An Roinn Sláinte
DEPARTMENT OF HEALTH

Circular Ref: 3/2016

10th February, 2016

Ms Rosarii Mannion
National Director of Human Resources,
Office of the National Director of HR, HSE,
Dr. Steevens' Hospital
Dublin 2

Re: Implementation of Haddington Road Agreement (Appendix 7) and Lansdowne Road Agreement (Chairman's Note) – Medical Nursing Interface - Task Transfer

Dear Rosarii,

I am writing to you to convey the Minister's approval for the implementation of the Transfer of Tasks from non-consultant hospital doctors to nurses/midwives under the Nursing/Medical Interface Section of the Haddington Road Agreement. This sanction is issued on the understanding that implementation will follow the terms of the document "Final Agreement on Transfer of Tasks under Nursing/Medical Interface Section of the Haddington Road Agreement", copy attached with related appendices.

The Minister for Public Expenditure and Reform has sanctioned the Agreement on the basis that payment should not commence any earlier than 1st July 2016. However, the sanction specifically provides that payment may be made retrospectively to 1st January 2016 subject to verification from the National Implementation and Verification Group (NIVG) as set out in Appendix 2 of the Agreement. The NIVG will have to ensure that (i) the tasks have transferred and (ii) associated benefits are being achieved as set out in the Agreement and associated appendices before payment may proceed.

I wish to confirm that the agreement with regard to the payment arising for the nursing grade will apply to nurses who work between the time of 6 p.m. and 8 p.m. The agreement states that the mechanism for determining the payment will be the payment of the arrangement, in quantum and related conditions, which previously applied between the hours of 6.00 p.m. and 8.00 p.m.

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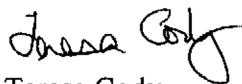
It is also specified that the HSE will ensure that the payment is applied using the same mechanism to the terms and conditions of members of the INMO and SIPTU Nursing in each sector in which it applied prior to the HRA.

It is recognised that implementation of the agreement will have significant benefits to the health service. I would ask therefore that arrangements be put in place as a priority to progress the implementation and verification processes as set out in Appendix 2 of the Agreement. This sanction is conditional on any costs arising being met from within your existing financial allocation.

Yours sincerely



Teresa Cody
Assistant Secretary
National HR

Final Agreement on Transfer of Tasks under Nursing/Medical Interface Section of the Haddington Road Agreement

December 17th 2015

Introduction

This agreement results from discussions between the parties in relation to the implementation of matters encompassed by the nursing medical Interface Section of the Haddington Road Agreement. The Parties commit to continue to cooperate fully with change and reform measures advanced under the framework of the Public Service Agreements, and in particular in relation to Appendix 7 of the agreement under Medical/Nursing Interface (Page 38) and Nursing/Medical Interface (Page 40), up to 2018 and in accordance with all of the arrangements set out in those agreements including commitments to consultation and engagement.

Background

In the section relating to the Medical/Nursing interface contained in Appendix 7 to the Haddington Road Agreement, it was indicated that a joint site-based review was taking place to assess the potential for task transfer of four specified tasks from NCHDs to nurses/midwives.

It was referenced that Management had agreed to revert to the LRC for further discussions with the IMO and nursing unions in relation to how savings could be applied. The section clarified that "any savings agreed as accruing from this initiative will be applied to the terms and conditions of the members of the relevant unions".

The agreement also stated that the IMO, INMO and SIPTU Nursing had agreed that the transfer of any further identified and agreed duties will be measured separately for savings. It stated that, as above, any resulting savings will be applied to the terms and conditions of the members of the relevant unions through negotiations.

The section relating to the Nursing/Medical interface contained in Appendix 7 to the Haddington Road Agreement mirrored the above elements.

In July 2014 the LRC set out a Framework for Progress in relation to this matter. This identified a process to capture current costs/spending and to be in a position to measure the cost saving effect of the transfer of duties from NCHD's to Nursing.

The framework set out key metrics for examination and identified a broad methodology.

It was also confirmed that all parties were clear that the process referred to in the Framework was to measure the parameters of the matter. It stated that implementation will follow engagement and agreement in accordance with Appendix 7 of the HRA.

Since 2013 the Health Service Executive, Department of Health, Irish Nurses & Midwives Organisation, SIPTU Nursing and the Irish Medical Organisation worked to progress task reallocation as part of implementation of the Agreement.

In the context of the Lansdowne Road Agreement a further engagement between the parties under the auspices of the Labour Relations Commission took place, resulting in a letter dated May 25th 2015 referred to in this process as the 'Chairperson's Note'. This noted a reaffirmation and commitment by the parties to a renewed engagement under Appendix 7 of the agreement under Medical/Nursing Interface (Page 38) and Nursing/Medical Interface (Page 40 Section 4). It stated

that the parties had agreed to engage proactively in an independently chaired process to bring it to completion.

During this process it has been indicated that while the parties made significant efforts to progress matters, key challenges included a limited focus on doctors at early stages of training, site selection, interaction with other reform processes and difficulties delivering change to existing work practices in a challenging clinical environment in the absence of appropriate support and/or resource allocation mechanisms.

The Nursing and Medical unions and Management undertook a significant amount of work in seeking to analyse and identify savings. However, agreement on the outcome of this work had not been finalised between the parties.

Progress in the current discussions has been predicated on the premise that it is recognised that the above phase of the process is concluded.

The current discussions have focussed on seeking to produce an implementation plan that will

- Clarify issues relating to the nature and extent of tasks that are transferring,
- Expand on how the transfers can benefit the overall Health Services,
- Specify arrangements for the tasks transferring,
- Set out how the transfers will be implemented and verified, and
- Agree how savings will be applied to the terms and conditions of nursing staff.

Agreement

Transfer of Tasks

A core principle underpinning the allocation of tasks to either medical or nursing/midwifery staff is that the task is undertaken by the staff member who is most appropriate to do so at that time and in that location.

Delegation of responsibility for relevant tasks to the appropriate grades in each location will be communicated in writing to the appropriate staff including an indication of the commencement date.

It is agreed between the parties that the following tasks, including their intrinsic elements, will transfer in accordance with this agreement from medical staff to Nursing/Midwifery.

- Intravenous cannulation; including, in the appropriate setting,
  - peripheral cannulation in adults.
  - peripheral cannulation in children which are subject to additional specific protocols and arrangements

  Advanced treatments some of which require specific medications may require additional protocols and attendance of a doctor.

- Phlebotomy — currently carried out by NCHD's as distinct from general routine phlebotomy, which is the responsibility of specifically trained and employed phlebotomy staff; This task includes, in the appropriate setting:
  - venepuncture in adults

  - venepuncture in children

- Intra Venous drug administration — first dose; including in the appropriate setting
  - Medication management
  - Basic Life Support Training
  - Safe use of any medical devices and vascular access devices (VAD's) used in order to safely administer IV therapy.
  - Theoretical knowledge of the medication prescribed in that clinical area (subject to local policy)
  - Anaphylaxis Treatment

- Nurse led delegated discharge of patients.

It is agreed and accepted that these tasks cannot be the sole responsibility of any one grade but that Nursing/Midwifery practice should expand to incorporate them. This should not de-skill medical staff and it is important that they maintain some involvement in order to ensure this does not occur. The appropriate measures required to ensure this occurs will be determined by the Clinical Director.

Nothing in this agreement diminishes the responsibility of each qualified and trained Health Professional to carry out such procedures, within their scope of practice, when necessary for patient care or safety.

It is agreed that in the context of the implementation of this agreement in relation to sectors outside the acute hospital sector that engagement will occur between the relevant parties with regard to the tasks appropriate to each sector that will apply when agreed arrangements are in place. Immediate discussions between the HSE and Nursing Unions will take place in order to agree appropriate arrangements and protocols for change in the relevant sectors. This will include a similar and separate process involving Mental Health unions which will commence shortly.

Benefits of task transfer to the Wider Health Service

Improving patient care is one of the central aims of this proposal and it is accepted that it can benefit patients beyond the acute hospital setting. In particular, services such as palliative care, care of the older person and the development of nurse/midwifery led clinics.

Nursing and Midwifery practice can and will enhance patient care in all of these areas of expanding practice by ensuring early and timely intervention, in the correct setting. This can only lead to better utilisation of services across acute hospitals, in the community and better outcomes for patients. Real investment in this area will progress a move away from acute hospital care, as these services will then be available in community based settings. Nursing and Midwifery led services in non-acute services are internationally recognised as good value for money and protocol governed care of this nature is also recognised as consistently delivering on safety targets.

The aim of the transfer of Intra-venous cannulation and administration of first dose antibiotics particularly involve the commencement of treatments at an earlier stage. This will lead to earlier treatment times and better outcomes for patients leading to quicker recovery and earlier discharge of patients.

Significant benefits will accrue to the Health Service through the redistribution of tasks away from NCHD's, resulting in better compliance with the EWTD as well as the benefits to the Doctors themselves where working time is reduced. This is also likely to result in better recruitment and retention over time, with an overall resultant benefit to patients and the service.

Patients who have been prescribed therapy require the administration of that therapy as close as possible to prescription time. Currently there is a time delay between task identification and initiation of intervention that could be minimised or removed completely. Particularly in the area of IV cannulation and first dose medication.

It will also decrease interruption to NCHDs providing treatment to other patient when contacted and allow better patient care.

Reduced time spent by nursing staff following up on requests to NCHDs to administer the therapy as well as well as improved job satisfaction between nurses and doctors as the NCHD may prioritise tasks at other locations.

This will reduce unnecessary delays in patient care by doctors which can only enhance patient recovery which in turn lessens patient hospital stay.

Significant improvements can be made in patient discharge due to the delay in the time it takes for the doctor to return to the ward to begin the discharge procedure. This knock on effect on reduced bed occupancy time can increase appropriate patient flow through the hospital service.

The benefits of integrated discharge planning in supporting optimal patient care and continuity of care have been well documented and include;

1. Seamless transition from one stage of care to the next (Hill and Macgregor 2001, NSW Department of Health 2006, Kripalani et al 2007)
2. Increased satisfaction with health care (Preen et al 2005, Hill and Macgregor 2001)
3. Reduced length of stay (Stewart 2000, Blue et al 2001, Koelling et al 2005, Tarling and Jaffeur 2006

Implementation

Responsibility for implementation of this agreement will be focussed in the first instance at local level. On the management side, responsibility will lie with the Chief Operating Officer, Medical Director and Director of Nursing. An agreed circular letter will issue to each location, outlining the requirement to prioritise this matter and ensure that the necessary actions are undertaken with immediate effect.

There will be a joint local implementation group made up of the Chief Operating Officer, Medical Director and Director of Nursing, a representative of the INMO, SIPTU Nursing and IMO. There will be joint chairs agreed locally at the outset. In order to ensure implementation within the agreed timescales:

- The local management group as indicated above will put in place initial and ongoing support arrangements for the provision of training in the relevant tasks, including sufficient appropriate training time.

- The local management team will prepare a proposal for any additional requirements in relation to staffing, including skill-mix in line with nationally agreed ratios. This will be discussed at the Local Implementation Group. In drawing up this proposal, local managers will prioritise these requirements within paybill management and control processes and associated accountability requirements. Consideration will also include overall benefits, efficiencies and ongoing savings accruing from the changes as set out above.

- Any dispute over this (or any other) aspect relating to implementation will be referred without delay to the National Implementation Group for determination.

- The IMO, SIPTU Nursing and the INMO will ensure that where appropriate training is provided and adequate staffing levels are in place (subject to above), union members will co-operate fully with the transfer.

- Delegation of responsibility for relevant tasks to the appropriate grades in each location will be communicated in writing to the appropriate staff including an indication of the commencement date.

Verification

There is significant variation in the extent to which tasks are undertaken both between and within hospitals. Taking this into account, it is important to ensure that each hospital acts to implement appropriate task allocation within the defined timescale, as agreed.

The parties agree that there will be a relatively short evaluation, verification and implementation period associated with progress in task reallocation. In this regard it is agreed the parties will commence a verification process early in 2016 and no later than February 1st 2016.

The verification process will be conducted by a National Implementation and Verification Group. The decision of the Group as to implementation in a particular site or clinical setting will be final. The group will include Department of Health, HSE, INMO, IMO, SIPTU Nursing representatives and have an independent chair. Representatives of the Group will conduct site visits where required, in order to verify progress.

In order for verification to occur the following will need to apply:

- Evidence that Training programmes are in place and undertaken by a sufficient quantum of nurses.

- Evidence of specific confirmation of tasks being undertaken by nurses and that associated benefits are being achieved.

- Evidence that at least three tasks have been undertaken by nurses.

- Evidence that the required level of cooperation required by the National Implementation and Verification Group in relation to transfers has been forthcoming.

- Where a task has not transferred for reasons outside of the control of nurses, they will not be disadvantaged by this.

- Where training has not been put in place, individual nurses will not be disadvantaged by this.

- The verification process will be conducted as set out in Appendix 2 to this agreement.

Timescales

- Transfer of tasks will commence from January 1st 2016 and no later than February 1st 2016.
- While the speed of progress will vary considerably from location to location, implementation in line with this agreement will occur by 31st March 2016.
- Verification will run parallel to this process and be conducted as set out in Appendix 2.
- The National Implementation and Verification Group may be required to continue in place to end of 2016 in order to ensure that progress in relation to the transfer of tasks has been sustained.

Appendix 7 of the Haddington Road Agreement

It is agreed, pursuant to Appendix 7 of the Haddington Road Agreement, and the chairperson's note under the Lansdowne Road Agreement that the benefits accruing from this initiative will be applied to the terms and conditions of the members of the relevant unions in the form of a Nursing-Medical Interface Payment. The mechanism for determining the payment will be the payment of the arrangement, in quantum and related conditions, which previously applied between the hours of 6.00 p.m. and 8.00 p.m. This ensures that the savings are applied in a manner which achieve best value for money and curtail increases in exchequer expenditure.

The HSE will ensure that the payment is applied using the same mechanism to the terms and conditions of members of the INMO and SIPTU Nursing in each sector in which it applied prior to the HRA, in line with this agreement.

Payment will be commenced in April 2016 following the first stage of the agreed verification process contained in Appendix 2 to this agreement. Payment will be backdated to January 1st 2016.

In circumstances, where the National Implementation Group has determined that task transfer has not taken place, and where the conditions in Appendix 1 have been met, payment may be stopped, suspended, deferred or postponed pending implementation.

Where agreement regarding the appropriate course of action cannot be agreed at the National Implementation and Verification Group, the independent chairperson will decide on the appropriate course of action. This decision will be accepted by the parties.

End

Appendix 1

Transfer of Task Allocation 2015

NATIONAL FRAMEWORK

It is understood that the transfer of the four tasks in question require the following as standard pre-implementation at local level;

- Transfer is contingent on safe nursing/midwifery staffing levels, inclusive of additional staff to facilitate the change
- Governance structures agreed locally to allow orderly and consistent safe implementation and continuing monitoring of safe practice
- Completion of recommended training and competence attainment for each of the four tasks undertaken
- Standard Operating Procedures (SOP) in place and evaluation of same

Any patient treatment initiated will result from the collaborative development by senior medical and nursing practitioners of a Standard Operating Procedure. Prior to decisions in relation to any of the four treatment interventions, under discussion, being initiated, it is a requirement that this SOP is agreed and in place.

This local SOP must be in place (encompassing assessment of patients by: age, speciality, underlying medical conditions, symptoms, treatment and diagnostic requirements etc.) prior to commencement of said procedure. This SOP must include provisions for ongoing assessment of need and effectiveness of treatment and cessation/removal when indicated.

Decisions regarding further developments in the Scope of Nursing & Midwifery Practice is contingent on enhancement of patient care and treatment based on:

Context –nursing and midwifery practice.

The 4 identified tasks (phlebotomy and IV cannulation, First dose IV medication and delegated discharge) must be considered within the scope of nursing and midwifery practice and the completion of the appropriate education and training.

The 'scope of practice' is the range of roles, functions, responsibilities and activities which a registered nurse or registered midwife is educated, competent and has the authority to perform (Scope of Nursing & Midwifery Practice Framework, NMBI 2015). In Ireland it is determined by:

- legislation,
- EU directives,
- international developments,
- social policy, national and local guidelines,
- education
- and the individual practitioners level of competence.

Levels of competence are determined by educational preparation, frequency of clinical exposure and the duration and experience in the particular clinical setting.

Expansion of the scope of nursing and midwifery practice includes other important factors; the core definitions and values that underpin practice, the channels of responsibility and accountability and the supports and resources available. In making decisions about scope of practice and expanded practice nurses/midwives must keep to the fore the rights and the needs of the patient and the provision of safe, quality patient care.

Support for nursing and midwifery expansion of practice includes; appropriate clinical governance structures, safe staffing levels, continuing professional development, relevant practice guidance, legislation, regulation and local and national Policies, Procedures, Protocols and Guidelines.

Managers and employers share the responsibility to facilitate role expansion:

- including access to further education
- allocation of necessary resources
- policy development and assessment of competence (Fealy et al.2014)

Nurses and midwives must also refer to the Code of Professional Conduct and Ethics for Registered Nurse and Registered Midwives (NMBI 2015) and other guidance and standards documents published by NMBI.

Education, training and practice requirements for;

1.Phlebotomy (venepuncture)
2.Intravenous (IV) cannulation

In addition to local policies and procedures a minimum of 1 year's post qualification appropriate clinical experience and the following national policies (2010) apply;

- National Clinical Policy and Procedural Guidelines for nurses and midwives undertaking peripheral cannulation in adults.
- National Clinical Policy and Procedural guideline for nurses an midwives undertaking peripheral cannulation in children.
- National Clinical Policy and Procedural guideline for nurses and midwives undertaking venepuncture in adults.
- National Clinical Policy and Procedural Guideline for nurse and midwives undertaking venepuncture in children
- National Peripheral IV Cannulation Programme Learner handbook
- National Venepuncture Programme –Learner handbook

The nurse/midwife must work within their scope of practice, comply with national and local policies and procedures, be competent in the skill and use of equipment, comply and be trained in and familiar with organisational infection prevention and control, health and safety and risk management policies as they apply to the procedures.

In order to undertake the procedure of phlebotomy and IV cannulation the nurse/midwife must have successfully completed a blended learning programme compliant with the *Guiding*

Framework for Education, training and competence validation in venepuncture and peripheral IV cannulation(HSE 2010);

- E learning module and on line assessment (HSELand) - 2.30 hours approx
- A written theoretical clinical knowledge assessment (CNME) 3 hours approx
- Skills demonstration and practice session
- Clinical supervised practice (6-10 supervised practices as defined within local policy)
- Competence assessment

In addition the nurse/midwife must have successfully completed an approved Management and Administration of IV Medication Programme (1 day) if undertaking IV cannulation.

The nurse/midwife must maintain and be supported in maintaining practice and skill in line with local policy and scope of practice.

The national policy and education programme is currently under revision.

3. IV medication and First dose IV medication administration.

HSE National Policy for the Administration of Intravenous Medication by registered nurses and midwives. (This policy includes first and subsequent dose of intravenous medication). The policy acts as a guide to enable local development and revision of Policies, Procedures, Protocols and Guidelines in relation to the administration of IV medications by the registered nurse/midwife.

The policy applies to all registered nurses/midwives who have successfully completed a recognised education, training and competence assessment to undertake intravenous medication administration.

The requirements for the provision of IV medication by nurses/midwives are;

- Must have successfully completed an IV therapy education programme (1 day)
- Have completed NMBI e learning programme on medication management
- Have completed Basic Life Support Training
- Have completed a period of supervision and assessment and been deemed competent in the administration of IV therapy
- Receive training in the safe use of any medical devices and vascular access devices (VAD's) used in order to safely administer IV therapy.
- Practice according to key principles for medication administration, national and local policy and procedures and within scope of practice.
- Is familiar with NMBI documents relating to nursing and midwifery practice, infection control and quality, safety and risk frameworks

In addition to the above the following is required for First dose IV medication administered by nurses and midwives

The decision to administer first dose IV medications should be based on local organisational policy, competency and accessibility to medical supervision if necessary and as determined by local SOP

- The RN/RM must be routinely working in the clinical area and have theoretical knowledge of the medication prescribed in that clinical area (local policy will apply)
- Must have completed Basic Life Support for Health Care Workers within the last 2 years
- Must have completed an approved Anaphylaxis Treatment Training programme. The local policy must specify the frequency of attendance to maintain competence in practice
- Appropriate clinical governance structures should be in place to support local policy/procedure

4. Nurse/Midwife Facilitated Discharge Planning.

The Guide for Nurse/Midwife Facilitated Discharge Planning (HSE June 2009) supports discharge planning practice and provides a template for local guidelines.

The policy applies to all nurse/midwives who have completed an education programme on integrated discharge planning. In addition the nurse/midwife that facilitates discharge must have at least one year post registration clinical nursing experience in their area of clinical responsibility.

Three levels of nurse/midwife discharge planning can be identified and have different education /competence requirements.

1. Discharge planning is an element of the undergraduate nurse curriculum and nurse/midwives engage collaboratively with the MDT. Requirement to engage in ongoing CPD.

2. Criterion based discharge refers to patient discharge when certain clinical criteria have been achieved. These criteria are agreed and documented by the Medical team. Requirement to engage in ongoing CPD and competence.

3. Nurse/midwife led discharge where the nurse/midwife has authority to agree an expected date of discharge and state that patient is clinically fit for discharge. This is underpinned by collaboratively agreed protocols. Further education and competency development in areas of assessment, discharge and diagnosis is required.

A generic education programme *'Guide to Support Integrated Discharge Planning Staff Education'* (2009) E Learning is available on HSEland and a 3 hour education/training programme provide by CNME's for all staff engaged in discharge planning.

Integrated Care guidance-a practical guide to discharge and transfer from hospital (HSE January 2014) states Nurses and HSCP should undertake specialist education and training in integrated discharge planning, opportunities to develop competence in authorised discharge with competence to be authorised by line manager. Local protocols and service user criteria should be agreed.

Appendix 2

Task Transfer Verification Process

- The verification process will conducted by a National Implementation and Verification Group (NIVG). The decision of the Group as to implementation in a particular site or clinical setting will be final. The group will include Department of Health, HSE, INMO, IMO, Siptu representatives and have an independent chair. Representatives of the Group will conduct site visits where required, in order to verify progress. Decisions of this group will be accepted by the parties.

- Local Implementation Groups (LIG) will be set up immediately and will comprise of the Chief Operating Officer (or equivalent officer), Medical Director and Director of Nursing, a representative of the INMO, SIPTU Nursing and the IMO. Where local circumstances dictate, it may be appropriate to co-opt additional members, subject to local agreement, including in some circumstances persons with specific expertise e.g. clinical educators. There will be joint chairs agreed locally at the outset. This group will be responsible for local implementation.

- The verification process will commence from January 1st 2016.

- Where training has been provided and resources permit tasks will transfer from January 1st 2016.

- Each LIG will be requested to ensure the completion of a verification questionnaire for each acute hospital provided by the NIVG, no later than February 29th 2016. Management responsibility for return of the questionnaire will be assigned to the Director of Nursing, in the first instance.

- The NIVG will analyse responses to the questionnaire and arrange site visits, where necessary, before March 31st 2016.

- A formal Verification meeting of the NIVG will occur by March 31st 2016.

- A Verification and Implementation report will issue immediately following this. It will encompass evidence of task transfer and benefits to the health service.

- Where insufficient progress has been made in any location, the NIVG will ensure that a second verification is carried out and this will be undertaken not later than June 30th 2016.

- In circumstances where the terms of the agreement have been applied and where the requirements set out in Appendix 1 have been complied with and specifically, where training has been provided and sufficient staffing resources apply, the NIVG will stop, suspend, defer or postpone payment in a particular location, where implementation has not occurred or where task transfer has regressed. In the absence of agreement within the NIVG, the independent chairperson will decide on the appropriate course of action and the decision will be accepted by the parties.

- Further formal verification meetings will take place in September and December 2016 to review and assess progress in each location.

- A final Verification and Implementation report will issue in December 2016.