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WIN

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Thank you – it

AS YOU may know, I am retiring at the end of this month, so this is my last editorial for *WIN* and in that context I would like to reflect, for a few moments, on the growth and development of this great Organisation since I started, as its first student officer, in June 1983 when the Organisation had just over 9,000 members. Between 1983 and 1998, when I became general secretary, I worked as student officer, industrial relations officer, head of industrial relations and deputy general secretary. Over that 15 years I worked with three general secretaries, Ena Meehan, John Pepper and PJ Madden (now Fr Madden) and wish to thank them, most sincerely, for the help, support and guidance they gave me in those early years.

I became general secretary in September 1998, following a threatened national dispute, in 1996, with the Commission on Nursing about to report and the Organisation having grown to over 20,000 members. In October 1999 we commenced a nine-day national strike which, like many of you, I remember very vividly. I am resolute in my conviction that the outcome of that dispute, in terms of pay, new career opportunities, the development of the honours degree programme and the acceptance of our involvement in all matters of concern to nurses and midwives, confirms those nine days were a watershed in the development of this Organisation.

In 2007/2008 the INMO was again involved in a nationwide dispute, as we sought a reduced working week in line with other allied health professionals. History will show that, in July 2008, the working week of every nurse and midwife in Ireland was reduced to 37.5. This was the first reduction in the working week of a single occupation for over 40 years. This campaign was remarkable in that the reduction was achieved without any loss of pay to any member of the Organisation.

This campaign was fought against the background of increasing levels of hospital overcrowding. In response to this the Organisation had initiated our daily Trolley Watch – the measurement of the number of admitted patients without an inpatient bed. Trolley Watch has now become synonymous with the INMO, and is accepted as the most potent measure of the levels of overcrowding being endured, by patients and staff, on a daily basis.

However, I now turn to the dark, and dismal, five years spanning 2009 to 2013. During this five-year period I had, as general secretary, to recommend members should accept cuts in pay and working conditions (including a return to the 39-hour week) because the alternative – government imposed cuts – would be worse. However, I want to state that this Organisation's refusal to accept cuts in Sunday/public holiday and night duty premium, as suggested in the first Haddington Road proposals, still represents one of the proudest days of my tenure of general secretary.

It must be understood that if the INMO had not led that campaign of rejection of those proposals, nurses/midwives, and all other public servants who work 24/7, would have suffered permanent cuts in premium pay. This was avoided because of our campaign which resulted in 14 of the 19 public sector trade unions rejecting the proposals – many of them against the recommendations of their executives. The INMO, during that dark period, led from the front and this is something of which I am very proud.

Since 1998 I have had the honour of working with seven presidents: Ann Cody; Clare Spillane RIP; Ann Martin; Madeline Spiers; Sheila Dickson; Claire Mahon; and, currently, Martina Harkin-Kelly. All great people, who have given time, determination and leadership to this Organisation. I wish to thank them for being so supportive of me at all times. I have served

has been a privilege

10 Executive Councils working with excellent people who gave up their time to lead, and at times make difficult decisions, in the interests of the entire membership.

It has also been my privilege to know hundreds of branch/section officers and local representatives over these years, who I respect, and appreciate, more than I can ever say in words. Our union can only thrive, serve and grow through the work of local activists. These officers and local representatives have been the backbone of this Organisation and I shall never forget their diligence, commitment, loyalty and steadfastness to do everything possible to help members with their workplace issues and difficulties. They are the reason we now have over 40,000 members.

I have, during my time, dealt with seven Ministers for Health, five secretary generals in the Department of Health and observed the transition from health boards to the HSE's Integrated Service Areas, to Hospital Groups and community health organisations (bureaucracies +++).

Throughout my time we have sought to ensure that nursing and midwifery is resourced, and managed, by senior nurses/midwives with autonomy and authority. As I leave I realise more work needs to be done to achieve this goal, and I know we will keep trying.

In 2002 the Organisation bought our current headquarters, The Whitworth Building, and in 2013 we bought the neighbouring Richmond Building which will open shortly as our Education and Event Centre. I am very proud that we now own these facilities which, together with our regional offices, are testimony to the growth of the Organisation and the range of industrial, professional and educational services we provide.

I now want to say a very sincere thank you to everyone who has worked with me in the Organisation. I have had brilliant, thoughtful, determined and committed people at my side at all times. The current team is simply the best and we have met the challenges, and the dark days, surviving only because we leaned on each other. On the way there were some laughs mixed with a steely determination to do the best we could for every member that we were so proud to represent. Please rest assured we will go from strength to strength under Phil and this great team.

Finally, may I say, to each and every member, how proud I am to have worked for you as general secretary for almost 20 years. When you are in the care of nurses and midwives, you are in the hands of dedicated, efficient and competent professionals and I am honoured to have been your representative.

Thank you – it has been a privilege.

Liam Doran
General Secretary, INMO

Farewell Liam, but not goodbye

We started out together in 98,
We were labelled a lethal cocktail.
From the front you led, no challenge or foe was too great, With leadership, courage and vision you delivered without fail.
In good times and bad you gave INMO members all you had,
The trade union leader of your generation, our parting now leaves me sad.
Bon voyage Liam, this is your time, spend it with Patricia and your family.
You have made your mark, Enjoy retirement, but never lose your spark.

– Dave Hughes

Having worked with Liam for 19 years, these past number of weeks have been both sad and incredibly informative. By that I mean the achievements, the single-minded attention to detail and unabashed promotion of nursing and midwifery, in any forum regardless of the audience, never ever gets switched off. He leaves behind a strong team with this focus ingrained and I hope, as I progress into the post of general secretary, to maintain and grow this momentum so that the professions of nursing and midwifery can prosper. **– Phil Ní Sheaghdha**

Opposite page (top): Liam Doran's first editorial photo from 1998; (bottom): Liam pictured at the successful campaign to reduce working hours in 2007; This page (top to bottom): Liam pictured recently in his office in INMO HQ; The student protest in 2012 marching down O'Connell St in Dublin; the 1999 strike campaign marching down O'Connell Street; The thousands of nurses who came out to protest in November 1999; and (left) Liam with Dave Hughes at the 2017 ADC

Your priorities with the president

Martina Harkin-Kelly, INMO president

Merry Christmas

MERRY Christmas to all of you and may the new year ring in with good cheer and a brighter future for you, our nursing and midwifery members from myself and the National Executive. It's like Ground Hog Day (again!) as the trolley crisis continues. Not once did our employer manage to achieve the daily target of 236 set by the Minister last winter. Limerick soars in numbers from week to week with 61 recorded on October 23 and even Navan recording 33 on the same day – with the overall October figure coming in at 8,093! When annualised for 2017, there is an increase of 8% on the first 10 months of 2016 at 82,459. This occurred in the same week that the HSE warned of the next big superbug CRE and the awaited arrival of the flu H1N3 strain from Australia. Yet, our employer has once again stooped to arguing about whether a cubicle space be counted as a bed. My response to that is simple – NEWSFLASH – THE ED IS NOT A WARD! We also rode out hurricane Ophelia and storm Brian. Despite many of you heading into work and leaving your loved ones and many of you being told to stay at home in the interest of safety, our employer decided to deduct pay resulting in the INMO having to get this decision overturned. Our employer, it seems, like our bankers, has no moral compass - the mentality is grab a buck at any cost. The INMO has sought engagement with the HSE on developing a national understanding regarding a 'Status Red' storm alert. *Have a wonderful, peaceful and enjoyable Christmas with your Family, loved ones and friends – le gach dea ghuí i gcomhair na nollag agus na h-ath bhliana.*

Farewell but not goodbye to Liam Doran

THIS month's journal presents Liam's last *WIN* editorial. Liam deserves to be saluted. He has been at the centre of the INMO for more than three decades – and his like will never be encountered again. For the two decades Liam has been general secretary, he has navigated the INMO through many difficulties. As he has said himself, he was 'wet around the ears', when he was faced with the 1999 strike after only a year in position. Liam galvanised the INMO and succeeded in earning better conditions for nursing and midwifery in Ireland. I only got to know Liam over the past five years and particularly over the past year working alongside him as president. I could not have asked for a better mentor, a master of timing, planning, brinkmanship and delivery. He possesses an innate ability to read the political landscape and we all know that a week is a long time in politics. Family life is everything to Liam, his wife Patricia and his two children Adam and Aoife, are a source of immense pride. This Organisation was also his family and the dedication he has demonstrated is truly remarkable. A gent whose many deeds and acts of kindness to members who found themselves in need of support echoed the familial role of care and compassion. The statesman image and style – the suits, crisp shirts and cuff links that articulated the tone of meaning to do business. All that is left to say is that, he will be missed; know this Liam, be proud of the Organisation's achievements under your leadership. On behalf of the members and the Executive Council I want to wish you very good health and happiness and that you will enjoy a well-deserved retirement – *comhairdeas leat. Go raibh mile maith agat, agus go n-éirí an bóthar leat.*

NMBI meeting on professional competency

I LED a four-strong delegation of the INMO to meet with Mary Griffin, NMBI CEO, and Bernie Carpenter, NMBI project lead of the Professional Competency Scheme. The meeting stemmed from the fact that the INMO had raised concerns re the initial consultation with registrants, on the Professional Competency Scheme's, process, timeline, notification and selected venues. While this engagement and consultation process is welcome, we strenuously emphasised that any NMBI scheme must not come as an additional burden to the nurse/midwife. The model must be user-friendly and allow the nurse/midwife to be facilitated by their employer in maintaining competence.

For further details on the above and other events see **www.inmo.ie/President_s_Corner**

Quote of the month

"The secret of change is to focus all of your energy, not on fighting the old, but on building the new"
- Socrates

Report from the Executive Council

RECENT Executive Council meetings were dominated by finalising the content and details of our evidence-based submission to the Public Service Pay Commission. The letter received on October 25 confirmed and set out that the commission will carry out its work in two modules. Module 1 will report on the priority areas of nursing and midwifery, consultants and non-consultant hospital doctors by end of second quarter of 2018. It was the Executive's view that, given that all possible initiatives have been exhausted, the government must now look in the direction of pay and hours to ensure that there is a strong nursing and midwifery workforce to meet future needs. As I always say, as sure as there is sand in the Sahara others will also present evidence of where we stand from their perspective. This is game on and we will play it to the nth degree to set the record straight. During this executive meeting series, the Department of Public Expenditure and Reform also published the Public Service Pay and Pensions Bill (2017), which gives effect to the Public Service Stability Agreement (2018/20). This Bill clearly signals the government's intention in relation to those not signed up to the agreement. Executive also welcomed the news that the PNA have accepted the PSSA.

The Executive Council was due to meet on December 11 and 12, 2017 with the first meeting of the new year on January 15 and 16, 2018.

Get in touch

You can contact me at INMO HQ at Tel: 01 6640 600, through the president's blog on www.inmo.ie or by email to: president@inmo.ie

Overcrowding at record level in 2017

INMO welcomes 7% reduction in November 2017 figures

THE number of admitted patients (91,147) on trolleys or overcrowded wards continued at record levels in the first 11 months of this year, according to the latest INMO trolley/ward watch figures. This is a 6% increase on the first 11 month of 2016 and a 95% increase on the first 11 months of 2007.

However, the figures for the month of November *(see below)* show a 7% reduction compared to November 2016. Broken down this saw 6,212 admitted patients on trolleys in EDs and 2,476 admitted patients on trolleys/extra beds on inpatient wards. This totalled 8,688 admitted patients without a proper inpatient bed in November 2017.

The INMO stated that placing extra patients on understaffed inpatient wards is not an appropriate or effective response to the continuing overcrowding crisis. Overcrowding wards simply compromises the care of all patients on that ward, as these wards are already short staffed resulting in essential patient care being delayed or left undone (missed care). Overcrowded wards are also contrary to best practice and increase the risk of cross infection between patients.

The hospitals with the highest number of patients on trolleys, in November were:

- University Hospital Limerick – 878
- University Hospital Cork – 651
- University Hospital Waterford – 624
- University Hospital Galway – 539
- Letterkenny General Hospital – 502.

The ED Taskforce was due to meet as we went to press at which the INMO would again be seeking confirmation that all hospitals are resourced to:

- Open all available beds
- Introduce incentivised recruitment/retention packages to ensure additional nursing staff are employed to deal with this continuing demand
- Ensure senior clinical decision

Table 1. INMO trolley and ward watch analysis (November 2006 – 2017)

Hospital	Nov 2006	Nov 2007	Nov 2008	Nov 2009	Nov 2010	Nov 2011	Nov 2012	Nov 2013	Nov 2014	Nov 2015	Nov 2016	Nov 2017
Beaumont Hospital	513	602	725	814	676	710	421	661	729	586	383	269
Connolly Hospital, Blanchardstown	237	219	260	231	423	292	276	425	514	443	261	266
Mater Misericordiae University Hospital	359	504	537	440	354	375	252	266	450	464	404	397
Naas General Hospital	280	144	239	366	387	192	160	104	315	108	256	257
St Colmcille's Hospital	38	91	246	216	237	172	167	42	n/a	n/a	n/a	n/a
St James's Hospital	55	87	351	201	121	112	89	62	231	178	309	153
St Vincent's University Hospital	369	581	570	495	593	546	322	63	250	464	379	213
Tallaght Hospital	329	326	570	463	607	181	135	245	375	459	293	451
Eastern total	2,180	2,554	3,498	3,226	3,398	2,580	1,822	1,868	2,864	2,702	2,285	2,006
Bantry General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	15	0	47	121
Cavan General Hospital	203	154	144	254	330	369	170	79	32	172	13	56
Cork University Hospital	188	478	480	383	635	479	339	361	329	424	648	651
Letterkenny General Hospital	308	6	25	25	26	81	68	209	47	184	481	502
Louth County Hospital	33	0	1	5	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Mayo University Hospital	289	129	94	100	113	37	108	18	198	108	213	259
Mercy University Hospital, Cork	107	97	123	79	198	168	217	308	236	141	424	237
Mid Western Regional Hospital, Ennis	109	51	32	4	76	1	47	0	n/a	10	1	13
Midland Regional Hospital, Mullingar	16	4	26	36	160	388	196	175	245	305	444	449
Midland Regional Hospital, Portlaoise	42	45	25	21	75	261	13	73	94	251	258	173
Midland Regional Hospital, Tullamore	3	1	29	0	117	190	77	65	272	248	399	290
Monaghan General Hospital	12	23	17	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Nenagh General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	4	1	2
Our Lady of Lourdes Hospital, Drogheda	348	276	414	56	350	709	533	248	584	578	607	386
Our Lady's Hospital, Navan	105	65	118	47	9	116	108	53	45	101	59	108
Portiuncula Hospital	8	11	14	125	52	132	109	21	121	56	144	79
Roscommon County Hospital	80	117	76	52	87	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sligo University Hospital	30	72	59	100	111	164	274	32	223	204	107	198
South Tipperary General Hospital	60	157	3	53	3	121	188	251	153	193	680	400
St Luke's Hospital, Kilkenny	n/a	n/a	n/a	n/a	50	109	67	86	96	339	360	398
University Hospital Galway	115	292	369	323	416	846	330	411	536	480	594	539
University Hospital Kerry	42	21	52	38	71	45	57	36	128	92	208	263
University Hospital Limerick	239	169	245	300	331	393	347	399	556	542	789	878
University Hospital Waterford	n/a	n/a	43	35	141	112	160	234	153	251	412	624
Wexford General Hospital	154	23	63	161	250	207	139	39	197	22	132	56
Country total	2,491	2,191	2,452	2,197	3,601	4,928	3,547	3,098	4,260	4,705	7,021	6,682
NATIONAL TOTAL	4,671	4,745	5,950	5,423	6,999	7,508	5,369	4,966	7,124	7,407	9,306	8,688

Comparison with total figure only:
Increase between 2016 and 2017: –7%
Increase between 2015 and 2017: 17%
Increase between 2014 and 2017: 22%
Increase between 2013 and 2017: 75%
Increase between 2012 and 2017: 62%
Increase between 2011 and 2017: 16%
Increase between 2010 and 2017: 24%
Increase between 2009 and 2017: 60%
Increase between 2008 and 2017: 46%
Increase between 2007 and 2017: 83%
Increase between 2006 and 2017: 86%

makers are available from 8am-10pm over seven day cycle.

In addition, the INMO will be pressing to ensure all available resources are provided for community beds/home care packages and community nursing requirements leading to no waiting lists for same.

INMO general secretary Liam Doran said: "The latest figures confirm a welcome 7% reduction in the number of admitted patients, without a bed in November, compared to November 2016. The reduction, in the numbers on trolleys in emergency departments is particularly welcome.

"However, the significant increase in additional patients on inpatient wards, on trolleys or additional beds, is most disturbing and suggests hospital management are increasingly repeating the mistakes of the past. Overcrowding wards has never solved the problem of hospital overcrowding, and this will only be done through additional acute beds."

INMO submission to Pay Commission

NURSING and midwifery grades are among the first grades being examined by the Public Service Pay Commission (PSPC), which under the Public Service Stability Agreement is charged with examining issues of recruitment and retention throughout the public service.

Following the PSPC's request for submissions from employers and trade unions, the INMO made a robust evidence based written submission by the November 29, 2017 deadline.

This highlighted all the factors affecting recruitment and retention of nurses and midwives, and stressed that *all* nursing/midwifery grades are having difficulties with both recruitment and retention.

The INMO pointed out that Ireland is the least competitive country from a parity of pay perspective based on the earning power of nurses/midwives, across the English-speaking countries of the US, Canada, Australia and the UK. These countries are now the chief destinations for Irish nurses and midwives. In addition, these countries are offering superior packages in recruitment campaigns in other countries that Ireland is seeking to recruit from, making them more attractive to prospective international nurse/midwife recruits.

The shortage of nursing in Ireland is well documented. The INMO reiterated the issues surrounding the difficulty with recruitment, and highlighted the fact that the 2016 annual figures illustrate that:

- 250 more nurse managers left the public health service than joined it
- The net increase in staff nurses was 302 WTE, as the recruitment of 2,573 staff nurses was negated by the fact that 2,271 left the workplace over the same period.

The INMO cited international evidence demonstrating the issues that staff shortages pose for nurses and midwives who work in this type of a health service, including burnout, increasing instances of injury and violence, and increasing resignations.

The submission presented evidence that inferior pay scales in Ireland are a major factor affecting the retention of nurses/midwives in the Irish health service. Nursing/midwifery pay scales are 15%-20% lower than allied health professionals, who have the same level of qualifications and a shorter working week. This is in contrast to international standards where the pay of allied health professionals is on a par with that of nurses/midwives.

The INMO emphasised the negative outcome for patients, of nursing/midwifery shortages and increased skill mix. It cited all relevant literature, including the RN4Cast study of 12 European countries, which recorded the consequences of missed care as increased mortality and poorer outcomes for patients, when nursing/midwifery ratios drop below safe levels. Evidence of unsafe hospital activity was also presented, referencing continuing overcrowding in EDs and wards.

The INMO submission also highlighted the reduction in workforce figures in recent years, stating that in 2017 the nursing and midwifery workforce remains 3,500 less than it was in December 2007 when there was a lower activity in the Irish health service.

The need to future-proof our health service in response to demographic changes as set out in the recent ESRI report, were included in the submission. This highlighted the projected need to expand the acute hospital services by 33% and older persons' services by 54% based on the increasing and aging population.

These expansion initiatives will require additional nursing/midwifery staff. To recruit and retain at a level that allows the overall nursing and midwifery population to grow requires new measures. The submission included evidence of the failure of all recent non-pay measures to deliver this outcome.

The INMO reminded the Pay Commission that nursing and midwifery are female dominated professions (91%) that have, since 2007, endured chronic shortages. Low pay is also evident when comparisons are demonstrated to other professions. The INMO said the need to break the cycle of low pay for Irish nurses/midwives has been ignored for too long. The evidence supports the fact that recruitment and retention of these grades are directly affected by uncompetitive pay and poor working conditions.

Next steps

Sean McHugh, the chair of the Nursing/Midwifery

INMO general secretary designate Phil Ní Sheaghdha with the INMO submission to the Public Service Pay Commission

Recruitment and Retention Agreement of February 2017 (which included delegated authority to directors of nursing and midwifery to recruit), has been requested by the PSPC to attend before it and set out the implementation progress of that agreement.

The INMO has asked to make oral submissions and presentations to the Pay Commission. Additionally, the Organisation requested the opportunity to provide expert testimony to support the evidence in its written submission.

The process has now started. The Commission is now examining all evidence presented to it. The INMO submission is evidence based and leaves no doubt that the chronic shortage of nurses and midwives will not be addressed until the issue of pay is addressed.

The Pay Commission's findings/recommendations for nursing and midwifery are expected in June 2018.

– Phil Ní Sheaghdha, INMO general secretary designate

ESRI report presents major challenge

10-year funded development plan now an absolute priority

THE INMO welcomed the recent report from the Economic and Social Research Institute (ESRI), which details the huge challenges facing the health service arising from the significant demographic changes that will occur in this country over the next 12 years to 2030.

The report identifies the need for a major expansion, of all areas of the Irish healthcare system, to ensure that health services can meet the now known demands that will face it in the coming years.

The stark declaration that demand for health services will increase in such pivotal areas as acute hospital services (up 33%) and older person services (up 54%), now requires the government, and all parties in the Dáil, to commit to fund, as suggested in the *Sláintecare* report, a major expansion of the health service so that it can serve the people of this country in the coming decade.

The ESRI report also supports the INMO's demand in its recent pre-budget submission, for the following:

- 25% increase in the nursing/midwifery workforce over the next five years, which will require a radical investment in nursing/midwifery both in terms of educating sufficient numbers of nurses/midwives, and ensuring that we retain adequate numbers for this expanding health service
- A minimum of 2,000 acute beds to meet the growth in demand – it is necessary to note that in the past decade acute hospital activity has increased by up to 20%, which has resulted in a 94% increase in the number of admitted patients on trolleys. A further increase in activity of up to 33%, as indicated in the ESRI report, can only be met by a significant and immediate expansion of our acute bed capacity
- Older person services – the significant increase in demand for older person services arising from our aging population can only be met by investment in the complete range of services required, including long-stay and intermediate care beds, public health nursing services and home care/home help services. This must be planned for, and funded, as it is labour intensive.

The government, and all political parties, must now move on from analysing and strategising about this challenge, and commit, in terms of multi-year funding, and multi-year manpower planning and capital investment to develop, deliver and sustain a significantly expanded health service capable of meeting the increase in demand identified.

The full ESRI report can be downloaded from: https://doi.org/10.26504/rs67

INMO general secretary designate, Phil Ní Sheaghdha, said: "This is a most sobering, evidence-based and well researched report, which confirms the dramatic challenges facing the health service over the coming decade and beyond. We will not meet this challenge as a country by simply, year on year, growing our health service in an incremental fashion. This report requires an immediate, collective and sustained response, from the political system and across society, which must address the resource implications arising from this report, so that we have, as the *Slaintecare* report proposes, a 10-year development plan for our health service.

"This report tells us what is going to happen over the next decade, and we must now act upon it. We must come together to deliver all actions necessary to ensure we address existing shortcomings and expand the service to meet this future demand. This will require that the actions necessary to implement this report must be integrated into all future health policy decisions.

"The INMO is calling for immediate discussions, of all interested parties, arising from the report with a view to agreeing the obvious actions and steps now required."

2018 Executive Council elections – call for leaders

THE election process to the INMO Executive Council for the period May 2018 to May 2020 is set to commence early in the new year, as set out in the special notice on *page 10*.

Completed nomination forms must be submitted to the INMO general secretary (the returning officer) on or before **5pm on Wednesday, February 7, 2018**. All details in relation to what is required to be an eligible member are included in the notice.

Together with their application form all candidates must submit:

- A photograph
- An election manifesto.

These will allow the Organisation to inform members of who you are, what your issues/priorities are if elected, where you work etc. Such details really help to make the election come alive for every member, so please submit your photograph and biographical data with your nomination form if you are intending to run.

The Executive Council is central to all INMO activities as it manages the affairs of the Organisation, while also seeking to implement policies adopted at annual delegate conference.

All eligible members are encouraged to come forward and, therefore, strengthen the democratic structures within the Organisation.

The INMO always needs a strong Executive Council. Now is your chance to become a leader and help shape all our futures.

Actions agreed at WRC ED review

AT THE WRC review of the Emergency Department Agreement last month, the INMO expressed its grave dissatisfaction with the worsening overcrowding in particular hospitals and the failure of the HSE to implement all elements of the agreement.

The meeting was chaired by John Kelly of the WRC. INMO representatives at the most recent meeting on November 13, 2017 included general secretary designate Phil Ní Sheaghdha, acting director of industrial relations Tony Fitzpatrick, IRO Philip McAnenly and two INMO reps Emma Marie Murphy and Mary Delaney Dunne.

Actions were agreed under a number of headings as follows.

Enhanced clinical role

Wording on the enhanced clinical role is to be agreed between the INMO and the DOH within two weeks and be submitted to the DOH Nurse Policy Division. This will be linked with the CNS development pathway.

Triage escalation

This was an action from the WRC ED review of June 16, 2017. The acute hospitals division was to link in with the emergency medicine programme and revert within two weeks to the INMO.

Staffing for admitted patients

The HSE outlined difficulties with recruiting the 124 posts earmarked for admitted patients. Management indicated that 50% of the 124 posts had been filled. However, there is significant difficulty in recruitment maintaining pace with the number of leavers. The HSE confirmed that it hoped to have all staff in place by the end of January 2018. Further work is ongoing, involving Prof Jonathan Drennan, on reassessing the staffing requirements for admitted patients based on the numbers of patients involved.

ADON patient flow

Management outlined that the agreed assistant director of nursing patient-flow positions had been filled. However, it was agreed that the HSE would request an audit report from directors of nursing and those appointed as patient-flow ADONs to establish if individuals are in post and are acting in accordance with the job description that was agreed nationally.

This audit should capture any additional roles that the ADON for patient flow is undertaking, including people management and day to day operational management within EDs.

The parties re-emphasised that there is a clear job description for the patient-flow ADON and management will ensure that all services follow that job description. The HSE was to revert within two weeks with regards to this.

Group wide executive forum/ hospital level meetings

The INMO outlined that a key component of the WRC agreement of January 11, 2016 is the requirement for the convening of group wide executive forums and hospital level forums. The membership of these groups is clearly set out and should involve the group CEO (forum chair) and the group director of nursing.

Management accepted that this is a key component of the agreement and agreed to stress the need for these regional and local forums to meet on a regular basis involving the CEOs and group DONs. The INMO emphasised the need for the group wide executive forum to meet regularly but also that the forum needs to be efficient to deliver best results.

CNM2 shift leaders and CNM1 posts

Management agreed that all CNM2 shift leaders and CNM1 positions should be filled. The HSE confirmed that these are funded posts and therefore any vacancy that arises should be filled. It was noted that all the initial CNM1 posts have been advertised and filled. However, vacancies may have arisen since appointments were made. However, these should be immediately backfilled.

Security report

The HSE confirmed that it would produce a report regarding the implementation of the recommendations of the independent security report of 2016. The INMO highlighted concerns that some departments still do not have a 24-hour security presence and do not have restricted access. The HSE is to address these deficits immediately.

Winter plan

The winter ED plan was due to be signed off by the Minister for Health at time of the meeting. The HSE undertook to provide details of the plan to include additional surge capacity, measures to be implemented to the worst affected hospitals and the detail of the ongoing supports to improvers. The HSE outlined that, for example, additional bed capacity would be provided including 30 beds to Galway, 17 to Limerick and 15 to Waterford. In addition, the details of home support care measures as part of the winter initiative would be forwarded to the INMO once approved by the Minister. It was agreed that no beds should open unless safe staffing is agreed and in place.

Bed closure reports

The HSE agreed to share the weekly data on acute and non acute bed closures in the system, as requested by the INMO. Management advised that 150-170 acute beds are closed each week due to staffing and infection control issues.

– Tony Fitzpatrick, acting director of industrial relations

ED staffing taskforce phase II – underpinned by three pillars

THE INMO continues to engage with the Department of Health and the HSE on the roll out of phase II of the ED staffing taskforce. Work is progressing well on an overall draft framework for this research, which will be underpinned by three pillars:

- Four care assumptions which are that patient care needs are different; nurse staffing number, profile and mix are key to ensuring high quality care to patients; the organisational environment in which patients receive care and staff deliver care has an impact on the ability to deliver safe, effective care; and that positive patient and staff outcomes are important indicators of the safety and quality of nursing care
- A PESTLE exercise
- An overarching unit to board governance framework.

The next meeting is due to take place in Hawkins House on December 19, 2017.

In parallel with this work, a pre-pilot test will be conducted in one emergency department to assess and validate whether to use the TRENDCARE or BEST tool when the pilot rolls out in three sites in 2018. The site chosen for the pre-pilot test is Our Lady of Lourdes Hospital, Drogheda.

HSE issues clarification on Trust in Care and Safeguarding policies

FOLLOWING clarification of several issues raised by the INMO, members are advised they may now participate with training on the Safeguarding of Vulnerable Adults policy. However, note that the Trust in Care policy remains the only policy in place to investigate and/or review any allegations against staff members.

The amended Safeguarding policy arose out of a WRC conciliation on October 23, 2017, subsequent correspondence from the HSE and the ongoing work of the Review Development Group (RDG) charged with revising the Safeguarding of Vulnerable Adults Policy document of 2014.

Several outstanding issues after the WRC agreement of July 12, 2017 have now been addressed, including those listed under the following headings.

Definition of institutional/ organisational abuse

The INMO is seeking a clear definition of institutional/ organisational abuse to be included in the Safeguarding policy. This will be addressed via the RDG on the Safeguarding policy, which is having ongoing meetings.

Practitioner working group

It was agreed that a practitioner working group would be established to streamline the documentation around safeguarding of vulnerable adults. The first meeting of this group took place on October 23, 2017 with a further meeting planned for December 2017.

Peer to peer abuse

It was agreed at conciliation on October 23, 2017 that the HSE would forward terms of reference for the pilot proposal to the INMO within three weeks. It is proposed this pilot will take place in CHO 1, 2 and 7, with a third party educational institution overseeing and evaluating the process.

Trust in Care policy

It was agreed at conciliation on July 12, 2017 that the Trust in Care policy remained the only policy in place to investigate and/or review any allegations against a staff member. The INMO requested management to issue a memorandum outlining this position. This was received on November 6, 2017 in the form of guidelines outlining the appropriate information sharing linkage between the Trust in Care and the HSE Safeguarding policies for dissemination to training facilitators, designated officers, safeguarding teams and other relevant management *(see Table)*. This guidance, while overdue, was welcomed by the INMO.

Designated officers

The HSE committed to ensuring the training of additional designated officers and would at all times ensure patient safety and fair procedures for staff. Directors of public health nursing are not designated officers, as designated officers are not required in the community approach.

Management has committed to training of approximately 100 officers. In relation to the number of designated officers per area, the INMO proposed 50 beds per designated officer and management is to revert on this.

Note the HSE's clarification clearly outlines that in cases where the service manager is also the designated officer, he/ she should delegate responsibility for liaising with the Safeguarding team to another appropriate manager.

Review Development Group

The RDG on Safeguarding is continuing its work and last met on November 15, 2017.

The addendum to the policy presentation which outlines the additional measures contained in the WRC agreement and the guidance sheet issued by the National Safeguarding Office can be viewed on **www.inmo.ie**

– Tony Fitzpatrick, acting director of industrial relations

Synopsis of guidance on linkages of Trust in Care and Safeguarding policies

Context

- Concerns of abuse or neglect can arise from a number of sources and the initial identity of the person of concern may not be clear
- The Trust in Care policy is the HR policy and should be invoked if a staff member is deemed to be a 'person of concern' who may have a case to answer. It is the agreed national HR policy for managing concerns or allegations of abuse in which a staff member may be implicated
- The purpose of the Safeguarding policy is to determine if there are reasonable grounds for concern to justify putting a protection plan in place for a service user. The paramount priority is the safety and welfare of the service user – there should never be undue delay in undertaking protective measures

Policy and procedure framework and information linkage

Trust in Care policy

- This provides for preliminary screening of a specific complaint/allegation against a staff member and, where required, the investigation process into the complaint/allegation
- The relevant line manager carries out a preliminary screening process. The outcome may be a decision for a formal investigation under the Trust in Care policy. If the findings of the investigation uphold the complaint/ allegation, the employee will be subject to the disciplinary process

Safeguarding policy

- This is the framework to protect service users from any potential risk of abuse or neglect
- The protective procedure is that the service manager and/or designated officer ensures that immediate standard safety steps are taken
- They should gather preliminary information but this should not be an investigation of a staff member or a specific allegation
- Where the service manager is also the designated officer, responsibility for liaising with the Safeguarding team should be delegated to another appropriate manager, while the service manager retains responsibility for managing the employee in accordance with Trust in Care. Delegation is intended to ensure that the Safeguarding team is provided with relevant information in respect of the service user while upholding the employee's rights to confidentiality and due process
- Without prejudice to the Trust in Care process, a Safeguarding preliminary screening notification may be submitted to the Safeguarding team. This screening only considers if there are reasonable grounds for concern to justify taking protective steps in relation to the service user

Information sharing and liaison

- Any information shared or notified to the Safeguarding team should relate to the service user's information only and not identify a person of concern. Such a submission is for notification purposes and the safeguarding team has no role or oversight on the Trust in Care process
- The Safeguarding preliminary screening therefore may need to be limited in certain details about the allegation, recording only that there are follow up investigations ongoing
- If further information is needed or reasonable grounds for concern exist, then a protection plan for the service user with a Safeguarding co-coordinator is needed
- At the conclusion of the Trust in Care process only information that is relevant to protection for any service user should be notified to the Safeguarding co-ordinator

Tony Fitzpatrick, INMO interim director of industrial

Transfer of tasks progressing well

THE national implementation verification group (NIVG), which was set up to verify progress on the transfer of four specific tasks from medical to nursing/midwifery staff, with the tasks then becoming shared between the two professions, has completed its verification process

The NIVG reports that significant progress has been made on the transfer of each of the tasks identified in the Haddington Road and Lansdowne Road Agreements. The fours tasks are intravenous cannulation, phlebotomy previously carried out by NCHDs only outside of normal hours, IV drug administration – first dose, and nurse-led delegated discharge of patients. They were agreed following intense negotiations in late 2015 and the transfer of tasks commenced in 2016.

The NIVG reviewed all information provided by the hospitals and hospital groups including:

- Position in each location
- Evidence from local meetings
- Written verification reports signed and/or completed by hospital managers, directors of nursing and clinical directors.

The transfer of tasks process has progressed through a significant collaborative approach between the Health Service Executive, Department of Health, the INMO, SIPTU nursing, the IMO and the acute hospitals. This involved representatives of each organisation visiting hospital sites to ensure that staff and management are committed to and delivered the required change. NIVG members are of the view that the revised practices have commenced and will become embedded across the system over time.

The original agreement provided for the agreed tasks being undertaken by the staff member who is most appropriate to do so at that time and in that location. A key element of the implementation relates to the professional requirement of training of nurses on the tasks prior to undertaking them. Based on figures provided by the HSE, the number of nurses who completed training on two of the tasks, ie. peripheral iv cannulation and venepuncture, increased year on year from 2015 to 2016 by 66.3% and 38% respectively.

The agreement outlined that these tasks can no longer be the sole responsibility of any one grade but that nursing/midwifery practice should expand to incorporate them. It was also agreed that the transfer should not de-skill medical staff and that they should maintain some involvement in the tasks to ensure that this does not occur.

The result is that the tasks identified are now part of nursing duties and form part of their scope of practice. It had been anticipated that some teething problems would arise. In particular, it is recognised that relevant staff, both doctors and nurses, must have confidence in this process. These issues have been discussed and identified by the NIVG of which nursing and medical unions are members.

To assist continued progress, the recently finalised Implementation and Verification report provides for issues outlined in the *Table*.

Table: Further provisions of NIVG report

- Clarification on the sharing of tasks
- Additional implementation initiatives
- Recommendations on additional availability and analysis of training
- Inclusion of modules on the agreement in induction processes for NCHDs and nurses
- A new protocol for doctors and nurses to raise concerns in relation to implementation locally, which can be escalated if unresolved
- Additional visits to locations to provide further impetus in relation to implementation of the agreement
- Ongoing reporting arrangements to provide information on implementation which can be analysed at hospital and group level, as well as the parties to the agreement
- Continuation of availability of the NIVG to address any concerns, if requested

Resolution close on PHN contracts of employment

THE WRC's assistance has been sought on outstanding issues regarding the PHN contract of employment. Progress has been made in regard to attendance pattern and reporting relationships, but placement of the PHN remains to be agreed.

A WRC conciliation conference was scheduled for December 1, 2017 but it was hoped the issue would be settled ahead of this. The INMO is in direct contact with CERS in the hope of bringing the issue to conclusion.

The HSE had sought that the allocation of the PHN would be to the CHO area. The INMO argued that this was too large an area, would contravene redeployment distances (45km) and placement needed to be confined to the Community Care Area/Local Health Office, for example, allocated to Meath Community Care Area, rather than CHO 8.

A meeting took place with the HSE on November 16, 2017 and it is hoped that this matter will be concluded ahead of a WRC due to take place on December 1, 2017.

PHNs who have graduated and are working as per their sponsorship agreement, are entitled to be paid a PHN salary pending the sign off on the national contract.

This matter was clarified by a CERS Circular 02/2017, which clearly states: "If the nurses concerned are employed as PHNs as per the circular, carrying out the full role and duties associated with their substantive PHN posts, it would normally be deemed that they have an implied contract of employment and they would be paid at the appropriate grade (not at a lower salary/grade) from the date of appointment." Also, the sponsorship contract signed by the PHN clearly outlines that they will be paid at PHN level, once they are registered as a public health nurse.

If PHNs are being paid at a lower level, they should immediately raise this with their director of public health nursing and HR department. If they are unable to resolve the matter locally, they should contact their INMO IRO.

relations, reports on current national IR issues

Governance of home helps under focus

THE first meeting of the group set up to resolve issues on the governance of home helps and the implementation of the single assessment tool to replace CSARs took place between the INMO and management on November 15, 2017.

The INMO team, led by acting director of industrial relations Tony Fitzpatrick and made up of PHNs and CRGN representatives, outlined the Organisation's serious concerns with the current system.

There is currently significant variation across community care areas on the provision and governance of home help services. The number of providers vary, with the western seaboard mainly consisting of HSE directly employed staff, while in Dublin, it is mainly voluntary agencies providing the service. Several areas have a combination of public and private providers.

The HSE outlined that it wishes to continue the clear linkage that exists between community nursing and home care services. Therefore, part one of this process will be to tease out the issues, inconsistencies and matters of concern that exist from the perspective of community nursing staff with regards to the current provision of home help services. The second part of the process for the working group will be to examine the implementation of the single assessment tool.

Several significant challenges must be addressed from the INMO perspective including:

- Current community nursing workloads
- Duplication of duties
- Prioritisation of duties that are currently in place, due to staffing and workload issues, which requires PHNs and CRGNs to deal with Priority 1 cases only. At present, P2, P3 and P4 cases are not completed and this matter is placed continually on the local risk register
- NMBI issues including delegation and supervision. Issues arise regarding the level of clinical supervision, the variation of grades, from HCA to home help, the current application process and the segregation of home help coordinators
- Current application processes and the induction of home helps and HCAs
- PHN assessment with recommendation and the modification of same by non-clinical staff
- Agency and private providers
- Eligibility criteria, ie. the PHN service is still governed by the eligibility criteria in the Health Act of 1970, while home help services do not require the same eligibility criteria
- Lack of IT infrastructure.

At the meeting of November 15, Michael Fitzgerald of the HSE outlined that the HSE was anxious to engage with the INMO to resolve the various issues with regards to the governance of home help. The process is being chaired by Sean McHugh and it is hoped the group will conclude its work within three months.

It was agreed that the HSE would forward an up to date presentation on the single assessment tool to the INMO, while providing a status document on the current models for the provision and governance of home help services.

The INMO will write directly to the chair clarifying its issues with the memorandum issued in August 2014 by the national directors. The chair of the group undertook to contact the Department of Health seeking its involvement in this working group, as requested by the INMO. The next meeting is due to take place on December 19, 2017.

Review of medication management in ID sector

FOR a significant period of time, the INMO has outlined its grave concerns to the HSE with regards to the management and administration of medications across intellectual disability services.

The INMO has long advocated the need for the HSE to develop appropriate guidance for medication management within disability services in order to ensure there is a homogeneous system that protects service users and staff.

The HSE has established a steering group to develop national medication management guidelines that will support the development of local policies and procedures on medication management.

The INMO team of Tony Fitzpatrick, Edward Matthews and Ailish Byrne met with the HSE on two occasions, most recently on November 20, 2017. The HSE advised that the Social Care Division, in partnership with the Quality Improvement Division, established a Quality Improvement Programme in December 2014. In 2015, the quality improvement teams visited 148 houses/units for people with intellectual disability and found variation in policies and in the duration and content of training programmes for staff in the safe management of medication across services. The subsequent report identified that medication management is being delivered by a range of caregivers, whose roles vary significantly across the services.

The INMO met with the HSE to discuss the work of the steering group, including its aim, scope, roles and responsibilities, project deliverables and governance. The HSE shared with the INMO the membership of the steering group and the terms of reference. The INMO sought a number of amendments to the terms of reference and to the membership of the steering group. The HSE has accepted the amendments to the terms of reference and acceded to have a minimum of four RNIDs on the steering group. The steering group and various subgroups have commenced their work.

It was agreed that no proposal or recommendation from the steering group or subgroups would be implemented until there is further engagement and consultation with the union oversight group.

Note that this review is at present looking at HSE intellectual disability services. However, whatever is agreed as the appropriate practice within the HSE, would be enforced via service level agreements with the Section 38 organisations. The INMO is due to meet with the HSE again on this issue on February 20, 2018 at the Corporate Employee Relations Services.

India main source of new recruits

INMO joins Malayalee nurses/midwives in celebration

MOST nurses and midwives working with the Irish health service readily understand that many of our acute hospital services and care of the older person facilities in greater urban areas would simply have to close except for the reliance on nurses and midwives recruited from outside of Ireland.

The number of nurses/midwives recruited into the country in 2016 and 2017 outstrips the number of new registrants trained in Ireland. Indeed, Ireland's reliance on nurses/midwives from other countries, in percentage terms outstrips that of most other developed nations.

In terms of destinations where our overseas recruited nurses/midwives arrive from, India consistently tops the list.

Recently the World Malayalee Federation, through its Irish chapter, held a major public event entitled 'A Tribute to Nurses' in Phibblestown Community Centre, Clonee, Dublin 15. On the night in question up to 500 nurses, with their families, attended the event, which was an Indian cultural night. The very special guest of the night was the Indian Ambassador to Ireland, Vijay Thankur Singh.

INMO deputy general secretary Dave Hughes(centre) and Indian Ambassador to Ireland Vijay Thankur Singh preform the ceremonial opening at recent World Malayalee Federation tribute to nurses and midwives working in Ireland

The federation very kindly invited the INMO and Dave Hughes, deputy general secretary, spoke on behalf of the Organisation and outlined some statistics which demonstrate the high reliance that Ireland has had on inward migration of nurses and midwives and, in particular, from India.

Malayalee Indians are those who originate from the southern regions in India, generally natives of Kerala and South India. It is a region of India with a rich culture and a strong sense of community participation. The Malayalee Federation promotes community participation as a key for the integration of nurses and midwives from South India into their Irish communities. It organises various events and activities throughout the year, including cricket and badminton tournaments, family days and celebrations to coincide with Indian festival occasions.

This special tribute for nurses and midwives working in Ireland was a truly inspiring affair and a real eye opener in terms of the settled community of Indians who now live throughout Ireland.

On the night there were speeches from INMO deputy general secretary, Dave Hughes, local TD Ruth Coppinger, the Indian Ambassador and a musical director who conducted a seven piece band playing music from Southern India.

INMO members Tony Thomas and 2017 CJ Coleman award winner, Dr Suja Somanadhan were honoured on the night for their academic achievements.

Success for community midwives' subsistence claim

THE INMO successfully represented 18 WTE community midwives employed by the Rotunda Hospital, Dublin at the Workplace Relations Commission and Labour Court in respect of the payment of subsistence.

Under the rules, a staff member is entitled to claim subsistence when over 8km and five hours away from their base place of work. The current rates are:

- €14.01 for 5-10 hours
- €33.61 for over 10 hour.

The Rotunda Hospital community midwife team was not aware that they were entitled to claim subsistence pay and therefore did not submit claims as they occurred.

After two conciliation conferences at the WRC, management agreed to pay subsistence going forward from September 2017.

Agreement could not be reached on the payment of retrospection so the INMO referred this aspect of the claim to the Labour Court. The Labour Court then recommended compensation of €2,500 to the members of the team in back payments.

INMO members who travel in the course of their work and meet the above criteria should contact their local IRO if they are not in receipt of subsistence payments.

– Lorraine Monaghan, INMO IRO

Temporary reassignment of IROs

THE INMO is currently re-organising areas of responsibility for some of its IRO staff, which is due to a number of factors, including an upcoming retirement and the exciting appointment of Clare Treacy to the Labour Court.

In keeping with the motion from ADC in relation to additional support in all workplaces, the Organisation is also currently reviewing how it delivers industrial relations services with the aim of improving these services for members.

Consequently a number of temporary changes have been put in place, with regard to IRO areas of assignment, until the full review of the services is completed.

Areas temporarily covered by reassigned IROs

Area	IRO	Contact details
Cork Voluntary/Private Branches, ID Services Cork and Kerry, Killarney and Tralee Branches	Mary Power	INMO Cork Office Tel: 021 4703000
Cork HSE South, CHO 4, North Lee, South Lee, West Cork and Mallow North Cork Branches	Liam Conway	INMO Cork Office Tel: 021 4703000
Carlow, Kilkenny, Wexford and South Tipperary including Cashel and Clonmel Branches	Liz Curran	INMO Limerick Office Tel: 061 308999
Tallaght Hospital, IBTS, Harold's Cross Hospice, Co Kildare, West Wicklow and Waterford Branches	Joe Hoolan	INMO Head Office Tel: 01 6640600
CHO 8 Midlands, Mullingar, Tullamore, Portlaoise and Portiuncula Hospital	Dean Flanagan	INMO Head Office Tel: 01 6640600
North East Area Branches and Our Lady's Hospital, Navan	Noel Treanor	INMO Head Office Tel: 01 6640600
Community Care Areas Dublin South West, CHO 7, Coombe Hospital, National Maternity Hospital, Temple Street Hospital, Crumlin Hospital, St James's Hospital	Mary Rose Carroll	INMO Head Office Tel: 01 6640600

The review will conclude prior to next year's annual delegate conference, at which a full report will be presented. The temporary reassignments of IROs is set out above.

Work to rule likely at St Finbarr's

MEMBERS at St Finbarr's Hospital, Cork have balloted for industrial action due to ongoing staffing concerns, unfilled CNM posts, ongoing short staffing levels in addition to massive cuts to agency spend. This has left areas of the hospital severely short staffed on a daily and ongoing basis with short term and long term sick leave and maternity leave.

Management has taken the position that the overall staffing levels are adequate for each ward/unit in the hospital, based on the cost of care model.

The INMO and its members in St Finbarr's are concerned that this does not reflect the reality on the ground, members are working with ongoing short staffing levels and have now reached the point where this cannot continue.

Notice of industrial action has been served, commencing with a work to rule at the end of November.

The INMO and its members are willing to engage with management in relation to their patient safety and health and safety concerns prior to commencing the work to rule.

However, Management's position remains the very polar opposite to the reality for our members in St Finbarr's at this time.

– Liam Conway, INMO IRO

CUMH update

INMO members at Cork University Maternity Hospital met early last month to discuss ongoing staffing concerns in all areas of the hospital.

The INMO industrial relations team is engaging with management locally to discuss and resolve the issues and concerns voiced by the members at this meeting.

– Liam Conway, INMO IRO

Staffing issues Bandon and Fermoy

MEMBERS at **Bandon Community Hospital** are continuing a work to rule over staffing levels with a move to a new building. Members have previously balloted for industrial action as they had concerns about management's position of retaining the same staffing level for increased bed capacity. Added to this is the fact that the majority of new building layout consists of single room occupancy. The matter was due to be heard by the WRC on November 29, 2017.

Meanwhile, ongoing concerns about staffing levels at **Fermoy Community Hospital** were heard at the WRC last month. These concerns were over the failure to maintain the nursing staffing complement of 31 WTE for the hospital. Following lengthy exchange between all parties, the INMO secured a proposal addressing the issues of concern and recommended acceptance of the proposals.

– Liam Conway, INMO IRO

Tallaght ED remains 'intolerable'

THE ongoing intolerable staffing difficulties and overcrowding in the emergency department of Tallaght Hospital were discussed by the INMO and Management last month. The INMO detailed the serious difficulties that nursing staff face on a daily basis and requested the presence of senior clinical decision makers on a 24/7 basis within the ED.

It was confirmed that:

- A shortage remains in the nursing staff in the ED
- The approved six WTE nursing posts required to specifically care for admitted patients in ED as agreed in July 2017 have yet to commence
- Difficulties in rapid access triage and ambulatory care were acknowledged and are due to staffing shortfalls
- The hospital remains in 'black escalation' on a continuous basis, including additional trolleys on inpatient wards.

Tallaght ED was investigated by HIQA in May 2012.

Section update

Care of the Older Person Section Conference

The Annual Care of the Older Person (COOP) Section conference is scheduled to take place on March 13, 2018 in the Midland Park Hotel (formally the Heritage Hotel), Portlaoise town centre. The day will focus on managing families' expectations as our loved ones reach the end of their lives, the expansion of the role of the COOP nurse, motivational coaching, governance and fitness to practise, and a session on pensions.

Bookings are available at: **www.inmoprofessional.ie** or you can contact the INMO directly at Tel: 01-6640616.

RNID Section

The RNID Section is set to hold its national conference on March 22, 2018 in the Midland Park Hotel Portlaoise. The theme is the RNID in Practice – Embracing Community Living. We are delighted to welcome, among many other prominent speakers, Kay Mafuba from the University of West London. There will also be sessions on challenging behaviour, a piece from the athlete leadership programme on the results of research carried out by clients on how best they wish to be addressed, the RCN NI LD nurse of the year Siobhan Rogan will share her experiences on setting up and leading CALMS. Please go to: **www.inmoprofessional.ie** to book your place.

Reminder to all national sections that your AGM will be scheduled prior to mid February, in keeping with the Organisation's ADC submission deadlines. Members, please keep an eye on the website as your AGM dates are confirmed

Midwifery students benefit from All-Ireland conference

MIDWIVES gathered in Armagh in October to attend the All Ireland Annual Midwifery Conference. With over 170 midwives in attendance, a great atmosphere for learning and networking pervaded. We were delighted to welcome a large contingency of students who travelled from UCD, for many of whom it was their first experience of such an event, and they thoroughly enjoyed it.

Here is a brief account from Jessica O'Brien, one of the students who attended.

As part of our training to become midwives, we were invited to the INMO midwifery conference and travelled from UCD to Armagh City Hotel. 35 student midwives (both higher diploma and direct entry students) attended the conference in October. The conference was enjoyed thoroughly by my class and we all found it to be extremely informative for our training.

When we qualify, we will be met by the new National Maternity Strategy and getting the opportunity to discuss the development of the strategy at the conference was extremely interesting as we saw first hand what amazing work is being done to develop the strategy. Of particular interest to my class was the topic of VBAC by Cecily Begley, which everyone found so interesting as we had the opportunity to listen to what midwives in other hospitals around the country are doing to develop the service.

As the caesarean section rates are on the rise it is of particular importance to us to understand what services we can offer women and empower them in future pregnancies.

Many other talks and presentations took place during the day and the conference was concluded with the poster competition, which saw many midwives develop new ideas and studies for the future of midwifery.

It was brilliant to see the areas of midwifery practice that midwives want to develop which will certainly improve midwifery services in Ireland in the future.

Overall, the conference was a big success and thoroughly enjoyed by all of my class who attended and we would like to thank the INMO for a really enjoyable day.

Pictured at the All Ireland Annual Midwifery conference in Armagh were (l-r): *Speakers Kysia Lynch, Chairperson, AIMS Ireland and Seana Talbot, president, National Childbirth Trust and Maternity Services Liaison Committee member*

Pictured (l-r) were: *poster competition winners, midwives Jackie Mc Brinn; Paula Boyle; and Barbara Strawbridge*

Conference attendees examining entries to the poster competition

Retired Section takes on the Viking city

STORM Brian did not dampen the spirits of the 26 members of the Retired Nurses Section as they headed to Waterford, the oldest City in Ireland, founded in the ninth century by Vikings.

Waterford had plenty of other notable residents including TF Meagher who conceived the Irish Flag, which flew for the first time in Waterford in 1848, and Blessed Edmund Rice who founded the Christian Brothers in 1802.

We visited many of the cultural attractions, including the World's First Viking Virtual Reality Adventure Centre, set in a replica Viking house – not for the faint-hearted!

Reginald's Tower, named after the Viking King who founded the city contains many treasures including a 12th century gold kite brooch. The Medieval Museum was another very popular attraction for us as it included the Cloth of Gold Vestments, on display behind bulletproof glass, and the 1373 Great Charter Roll of Waterford. We viewed the oldest piece of Waterford crystal (1789) in the 18th century Georgian Bishop's Palace.

It was a great trip and we are looking forward to our Spring break already and another chance to catch up with friends and colleagues. Before that we have our Christmas Lunch in Wynn's Hotel, on January 18, 2018. We will meet at 12.30 for a meal at 1pm. Enquiries to :Ann Igoe at: a.igoe123@gmail.com or Geraldine at Tel: 0872794701.

Raising the status of nursing globally

Elizabeth Adams introduces the Nursing Now! campaign which aims to release the potential of nurses to deliver universal health coverage

NURSING Now! is a campaign focused on raising the status and profile of nursing globally and maximise the contribution that nursing makes to universal health coverage (UHC), women's empowerment and economic development. Nursing Now! – a three-year global campaign and programme of the Burdett Trust for Nursing – will launch in the New Year.

Lord Nigel Crisp who will chair the new global Nursing Now! board (the membership of which is set to be announced in the near future), is an independent crossbench member of the House of Lords where he co-chairs the All-Party Parliamentary Group on Global Health. He was previously chief executive of the NHS and permanent secretary of the UK's Department of Health – the largest health organisation in the world with 1.3 million employees – where he led major reforms between 2000 and 2006.

Lord Crisp has published extensively on global health including, *Turning the World Upside Down – the search for global health in the 21st Century; Global Health Partnerships;* and *One World Health – an overview of global health after Global Health Partnerships.*

A Cambridge philosophy graduate, he worked in community development and industry before joining the NHS in 1986. He has worked in mental health as well as acute services and from 1993 to 1997 was chief executive of the Oxford Radcliffe Hospital NHS Trust, one of the UK's leading academic medical centres. Further information available at: **https://nigelcrisp.com/**

Background

This Nursing Now! campaign is based on the report *The Triple Impact of Nursing – how developing nursing will improve health, promote gender equality and support economic growth* (2016) published by the UK's All-Party Parliamentary Group on Global Health (APPG) following its review of nursing globally. The report concluded that:

- Universal health coverage will not be achieved without developing nursing globally. Nurses are the largest part of the professional health workforce and provide an enormous amount of care and treatment worldwide; however, they are very often undervalued and underutilised. Nurses could have an even more significant impact in the future – and will be decisive as to whether UHC is achieved
- Developing nursing will have the triple impact of contributing to three of the Sustainable Development Goals – improving health, promoting gender equality, and strengthening economies.

The report also noted the very large shortfall in health workers globally, estimated by the WHO as 7.2 million in 2013 and increasing to 12.9 million by 2035, and their maldistribution which means that low and middle-income countries have far fewer nurses than high-income countries do.

The report has been so well received that planning is underway to launch a global campaign to strengthen and develop nursing. This already has the support of the WHO and UK ministers from both the Department for International Development and the Department of Health.

Nursing organisations nationally and globally are providing support and discussions are in hand with the Commonwealth Secretariat, the World Bank and other organisations.

Under the leadership of Lord Crisp, the Nursing Now! global campaign will build on nurses' unique position as the health professionals who are at the heart of every health system, provide continuity

of care for their patients and are part of their local community.

The campaign aims to raise the status and profile of nursing globally so that it can make an even greater contribution to improving health and wellbeing.

The Campaign will be launched in early 2018, and will position nursing more central to health policy and ensure that nurses can use their skills, education and training to their full capacity. The campaign will seek to:

- Influence policy and decision makers by demonstrating what nurses can achieve and advocating for specific objectives and goals
- Create a grassroots movement among the global nursing workforce to generate energy, boost morale and encourage recruitment.

Foundation for future long-lasting change

Change will take a generation or more, however, a step-change and lasting improvements can be made in three years. The Nursing Now! campaign's objectives are to:

- Promote the influence of nursing and develop nurse leadership – ensure that there are more nurses in senior leadership roles where they can influence policy and provide more opportunities for development. This will be supported by a suite of development programmes for nurses at all levels and a flagship global senior leadership programme
- Provide evidence of the beneficial impact of nurses – disseminate evidence and seek more investment on research into the impact of nursing on health, women's empowerment and economic growth. This will be supported by a landmark study on the economic impact of nursing – covering the impact of job creation and greater workforce participation by women as well as the positive benefits of the improved health of the workforce
- Support nursing as a route for women's empowerment – showing how nursing affects the status and economic power of women. This will involve working with other global institutions to improve the life of women at work
- Demonstrate the effect of 'Nursing in all Policies' – working with a small number of exemplar countries or states to show how developing nursing and engaging nurses in policy making can improve health - and developing better ways of sharing good practice.

Pictured at the recent fourth Global Forum on Human Resources for Health in Dublin were (l-r): Dr Catherine Hannaway, global health consultant; Lord Nigel Crisp, independent crossbench member of the House of Lords and co-chair of the All-Party Parliamentary Group on Global Health; and Elizabeth Adams, director of professional development, INMO

The campaign will work with the WHO, UN Women and other bodies to ensure that its activities are linked with the global health workforce strategy and the five-year Action Plan of the Commission on Health Employment and Economic Growth, in addition to other global strategies.

Nursing Now! Global Board

Janet Davies, CEO and general secretary, Royal College of Nursing, UK, supported my nomination to the Board to represent the European Region. The nomination committee have now met with Lord Crisp, chair of the campaign Board, and Alan Gibbs, chair of the global Burdett Trust for Nursing. The announcement of the appointments to the Board is anticipated in January 2017.

I had a very welcome opportunity to meet with Lord Crisp at the Fourth Global Forum on Human Resources for Health in Dublin – *see photo above*.

Further information

Background information on how this campaign has evolved is available at: **www.appg-globalhealth.org.uk/home/4556655530** and on Twitter Page: **www.twitter.com/nursingnow_** You can also follow the #NursingNow hashtag.

Newsletter

You can subscribe to the Nursing Now! newsletter and register for updates at: **http://bit.ly/globalhealth_newsletter**

Elizabeth Adams is INMO director of professional development

European leadership in action

Brussels meeting: *The new president of the European Federation of Nurses Associations(EFN), Elizabeth Adams met with Dr Paul De Raeve, EFN general secretary with a renewed focus and vision to strategically strengthen nursing across Europe*

Leading the way

The Nursing and Midwifery Leadership Network was set up to foster collaboration and innovation among leaders nationally

THE reason for establishing the Nursing and Midwifery Leadership Network (NMLN) was a desire to bring nursing and midwifery leaders together to draw on their collective experiences and expertise. Leaders across all nursing and midwifery organisations gathered for a series of conversations to explore key questions about the future of our professions and the environment within which we provide care.

The Network is convened by the Irish Association of Directors of Nursing and Midwifery (IADNAM) and the partner organisations include The Chief Nurse's Office at the Department of Health, Office of the HSE's Nursing and Midwifery Services Directorate (ONMSD), the INMO, RCSI, NMBI and the heads and deans of the various faculties of nursing and midwifery, including UCC and, in particular, UCD.

These leaders were keen to not only support colleagues working in very challenging environments but also to ensure the professions of nursing and midwifery thrive and are at the forefront of crafting new models for health and social care systems in the years ahead.

Future uncertainties

What will this future look like? What direction will 'the systems' in wellbeing, health and illness take? How should we structure our professions so that we have greater impact and sustain our professional credibility and standing within health and our contribution to our communities? How do we build capacity to work in partnership with our colleagues in our respective workplaces and with people who require our care and clinical expertise? Are we prepared to use our voice(s) as leaders and take up an advocacy role when required? These were just some of the future uncertainties on which we deliberated.

Debate

The process we engaged in was extremely dynamic and challenging at times. We were determined to incorporate the totality of the themes that mattered to us, while also accepting that we held disparate views that had the power to both unite and challenge the very core of what we believe.

Members of the Nursing and Midwifery Leadership Network pictured at Richmond Barracks in June 2017 at the launch of NMLN Publication 'The Power of Conversation' were (l-r): Prof Josephine Hegarty, School of Nursing and Midwifery, UCC; Mary Brosnan, director of midwifery and nursing, National Maternity Hospital; Mary Griffin, CEO, NMBI; Thomas Kearns, CEO, Faculty of Nursing, RCSI; Anne Marie Ryan, deputy chief nurse, Department of Health; Suzanne Dempsey, honorary president, IADNAM; Avilene Casey, director of nursing, , ONMSD; Prof Martin Mc Namara, UCD Health Sciences Centre; Georgina Bassett, leadership and innovation advisor, National Leadership and Innovation Centre, HSE; and Mary Wynne, director, ONMSD

For example, the debates about the impact of the traditional hierarchical structures in nursing and midwifery, or interprofessional rivalries around patient care are important in the context of identifying impediments and improving the overall patient experience.

Our 'Big Group Conversations' and all the associated work allow us to explore new ways of considering the future roles of nursing and midwifery as key components in enabling people to 'live well' at all stages of life.

This approach is not always popular in our profession which often assumes a rather narrow view of 'tangible output' and 'action'. We are proud that throughout the project we are reflecting a true thought-leadership model and a commitment to positivity and change-making with a collective appreciative inquiry approach. The series of conversations on the themes outlined above are described in the recent publication *The Power of Conversation: Nursing and Midwifery Leadership in Action*.

Collaboration and support

Such an enormous and challenging project would not have been possible without the successful and meaningful engagement with advocacy groups, nurses and midwives and other health professionals as well members of the public from across a wide range of disciplines and across the entire country. We are extremely grateful for this support to maintain the momentum over the past three years.

We are thoroughly indebted to our colleagues in the corporate community who created the environment for our 'Big Group Conversations' and motivated us to maintain the impetus to complete this first phase of our deliberations. It has been a very exciting and energising process and we look forward to expanding our networks as we involve nurses and midwives from all areas of practice. Our conversations will continue to challenge our current thinking about key aspects of the future of health care in Ireland.

Join us

If you would like to join us in our next phase of our work, please get in touch with any of the members of the Network or tweet us using #NMLNetwork.

If you would like to read *The Power of Conversation: Nursing and Midwifery Leadership in Action,* you can find it on: **www.IADNAM.ie**

Mary Brosnan and Paul Gallagher, IADNAM; Mary Wynne, ONMSD; and Elizabeth Adams, INMO

INMO playing its part in fight against cancer

The INMO has relaunched its successful Pink and Blue Power cancer screening campaigns

Pictured at the recent re-launch of the Pink and Blue Power cancer screening initiative were (l-r): *Clodagh Ruddy, client services manager, Cornmarket; Ivan Ahern, director, Cornmarket; Martina Harkin-Kelly, INMO president; Liam Doran, INMO general secretary; and Tara Cassidy, salary protection account manager, Cornmarket*

THE INMO has relaunched a free breast health assessment initiative, under the banner of 'Pink Power' for members of its Income Protection Scheme. The aim of the initiative – which is being introduced in partnership with Cornmarket – is to make a breast assessment available to all INMO Income Protection Scheme members.

Through this powerful initiative the INMO can promote breast health awareness, the importance of regular checking and help save lives.

Pink Power

Some INMO members will remember this programme from five years ago. Following a high level of breast cancer claims in the INMO Income Protection Scheme, the INMO originally pioneered this service back in 2012 together with Cornmarket, the administrators of the Scheme.

Irish Life proudly sponsored the programme and more than 3,100 members availed of a breast screening or prostate check with 282 mammograms and 211 ultrasounds performed. Three members were diagnosed with breast cancer. Thankfully, their outlook was positive due to early intervention through the service.

More women get Breast Cancer than any other cancer

- Breast Cancer is the most common cancer in women in Ireland
- 2,800 new cases of breast cancer diagnosed each year
- Survival rates are increasing thanks to assessment/screening initiatives – education and early intervention are key.

Invitations

Once again, Pink and Blue Power is being made available nationwide to 7,765 eligible members of the INMO Income Protection Scheme. The launch date is January 2018. Costs are covered under members' income protection policies. Female members under the age of 50 and male members aged between 40 and 65 will be invited to attend on an area by area basis. (*See Table for details*)

Speaking on the campaign, INMO president Martina Harkin-Kelly said: "At the moment, there is no official national prostate or breast assessment service available in Ireland for these age groups so when you are invited, we strongly encourage you to attend. BreastCheck, the national breast cancer screening programme is only available for females over age 50. But sadly, cancer knows no bounds. Some 26% of women diagnosed with breast cancer in Ireland are under age 50 so we were keen to make this service available to this age group. It is a unique opportunity for members to get a comprehensive GP assessment, mammogram, ultrasound and biopsy, if needed".

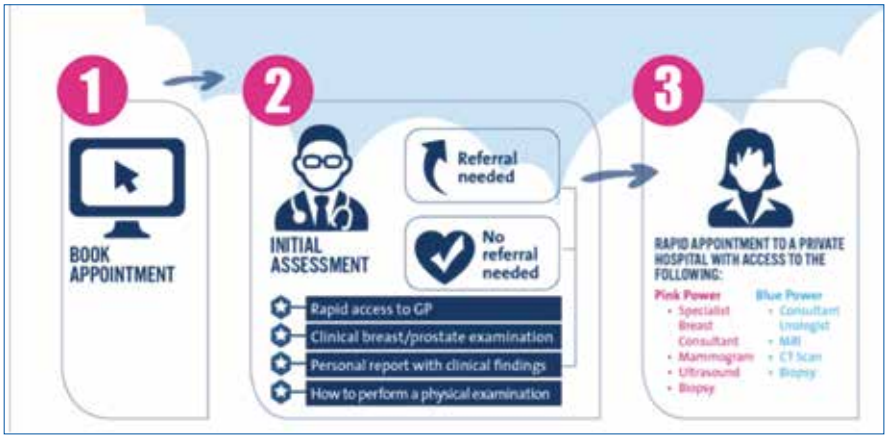
Screening invitations

Month	Invites to members working in
January 2018	Dublin
May 2018	Leinster (excluding Dublin)
July 2018	Munster
January 2019	Connacht and Ulster

How the service works

The initial GP assessment only takes 15 minutes. It can be booked easily online where you can also view the locations and times available. Thanks to the kind support of directors of nursing and midwifery, assessments will be made available in many hospitals nationwide, as well as select GP clinics. The service is provided by private GP service providers Full Health Medical.

Booking is as easy as 1, 2, 3…



Mobilising for justice

Ruth Powell explains how Comhlámh can assist nurses and midwives who are thinking about volunteering their skills either at home or abroad

COMHLÁMH is a member and supporter organisation open to anyone interested in social justice, human rights and global development issues. The group was set up in 1975 by Irish development workers, who defined the organisation's principle objective as, "to enable persons who have rendered services overseas in developing countries upon their return to Ireland to bring to bear their own particular experience in order to further international development co-operation."

The Irish Nurses and Midwives Organisation (INMO) became an official supporter of Comhlámh earlier this year, and we were delighted that INMO came to the launch of the network in February 2017. Comhlámh is the Irish association of volunteers and development workers and, while we do not recruit and send nurses and midwives on placements overseas, we provide a wide range of diverse supports and services for people thinking about volunteering in the so-called global south.

Firstly, Comhlámh recommends that any nurses or midwives, who are thinking about volunteering overseas, should only travel with a volunteer sending agency that has signed-up to the Comhlámh Code of Good Practice. This code ensures responsible and responsive practices for the volunteer health worker, the sending agency, the host community and project.

Some 44 organisations have signed up to the Code and many of them have long- and short-term placements for nurses and midwives.

We offer information for people looking for volunteering placements. In addition to our Comhlámh social media presence, we also have a dedicated social media platform called #VolOps, where we summarise the vacant placement information every week. We also have a free, online, pre-decision course entitled 'Where do I start?' to help nurses and midwives to think about their first steps.

We present information about volunteering at many outreach events, such as at volunteering fairs or other conferences, and we answer questions online, on the telephone or face-to-face in informal meetings at our office on Parliament Street in Dublin.

Pictured at the Irish Aid Volunteer fair in October were (l-r): Áine Lynch, Volunteering in Humanitarian Aid, project officer Comhlámh; Kathleen Cass, Comhlámh chairperson; Mark Cumming, Comhlámh head; Ciaran Cannon, Minister of State at the Department of Foreign Affairs and Trade; and Jean-Christophe Crespe, director, La Guilde

We can help nurses and midwives find appropriate placements. We can help you decide when to go, where to go and what to do when you get there. And while you are overseas, we can assist you with your PRSI or PSPS contributions so that when you return to Ireland your payments have been met.

Nurses and midwives are needed for short-term or long-term placements, in many areas of the world for all types of projects and programmes. Typically, a short-term placement is from two to four weeks and for this you would be expected to raise funds to financially support the project. However, most agencies will give you a fundraising kit so that you would not need to ask family or friends for sponsorship, but rather organise one or two fundraising events before travelling. In longer-term placements – for six months to two years – the nurse or midwife would be paid a small stipend from the organisation and other expenses such as flights and accommodation, would be covered. Each organisation has different packages, and each organisation should be able to breakdown the costings for you.

We state that we educate, support, nurture, innovate and activate our members. So to that end, we hosts a number of events throughout the year, such as the First Wednesday Debates (every first Wednesday of the month) training workshops and social events. We are very proud to work with six very active membership groups so if volunteering overseas isn't for you right now, you could join one of these groups and get involved that way.

We were delighted to launch our 'Supporter Network' in 2017, for organisations that do not send volunteers overseas, but adhere to the principles and values embedded in our code of good practice. It is a great endorsement that the INMO officially became a supporter in 2017.

Why not phone Comhlámh today, for that face-to-face meeting about all your volunteering options? Or you can contact us to find out more about our active membership groups, events, activities and our social occasions. We would love to hear from you. You can contact Comhlámh by email: info@comhlamh.org or by phone at Tel: 01 478 3490.

Ruth Powell is an information and support services project officer at Comhlámh

Q and A Bulletin Board

With INMO director of industrial relations Phil Ní Sheaghdha

Query from member

I have read about the pre-retirement initiative as part of the Recruitment and Retention Agreement in March 2017. Could you let me know more details on this and if I need to complete a special application form?

Reply

As a retention measure, the INMO sought and secured a pilot pre-retirement initiative for nurses and midwives. This will operate as follows:

- The scheme will be operated strictly on pilot basis for two years, following which an evaluation will be conducted to establish the effectiveness of the intervention as a retention mechanism. With the benefit of this evaluation, a decision will be taken on the continuation of the initiative
- Eligibility will be confined to nurses and midwives aged 55 and over who have 20 years' public service or more whole-time service and do not have enhanced superannuation benefits. Nurses and midwives up to clinical nurse/midwife manager 2 (or equivalent) and basic grade public health nurses will be eligible for the scheme
- The pilot initiative will be limited to a maximum of 250 in each of the two years of the pilot phase
- Nurses and midwives who opt for the scheme must retire upon completion of the job-sharing period and not later than attaining age 65
- Nurses/midwives in full time (1.0 WTE) permanent positions aged 55 or over may apply to work on a 0.5 WTE job-sharing basis for a maximum of five years prior to retirement. Superannuation benefits will then be calculated based on actual service plus a maximum of two and a half years in respect of the pre-retirement job-sharing period, subject to over-all maximum of 40 years' service
- If a nurse/ midwife who has opted for the pre-retirement initiative were to apply to return to full-time employment, then the service given would be counted as actual service without addition.

Circular 014/2017 was issued June 20, 2017 and gave effect to the above with a start date of July 1, 2017. Please visit **www.inmo.ie** to view the circular. There is no special form that you need to complete, just place your request in writing and forward to your director of nursing. You should always seek acknowledgement of receipt. Should you have any queries regarding this, please contact the INMO Information Office at Tel: 01 6640610/19.

Query from member

I advised my employer of my pregnancy a few weeks ago. I requested time off to attend a medical appointment and this request was put in writing to my employer. My employer has advised that I am not entitled to time off to attend this medical appointment, that I must take this time out of my annual leave. It happens that this appointment falls on a day that I am required to work. I believed that I have an entitlement to paid time off to attend this medical appointment. Can you please clarify?

Reply

Yes, you have the right to time off work without loss of pay to attend antenatal and postnatal appointments. This time off includes the time required to travel to and from the appointment. You must notify your employer in writing of the date and time of the medical appointment as soon as is practicable and in any event not later than two weeks before the date of the appointment and proof must be produced if requested. Should you have any further queries regarding this please contact the INMO information office at Tel: 01 6640610/19.

Know your rights and entitlements

The INMO Information Office offers same-day responses to all questions

Contact Information Officers Catherine Hopkins and Karen McCann at
Tel: 01 664 0610/19
Email: catherine.hopkins@inmo.ie, karen.mccann@inmo.ie
Mon to Thur 8.30am-5pm; Fri 8.30am-4.30pm

- Annual leave
- Sick leave
- Maternity leave
- Parental leave
- Pregnancy-related sick leave
- Pay and pensions
- Flexible working
- Public holidays
- Career breaks
- Injury at work
- Agency workers
- Incremental credit

Pre-conception advice

In the latest clinical update from Clarity Informatics, **Rebecca Elliot, Nina Thirlway** and **Gerry Morrow** focus on pre-conception advice for women who are planning a pregnancy

PRE-CONCEPTION care is defined by the World Health Organization as "providing biomedical, behavioural and social health interventions before pregnancy occurs to improve health and modify behaviours and environmental influences".[1] The goal is to improve the long- and short-term health outcomes of women and their children.

Pre-conception care is important because a woman's health around conception and in early pregnancy impacts on their lifelong health and that of their children. It allows physical and mental health conditions and social needs to be addressed and managed prior to pregnancy. In addition, it allows women to be aware of any potential risks and make informed decisions about their pregnancy. Many potentially modifiable risk factors that influence pregnancy outcomes are present before conception. This means that prenatal care is often given too late to change the outcome of the pregnancy.

Timing of pregnancy

The potential impact of maternal age on fertility and birth outcomes should be discussed. Women over 35 years have an increased risk of miscarriage, chromosomal abnormalities and obstetric complications compared to younger women.[2]

Interpregnancy interval (the time from delivery of one child to conception of the next) should also be discussed. There is evidence to suggest that an interpregnancy interval of 18-59 months is safer in terms of perinatal outcomes but the decision should take into account the woman's individual circumstances, for example a shorter interpregnancy interval may be appropriate for older women concerned about age-related decline in fertility.

If the woman has had a previous miscarriage, it is important to discuss the fact that there is no definite 'right time' to start trying to conceive again. The decision will be influenced by a number of factors including when the woman and her partner feel ready; speed of physical recovery; and whether the woman is awaiting test results or being followed up after surgery,or ectopic or molar pregnancy.[3]

Advice on conception

Of 100 couples (where the woman is aged under 40 years) having regular sexual intercourse without contraception, more than 80 will conceive within one year. About half of those who do not conceive in the first year will do so in the second year. The remainder will take longer and some of these may need help for them to conceive.[4]

Sexual intercourse every two to three days optimises the chances of pregnancy. There is no need to plan intercourse to coincide with ovulation – this does not increase the chances of success and can cause stress for the couple.[4]

Advise women planning pregnancy who have been using the progestogen-only injection for contraception that normal fertility may be delayed for up to one year after the last injection.

Folic acid

Assess the couple's risk of a neural tube defect (NTD). Couples are at high risk of conceiving a child with an NTD if:

- Either partner has an NTD, they have had a previous pregnancy affected by an NTD, or they have a family history of an NTD
- The woman is taking antiepileptic medication
- The woman has coeliac disease or other malabsorption state, diabetes mellitus, sickle cell anaemia, or thalassaemia
- The woman is obese (defined as a body mass index [BMI] of 30kg/m^{2}or more).

Advise women who are at normal risk for an NTD to take folic acid 400 micrograms daily, and once pregnant, to continue this until the twelfth week of pregnancy. Those at high risk of an NTD should take folic acid 5mg daily and, once pregnant, to continue this until the twelfth week of pregnancy. Women who are obese (BMI of 30kg/m^2 or more) should take folic acid 5mg daily starting at least one month before conception and continuing during the first trimester. Women with sickle cell disease, thalassaemia, or thalassaemia trait should take folic acid 5mg daily throughout pregnancy.[5]

Weight management

Women considering pregnancy should be advised to eat a healthy, balanced diet. Advise women that achieving a healthy weight (BMI 18.5-24.9kg/m^2) before becoming pregnant reduces the risk of pregnancy complications. The potential pregnancy-related health risks of being obese (BMI of 30kg/m^2 or more) include:[6]

- Reduced fertility
- Increased risk of miscarriage
- Gestational diabetes
- Gestational hypertension/pre-eclampsia
- Macrosomia and shoulder dystocia
- Preterm delivery
- Birth trauma
- Caesarean delivery
- Postpartum complications (for example haemorrhage, thrombosis and infection)
- Stillbirth
- Congenital anomalies (for example neural tube defects, cardiovascular anomalies, cleft palate, limb reduction, anorectal atresia, hydrocephaly).

Advise and encourage women who are obese (BMI of 30kg/m^2 or more) to lose weight before becoming pregnant. Women should be informed that losing five to 10% of their weight (a realistic target) would have significant health benefits and could increase their chances of becoming pregnant.

Women should be aware that if they do become pregnant, there is no need to 'eat for two' or to drink full-fat milk.

Advise women with a low BMI (less than 18.5kg/m^2) of the potential health risks of being underweight, including

reduced fertility, first-trimester miscarriage, preterm birth, low birth weight and gastroschisis.

Smoking/alcohol intake/illicit drug use

Advise all women planning pregnancy who smoke to stop smoking. Women who wish to stop smoking should be referred to a smoking-cessation service. Advise women who may become pregnant to initially try to stop smoking without using nicotine replacement therapy (NRT). Consider offering NRT to women who are planning a pregnancy and who have tried and failed to stop smoking without using NRT. Bupropion or varenicline should not be prescribed to women who may become pregnant.[5]

Advise women planning pregnancy (or who are at any stage of pregnancy) to avoid drinking alcohol. Specialist referral should be offered if a woman is unable to reduce her drinking with support in primary care.[7]

Advise women planning pregnancy who use illicit drugs to stop using drugs (including so-called 'legal highs'), if they are able to do so. Women planning pregnancy who use illicit drugs and are unable to stop with support in primary care should be referred to a specialist service. Women using illicit drugs who may become pregnant before illicit drug use has stopped should be offered contraceptive advice. Women injecting illicit drugs should be offered testing for hepatitis B, hepatitis C, and HIV.[5]

Hazardous substances or radiation

Advise women planning pregnancy to be aware of the potential for exposure to toxic substances in their home, workplace and surrounding environment, and to avoid them if possible. It is possible for chemical exposure to occur through breathing, eating or drinking, or skin absorption. Advise a woman who is planning pregnancy and is concerned about work exposure to hazardous substances, infections or radiation to discuss her intention of becoming pregnant to her employer if possible. It may be possible at some work places to have a discussion with an occupational medicine specialist, if this is available.[8]

Prescription and OTC medication and herbal remedies

If the woman is taking prescribed medication, discuss any changes that may need to be made, taking into account that it is important to continue certain drugs (for example if stopping the drug would cause a worsening of the underlying disease that would be considered to be a higher risk to the pregnancy). Some medications are not considered to be safe in pregnancy and may potentially adversely affect the foetus. There may be a need to switch to a safer alternative medication before conception. Some medications will need to be stopped if they require a washout period before conception. Ideally, the smallest number of medications at the lowest dose possible should be used when trying to conceive. Advise women planning pregnancy not to take any over-the-counter medicines without consulting a pharmacist to ensure that these products are safe to take if she were to become pregnant. Advise women planning pregnancy not to take any herbal remedies.[8]

Cervical screening

Advise all women planning pregnancy who are due a cervical smear test to have the test as soon as possible, before becoming pregnant.

Immunisations

Determine if a woman planning pregnancy is protected against rubella (for example documentation of having received two doses of rubella-containing vaccine or a positive antibody test for rubella). Offer measles, mumps, and rubella (MMR) vaccine to seronegative women planning a pregnancy.[9]

Determine if a woman planning pregnancy has immunity to varicella (if there is a definite history of chickenpox or herpes zoster, she can be considered to be protected).

If there is no definite history of chickenpox or shingles, and the woman is eligible for the vaccine (for example healthcare workers who come into direct contact with patients; laboratory staff where exposure to varicella virus is an occupational risk; and healthy, susceptible close household contacts of immunocompromised patients), offer serological testing. Also offer vaccination if the woman does not have evidence of varicella zoster antibody.[9]

Note that the varicella and rubella vaccines should not be given to immunocompromised or pregnant women, and women who are not pregnant should avoid pregnancy until one month after administration of the last dose.[9]

Women planning pregnancy should be vaccinated against hepatitis B if they are at high risk of contracting the disease. People at risk include intravenous drug users, those who change sexual partners frequently, those with chronic renal or liver disease and those who are in close contact with people with hepatitis B.[9]

Mental health problems

Discuss with the woman how pregnancy and childbirth could affect her mental health problem – for example risk of relapse of an existing mental health condition – and how her mental health problem and/or its treatment might affect her or her baby, before and after birth. The risks of not treating her condition and the importance of controlling symptoms before conception should be explored.[10]

Consider referring women with a current or past severe mental health problem, such as severe depressive disorders, bipolar disorder and psychosis, to secondary care for pre-conception counselling. Ideally refer to a specialist perinatal mental health service if available. Advise the woman to continue using effective contraception until a full assessment by the psychiatrist has taken place. Advise the woman not to stop taking her medication unless otherwise directed by the psychiatrist.[10]

Dr Rebecca Elliot is clinical author at Clarity Informatics, Nina Thirlway is style editor at Clarity Informatics and Dr Gerry Morrow is editor and medical director at Clarity Informatics. Clarity Informatics is contracted by the National Institute for Health and Care Excellence (NICE) to provide clinical content for the Clinical Knowledge Summaries service available through the Clarity Informatics Prodigy website at: https://prodigy-knowledge.clarity.co.uk/

References (full reference list available from the Prodigy Pre-conception advice and management topic. https://prodigy-knowledge.clarity.co.uk/)

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CPD Quiz

There may be more than one correct answer to the multiple choice questions listed here. The correct answers *(given below in the inverted text)* are those deemed most appropriate by the authors in the context of this CPD article.

1. There is evidence to suggest that an interpregnancy interval of how long is safer in terms of perinatal outcomes:
A) Five to nine months
B) Eighteen to 59 months
C) Eight to 19 months
D) One to five months

2. Of 100 couples (where the woman is aged under 40 years) having regular sexual intercourse without contraception how many will conceive within one year?
A) 50
B) 60
C) 70
D) 80

3. Women who are obese (BMI of 30 kg/m^2 or more) should take:
A) 5mg folic acid daily before conception and during the first-trimester
B) 400 micrograms folic acid daily and until the twelfth week of pregnancy
C) 5mg folic acid daily throughout pregnancy
D) 400 micrograms folic acid daily throughout pregnancy

4. Women who wish to stop smoking prior to pregnancy should be:
A) Referred to a smoking cessation service
B) Prescribed bupropion or varenicline
C) Encouraged to try to stop without using NRT in the first instance

5. Women planning pregnancy should be vaccinated against hepatitis B if they:
A) Are intravenous drug users
B) Have chronic renal or liver disease
C) Are in close contact with people with hepatitis B
D) Change sexual partners frequently

After reading this article you may wish to reflect on what you have learned, how this might be applied to your own work and to make a note of this in your portfolio.

For further information and resources: **www.clarity.co.uk**

Clarity informatics

Answers: Question 1: B Question 2: D Question 3: A Question 4: A, C Question 5: A, B, C, D

Advice for AGM season

INMO organiser **Albert Murphy** focuses on the preparation involved in the lead up to branch AGMs

AS THE weeks count down to Christmas members may be getting excited at the prospect of the annual general meetings which will start in January 2018. The following is some advice in relation to organising effective annual general meetings.

Preparing for annual general meetings

The AGM for each branch is required under the rules of the organisation. These meetings are perhaps the most important meetings of the year for the branch and it is crucial that as many members as possible attend. Vibrant branches are an important part in the democracy of every trade union, particularly the INMO.

The purpose of the branch meeting is to appoint the officers of the branch for the coming year. The branch committee is comprised of the following:

- The branch secretary arranges meetings, implements decisions, represents branch issues to head office and provides monthly reports to the branch committee
- The branch chairperson presides at branch meetings and annual general meetings ensuring that the meetings are conducted properly
- The branch committee members assist and participate in the implementation of policy.

At your AGM you will be asked to elect an incoming committee which will consist of the aforementioned officers. In addition, some branches will appoint a student representative and an equality representative who will act as a contact person for equality related matters. Some branches will also nominate a health and safety rep who will report on the health and safety issues of concern to the branch.

ADC delegates

The annual delegate conference takes place in May of each year. This conference is the supreme democratic forum of the union where policy is debated and decided upon. In this context branches are asked to forward a number of motions for debate at the conference.

The motions fall into a number of categories namely educational, industrial relations and professional.

A motion to conference is simply a statement requesting that an action is taken by the union or a policy objective is set by the union for implementation.

University Hospital Galway gets new representative

The INMO is delighted to announce that Sean Shaughnessy has been appointed as the released representative for University Hospital Galway. The Organisation wishes Sean every success in this important role for advocating on behalf of Members in University Hospital Galway.

Group scheme

Congratulations to the five winners of the GroupScheme competition. Each winner received a €100 gift voucher card for registering or clicking onto the INMO GroupScheme. The winners were Deirdre O' Keeffe, Yvonne Landers, Jean Mc Phillips and Sarah Buggy. The fifth winner chose to remain anonymous.

New UHG rep: *Sean Shaughnessy (left), new INMO rep for UHG, is pictured at INMO HQ with Albert Murphy*

INMO members of the GroupScheme are eligible to huge discounts from companies including Expedia, Click&Go, Skechers, Halfords, ASOS, M&S, Benefit Cosmetics, Argos and most recently Peter Mark. For information on how to register and save check the GroupScheme on the INMO website.

Rep training

The Basic Rep Training course was held in October at the Slieve Russell Hotel, Cavan. The participants of the course reported that they learned new skills and gained confidence at the training course. Noel Treanor is the IRO covering Cavan and he also attended the course. He stated that "it was a great opportunity to meet the local reps in the area, and in particular, in relation to Cavan General Hospital".

Albert Murphy is INMO industrial relations officer/organiser; Email: albert.murphy@inmo.ie

Students shaping the future

INMO student and new graduate officer, **Liam Conway**, reports from the AGM of the European Nursing Students Association in Brussels

THE European Nursing Students Association (ENSA) AGM took place in Brussels in October. I was delighted to represent the INMO and the student members at this event. We met at the European Commission on the first day of the meeting to receive an update on innovative and personalised medicine and healthcare system policies.

The next day, delegates from all over Europe met to discuss current student issues both nationally and across Europe. It was very interesting to discuss the different education systems and pathways into nursing and midwifery. For example, in Germany there are three methods of entry, direct third-level BSc Level 8, apprenticeship-style directly with the hospital and a combined method of apprenticeship initially and the opportunity to complete the BSc after. Education funding varies from each country, with Ireland's current fees ranked in the most expensive category. This was also seen recently in the European Commission's report. The UK has the highest tuition costs out of all the countries, with Ireland second.

Within this forum, we explored how we can empower students. In relation to this topic, the INMO has advanced structures in place compared to many of our European Counterparts. INMO student members can have their say and be involved in decision making both at local and national level through the INMO Student Section. We continue to encourage as many students as possible to get involved in the Section and to avail of our free two-day rep course. The topic of shift patterns and hours worked – eight hours versus 12 – was examined from country to country. Public versus private healthcare systems were debated. The role of a nurse or midwife was debated and CPD and postgraduate education was also discussed.

I was delighted to be elected as the vice president of ENSA for 2017-2018. At the conference, delegates voted for ENSA to apply to join the Global Association of Student and Novice Nurses (GASNN). This will only strengthen student's voice and empowerment on the global stage.

Getting involved

We want you to get involved in the Student Section. If you are a class rep why not represent your class and area in the INMO Student Section. If you are not a class rep but want to get involved then this is an ideal opportunity to have your say. All students from first to fourth year are eligible to become involved in this Section.

Members of the Section will be given the opportunity to be nominated as a delegate to attend the ADC. You will be a voice for the students both locally and at national level through the INMO. The Section has full autonomy within the INMO to shape campaigns and decision making. Student members can also avail of free rep training, which will stand out on your CV. Other benefits of becoming involved with the Student Section of the INMO include the chance to represent Irish nurses and midwives at the ENSA AGM. In previous years students have represented Irish nurses in Copenhagen, Istanbul and Barcelona. Active student reps can also avail of two free professional development courses run in the INMO's Professional Development Centre throughout the year.

The Student Section was recently involved in organising and fighting for permanent contracts for all new graduates of 2016 and 2017. The Section attended the press conference for the launch of the INMO Nursing and Midwifery Internship Survey 2017 and this delegation also met with Minister Simon Harris at the ADC in May. The students lobbied for a review and increase of the current travel/accommodation allowance for supernumerary students on clinical placement. The more students that get involved the better. We need representatives from all over the country.

Pictured (l-r) at the ENSA AGM in Brussels were: *Gabriel Boyreau, ENSA treasurer (France); Max Zilezinski, ENSA president, (Germany); Kristin Werner (Norway), Liam Conway (Ireland); and Stefanie Pinto (Switzerland)*

For fourth year students, why not get involved in the INMO Youth Forums? Free rep training involving a two-day course is provided. Accommodation, travel expenses and meals are provided for. You can gain invaluable experience in representing yourself and your colleagues in the workplace.

It is easy to get involved. Just contact me and I will send you information about how you can join us. The Student Section and Youth Forums communicate regularly about current issues and campaigns. By getting involved in the INMO you will always be informed, gain valuable experience, free training and there is also the networking and social side to the INMO. You, as a member, are the future of the INMO and the future of Irish healthcare.

Shape the conditions of today, to better your tomorrow.

Liam Conway is INMO student and new graduate officer
Email: liam.conway@inmo.ie; Tel: 01 6640628

Introducing Executive Council members

Catherine Sheridan

RGN, RCN, University Hospital Galway

I trained as an RGN in St James's Hospital and subsequently as an RCN in the National Children's Hospital, Harcourt Street, Dublin. I have spent most of my career working as an RCN in the Children's Unit, University Hospital Galway. I am currently the Paediatric Early Warning System (PEWS) co-ordinator for Galway University Hospitals, providing ongoing staff education and supporting implementation of PEWS within this busy hospital. I completed a postgraduate diploma in clinical education, NUIG in 2016. I am keenly interested in paediatric nurse education at a clinical level and enjoy participating in initiatives which will improve safety and quality of care for sick children.

I have been a local INMO representative in UHG for a number of years and this is my second term representing children's nursing on the national Executive Council. I am a member of the Paediatric Nursing Associations of Europe on behalf of the INMO. This is an exciting time for children's nursing in Ireland as we await the building of the new children's hospital, however we must never lose sight of the reality that in order to provide safe quality care for children, we must have enough appropriately skilled nursing staff working in every children's hospital/unit nationally, including emergency departments.

There continues to be a national crisis in respect of retention of RCNs both within the larger hospitals and regional units. My role on Executive Council allows me to continually advocate on behalf of my colleagues in this regard. I have learned that many issues do not have immediate resolutions, however there are processes we can follow which often require great patience. Ultimately, we must unite as a collective mutually supportive group if we are to see future changes – *Ar scáth a chéile a mhaireann na daoine*.

Bernadette Stenson

ANP candidate, Rapid Assessment Unit, St Vincent's University Hospital

I am currently an ANP candidate in the rapid assessment unit in SVUH, where I was previously CNM2 in the ED. I have 18 years hospital-wide nursing experience and have experienced first-hand the deteriorating conditions and working environment for nurses on the frontline. I have been involved with the INMO for 18 years both as the ED rep and the hospital INMO rep. I am actively involved with INMO activities at local and national level. I was involved in local meetings on the ED Forum progressing nursing concerns at the Ireland East Hospital Group and am currently involved with phase 1 and 2 of the Expert Group on Staffing and Skill Mix in the ED to ensure safer staffing levels, safer working environments and a protection for nurse's registration when working in high risk circumstances. I am 100% committed to the following:

- Being a passionate advocate for the nursing/midwifery professions
- Introducing initiatives to recruit and retain nurses and midwives
- Agitating for a pay rise for nurses and midwives to ensure that our contribution to the economic recovery is acknowledged
- Agitating for the removal of the pension levy and USC
- Lobbying for safe staffing and a safe working environment in all clinical areas
- Provision of career development opportunities at CNM/CMS and ANP/AMP level
- Ensuring there is no further attempt to increase the NMBI retention fee.

My professional qualifications include RGN, RSCN, HDip in adult emergency nursing, HDip in Children's emergency nursing, BSc in nurse management/leadership/healthcare planning and organisation and I'm currently studying for a masters in advanced practice.

Grainne Walsh

RGN, RM, PHN, Waterford CCA

I began my nurse training in 1990 on the Project 2000 higher diploma in nursing and graduated in 1993. This was followed by two years working on a busy surgical ward at the Luton and Dunstable Hospital, Luton, England.

On my return to Ireland I commenced my midwifery training in the National Maternity Hospital. Graduating in 1997 with a higher diploma in midwifery I remained at Holles Street for a further three years on the postnatal ward and then in the theatre department.

In 2001 I commenced a postgraduate diploma in theatre nursing which I completed in 2003. I worked in the theatre department in Waterford Regional Hospital in the ENT and orthopaedic theatres.

I worked as a community RGN in Waterford and Wexford for two years before commencing my PHN training in 2007. I have been employed as a PHN in Waterford community care for the past nine years.

I have been an active member of the INMO for over 18 years. In my student days I was class rep and assisted my fellow students on a number of issues. I have been union rep in Waterford community care for the past five years and am currently secretary of the INMO Waterford Branch. I have really enjoyed my time on the Executive Council, fining it both challenging and informative. As a PHN I feel it is imperative we have strong voices at Executive Council as primary care transforms at breathtaking speed and the role of the PHN and our contribution to the health of the population needs to be articulated and reaffirmed.

I travel to Lourdes every year with the Waterford and Lismore Dioceses and have been chief pilgrimage nurse for the past six years which I enjoy.

Quality & Safety

A column by Maureen Flynn

Measurement for Improvement Curriculum

IN THIS month's column, we invite nurses and midwives who may be interested in learning more about the measurement aspect of QI to review the recently launched 'Measurement for Improvement Curriculum', which is a reference document to support consistent Measurement for Improvement Training in Irish healthcare (2017) developed by the Quality Improvement Division, Measurement for Improvement (MFI) Team. Measurement represents one of the six drivers or key elements of the Framework for Improving Quality in our Health Services alongside leadership, person and family engagement, staff engagement, use of improvement methods, and governance (which have featured in previous columns). MFI can be applied at the frontline of service delivery – at PDSA (Plan Do Study Act) cycle or QI project level – or at organisational level.

MFI

MFI can be defined as the analysis and presentation of quantitative and qualitative data to identify opportunities for improvement and to demonstrate if a change has resulted in an improvement. Its purpose is to drive better decision making and support sustainable improvements in the quality of care. The key principles of MFI are:

- Measure only what matters: define a limited number of measures that are relevant to your QI project
- Being smart in how we measure: use available data; measure once, use often; look at families of measures (eg. looking at infection rates, hand hygiene and hospital length of stay together provides a better understanding of how a hospital is performing in relation to the prevention of HCAIs); measure variability; trends over time; and benchmark with peers
- Transparency: ensure transparency in the measuring, sharing and reporting of information
- Include the patient voice: so that the experiences and perspectives of patients and their families are included alongside clinical outcomes
- Building capability: for extraction and sharing of information from data to provide assurance and support improvement
- Adopt measurement as routine: building good data collection practices into routine work and record keeping

Uses of the MFI Curriculum

The MFI Curriculum can be used as a reference document for those designing and delivering MFI training, and by nurses and midwives seeking to assess their level of understanding of MFI. The purpose of the Curriculum is threefold:

- To map out the essential components of MFI training and education in Ireland
- To drive consistent, high quality and comprehensive MFI training and education in Ireland
- To make MFI training accessible to more staff working in the Irish health services

The MFI Curriculum maps out four stepwise levels of MFI expertise ranging from level one – which provides a basic appreciation of the value of MFI – progressing to level four – which represents a comprehensive knowledge and skill set in MFI.

Seven steps to effective MFI

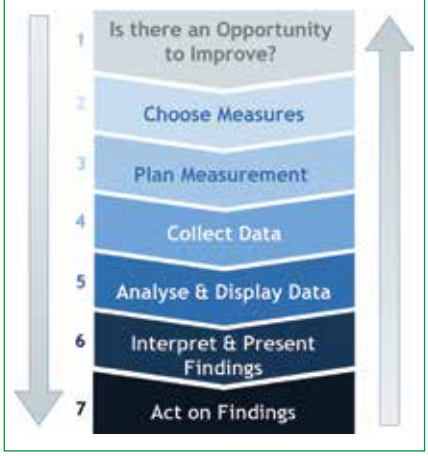
The MFI Curriculum outlines the seven steps to effective MFI and details the tasks, knowledge areas and skills those engaging in MFI require at each step - see *Figure*.

Get involved

The MFI Team's vision is that everyone working in health and social care services receives some training in MFI, depending on their requirements and the needs of their organisation. To that end, level one training is currently being developed into an online training module. Nurses and midwives completing level one training will:

- Have an understanding of the value of Measurement for Improvement
- Have information on the basic principles of Measurement for QI
- Understand when and why Measurement for Improvement should be considered
- Have an awareness of the three contexts of MFI – PDSA, QI projects and Organisational Level
- Understand how to collect data for MFI: Following level one training, those interested in obtaining further MFI skills can sign up to workshops delivered throughout the year.

Figure: Seven steps to effective Measurement for Improvement



Access the MFI urriculum

Go to: **http://bit.ly/MforI**

Feedback

This version of the Curriculum is being tested and refined through delivering MFI training with frontline staff from the Clinical Microsystems and Pressure Ulcer to Zero Collaborative. We would welcome your feedback or comments on the Curriculum through the following short survey: **www.surveymonkey.com/r/N83TYWL**

Maureen Flynn is the director of nursing ONMSD, lead governance and staff engagement for quality HSE Quality Improvement Division

Acknowledgement: Special thanks to Dr Gemma Moore and the measurement for improvement team for writing this column. We would like to acknowledge the following for their feedback and suggestions for improving earlier drafts of the MFI Curriculum; Dr Mary Browne, Dr Philip Crowley, Dr John Fitzsimons and Lorraine Murphy (QID, HSE) Caralyn Horne (SCD, HSE), Dr Peter Lachman (ISQua) and Lloyd Provost (Associates in Process Improvement)

Measuring up: Role of the midwife

Paula Barry examines the strengths, weaknesses, opportunities and threats relating to the midwife's role in the Irish health service

I HAVE been a midwife at the Coombe Women and Infants University Hospital since 2003. In my various roles across clinical practice, education, practice development and research, I have seen many changes. The following are my reflections on the role of the midwife in December 2017 via a SWOT analysis.

Strengths

Great passion and commitment for midwifery exists among midwives in Ireland. For many, it is more than just a job or a career, it forms identities. Midwives are 'with woman' before, during and after birth, and for this reason are integral to the health and wellbeing of women and babies, families and society as a whole.

There is a high standard of education for midwives working in Ireland. Similar to our medical, nursing and allied healthcare colleagues, we have moved from the apprenticeship, to an academic model of training. Hospitals are affiliated with universities and many midwives are at degree, if not master's level. Midwives are involved in research, audit, policy and guideline development and there is an emphasis on the provision of evidence-based, high-quality care.

There is great emphasis on continued professional development with midwives attending courses, and conferences in Ireland and abroad. Leadership and management training has also become common place. We have strong clinical governance structures. The NMBI regulates and guides our practice. As midwives we work within our scope of practice, and are cognisant of our Midwifery Practice Standards and Code of Conduct.

Maternity care is constantly evolving. With new approaches to screening, diagnosis, advances in pharmacology and the care/management of women and babies, it is a moveable feast. In relation to midwifery care, there are fantastic advances throughout the country. Examples include; implementation of midwife clinics, the Domino model of care, the development of home birth services, and facilitation of water immersion for labour/birth. Initiates have developed such as 'Hopscotch', woman-centred caesarean section, facilitation of birth options, (VBAC) clinics, specialist care of women in the HDU setting, birth reflections and bereavement services. The publication of the National Maternity Strategy (2016) brings with it, great opportunity for change. This will be discussed in more detail later in this article.

Because of the changing face of Ireland, we care for women from many countries. This diversity has made us more aware of other cultures, creeds, health needs and wishes. This has expanded our hearts and minds and can only be a good thing in that it enhances our skills, experience and makes us better health care professionals, and human beings in general.

Many of our maternity units accommodate midwifery, medical and nursing students. This is a strength. Students keep us on our toes, they challenge practice and bring new ideas. Having students creates stronger links between the hospital and the university. Clinical learning and theoretical leaning must go hand in hand for safe, high quality care provision.

Weaknesses

In my opinion midwifery as a profession, when compared to our nursing colleagues, has been slow to evolve. Our role became somewhat eroded over the years and as a result has lacked real vision. There has been a paucity of strong midwifery leadership at many levels. This may be due to the structure of the midwifery profession or the systems in which we work. Many midwives generally move into one particular area or role. An example of these areas are; clinical, managerial, policy development, education or research. In comparison, our medical colleagues have a multidimensional aspect to their role, including clinical practice, academia, research, audit and managerial responsibilities.

Although, it may not work for all midwives, or all areas of practice, perhaps there should be more flexibility within our role. It might help keep us grounded, but also allow us see 'outside the box', keep abreast of best practice and be better change agents. Unlike the nursing profession, we have been slow to implement advanced practice. We need to urgently role out advanced midwife practitioner (AMP) posts in all areas of midwifery, particularly as the expert/lead carer for healthy women with uncomplicated pregnancies.

Most maternity care in Ireland is fragmented. This results in many women never really getting to know any one midwife. They may see several midwives during their pregnancy and in the postnatal period, and have never met the midwife caring for them during labour/birth. This can lead to frustration among women as service users and among midwives as care providers.

Continuity of care is key for safe, satisfactory care and is recommended by the Department of Health.[1] Another potential weakness within the system is the use of blanket policies/guidelines; while essential in certain situations, they can make it difficult to individualise care. This can be particularly evident within units where activity levels are high and challenges exist

with staffing and resources. Often we have to adopt a 'greatest care, for the greatest good' philosophy, but this can leave service users and staff feeling frustrated.

I have discussed advances in midwifery care under 'strengths', these initiatives are sporadic and often depend on geographical location. Services such as Domino or home birth are not available to all women in Ireland. So, although advancements are being made, they are slow and will require great effort's to implement nationwide.

Midwifery students, are now part of university life. Although, I have placed the standard of midwifery education under the 'strength' heading, it could come under 'weaknesses' also. Yes, midwifery should be at degree level, but one could argue that the education programme has become too academic with not enough emphasis being placed on clinical exposure. There is a theory/practice gap and most of us would agree the best place to learn is in the clinical area, it is difficult to beat 'hands on experience'. A balance of theory and clinical is essential.

Opportunities

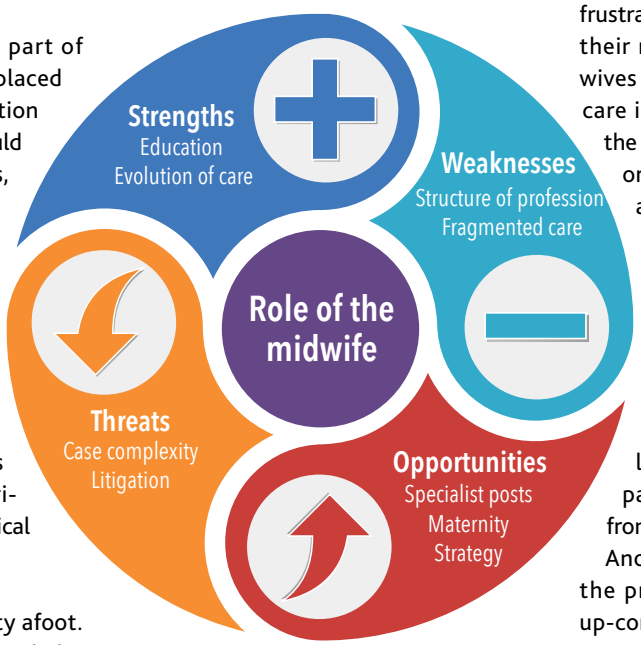
There is change and opportunity afoot. With emphasis on education and the changing role of the midwife, posts such as clinical midwife specialist (CMS) and that of the AMP have evolved and will continue to evolve into the future. There is great educational opportunity, with various options including full/part-time and online courses. This flexibility opens doors for all grades of staff.

Midwives are now part of guideline development groups, committees and working groups. The diversity in our role provides opportunity to be agitators and change agents, not just at clinical level, but at managerial and organisational level also. Being part of the multidisciplinary team at all levels is essential, exciting and progressive in so many ways. It enhances working relationships, morale, and job satisfaction. More importantly it enhances care. The Twitter hashtag '#togetherisbetter' comes to mind and is so true.

Women (service users) want change, they want options and various models of care and this is having a positive impact on the role of the midwife. The National Maternity Strategy supports pathways of care, choice and the overarching framework of supporting physiological birth irrespective of a woman's 'risk' status. This is music to many midwives ears. It gives us the opportunity to flourish and be experts in 'normality', but also care for women who develop risk factors/complications.

Midwives are integral to the care of all women and babies.

Visits from HIQA, although often dreaded, can encourage us to take stock, review practice and standards and also supports us to make improvements. It makes us take responsibility for our service and value what we do.



We are told Ireland is coming out of the recession. This should mean more money and scope to employ more midwives. The past few years of financial constraints and staffing embargoes have negatively impacted the health service in general.

Threats

Care has become complex. Increasing numbers of women are attending with various health needs and co-morbidities, which can impact negatively on pregnancy. Rates of obesity and diabetes have increased. Advanced maternal age, increase in IVF conception and other medical conditions can impact on pregnancy and the maternity service in general.

Fear of litigation has had a significant effect on care provision. Many midwives work in fear and practice defensively. This can leave midwives feeling disempowered resulting in stress, and can eventually lead to burn out.

Centres of excellence, although they offer fantastic learning opportunities through the diversity of women and babies and complexity of care, it can however take its toll on midwives. Challenges such as high activity levels, throughput of women/babies, lack of resources and time to give women the care they deserve adversely effects the morale of midwives.

The medicalisation of pregnancy and birth can threaten the role of the midwife. The midwife, within her Scope of Practice as per the NMBI,[2] is the expert in 'normality'. Often this is lost in an increasingly technological, medicalised environment. Some midwives feel relegated to the role of obstetric nurse and express a sense of frustration at not being able to fully utilise their role. This can result in some midwives leaving to work in countries where care is primarily community based and the option of practising in birthing units or in a home births service is readily available.

Similar to our nursing and medical colleagues, many midwives are deciding to leave Ireland for overseas work opportunities. This has devastating consequences for Irish maternity units. We lose our own home grown midwives, resulting in lengthy and costly recruitment campaigns in-order to recruit midwives from abroad.

Another issue that will directly affect the provision of maternity care is the up-coming referendum to repeal the 8th amendment to the Irish constitution in spring/summer 2018. It will have direct consequences on the role of the midwife in Ireland. There will be midwives on either side of the debate and indeed many will sit on the fence. Some may see it as an opportunity for change, a women's rights issue. Others will say 'what about the rights of the unborn'? Whatever side of the fence we sit on it will not be easy. It will require respectful debate and understanding and thankfully both are abundant among midwives in Ireland.

In summary, using a SWOT analysis framework, I have given a snapshot of my thoughts on the role of the midwife in Ireland in 2017. Some thoughts fall under one definite heading, others overlap.

Are there challenges ahead? Yes

Are there exciting times ahead? Yes

The future will bring both change and opportunity for midwives in Ireland, this is for sure.

Paula Barry is research midwife at the Coombe Women & Infants Hospital in Dublin

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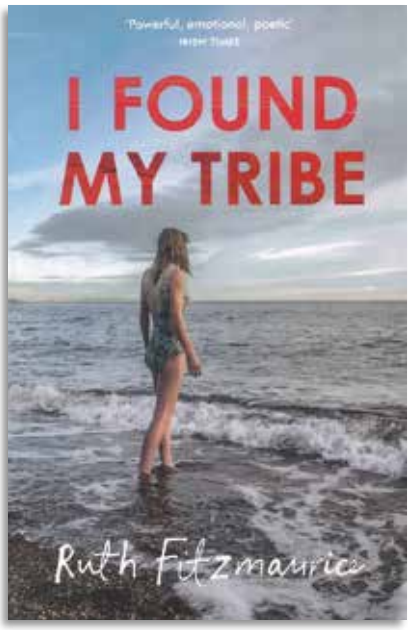
Triumph in the face of adversity

ALTHOUGH I didn't know him personally, I felt great sadness when I heard recently that Simon Fitzmaurice had died. I felt great empathy for his wife Ruth and their five young children, who I had got to know through Ruth Fitzmaurice's moving memoir *I Found My Tribe*.

Simon was diagnosed with motor neurone disease in 2008 and was given three years to live. Ruth describes the MND in the initial years after the diagnosis as "like water torture, slowly drip-drip-dripping. A tiny nerve ending, a small piece of strength, gets stolen every single day."

Simon went into respiratory failure in 2010 and was put on a ventilator during an emergency procedure. Ruth's memoir gives us a rare insight into the feelings behind those facts. "The carer-patient bond may not sound so sexy but it is stronger than the urge to eat. By the time Simon landed in hospital with pneumonia, we were so silently in tune I could almost read his thoughts. My hands knew where to lift. A mere glance of his eyes could tell me where it hurt and how I could help."

Simon survived those three months in ICU and returned home with the ventilator and went on to live a further seven years. These were fruitful years – he and Ruth had



twins in 2012 and, despite being completely paralysed, he continued his film-making career. Using iris recognition software, Eye Gaze, he typed a memoir *It's Not Yet Dark* and wrote and directed a feature film *My Name is Emily* in 2014. Last year he adapted his memoir into a documentary, which he then directed, with it premiering at the Sundance Film Festival 2017.

Meanwhile, Ruth and their family carried on. In *I Found My Tribe*, she describes the frustrations of sharing their home with a team of nurses and carers.

Ruth succinctly describes the "merry band of the kindest souls mixed with some wonderful freaks" that passed through their home as nurses and carers. There was the nurse who slipped Ruth presents of holy medals and believed the devil talked to her in person; a night nurse with a ghoulish white face who seemed to hide behind hall corners and jump out at her each time she passed; nurses brandishing big jewellery and natural remedies; the unfortunate carer with spina bifida who could barely walk sent by the agency to help hoist Simon.

Fortunately for her (and the profession) there were many good nurses also, bringing their musical voices, mischief and laughter. But most came and went, until Marian arrived – at last a nurse that Ruth didn't need to run from and whom she implored would never leave.

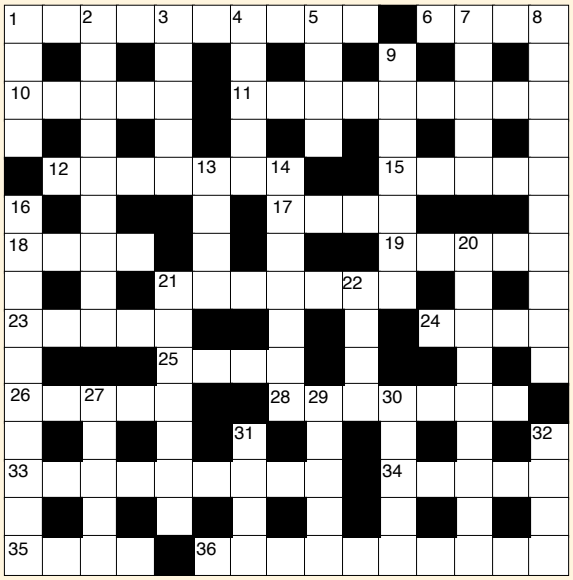
I Found My Tribe is a raw, moving and sometimes tragic account of lives lived to the full. It is a book you will want to recommend to your friends and colleagues.

– Tara Horan

I Found My Tribe by Ruth Fitzmaurice is published by Vintage (2017), ISBN 9781784741471, RRP €15.99

Crossword Competition

WIN A €30 BOOK TOKEN



Across

1 Pays no attention to good wishes from the detective inspector (10)
6 Performs a role in the 11 across (4)
10 Cuticles (5)
11 Mint a poem anew to create a Christmas show (9)
12 Tugging (7)
15 Brown shade associated with old photographs (5)
17 Mislaid (4)
18 Mesmerised, having put paper on the presents, by the sound of it! (4)
19 Equipped with weapons (5)
21 Gift token (7)
23 Composer of La Traviata (5)
24 A home for birds all year round, but for a fairy at Christmas! (4)
25 Sent around some fishing equipment (4)
26 With perfect timing, where the snooker chalk goes (2,3)
28 Might the poet rig up an occasion of self-praise? (3,4)
33 Principality near Rimini (3,6)
34 Synthetic material (5)
35 Major US university (4)
36 Zygomatic features of insolence given to Star Trek's Dr McCoy? (10)

Down

1, 5d, 20d & 30d Carol about having a drunken argument upstairs? (4,4,7,2,4)
2 A garment for winter sports equipment, provided by Eddie the Eagle, for example? (3-6)
3 Artist's stand (5)
4 Quivering tree (5)
5 See 1 down
7 Noise from a bird (5)
8 Scarpered (10)
9 As identifies Sirius - or Rin Tin Tin? (3,4)
13 Informal data? Well, partly informal! (4)
14 Clues go out for sugar (7)
16 Earlier (10)
20 See 1 down
21 You might sprinkle it on your chips (7)
22 Trans-national currency (4)
27 Man-made waterway (5)
29 Not a happy participant in certain Christmas dinners! (5)
30 Pulsate (5)
31 See 1 down
32 Burden, responsibility (4)

Name: .....

Address: .....

The prize will go to the first correct entry opened.
Closing date: Friday, January 19, 2018
Post your entry to: Crossword Competition, WIN, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Co Dublin

November crossword solution:

Across:
1 Ire 3 Antechamber
8 Double Dutch 9 Chain-saw
10 Gasps 11 Lough Neagh
13 Spawn 15 Tension
16 Macroom 21 Navel
23 Perth 24 Bungling
25 Gerbil 26 Treacherous
27 ETA

Down
1 Indigestion 2 Emulsion
3 Atlas 4 Each-way bet
5 Ariel 6 Bisque 7 Raw
12 Haemophilia 13 Scold
17 Operable 18 Stagger
19 Avenge 22 Lilac 23 Poets
24 Bets

The winner of the November crossword is:
Graham Knight
Leopardstown
Dublin

MONEY MATTERS

P60: your ticket to a tax refund

Ivan Ahern explains how to find out if you are due a tax refund in 2018

AS WE look forward to the new year and make our resolutions for 2018, pledges to cut costs feature high on many of our lists. Before cutting your spending, why not review your P60 and find out if you could be due a tax refund?

Your P60 shows how much you earned in 2017 and, most importantly, how much tax you paid on your income. It is really important to review your P60 as tax is most likely the biggest bill you paid last year.

Here are our top tips to understanding your P60, to help you get on top of your taxes this new year.

Assess your potential tax refunds

If you have not reviewed your tax affairs in a number of years or there are changes in your personal circumstances, such as getting married, changing employer or changing working hours, you could find that you have additional tax relief, tax credits or allowances – which could mean a tax refund.

At Cornmarket, we often find many INMO members don't claim their entitlements and their unclaimed tax relief accumulate year on year. You can claim back tax refunds for up to four years – that's since 2014. For this reason, many INMO members may be due a substantial amount of money if they haven't filed a tax return over the past few years.

To put this into context, the average tax refund is €1,100.[1]

Claim your flat rate expenses

Nurses and midwives are also able to claim for flat rate expenses. This is a job-related tax relief and is given at your marginal rate of tax. Examples include:

- Supply and launder your own uniforms – tax relief of €733
- Supply your own uniforms but are laundered free – tax relief of €638
- Launder uniforms that are supplied by employer – tax relief of €353
- Uniforms supplied and laundered by your employer – tax relief of €258

- Nurses on short term contracts through an agency – additional tax relief of €80. Claiming this allowance alone could be worth €293 per annum (based on a nurse earning €40,000 and claiming tax relief at €733)

Check your payslip regularly

Do you check your payslip regularly? Nurses and midwives can often discover they have been on the incorrect point of the salary scale or their standard rate cut-off point and tax credits are incorrect. Get familiar with your payslips and make sure your tax is being calculated correctly.

Submit your medical & dental expenses

This is another area where tax refunds can accumulate over the years. You can claim for tax relief at 20% on the following expenses:

- Doctor, GP, consultant or hospital fees
- Orthotics or similar treatment referred by a practitioner
- Drugs or medicines prescribed by a doctor, dentist or consultant
- Items or treatments prescribed by a doctor, eg. physiotherapy
- Transport by ambulance
- Non-routine dental treatments, eg. crowns/veneers/root canal
- Certain dietary products recommended by a doctor, eg. for those with coeliac disease or diabetes.

Get to know your tax credits

An example of some of the tax credits which you may be entitled to claim for 2017 are listed below:

- Single Person: €1,650
- Married Person Credit: €3,300
- PAYE Credit: €1,650
- Lone Parent Credit: €1,650
- Widowed Person Credit (without dependent children): €2,190
- Incapacitated Child Credit: €3,300
- Dependent Relative Credit: €70
- Home Care Credit: €1,100
- Age Tax Credit Single: €245, Married: €490

Other tax relief

There is also tax relief for college fees, single premium pension contributions, nursing home fees and rent, among others. Cornmarket's Tax Return Service can advise you on these and tell you if you are due a tax refund. Call us at Tel: 01-4086261 to find out how to avail of this service.

Ivan Ahern is a director of Cornmarket Group Financial Services Ltd.

References
1. Cornmarket PAYE Tax Return client statistics, 2016

Harris launches new ANP programme

Minister says 700 additional ANP posts will be delivered by 2021

HEALTH Minister Simon Harris recently launched a new programme for advanced nursing practice (ANP), which he said would result in the delivery of 700 ANP posts by 2021.

Speaking at the launch, Mr Harris said: "This will mean more nurses as senior decision makers and will drive improvements in our health services. This new ANP education model will see 120 ANPs trained to provide care in the areas of older person services, management of chronic diseases, including rheumatology and respiratory conditions, and the management of unscheduled care.

"This is a great programme and I am confident that he introduction of more ANPs across our health services will have a very positive impact. It will help ensure that we are providing the right care to the right person in the right location, be that a hospital, a community-based service or a patient's home. I would also like to confirm that funding has been allocated to backfill on a permanent basis the posts vacated by the candidate ANPs so these are all new posts."

Minister Harris added: "This initiative will provide patients with more appropriate, safe and accessible care across a range of services. I am delighted to be Minister in this next phase of advanced nursing practice that is building and growing the future for ANPs in Ireland. This type of transformational leadership by Irish nurses developed an initial framework for advanced nursing practice here in Ireland that has been referenced in other countries. Currently, ANPs in Ireland play an important role in clinical practice particularly in EDs and Local Injury Units. The value of these roles is acknowledged and adds to the quality of healthcare in Ireland. There are however areas of advanced practice that are under developed within our health services particularly around services for older person care, chronic disease management and unscheduled care which are the focus of this initiative."

The chief nursing officer, Dr Siobhan O'Halloran, in welcoming the commencement of the programme thanked the National Steering Committee, the NMBI, the HSE Nursing and Clinical Care Programmes, the Education Consortium and the nurses who have embraced the initiative. She said "A critical mass of ANPs delivering services in these specific areas will contribute to reducing presentations to EDs and give patients choice over when and where they receive care."

The programme will be run by a consortium of colleges, led by University College Cork and including the Schools of Nursing and Midwifery from Trinity College Dublin, the National University of Ireland Galway and University College Dublin.

Oncology nurses launch research competition

THE Irish Association of Nurses in Oncology (IANO), in association with Bayer is delighted to announce the launch of the 2018 IANO President's Prize. Applicants are asked to submit a research project and one successful winner will be chosen to do a clinical placement in Memorial Sloan Kettering Cancer Centre (MSKCC) for one week. This is the fifth President's Prize of this kind, the prize will be presented at the IANO annual conference on April 14, 2018.

Veronica McInerney, early phase clinical trial manager with the Health Research Board, who was the 2016 President's Prize winner, recently spoke about her experience: "Winning the President's Prize was brilliant because it permits such a unique opportunity to visit one of the biggest cancer centres in the world. This award is an excellent opportunity for the successful candidate to work alongside a multidisciplinary oncology team within their chosen specialty area, in a world-renowned centre of excellence."

The deadline for submissions is January 31, 2018.

TV campaign designed to aid better understanding of dementia

Pictured at the launch of the HSE's Dementia: Understand Together initiative were: Maureen O'Hara who has shared her experience of living with dementia for the campaign, and Simon Harris, Minister for Health. The initiative, Ireland's first-ever TV, radio and online advertising campaign to raise awareness and understanding of dementia, being undertaken in partnership with the Alzheimer Society of Ireland and Genio, seeks to lift the veil of stigma and isolation around dementia through the real-life stories of people living with the condition. It is estimated that there are 55,000 people living with dementia in Ireland and this number is expected to more than double to 113,000 by 2036. For more information, including details of county-by-county supports and services available, visit www.understandtogether.ie or Tel: 1800341341

Third of women not meeting advised folate levels in early pregnancy

SOME 33% of women in Ireland are not meeting WHO recommended blood folate levels for the prevention of neural tube defects (NTDs) in early pregnancy. This was the key finding of a new report commissioned by safefood entitled *The folate status of pregnant women in the Republic of Ireland; the current position.*

The report revealed that only one in four women who took folic acid started it at the recommended time, ie. at least 12 weeks before conception. Almost all (98%) of women reported that they started taking folic acid after they found out they were pregnant. However, on average this was at five and a half weeks into the pregnancy. Folic acid is needed to support the effective closure of the neural tube of the spine and brain, which happens very early in pregnancy (at approximately 21-28 days after conception).This early closure is why the WHO recommends all women who may become pregnant to take a daily supplement of 400 micrograms of folic acid prior to conception. The supplement should also be continued until at least the 12th week of pregnancy.

Three-quarters (76%) of the women who did not take folic acid reported that it was because they did not expect to get pregnant and 35% reported that they did not know that they needed to take folic acid before becoming pregnant.

The UK and Ireland have had a higher rate of NTDs than other European countries and a recent study showed that incidence rate of NTDs in Ireland has increased from 0.92 per 1,000 births in 2009 to 1.17 per 1,000 births in 2011.

Commenting on the report, Dr Cliodhna Foley Nolan, director of human health and nutrition for safefood, said: "This report highlights that one-third of pregnant women are not being adequately protected against the risk of NTDs. It is concerning that the number of babies developing NTDs has increased in recent years and along with the UK we have a higher rate of NTDs than other European countries due to our genetic disposition.

"A high proportion of pregnancies are not formally planned and this research underlines the critical importance of taking daily supplementation of folic acid for all women who could become pregnant. A daily supplement is the way to go as a healthy diet alone won't help women achieve the WHO levels," she said.

Global migraine patient survey

THE Migraine Association of Ireland has urged migraine sufferers to take part in the first Global Burden of Migraine Patient Survey. Migraine is the third most common disease worldwide but is often overlooked or people underestimate the significant impact that migraine has on the lives of those affected.

The global survey gives migraine sufferers the opportunity to share their first-hand experiences of living with the disease and the impact it has on their lives and the lives of those around them. The three topics covered in the survey include:

- How migraine affects your everyday life and wellbeing
- Your experience of migraine, from first symptoms to diagnosis and treatment
- Your experience of migraine medications and treatments.

The survey takes around 25 minutes to complete. The data is entered anonymously and the results when analysed will be shared with patient advocacy groups, physicians and medical societies. It may also be published in peer-reviewed journals, presented at medical congresses and reported on in the media.

To take the survey go to: **www.migraine.ie/worldwide-burden-patient-survey/**

Ireland one of few European countries not on track to eliminate hepatitis C

IRELAND is one of the few countries in Europe not on track to eliminate hepatitis C by 2030 based on the current policy. This was according to Charles Gore, CEO of the World Hepatitis C Alliance, who was speaking at a recent seminar to explore how Ireland can match up to the global push to make the virus a rare disease by 2030

Ireland has one of the highest rates of infection among vulnerable groups when compared to other European countries. Over 73% of people who inject drugs have the virus and 35% of people who are homeless are infected here.

Mr Gore also said that other countries that are further along the journey to elimination had secured deals with drug companies, whereby the pharmaceutical costs were reduced as treatment rates were increased. However, he stressed that treatment of the virus should not be based on a prescription approach only but one that focused on diagnosis, outreach, and prevention.

"Working proactively to eliminate the virus will also eliminate much of the cost associated it," he said. "People won't get liver cancer because of the virus, they won't be progressing to cirrhosis. There won't be the same need for drug treatment. It makes sense, from a health and cost point of view, that Ireland sets its sights on making this disease a rare disease, moving with the rest of Europe.

Dr Jack Lambert, consultant in infectious diseases at The Mater Hospital, questioned why funding allocated by the State to the treatment of the virus should not be spent on drugs only.

The government allocates €30 million to the hepatitis C programme, primarily for drug purchase. He said that there had to be greater transparency in the way in which this significant funding is allocated.

"What my patients need most is care and outreach in homeless services, drug treatment services, in methadone GP practices. They need peer support and community response," he said. "We're not prioritising these and so we are not doing the right things to make elimination a reality."

Dr Lambert also said that there was a discrepancy between accepted notification figures for the virus and the reality of the situation on the ground, leaving a huge gap between treatment numbers and those actually infected.