

### Q1. Has the 'Transfer of Tasks' process agreed under the HRA and LRA concluded?

A. Yes, a lengthy process of negotiation has resulted in an agreement that will enable an orderly transfer of the four identified tasks, *when* staffing levels are agreed and training has taken place.

### Q2. What are the four tasks?

A. 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:

#### 1. *Intravenous cannulation*, including in the appropriate setting:

- Peripheral cannulation in adults
- Peripheral cannulation in children, which is subject to additional specific protocols and arrangements

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

#### 2. *Phlebotomy*

This is currently carried out by NCHDs 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

#### 3. *Intravenous 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 (VADs) used in order to safely administer IV therapy
- Theoretical knowledge of the medication prescribed in that clinical area (subject to local policy)
- Anaphylaxis treatment.

#### 4. *Nurse led delegated discharge of patients.*

### Q3. Will nurses/midwives be the only grades undertaking these tasks?

A. No, 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.

### Q4. What happens in relation to sectors outside the acute hospital?

A. 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 these tasks and appropriate measures to allow for their implementation in sectors outside the acute hospital settings. 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.

### Q5. Does this mean four different tasks might apply outside of the acute hospital setting?

A. No, the tasks remain the same. However, it may be some time before the service can be adapted and protocols developed to allow nurses and midwives expand practice in locations outside the acute sector. The agreement is specific that if this is the case the requirement in the first instance is for engagement to discuss this process.

### Q6. What training will be provided?

A. A detailed document setting out training requirements was agreed as part of this process. It clearly sets out that staffing levels have to be in place to allow nurses/midwives expand practice in these areas. It also sets out the standard requirements in respect of nursing practice in accordance with Nursing and Midwifery Board of Ireland scope of practice guidelines, which are available at [www.nmbi.ie](http://www.nmbi.ie)

### Q7. Will this training be working time?

A. Yes, it will be agreed with the director of HR HSE that any classroom training will be working time, and IT based training, which can be undertaken outside of the hospital, will be considered working time also. In a side letter between the chairperson and the INMO director of industrial relations, it states:

"I refer to the paragraph contained in the Transfer of Tasks Agreement concluded on December 1, 2015, which reads as follows:

*'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 Agreement also states that 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. I wish to confirm that the HSE will agree to include confirmation that nurses undertaking relevant training in relation to such tasks, as set out in Appendix 1 to the Agreement, will be facilitated with offsite personal training time of not less than two days."

### Q8. How will the process begin?

A. A national overseeing group will be set up immediately. The Department of Health, the HSE and trade unions will have a representation on this group and it will be independently chaired. The INMO director of industrial relations will be the INMO representative. This group will be responsible for confirming the terms of this Agreement have been complied with.

Also, they will have the ability to meet individual hospitals if required if difficulties arise. The independent chair will have the final authority in respect of any dispute.

### Q9. How will this be organised in the local hospital?

A. 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 the IMO. There will be joint chairs agreed locally at the outset. In order to ensure implementation within the agreed timescales.

**Q10. What if staffing levels are disputed?**

A. In accordance with the Agreement:

- 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 pay bill 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 INMO, SIPTU Nursing and the IMO 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.

**Q11. What if agreement on staffing cannot be reached at local level?**

A. The parties would then refer the issues in dispute to the national implementation group. The national group would then either:

- Meet the local group at hospital level; or
- Examine the issues raised in correspondence.

Either way the national group would endeavour to assist the parties at local level reach agreement. If this is not possible the independent chair of the national group can make a recommendation which would be accepted by the parties.

**Q12. Will time and one sixth be restored as set out in the HRA if transfer of tasks occurs?**

A. Yes, the Agreement states that on verification of the training being provided, evidence of tasks transferring and no obstacles being created the payment which was in place prior to the HRA for hours worked between 6pm and 8pm will be reinstated.

**Q13. When will payment commence?**

A. As soon as the verification has been completed, which should be no later than July 1, 2016 and the payment at that stage will be backdated to January 1, 2016.

**Q14. What if the evidence is not there that tasks have transferred but this is not due to staff refusal, but due to training or staffing not being provided?**

A. The Agreement is specific that staff cannot be disadvantaged if circumstances outside their control prevent implementation of the Agreement.

**Q15. Is the payment of time and one sixth pensionable?**

A. Yes it is, as are all other premium payments made.

**Q16. Is this payment for the transfer of these tasks?**

A. No, the HRA is specific that time and one sixth could be restored to those who work the period 6pm to 8pm by savings generated from changes to work practices including transferring certain duties to nurses/midwives from medical staff. The value of the role of the nurse/midwife following the expansion of the role in this way would then have to be examined as clearly the role would have changed via this process.

**Q17. Will this lead to a better service for patients?**

A. Yes, the whole point is that interventions such as these can be delivered earlier and in a more timely fashion when led by nursing/midwifery staff. The benefits to patients of these developments are well documented as:

- Earlier treatment and better outcomes for patients
- Consistently delivering on safety targets
- Reduced levels of infection
- Enhances patient recovery which lessens patient stay in acute hospitals
- Reduces bed occupancy by earlier discharge leading to better bed utilisation, and improves patient flow throughout the hospital.

**Q18. What benefits would arise outside the acute hospital?**

A. The benefits outside of the acute hospital are potentially very important in changing the way health care is delivered. This can lead to a lesser dependency on the acute hospital and ultimately a greater degree of authority and autonomy for the nurses/midwives working in these sectors.

**Q19. Why should nurses and midwives take on these tasks?**

A. There are a number of benefits to the formal expansion of the role of nurse/midwife in this orderly way;

- The reality is that some of these tasks are being undertaken by nurses and midwives already. However, this is not governed by a national agreement and therefore it is being rolled out in an ad hoc manner without definite agreement between nursing and medical staff in various locations
- Nurses and midwives scope of practice will incorporate these tasks and this will become part of the review of the emerging changed role of the nurse/midwife
- Once staffing levels allow and the nurse/midwife is educated and deemed competent, they will have the authority to undertake these expanded roles within the workplace. This ultimately will increase the profile and general authority of the nursing/midwifery grades and lead to a greater level of satisfaction in respect of the performance of the role in acute hospitals and in services in long-term care/community settings
- This orderly process, governed by agreed rules, will determine the pace and extent of the process. This is safer and fairer than the ad hoc transfer that is occurring in some locations now
- The role and function of nurses and midwives by expanding and changing in this manner will need to be reviewed at the completion of the process with a view to assessing the benefit and extent of this change
- The Haddington Road Agreement and the Lansdowne Road Agreement "Provided for the re-installment of payment between 6pm and 8pm (time and one sixth). On transfer of these tasks, the Agreement now confirms that this will occur and be paid to all nurses/midwives in all sectors, where it applied prior to July 2013.