowledge with respect to the ‘hidden’ role of staff often working alone in the community with vulnerable clients. The underestimation of the numbers of staff involved, their education and qualification requirements could lead to an underutilisation of the grade and the valuable role it already provides. A report of this stature would also assist as a foundation for the registration and regulation that will inevitably become necessary.

Intellectual Disability

Care Assistants ID Sector Nov 2019

- 13.23 The delivery of care to residents in long term intellectual disability settings has been transformed since the introduction of de-congregation, which moved care to those with intellectual disabilities from centralised residential settings into residential settings in the community.
- 13.24 This means that the care provided by Care Assistants in the ID Sector has moved from the former Medical Care Model to a Social Care Model for residents.
- 13.25 Most of the care for those in long-term intellectual disability care is provided by the not for profit sector Sections 38 and Section 39, who have suffered cuts to funding over the last 10 years.

In order to deliver quality sustainable care funding must be restored to levels which allow for agencies to implement development plans which enhance care and support for those require it, and training for those delivering care and support which is crucial to enhancing the lives of the citizens requiring it.

- 13.26 Crucially, Care Assistants in the Sector must be re-evaluated in terms of the new levels of duties they are required to perform which include a range of activities and responsibilities far greater than was originally agreed in their job specifications and is effectively a Social Care model. The issues of appropriate remuneration for the duties as they have evolved and the need to attract and retain a high quality workforce must be an integral part of any universal health care structure.