Irish Nurses and Midwives Organisation
Cumann Altraí agus Ban Cabhrach na hÉireann
Working Together

The Whitworth Building
North Brunswick Street, Dublin 7, D07 NP8H
Tel: 01 664 0600 Fax: 01 661 0466
Email: inmo@inmo.ie

General Secretary
Phil Ní Sheaghdha

PNiS/MR

31 July 2018

Mr Kevin Duffy
Chairman
Public Services Pay Commission
3rd Floor St Stephen's Green House
Earlsfort House
Dublin 2

By email to: info@paycommission.gov.ie

Dear Mr Duffy

I refer to correspondence issued to the Public Service Pay Commission, dated 20th July 2018.

I now attach copy of correspondence, issued to the Minister for Finance, in relation to the **Spending Review 2018 - Health Expenditure: Nursing and Midwifery Paper prepared by IGEES.**

The purpose of this letter, to the Minister for Finance, is to correct this inaccurate report. Furthermore we would like this correspondence to be brought to the attention of the Public Service Pay Committee.

Thank you for your attention.

Is Mise

PHIL Ni SHEAGHDHA
General Secretary

Irish Nurses and Midwives Organisation
Cumann Altraí agus Ban Cabhrach na hÉireann
Working Together

The Whitworth Building
North Brunswick Street, Dublin 7, D07 NP8H
Tel: 01 664 0600 Fax: 01 661 0466
Email: inmo@inmo.ie

General Secretary
Phil Ní Sheaghdha

PNiS/MR

31 July 2018

Mr Paschal Donohoe TD
Minister for Finance/Public Expenditure & Reform
Department of Finance
Government Buildings
Merrion Square
Dublin 2

Dear Minister Donohoe

I refer to the ***Spending Review 2018 - Health Expenditure: Nursing and Midwifery*** paper prepared by IGEES.

I would now ask you to note that there are several inaccuracies, in the paper, which are set out below:

2.1 Nursing Capacity – Combined increase in agency nurses and additional hours reflects an increase of 397 FTE on Q4 2007

Additional Hours

Under the Haddington Road Agreement, additional hours from public servants formed a core part in the modernising agenda of the public service. In the health sector, that productivity allowed for the continued delivery of services at a time of significant resource constraint and where there had been and continues to be significant demands on the health service.

To seek to convert additional nursing hours provided for under the Haddington Road Agreement to inflate the WTE nursing workforce is disingenuous in circumstances where there was no provision/intention for such a conversion under the HRA in the first instance, and where no other grade within the civil and public service has had their WTE numbers inflated in such a manner.

Agency Nurses

The straightforward comparison in nursing numbers between 2007 and end March 2018 shows that there are 2664 fewer directly employed nurses in the health system than there were in 2007 (39,006 - 36,342).

The HSE have admitted that since January 2018 they have been double counting the student nurse number. Following a Workplace Relations Commission process this has now been corrected and the correct number will be reflected in the July census. In any event recruitment and retention applies to qualified nurses, not nurses in training. Therefore, when comparing, the student number should be discounted in full. This means that there are in fact 2,664 less qualified nurses employed in the health service than in 2007.

Even where the estimated agency nurse compliment is taken into consideration, there are still considerably fewer nurses employed in the health service at end of March 2018 than in 2007:

Year	Direct	Agency (Est)	Total
2007	39,006	761	39,767
2018	36,342	1,400	37,742
Number of fewer directly employed and agency nurses than in 2007			**2,025**

In addition to this figure, as pointed out in our submission to the Public Service Pay Commission, the February 2017 agreed Nursing and Midwifery Workforce Plan provided for a total increase of 1,224 WTE, of which 1020 are at staff nurse grade. Therefore, at the end of 2017 there should have been a total of 25,798 WTE staff nurses. The HSE statistics show that this target was not met and at the end of 2017, 25,313 staff nurses were employed in the health service, a shortfall of 485 on the 2017 agreed figure. By the end of March 2018, the staff nurse WTE figure had again decreased to 25,246, representing a shortfall of 552 on the agreed 2017 figure.

The figures indicate that rather than the nursing and midwifery workforce increasing it is decreasing and vacancies are growing across all services. In the 26 Emergency Departments alone, there at least 216 nursing vacancies. It is also revealing that the HSE and the Department of Health did not yet engage with the INMO on agreeing the Funded Workforce Plan in respect of nursing and midwifery which was agreed would commence in November 2017. The matter is now in dispute and proceedings at the Workplace Relations Commission (WRC) have commenced with a view to resolving this dispute. An adjournment was sought by the HSE until 17th August 2018 and the parties will reconvene on that date.

2.4 Nurse and Midwife: Productivity Improvements and Reform

Other inaccuracies in the report relate to blood transfusion and IV fluid balance. These have always been the core function and role of nursing and midwifery. The expanded role of the nurse/midwife, in 2013, included IV cannulation, out of hours emergency phlebotomy, administration of first dose IV antibiotics and delegated discharge of patients.

The inaccurate reporting of same demonstrates further that the report cannot be relied upon.

2.5 Health Care Assistants (HCAs)

HCAs are not undertaking many of the tasks historically performed by nurses and midwives as claimed in the report. A national review of HCAs is underway and is due to report in September. The initial finding of this report is that while titled HCA, many of the grades are, in fact, incorrectly titled. The function range of HCAs is multi-task from catering, cleaning to direct patient care and this is the matter under review.

2.6 Nurse and Midwife: Advanced, Specialist and Senior Staff Nurse

It is a fact that there has been a modest increase in the number of specialist grades, and in fact no great move from those that were already practising at specialist level in 1999, when the Commission recommended the grade of Clinical Nurse Specialist (CNS).

Since then the numbers appointed at CNS remain at a very low level, 1,504 across all disciplines of nursing. The Department of Health have sought that Advanced Nurse Practitioners make up 2% of the nursing population and that would be 700, based on today's full-time equivalent figures. However, currently, that target has not been met with 272 whole-time equivalent Advanced Nurse/Midwife Practitioners employed in the public health service.

This year alone reflects a drop of 100 funded posts since last year, from 130 Advanced Nurse Practitioner candidates in 2017 to 30 in 2018. This indicates that this growth will not be achieved over the next decade. Therefore the statement in the IGEES's report that *there has been significant compositional shift towards advanced and specialist grades* is completely erroneous. There has not been a major shift, there has a been a re-titling of posts at Clinical Nurse Specialist level in 1999 and no real growth since. The reality is that the targets set by the Department of Health for the development of the Clinical Nurse Specialist and Advanced Nurse Practitioner, in reality have fallen well short of projected requirements.

It is important to note that the grade from which Advanced Nurse Practitioners and Clinical Nurse Specialists are recruited is usually the Staff Nurse grade which, as evidenced above, has recruitment difficulties.

It is also wrong to state that *Senior Staff Nurse* status *is automatically acquired after a specified period as a Staff Nurse; there are no additional duties or responsibilities attaching to these posts…"* The factual position is that the process is not automatic. In order to become a senior staff nurse the employee must agree to act in a higher post at ward level for annual and short-term leave, up to a three month period, without any additional payment. Staff nurses/midwives may choose not to take on this responsibility.

2.8 International Comparisons

In relation to the OECD Table illustrating the number of active nurses per 1000 population, it is inconceivable how such a comparison could be given any credibility at all. It is utterly meaningless in circumstances where the authors themselves warn that such an international comparison should be treated with caution and where those working as managers, educators and researchers, etc. are included in the statistics.

The fact of the matter is that in Ireland we have an ageing population (those aged 65 years and over, which is up 20,000 per annum, with an expected increase in age related chronic illness of 40% by 2020) and we have the second highest birth rate in the EU. The latest census figures reveal that the group aged 65 and over grew by almost one-fifth, 19.1%, over the period 2011-2016. The Minister of State with special responsibility for older people acknowledged that this will lead to increased demands on the health service.

In addition, the age profile of nurses and midwives in the HSE poses a serious challenge in terms of workforce planning, recruitment and retention. 65% of the HSE nursing/midwifery population is over 40 years of age and there are over 9,000 over the age of 50.

When these factors, and the multitude of others that make our health service unique, are taken into consideration, the OECD Table proffered by the authors is utterly unreliable, irrelevant and deliberately misleading. The INMO estimate that the number of staff nurses to 1,000 population is 6.04.

3.2 Domestic Outflows - Nursing Turnover

A comparison of turnover rates between countries is yet another tactic employed by the authors of the paper to suggest that Ireland does not have a nursing/midwifery recruitment and retention problem. Measuring and comparing the costs and rates of turnover is difficult because of differences in definitions and methodologies. The authors acknowledge this, yet they still continue to draw a comparison between Ireland and the UK and Australia. Such a comparison is inappropriate in circumstances where the data is unreliable and in the case of the UK, completely inaccurate.

The authors state that the nursing/midwifery turnover rate in the UK increased from 12.3% in 2012-2013 to 15% 2016-2017. This is incorrect. The Draft Workforce Strategy for NHS England shows that this figure relates to nurses leaving NHS trusts to move to other parts of the health service. The actual turnover rate of NHS nurses who left the health service in 2016-2017 is 8.7%.

4.1 Starting Salary

The report compares the starting salary of nursing and midwifery with other areas of graduate recruitment to the public service and with the average starting salary for a graduate in the private sector. Both of these comparisons are completely inappropriate in circumstances where you have direct

comparators in the Allied Health Professional (AHP) grades who work alongside nurses and midwives on a daily basis and where the same level of education is required to graduate in the relevant profession.

The grades of physiotherapist, speech and language therapist, occupational therapist, etc. all commence their working career with the same employer as that of the grade of nurse and midwife. The annual starting salary of the AHP grade, however, is significantly higher at €35,319 compared to the SN/SM grade at €28,768 (€30,802 following 16 weeks employment), a difference of €6,551 (or €4,417 following 16 weeks employment). The difference is greater when you take into account the hourly rate: AHP - €18.29 compared to SN/SM - €14.14 (€15.14 after 16 weeks).

The starting salary of a teacher is also relevant and appropriate for comparison purposes at €35,958 per annum. In addition, the starting salary of a Garda is €29,699. Of the four grades, the starting salary of the staff nurse/midwife is considerably lower.

Premium Payments

The authors thought it important to point out that nurses and midwives have access to premium payments of approximately 20% and that this should be taken into consideration when comparing their pay with the basic pay of other graduates in the public and private sectors. Again, as is the case throughout the paper, such a comparison is entirely inappropriate since it does not compare like with like. Nurses and Midwives have a contractual obligation to work unsocial hours, they have no choice in the matter. They are required to work at night, on Saturdays, Sundays, public holidays, Christmas Day, St Stephen's Day and to be on-call.

There is a considerable body of research evidence regarding the negative effects of night and shift work. These effects include:

- Disruption of the internal body clock (circadian rhythms)
- Sleeping difficulties
- Fatigue
- Health effects
- Individual factors
- Social and family factors
- Errors and accidents

The health effects are considerable: recent research in the US and Denmark found increased rates of prostate cancer in men and breast cancer in women who regularly carried out night work over a period of years. As a result the World Health Organisation classified night work as a probable carcinogen in 2009 (Source: Health and Safety Authority *Guidance for Employers and Employees on Night and Shift Work).*

It is the case that all grades, including nurses/midwives and AHP grades, employed in the public service who are required to work unsocial hours are

compensated for the potential risks to their health and massive disruption to their lives.

The statement that payment of allowances and premia payments is not confined to the Staff Nurse/Midwife grade and occurs throughout the nursing and midwife cohorts is incorrect. Allowances are confined to staff nurse and CNM2 grade with exception of a few employees in higher grades who held the allowance in 1999 on a red circled basis. Managerial grades do not qualify for allowances and are not entitled to premia payments as they work 9.00 a.m. to 5.00 p.m. Monday to Friday. Allowances are not universally applicable and a mere one-quarter of the total nursing/midwifery workforce are in receipt of same.

4.1.1 Career and Salary Advancement

The authors point out that there are an estimated 13,613 of staff nurses and midwives on basic pay in excess of €40,000 - point 9 is actually €40,080. The authors have conveniently failed to point out that the Allied Health Professional (AHP) grades are on basic pay in excess of €40,000 at point 4 of their scale, teachers reach the €40,000 mark at point 5 of their scale and gardai reach it at point 6. At point 9, the AHP grades are on €45,843, a teacher is on €46,432 and a member of the Gardai is on €48,271.

4.5 International Pay Comparisons: OECD

There are many data comparability issues existing in the OECD Table which are set out in the document, *"Health Statistics 2018 Definitions, Sources and Methods* on the Remuneration of hospital Nurses". It illustrates yet again, that the results cannot be relied upon in circumstances where the comparison is not on a "like for like" basis

The study covers *certified/registered nurses actively practising in public and private hospitals, including full-qualified nurses with (post-secondary education in nursing) and associate/practical/vocational nurses (with a lower level of nursing skills but also usually registered).*

In relation to Australia, the data covered all levels of nurse, figures included payments for overtime, there were inconsistencies in staffing categories among jurisdictions and in some instances best estimates were reported.

In relation to Canada, the source of data is the Labour Force Survey: lower levels of nurse were included, i.e. those who had a post-secondary certificate of diploma which would affect average salary, the data also included nurses in outside hospitals.

In relation to the UK, the source of data is the NHS Electronic Staff Record: **Additional payments above basic salary are not included**: *Figures are calculated per person based on a methodology that does not aggregate all additional payments over and above basic salary by FTE as additional payments are typically made on an individual level basis only not related to*

FTE. Mean total earnings are calculated by dividing the total amount of pay earned by staff in the group by the total number of staff.

In relation to Ireland, the source is the HSE. The report states that ***"Data refer to "professional" nurses resulting in an overestimation compared with other countries that also include "associate professional" nurses.***

Data come from payroll data and refers to staff nurses working full-time in publicly-funded hospitals. The data includes basic pay plus allowances paid for basic overtime, on-call allowances, weekend and public holiday premiums, night duty and arrears.

It is obvious that the study has major data comparability issues which makes it totally unreliable. Comparing data collected from a Labour Force Survey with accurate data collected from a pay roll system is inevitably going to give very different results. Including different levels of nurse who are paid different rates of pay will also produce unreliable results as will the extent to which allowances and overtime rates are included in the calculation.

The authors state that "*the data should not be considered definitive, due to the difficulties inherent in comparing across jurisdictions, it is included here as indicative*". The question arises, therefore, as to what purpose does it serve given the acknowledged comparability issues, and more importantly, whose purpose does it serve.

The same questions could be asked in relation to the whole Paper: - what purpose does it serve and whose purpose does it serve. The Department of Public Expenditure & Reform has stated on the cover of the report that it has been prepared by the staff in the Department and the views presented therein "*do not represent the official views of the Department or the Minister for Public Expenditure & Reform*". Yet, the paper bears the Department's logo and the views expressed therein have been reported in the newspapers and the *Industrial Relations News* as being those of the Department.

In light of all of the above, the INMO is requesting the Minister to formally and publicly confirm that the views presented in the paper are not those of the Department or the Minister for Public Expenditure & Reform.

This same request will also be made to the Minister for Health.

Thank you for your attention to this letter.

Is Mise

Phil ni Sheaghdha

PHIL Ni SHEAGHDHA
General Secretary