

## Part 2: Sectoral Agreements

### 1: Health Sectoral Agreement

Over the coming years, the population will continue to grow and age, and the factors impacting on demand for services (such as the incidence of cancer and chronic diseases) will increase. At the same time, the numbers working in the health services will reduce. Against this background of reduced budgets and workforces, the challenge therefore is not only to maintain the level, quality and safety of services but to expand the range of services that can be easily accessed by patients and clients in their own communities so as to avoid them having to attend hospital.

The required reorganisation will focus on:

- (a) providing, across all settings, planned services over an extended (8 a.m. to 8 p.m.) day on a Monday to Friday basis and/or five over seven day basis, while also providing emergency services on a 24-hour 7-day basis, thereby reducing the staffing and other resources required at nights and weekends;
- (b) achieving a more productive match between staffing and service activity levels across the working day/week/year while safeguarding quality and clinical performance;
- (c) achieving ongoing reductions in the number of in-patient beds and increases in day case, outpatient and diagnostic capacity, in order to provide faster access to services at lower unit costs;
- (d) providing a greater range of services in community settings, particularly through primary care teams and social care networks, including the provision of such services on a planned basis in the evenings and at weekends;
- (e) delivering better health outcomes and more cost efficient services by reconfiguring a range of other services, including the National Cancer Control Programme, Vision for Change, the medical laboratory services and pre-hospital emergency services;

- (f) compliance with the requirements of the European Working Time Directive;
- (g) the development and implementation of care/disease pathways, processes and protocols to deliver better quality care at lower unit costs;
- (h) further developing and utilising the skills of all health professionals through the introduction of expanded roles and direct referral pathways; and
- (i) the identification and implementation of all opportunities to centralise functional, transactional, support and other services at national level, including areas such as medical card and other scheme processing functions, payroll, procurement and purchasing, ICT and HR management.

Services will have to be maintained and increased/improved within:

- (i) an employment control framework for the health services which incorporates the existing moratorium on recruitment and promotion, including its provisions for limited exemptions for some grades and exceptions in some circumstances;
- (ii) the implementation of the incentivised scheme for early retirement, the special career break scheme and the shorter working year scheme; and
- (iii) expenditure control/management arrangements which require adherence at all levels to pay and non-pay expenditure allocations, while building on the arrangements now in place to manage expenditure in other areas like demand-led schemes and the Fair Deal.

The following collaborative approach involving unions and employers is agreed so that the challenges outlined above can be faced in a manner that delivers significant cost efficiencies while protecting the quality and effectiveness of services provided to the public.

Significant improvements have been made in performance measurement in the health system in recent years and this must be continued with renewed effort and focus. The parties also undertake to develop and implement an agreed system for measuring and tracking changes in the input costs (both pay and non-pay) and outputs delivered by the health services over the period

covered by this Agreement. This system will be put in place within three months of this Agreement, and will have an important role in the quantification of change and productivity. It will be used to record the contribution of staff to improved quality, productivity and outputs in the context of the work of the Implementation Body and accountability to the public.

The parties agree that the following range of measures which will need to contribute to the goals of high quality and cost effective services will be developed and implemented under the overall direction of the Implementation Body in order to achieve the foregoing service outcomes in a way which respects the above expenditure, employment and staff engagement requirements.

Organisational and service change, on the scale required by this Agreement, requires robust consultation with the trade unions, which takes account of staff concerns and rights. The health services' information and consultation mechanism will be used to assist implementation of the required change in an atmosphere of industrial peace.

All previous agreements, collective or otherwise, or recommendations by industrial relations bodies remain intact, however, nothing in these should delay implementation of these measures.

It is agreed that measures 1 to 11 below will be implemented with immediate effect:

1. the redeployment/reassignment, in accordance with the agreed scheme (Health Sector Redeployment Protocol in Part 3), of staff within and across service locations within the publicly-funded health service, and across the wider public service;
2. further development and delivery of integrated patient centred care;
3. changes to organisational structures, including changes arising in the context of the roll-out of the integrated services programme (the HSE and IMPACT are involved in discussions at the LRC for the purpose of reviewing and agreeing changes to the HSE/IMPACT Framework Agreement and to agree an ongoing process to deal with organisational changes);
4. multi-disciplinary working and reporting arrangements, in addition to existing intra professional clinical governance, that extend beyond professional boundaries particularly in community services;
5. pro-active engagement through partnership structures at all levels to identify and implement initiatives designed to reduce non-pay expenditure through measures to

improve value for money, elimination of waste, supply chain management, reduce unnecessary diagnostic tests, etc;

6. revised cross-cover arrangements and reductions in on-call tiers, particularly for NCHD grades, in relation to achieving compliance with the European Working Time Directive;
7. better management of risk, safety and quality within the health sector, through adherence to systems, care pathways, disease programmes, protocols, audit, information management systems, etc. Such systems must be developed under the authority of the Director of Quality and Clinical Care and operationalised under the direction and oversight of the relevant clinical leaders at local level e.g. medical, nursing or allied health professional grades, consistent with the recommendations of the Commission on Patient Safety and Quality Assurance;
8. the use of evidence-based performance measurement, to drive continuous improvements in efficiency/effectiveness;
9. the application of merit-based and competitive promotion policies, based on best practice, at all levels;
10. strengthening of individual, professional and statutory accountability for senior management (General Manager and its equivalent upwards) and comparable clinical grades: preparations for the introduction of PMDS in 2011 will involve discussions with unions during 2010 drawing on experience from elsewhere in the public service;
11. the centralisation of functional, transactional, support and other services, as outlined earlier, including through the use of shared services within the public health services;
12. the introduction of an extended working day covering the period 8 a.m. to 8 p.m.(i.e. same contracted hours but different scheduled attendance patterns) for all grades in service locations where this is identified as needed to meet service requirements<sup>1</sup>;
13. the introduction of new arrangements to support the delivery of services over an extended period up to and including 24/7 emergency services (i.e. same contracted hours but rostered differently) for all grades in service locations where this is identified as needed to meet service requirements<sup>1</sup>;
14. reviews by management, including nurse management, of existing rostering arrangements including skill mix, to incorporate changes to achieve the optimal match

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<sup>1</sup> It should be noted that with effect from 16 December 2008 (HSE Circular 03/09) all new employees of the HSE and HSE funded agencies are already liable to work rosters necessary to deliver extended services beyond Monday to Friday including weekends where flexibility is required to address real service demands. New employees include existing staff appointed to promotional posts and staff on renewed temporary contracts.

between staff levels, service activity levels and patient dependency levels across the working day/week/year;

15. as part of the transformation programme across the health service, a process involving all relevant stakeholders is well advanced to deliver major change to the medical laboratory services and associated work practices. The programme will deliver the optimal structures to ensure a quality and fit for purpose 24 hour service.

### **National / Local Engagement**

The parties recognise that building trust at both national and local level is a key component to the successful implementation of the transformation programme for the health sector. The parties accordingly commit to a new 'Strategic Engagement and Innovation Initiative' that will provide the context for both national-level and local-level engagement between management, unions and health service staff. The focus of this initiative will be on working together on a collaborative basis to achieve specified and measurable outcomes in relation to cost containment, service integration / reconfiguration, staff engagement and well-being, redeployment, etc.

Key elements of the strategic innovation initiative will include a number of initiatives, drawing on existing resources and expertise available within the HSE, including:

- a national level Steering Committee involving the HSE, other health service employers, trade unions, service users to monitor and support the significant work being undertaken at local level by unions, management and staff;

Acknowledging the urgency and the need for the speedy implementation of change as set out in this Agreement, the parties agree to utilise existing formal procedural protocols and to apply them in a positive and constructive manner to support the implementation of the overall agreement across the health service. This undertaking includes compliance with:

- The Health Service Information and Consultation Agreement of September 2006 (which gives effect to the EU Directive and the 2006 Act)
- Improving our Services: The HSE Guide to Managing Change in the Health Services of July 2008.

### **Consultation / Adjudication Process**

In the case of measures 12, 13 and 14, each measure will be discussed with trade union representatives at local level; each proposal presented to the trade unions will contain a full description of the planned change and an assessment of the impact, if any, the change will have on employee numbers, rosters, earnings, redeployment/re-skilling and family circumstances. Training and development remains a priority for the health sector.

Where the service change will impact on the family commitments and personal or social arrangements of staff, the consultative process will be used to satisfactorily address the issues arising for individuals in advance of the introduction of the change. Opportunities for re-skilling and re-assignment will be promoted as a key method to retain and secure employment in equally attractive roles within the health service where continuation in a current role is not possible.

In particular, in implementing measures 13 and 14, management should present a plan which contains the following:-

- the strategic/policy/legislative basis for change
- the objectives of the plan
- an analysis of the need/demand, which underpins the plan
- confirmation by management that the alternative working arrangements will meet quality and clinical care requirements
- impact on human resources – numbers/rosters/earnings across all disciplines
- any information on cost savings
- impact of the alternative attendance pattern on earnings, family commitments and personal or social arrangements.

In the case of measure 12, the process will deal solely with the impact of the alternative attendance pattern on earnings, family commitments and personal or social arrangements.

Where agreement cannot be reached at local level within 7 days either side may seek the intervention of a Joint Review Group.

The Joint Review Group consists of 2 staff representatives and 2 management representatives including 1 representative from the relevant discipline on both sides.

### **Affirmation (2<sup>nd</sup>. Stage)**

The Joint Review Group will assess the proposals and endeavour to assist the parties within 7 days of referral. The process shall, in addition, identify and address the clinical risk, governance and related issues arising from the proposed service reconfiguration.

### **Dispute Resolution (Final Stage)**

If the Joint Review Group cannot resolve the matter within 7 days of the referral, either party can refer issues relating to the impact of the alternative attendance pattern on earnings, family commitments and personal or social arrangements to an agreed third party adjudicator who will hear the dispute and issue binding proposals to both sides within 21 days of the referral. Implementation of the adjudicator's findings will commence immediately. Adjudications in relation to loss of earnings will be paid within 90 days or as otherwise recommended.

The existing premium rates, as confirmed by letter to the Staff Panel, will continue to apply, and will also apply equally to categories of staff who historically have not worked these patterns and who, therefore, did not receive these premium payments.

### **Discussions with the Irish Medical Organisation**

Further discussions will take place with the Irish Medical Organisation in relation to the Government commitment to make appropriate changes to the Competition Act and a transformation agenda for General Practitioners (GPs). These discussions will be completed within two weeks.