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WIN

Journal of the Irish **Nurses** and **Midwives** Organisation

World of Irish Nursing & Midwifery

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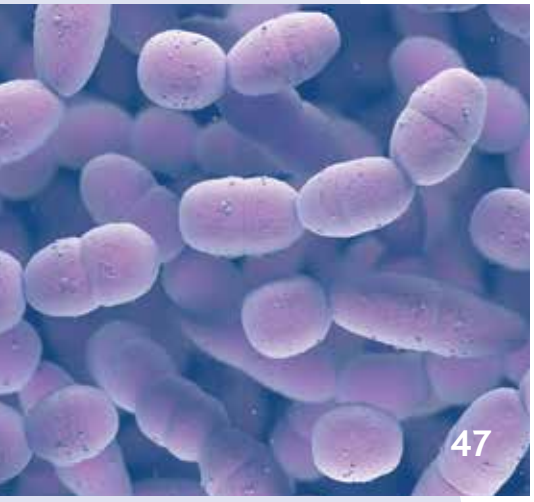

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2018 – a year of decision

IN THE pages of this issue of *WIN* you will receive an update on a number of issues critical to the Organisation at this time. In effect they all clearly point to the reality that, on a number of fronts, 2018 will be the year of decision for government and how it approaches nurses, midwives, the recruitment and retention crisis and, ultimately, funding our health service.

In recent days, the government has approved the terms of reference for the second phase of work by the Public Service Pay Commission (details covered later). The INMO has made it very clear that this Commission, and its examination of the recruitment and retention crisis, is the last chance, through procedure, for this country to treat nurses and midwives equitably and in line with other health professionals.

The current – and growing – crisis with regard to recruitment and retention, cannot be resolved by continuing to treat the professions of nursing and midwifery as vocations. The only long-term, sustainable and viable solution to this crisis is to pay every nurse and midwife in this country what they are truly worth and fully in line with all other degree-level health professionals.

The Public Service Pay Commission is beginning its work and is expected to make its recommendations, by the second quarter of next year *(see page 8)*.

It is already agreed that the management side will sit down with the INMO within four weeks to discuss the implementation of all the Commission's recommendations. The government must accept that these recommendations, if they are to resolve the crisis, must improve the pay levels of nursing and midwifery and bring them in line with all other health professionals.

Closely aligned with the work of the Pay Commission, is the full implementation of the Staffing Agreement that was agreed last March. It provides for an increase, in the nursing/midwifery workforce of 1,224 by the end of this year. In that context, *see page 11* for a summary of the second report from the National Implementation Committee for this agreement, which confirms that, to date, the nursing and midwifery workforce has grown by 13 (yes, 13) since the agreement came into place. This is graphic, official confirmation – if it were needed – that all measures taken to date, including international recruitment, initial incentive payments and other initiatives, have completely failed to address the problem.

In addition to this the latest census figures from the HSE confirm that, in the same period, the number of senior managers had increased by over 290, or 16%, while the nursing workforce (at staff nurse level) had decreased by 1%. No other evidence is needed to prove we have a staffing crisis and this will only be solved when we pay nurses and midwives properly in this country.

2018 will also see the government have to make a decision with regard to funding the health service, not only in terms of maintaining and expanding services but also working towards implementing the *Sláintecare* report. This report recommends a single-tiered, universally accessible public health service. The latest budget, while providing additional monies, fails to make a special allocation to begin implementing this landmark report. In 2018 the government is going to have to review its position and commit, in a tangible way, to implementing the *Sláintecare* report which has cross party support.

In summary, with regard to pay, staffing and overall health service funding, 2018 will be a year of decision for the government. If it makes the correct decision, to address these problems then our public service will be truly worldclass and fit for purpose. If it fails then, particularly with regard to pay and staffing, the INMO will have to take whatever measures are necessary to address the critical issues of pay and staffing once and for all for our members. The ball is in the government's court!

Liam Doran
General Secretary, INMO

Your priorities with the president

Martina Harkin-Kelly, INMO president

Budget 2018 and the progress map

IN THE aftermath of Budget 2018, I am reminded of a quote credited to Dick Armey, "Three groups spend other people's money: children, thieves and politicians. All three need supervision." I am not so sure that politicians know where the economic priorities lie or how to spend the taxpayer's money for the greater good. While the health service is beyond breaking point, the budget aired on the side of safety. It was a voter-friendly budget with an eye on the next general election and not on the next generation. As a result, hard choices were not made. Yes, €685 million extra health spending was allocated bringing the overall allocation to €15.3 billion, but this will just about cover 2017 health service overruns. In our pre-budget submission, the INMO called for measures to increase the capacity of the health service in terms of staffing and beds. We also sought a commitment of a 25% increase in the nursing and midwifery workforce over the next five years. While I welcome the announcement of an 1,800 increase in health service staff, at a minimum 1,300 of these must be frontline nursing staff. This is necessary to allow the service to begin to deal with the record levels of hospital overcrowding – now at a staggering 70,000 plus and estimated to hit 100,000 by year end. Not to mention the growing waiting lists for treatment and procedures at an all-time high of around 700,000 – equating to the population of between eight to 10 counties – simply staggering.

The budget failed to provide for the implementation of the recently-published Sláintecare Report, which calls for a 10-year transformational change programme. While the Health Minister has started a three-step healthcare reform plan, the resource allocation required was, notably absent. The proposed expansion of services, is rhetoric for rhetoric's sake, in the absence of clearly allocated funds to introduce improved pay and conditions to reflect the competitive international labour market for Irish nurses and midwives.

WFP National Implementation Group meetings

THE purpose of these meetings is to ensure implementation of the Workforce Plan (WFP). The key focus is progress on nursing and midwifery staffing to ensure that the targeted 1,208 extra nurses and midwives are appointed by end of December 2017. It is fair to say that these meetings are protracted and difficult, despite this being a national agreement the employer seems to have set it aside and decided to fixate on the 1,208 figure. It will be a huge challenge to achieve a nursing and Midwifery workforce of 37,000 by December 31, as those retiring will not even be replaced by the graduates. Staff on panels should be appointed immediately. Even with conversion of agency staff the figure would not be breached, but so what if it was? The 2018 WFP will facilitate this. It is a travesty that at the end of October 2017 there were only 13 additional staff nurses in the system.

NWCI budgeting research launch event

I ATTENDED this congress and affiliate trade unions research event, which launched a concerted call to end the gender pay gap, which stands at 13.9%. The Department of Justice and Equality launched a consultation process in August, resulting in trade unions being to the fore in suggesting actions to tackle the gender pay gap. Actions range from company reporting, job evaluation, tackling low pay, promoting girls into STEM (science, technology, engineering and mathematics) subjects, providing quality affordable accessible childcare are among some of the mechanisms. Josepha Madigan, TD and chair of the budgetary oversight committee, addressed the launch and reiterated that gender responsive budgeting is a cornerstone of the budgeting process and something we should not be fighting for. With the launch of the National Strategy for Women and Girls (2017-2020) the message from government is of an 'Ireland of opportunity' and a 'Care-based economy'. The strategy document can be accessed at: **http://bit.ly/womenandgirls_strategy** The Institute of Public Administration published a special edition devoted to the topic and is well worth looking at. It is available here: **http://bit.ly/IPAjournal**

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

Quote of the month

"I am only one, but still I am one, I cannot do everything, but still I can do something; and because I cannot do everything, I will not refuse to do something that I can do."
Helen Keller

Report from the Executive Council

Congratulations, to our two Executive Council Members Mary Gorman and Eileen Kelly on securing the midwifery and care of the older person seats respectively in the recent NMBI Elections. Sharon Phelan was unsuccessful in her bid for the ID seat. Representation on the regulator is critical given the advent of the Competency Scheme under the Nurses and Midwives Act 2011, therefore it is vital that those in this privileged position advocate on behalf of those at the coalface.

Elizabeth Adams, director of professional development and the Richmond Education and Event Centre, has been elected president of the European Federation of Nurses Associations (EFN). The EFN will go from strength to strength with Elizabeth as its leader. Her worldwide experience will bring a breath of experience and knowledge of all issues facing nursing. I wholeheartedly congratulate Elizabeth, I am proud of her deserved achievement and I look forward to supporting her during her term of office.

Given the many items discussed at October's Executive Council meeting, it was restated by the Executive that the government and health service management had one further opportunity, under the new agreement, to address the nurses' claim for pay parity with other degree-level health professionals. As a union we are now focused on accelerating the reviews of recruitment and retention problems – and measures that can be put in place to address these – which are scheduled to report back to the INMO in the second quarter of 2018. It is then that the members of this Organisation will have a momentous decision to make in determining if the measures go far enough.

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

Pay Commission begins next phase

Terms of reference approved by government

THE terms of reference for the next phase of work by the Public Service Pay Commission (PSPC) were formally approved by the government at its Cabinet meeting on October 17, 2017.

Within the new pay agreement for public servants, known as the Public Service Stability Agreement (PSSA) 2018-2020, which was recently accepted by INMO members, there is an explicit commitment to examine the issues of recruitment and retention difficulties in the public service.

In addition, through a series of meetings in the summer and prior to members balloting on the proposed agreement, the INMO secured a clarification that nursing and midwifery will be examined as part of the first module of work, starting immediately, by the Commission.

The government, in a press statement issued after the Cabinet meeting, confirmed that while there are no significant recruitment difficulties across the public service, certain areas, including the health sector, require more comprehensive examination and this would be the work of the Commission in the coming months.

The INMO will immediately engage with the Commission, with regard to the recruitment/retention crisis within nursing and midwifery, and the Commission has committed to issue its first report, covering nursing/midwifery, in the second quarter of 2018. Furthermore the INMO has also secured agreement from public sector management that, within four weeks of this report being issued, they will sit down to discuss implementation of all recommendations.

The terms of reference for the PSPC in this next phase of its work are to:

- Seek to establish firstly whether, and to what extent, a difficulty exists in terms of recruitment and retention for specific groups/grades/sectors of the public service
- Where a difficulty is identified, examine the full range of causal factors, having regard as the Commission considers relevant to:
  - the totality of the current remuneration package available
  - the planned future pay adjustments and alleviations from current rates of the pension related deduction provided for in the PSSA 2018-2020
  - remaining FEMPI pay unwinding post 2020, where applicable
  - supply constraints, for example, of newly qualified graduates of relevant post-Leaving cert/third level programmes
  - work environment/organisational issues
  - career structures
  - learning and development provision
  - communications/engagement
  - other relevant HR practice or organisational issues and any other factor considered relevant by the Commission.
- Develop appropriate methodological and analytical criteria to ensure a robust evidence-based approach to this exercise
- Have regard to arrangements and best practice in other jurisdictions and, where appropriate, the domestic private sector in Ireland in relation to such issues, particularly in respect of those areas where a global labour market exists as well as the responses being adopted in other jurisdictions where similar recruitment and retention problems pertain
- Commission such external expertise as the Commission deems necessary to inform its deliberations in the context of the methodologies developed
- Provide the parties to the PSSA with the opportunity to make submissions to the Commission
- Generate a range of costed options for resolving the specific issues identified having full regard to the fiscal constraints and requirements on government to manage the Exchequer pay bill in a sustainable way over the medium and long-term
- Produce a final report to the Minister by end of 2018 and/or at such interim stages as the Commission may decide.

World news *Nurses and midwives in action around the world*

Australia
- Nursing home to hospital transfers are booming
- Victorian nurses walk off the job at Bupa
- Wollongong's birthing suites 'dirty, outdated and understaffed'

Brazil
- Nurses repudiate national action affecting basic healthcare

Canada
- Debbie Forward acclaimed Registered Nurses' Union president for ninth term

Dominic Republic
- Nurses start 72-hour strike at a children's hospital

Kenya
- Nurse officials appeal ruling to escape six-month jail term
- Kisumu County to hire 210 as nurses' strike bites on

Philippines
- Philippines is nursing a crisis

Portugal
- Nurses' unions return to negotiate with government
- Nurses admit to reaching agreement with government and clear strike

Spain
- SATSE union does not want to bargain for a 35 hour work week until it is made law
- One thousand new hires needed to mitigate staff shortages in nursing homes
- Satse challenges the Decree that regulates nursing homes

UK
- It's time for fair pay for the heroes in our hospitals
- Brexit blamed as nursing numbers fall for first time in years
- £566k overseas recruitment campaign yields just 12 nurses
- Hunt scraps 1% pay cap for nurses

US
- Registered Nurses say patient safety sparks UCI Medical Center rally
- A year after strike, Allina nurses seek mediation for new contract

Increased health funding welcomed but recruitment remains a challenge

THE INMO welcomed the increased allocation for public health services of €685 million, announced in the government's Budget for 2018. The Organisation also noted the stated commitment within the budget allocation to increase the number of frontline posts by 1,800 in 2018.

However, the Organisation pointed out that the commitment contained in last year's Budget statement and in the staffing agreement reached between the Department of Health/HSE and the INMO, explicitly provided for more than 1,000 additional nursing/midwifery posts for the public health service in 2017.

Despite this, in the latest employment census it was confirmed that only 13 additional nursing/midwifery staff have been recruited in the first nine months of this year. This fact confirms that the Irish public health service continues to face a nursing/midwifery recruitment/retention crisis.

The INMO said that, while welcome, the additional funding must also be considered in the context of the record number of patients (over 73,000) admitted for care in Irish hospitals, who have found themselves on trolleys in the first nine months of this year. The Organisation said it is absolutely imperative that the access plan, contained within the Budget allocation, delivers additional nursing/midwifery staff which must, in turn, provide for additional acute and long-term care beds so that these admitted patients can be cared for properly with privacy and dignity.

As we went to press, the INMO was due to meet with Minister for Health Simon Harris on October 26 to discuss the implementation of the funded nursing/midwifery workforce plan for 2017, which was agreed last March. The Organisation was set to take that opportunity to seek further details, about the health budget allocation for 2018, with specific reference to:

- How, within the increased allocation, the government will ensure that all recruitment targets, set to restore the nursing/midwifery workforce, are met
- How the budget allocation will ensure that the various nursing/midwifery initiatives, including the staffing taskforce (which will determine how safe staffing levels are determined and maintained), are implemented, throughout the health service, to improve access and the quality of patient care
- Guaranteeing that all nurses/midwives, graduating in 2018, will be offered permanent fulltime posts, immediately, to ensure they are available to the very understaffed health service.

INMO general secretary designate Phil Ní Sheaghdha: *"The increase in the health allocation should be welcomed. However, the challenges facing our health system in terms of meeting demand make it essential that all of this additional money is channelled into the frontline where the patient must come first"*

The INMO also welcomed, as sought in its pre-budget submission, the introduction of a sugar tax on drinks with high sugar content, and the increase in excise duty on cigarettes. The Organisation believes these are necessary measures to change damaging lifestyles which, in turn, result in illness and poor health in later life.

INMO general secretary designate Phil Ní Sheaghdha said: "The increase in the health allocation should be welcomed. However, the challenges facing our health system in terms of meeting demand, recruiting/retaining the nursing and midwifery workforce and expanding services, particularly in primary care, make it essential that all of this additional money is channelled into the frontline where the patient must come first.

"The INMO remains very concerned, in the absence of enhanced terms and conditions of employment, that, notwithstanding any budgetary commitments, the Irish public health service will not be able to recruit and retain the number of additional nurses/midwives required to meet existing service need and ever-increasing demands. The reality is that last year's commitment to recruit over 1,000 nurses/midwives has not been delivered."

Ms Ní Sheaghdha said: "It is also disappointing that there appears to be no overt provision, in the form of a protected budget, to begin implementing the Sláintecare report which has cross party support.

"At our forthcoming meeting with the Minister, the INMO will raise all of our concerns including the implementation of all agreements the INMO has, with health management, in such critical areas as staffing levels, to ensure safe patient care and further measures necessary to address the record numbers of patients on trolleys".

Hospital overcrowding continues

INMO calls on HIQA and HSA to carry out immediate inspections

A RECORD number of 8,101 patients admitted for care were on trolleys in emergency departments or wards during the month of September, according to INMO trolley/ward watch figures. This is a 7% increase on September 2016 and a 132% increase on 2007 (3,494) *(see Table 1)*.

The latest figures also confirmed that in the first nine months of 2017, a record number of 73,556 admitted patients were on trolleys, which again represents a 7% increase on 2016, and a 94% increase on the same nine months in 2007. At that time the overcrowding situation was declared a national emergency.

The hospitals with the greatest levels of overcrowding in the past month were:

- University Hospital Limerick, 902
- Cork University Hospital, 628
- University Hospital Galway, 598
- University Hospital Waterford, 505
- Tallaght Hospital, 448.

The INMO Executive Council considered the latest report in early October in the context of implementing the Funded Workforce Plan for Nursing/Midwifery in 2017. As part of this agreement, the HSE committed to employ an additional 123 nurses to look after admitted patients across a number of EDs. However, the latest report confirms that only 17 of these posts are currently in place.

Against this stark background the Executive Council, recognising the deepening crisis with regard to overcrowding and understaffing, decided to seek emergency talks with the HSE/Department of Health. The aim of this was to bring forward a range of emergency actions, which must include the provision of additional financial resources, and staffing, to ease the crisis in the face of the late autumn/winter period.

The INMO also said that the current situation, is a major factor in the recruitment/retention crisis which

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

Hospital	Sept 2006	Sept 2007	Sept 2008	Sept 2009	Sept 2010	Sept 2011	Sept 2012	Sept 2013	Sept 2014	Sept 2015	Sept 2016	Sept 2017
Beaumont Hospital	310	409	608	830	680	730	280	620	644	732	383	254
Connolly Hospital, Blanchardstown	211	229	226	176	297	387	317	540	485	327	172	205
Mater Misericordiae University Hospital	262	366	519	443	446	368	334	187	311	371	350	373
Naas General Hospital	85	17	243	157	370	230	151	118	249	180	156	212
St Colmcille's Hospital	32	29	152	200	89	240	119	45	n/a	n/a	n/a	n/a
St James' Hospital	22	39	178	169	150	114	84	117	329	159	219	108
St Vincent's University Hospital	459	536	500	389	584	638	405	163	200	419	415	257
Tallaght Hospital	166	329	383	354	661	175	63	337	312	450	450	448
Eastern	1,547	1,954	2,809	2,718	3,277	2,882	1,753	2,127	2,530	2,638	2,145	1,857
Bantry General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	6	3	25	36
Cavan General Hospital	74	267	91	262	433	341	142	206	15	180	39	78
Cork University Hospital	229	235	275	437	567	529	146	304	326	477	441	628
Letterkenny General Hospital	281	34	16	33	49	25	28	176	130	158	263	459
Louth County Hospital	19	0	0	24	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Mayo University Hospital	202	72	28	114	147	45	145	57	64	118	206	132
Mercy University Hospital, Cork	107	71	113	90	195	185	149	134	240	142	220	215
Mid Western Regional Hospital, Ennis	43	9	17	23	10	3	12	0	n/a	14	16	8
Midland Regional Hospital, Mullingar,	22	4	18	31	116	275	186	146	255	453	380	383
Midland Regional Hospital, Portlaoise,	38	24	6	0	24	254	25	79	44	147	216	222
Midland Regional Hospital, Tullamore,	0	2	8	4	56	113	96	13	508	302	411	445
Monaghan General Hospital	6	2	22	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	0	2	4
Our Lady of Lourdes Hospital, Drogheda	349	116	302	323	331	842	626	214	593	606	507	134
Our Lady's Hospital, Navan	40	47	72	169	7	75	8	57	26	33	49	243
Portiuncula Hospital	21	9	0	105	33	149	26	36	49	36	98	94
Roscommon County Hospital	50	60	80	50	113	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sligo Regional Hospital	79	56	8	55	168	153	102	45	200	210	51	323
South Tipperary General Hospital	34	92	10	64	13	125	123	224	97	107	350	396
St Luke's Hospital, Kilkenny	n/a	n/a	n/a	n/a	34	47	35	209	128	278	188	229
University Hospital Galway	126	209	380	321	356	642	271	282	446	514	499	598
University Hospital Kerry	129	46	11	16	73	68	59	51	91	138	133	114
University Hospital Limerick	139	166	72	201	502	384	279	345	551	784	825	902
University Hospital Waterford	n/a	n/a	63	46	164	59	136	152	68	257	333	505
Wexford General Hospital	189	19	42	178	336	490	53	73	144	35	154	96
Country total	2,177	1,540	1,634	2,546	3,727	4,804	2,647	2,803	3,981	4,992	5,406	6,244
NATIONAL TOTAL	3,724	3,494	4,443	5,264	7,004	7,686	4,400	4,930	6,511	7,630	7,551	8,101

Comparison with total figure only:

Increase between 2016 and 2017: 7%
Increase between 2015 and 2017: 6%
Increase between 2014 and 2017: 24%
Increase between 2013 and 2017: 64%

Increase between 2012 and 2017: 84%
Increase between 2011 and 2017: 5%
Increase between 2010 and 2017: 16%
Increase between 2009 and 2017: 54%

Increase between 2008 and 2017: 82%
Increase between 2007 and 2017: 132%
Increase between 2006 and 2017: 118%

continues with regard to nursing/midwifery. To address this the INMO is calling for special pay measures, which will increase the supply of nursing staff, improve staffing levels and the quality of care available to patients, while allowing for the opening of additional beds and expansion of other needed services.

In addition the INMO is calling on:

- HIQA to carry out inspections of all hospitals with high levels of overcrowding, not just the EDs, to examine and report on the patient safety and welfare issues which are being severely compromised on a daily basis
- The Health and Safety Authority to carry out unannounced inspections to determine whether employers have breached their statutory obligation to maintain a safe place of work for their staff and immediately issue improvement orders.

INMO general secretary Liam Doran said: "This record level of overcrowding, when combined with the abject failure of the HSE to ensure safe staffing in these overcrowded departments, must be recognised as a deepening crisis requiring immediate attention by a number of agencies. It is quite clear that, in many hospitals, the daily situation is beyond breaking point with patients left without dignity and privacy. Furthermore, due to the failure to employ additional staff, consistent with an agreed dependency tool and best practice, the care of those patients is being compromised.

"Urgent talks are now required, with both the HSE and the Department of Health, to ascertain what measures, including pay incentives, they intend to put in place as we enter the winter period in response to the severe shortage of beds and staff confirmed by the latest trolley/ward watch figures.

Net increase of just 13 WTE nursing/midwifery posts

THE most recent HSE staffing report issued to the Minister for Health at the end of September was disappointing but not surprising, according to the INMO. It revealed a net increase of just 13 whole-time equivalents (WTEs) to the nursing and midwifery workforce since December 2016, despite the recruitment initiatives.

The agreement reached with the HSE and the Department of Health, in February 2017, requires an increase in the total staffing of 1,224 additional nursing and midwifery posts by December 2017. This increase is based on the total number of nursing/midwifery posts in place in December 2016, that is 35,430, and the increase has been monitored on a quarterly basis since the agreement was brokered.

Obviously there is a long way to go to get to the 1,224 figure. The INMO is adamant that this clearly illustrates the difficulty in retention and recruitment within the nursing and midwifery professions. The Organisation has continuously argued that until the workforce is adequate this problem will continue and, in order to have an adequate workforce the terms and conditions of employment need to be improved. This includes basic pay and hours of work that are comparable with other health professionals working in the Irish public health service.

When the Minister for Health invoked Section 10 of the Health Act 2004, responsibility for recruitment was delegated to directors of nursing/midwifery to remove bureaucracy and speed up the process of recruitment and to allow directors of nursing/midwifery to have more influence over recruitment.

In respect of the additional midwives required under the National Maternity Strategy, the target for 2017 was an increase of 96 employed WTE midwives. The September report issued to the Minister identifies that two additional midwives have been recruited and the overall number of midwives dropped by 52 WTEs this year to date.

Obviously it is going to be very difficult to reach the target of 96 which was set for this year, with a further 104 to be recruited in 2018. These figures are determined based on the aim of 1 to 29.5 ratio of midwives to births in each of the maternity services.

The reliance on agency staff remains very high with the most recent HSE figure demonstrating that the cost of agency for the first 35 weeks of the year for nursing has increased to just over €40 million. The cost of healthcare assistants is €40.4m, almost €17m for allied health, €6m for social care and €50.45m for medical staff.

The total cost of agency for the first 35 weeks of 2017 is recorded for HSE use only at €154,131,060. This is an extraordinary cost by any measure and will only be corrected when direct employment is prioritised, resourced, and funded correctly.

The next staffing report is due to be submitted to the Minister at the end of December 2017 and the INMO will continue to meet with the employer to assess progress leading up to that point.

– Phil Ní Sheaghdha, INMO general secretary designate

Table 1. Nurse/midwife profile Dec 2016-Aug 2017

Nursing/midwifery WTE	Dec 2016	Apr 2017	Aug 2017	Change YTD*
Total nursing/midwifery WTE	35,835	36,551	36,278	+443
DON/M, ADON/M, CNM/CMM	7,278	7,340	7,405	+127
CNS / CMS	1,416	1,445	1,451	+35
ANP / AMP	164	181	194	+30
Staff nurse/midwife	24,768	24,891	24,595	-173
PHN	1,499	1,489	1,497	-2
Nursing/midwifery student**	405	900	835	+430
Nursing/midwifery other	305	305	300	-5

** year to date*
*** student nurse computed as 0.5 WTE in census, intended to be reflective of duties/responsibilities attached to role*

Working unpaid hours must end

Irish nurses and midwives work longest hours in EU

A REPORT from the Department of Public Expenditure and Reform, entitled *Estimated Value of Additional Hours Worked,* has been rejected as exaggerated by the INMO.

The Organisation confirmed that the imposition of additional hours under the Haddington Road Agreement, was particularly penal as it required nurses and midwives to attend work for a minimum of six additional unpaid shifts a year.

The Organisation pointed out that the document itself was produced in the context of negotiations on public sector pay restoration. The figures in the document were contested, at the time, and are highly exaggerated and would not, in any way, deter the INMO from seeking a 37 hour week.

INMO general secretary designate Phil Ní Sheaghdha said: "Following a protracted dispute in 2007, our members gained the 37.5 hour week, however, it was applied on a cost neutral basis. In 2013 when the state borrowed additional unpaid hours from public servants, including nurses and midwives, the application of those hours was particularly penal and involved nurses and midwives giving six free shifts a year to their employer. This situation is untenable in the long term and militates against recruitment and retention. Nurses and midwives in the UK are working a 37.5 hour a week".

There is currently a major shortage of nurses and midwives in Ireland, which is a reflection of a general shortage of nurses and midwives across the OECD countries. Ireland depends, to a large extent, on the recruitment of non-EU nurses to compensate for its failure to retain or recruit, according to the INMO. The long hours and low pay for nurses and midwives is forcing nurses and midwives to leave. The HSE has failed to recruit even the numbers required to meet its service plan for 2017.

The recruitment and retention of nurses and midwives is now a priority issue for the Public Service Pay Commission.

Ms Ní Sheaghdha said: "The achievement of a 37 hour week is very high on the INMO agenda as nurses and midwives are the only professionals in the health service working more than 37 hours per week. The current hours are a disincentive and have not impacted on HSE agency costs which have, in fact, increased.

"The health service is incurring a substantial agency cost as many nurses cannot commit to the full working week and are forced to work shorter part time hours. In the long run the additional hours have not contributed to savings in the health service but have driven people away from it and left many wards understaffed and under pressure".

Health staff commended during red weather alert

THE INMO acknowledged the commitment of nursing, midwifery and all health service staff as they maintained essential health services during the recent red weather alert.

As well as essential hospital services, community nursing and home help services were maintained as best as possible, despite difficult travelling conditions. Some planned services were cancelled, including outpatient appointments in the interest of public safety, but all essential/emergency services were maintained.

There was some disruption to health services after the storm passed to allow hospitals to deal with the fallout of the extreme circumstances, which limited discharges from hospitals as people could not be transported home.

INMO general secretary Liam Doran said: "The priority was to maintain all essential/emergency services. This was only achieved as a result of the commitment of frontline staff which, once again, the INMO acknowledges and applauds.

"In particular we acknowledge the commitment, which was nationwide, to maintain, as far as is possible, community/home based services and visits. In such weather everyone must be vigilant and particularly aware of neighbours who normally receive such services and may need extra care and attention at this time. The INMO also acknowledges the commitment of all frontline staff, from the entire range of public services, who served all of us so well as they strived to maintain a safe environment for everyone in the face of the storm."

Employees must be paid for time lost due to Storm Ophelia

THE INMO, reacting to threats by some employers to offset Monday, October 16 against annual leave had warned that it would not tolerate employers deducting pay or insisting that employees take annual leave as a result of needing to stay away from work due to Storm Ophelia.

The red weather warning was issued for the entire country, INMO deputy general secretary Dave Hughes said: "The decision to declare a red weather warning was to save lives. The government reinforced the red weather warning and the Taoiseach himself indicated that he was appealing to employers to act reasonably where employees adhered to that warning."

"Many nurses and midwives did attend work on the day and continued to provide emergency and essential services. Small-minded deductions by employers would entirely undermine the purpose of red weather warnings and a government's declaring national emergencies for such circumstances. Forcing people to take chances on such days will inevitably have consequences which go way beyond the value of a single day's pay."

As we went to press, the INMO welcomed the written confirmation by the HSE national director for HR that staff who adhered to the red weather warning on October 16 will not be docked pay.

Mr Hughes said: "Lessons have been learned from how Hurricane Ophelia was handled and in respect of employment rights, the government must, in future, make it clear that when they call for public adherence to the stay at home message, they must equally make it clear that the day amounts to the equivalent of a public holiday."

Preliminary talks on children's hospital

THE INMO had a preliminary meeting with management of the Children's Hospital Group last month on the process for future engagement and consultation.

The Organisation was given a presentation on the overview of governance arrangements and activities, in preparation for the commencement of the new Children's Hospital and discussion took place on the employee relations framework and the proposed terms of reference for same.

The Children's Hospital Programme was established to oversee the integration of the three existing children's hospitals into the Children's Hospital Group. The existing hospitals are:

- Our Lady's Children's Hospital Crumlin
- Temple Street Children's University Hospital
- The National Children's Hospital at Tallaght Hospital.

The new children's hospital is being built on the 50-acre campus shared with St James's Hospital. It will be supported by two paediatric outpatient and urgent care centres, on the grounds of Connolly Hospital, Blanchardstown and Tallaght Hospital. These two centres will provide services for children, young people and their families in the greater Dublin region. In the future, staff of the three children's hospitals will be working together in a state of the art hospital , which will be custom-built to deliver the best care and treatments available.

The programme also includes the roll-out of the phased implementation of a national electronic health record (EHR) system and the capital and equipping projects for the new facilities. Finally, the programme includes workforce planning, people and cultural activities, and staffing the new facilities.

The INMO believes that this is an extremely important project and one that requires the parties to work together to ensure the provision of a first-class health service for the children of Ireland. The INMO will be working to ensure safe and appropriate staffing in all departments as well as ensuring the development of specialist nursing posts.

The general scheme of the (Children's Health) Bill 2017 is now going through the houses of the Oireachtas. It is planned that the INMO will form INMO representative committees in Temple Street, Crumlin and Tallaght to assist in the engagement and consultation process.

The INMO negotiation team will be made up of Tony Fitzpatrick, acting director of industrial relations, Edward Matthews, director of regulation and social policy, Catherine Sheridan who is the paediatric representative on the Executive Council, Mary Rose Carroll, IRO for Temple Street and Crumlin, Joe Hoolan, IRO for Tallaght Children Services, and Lorraine Monaghan, IRO for Connolly Hospital where one of the outpatient and urgent care centres will be based. The INMO looks forward to proactively working with management of the new children's hospital to ensure that appropriate nursing management structures, staffing and skill mix are secured.

Members working in the three children's hospitals should contact their local IRO with any questions on the engagement process.

– Tony Fitzpatrick, INMO interim director of industrial relations

INMO makes submission on home care to DoH

IN A position paper on home care submitted to the Department of Health last month, the INMO outlined its many concerns with the current home care scheme.

It was extremely difficult to identify where the scheme worked well. The INMO outlined that there needs to be uniformity of practice across the country and as part of a multidisciplinary approach it is essential that the public health nurse and the community RGN's role is recognised throughout the process, with clear lines of accountability.

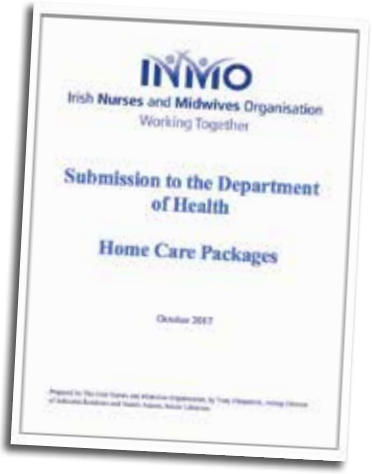
The INMO said the current system of home care provision is not fit for purpose and that there are vast differences across geographical areas and professional disciplines. The INMO said it is essential that as part of the development of an integrated model of care, all sectors of the health service, including primary, community and acute, are working for the good of the patient/client. Staff should be directly hired and answerable to a public service provider.

The INMO outlined that confusion and inconsistency currently exists across the system. The PHN and CRGN provides the initial assessment. However, once that assessment goes through the administrative process, the recommendation for care hours required to aid with activities of daily living are reassessed based on financial and resource parameters. The INMO stated that the PHN/CRGN's clinical judgement should be respected by the administrative system.

The INMO welcomes the goals and commitments in the *Sláintecare* report to increasing spending on home care services. However, it is essential that plans be put in place to ensure this commitment is actualised and funding secured now and into the future. Furthermore, this must include workforce planning and recruitment for the 900 nursing posts recommended for the community in this report.

The INMO argued that to have a fair and equitable service, with clear and transparent processes, it is important that national policies exist for the application, assessment, monitoring and appeals processes.

Any changes to homecare services must be done reflecting the *Sláintecare's* call for a single tier universal healthcare model, one that supports integrated care, is person centred, and provides quality and excellence. This can only be achieved by clear planning, funding and governance structures and ensuring the appropriate level of staffing throughout the entire health service.



The full submission can be read at **www.inmo.ie**

– Tony Fitzpatrick and **Niamh Adams**

Tony Fitzpatrick, INMO interim director of industrial relations, reports

Talks begin on staff mobility/ transfer policy

THE INMO and other unions met with the HSE on October 13, 2017 regarding the development of a transfer policy for the HSE and Voluntary agencies.

As part of the recruitment and retention campaign, the INMO secured that a staff nurse/midwife transfer panel would be established to ensure that staff working within the health service and voluntary agencies could seek a transfer from one facility to another. It is important that staff have access to a transfer panel. This is reinforced by the fact that 50% of applicants for posts, advertised in the HSE via NRS, are already working within the health service but do not have access to a transfer panel. Therefore, a transfer panel would significantly reduce administration in filling vacant posts.

A further meeting on this is planned for November 10, 2017.

Peer vaccination ban lifted

FOLLOWING staffing commitments by the HSE, the INMO has lifted the ban on members volunteering to carry out peer vaccinations. The Organisation had requested that nurses and midwives did not volunteer for the Peer Vaccination Programme throughout 2016, due to the failure of the HSE to provide additional staffing.

The INMO's main concern was the implications for staffing levels and patient care if nursing staff were diverted away from their normal duties to provide peer vaccinations. In addition the HSE had failed to engage as required under the Protection of Employees (Information and consultation) Act 2006.

However, the INMO has secured additional staffing resources to allow members to cooperate with the Peer Vaccination Programme 2017. The terms of the agreement are:

- The programme will be delivered within six hours per week for eight weeks in each HSE-run care of the elderly facility and acute hospital
- The delivery can occur in one six-hour period, two three-hour periods or other arrangements as long as the quantum of six hours is not breached
- This will involve approximately 175 locations. One six-hour period in each of these 175 locations would total 1,050 hours and for an eight-week period would equal 8,400 hours or a total of 1,400 six-hour periods
- The HSE confirmed that it would fund the backfilling of these hours in each of the locations, and directors of nursing/midwifery are to act on this immediately
- If usual arrangements for backfilling are not possible, or available, the rehiring of retired nurses will be permitted for this initiative in accordance with the arrangements set out, ie. six hours per week for no more than eight weeks per location
- The HSE will provide assurance on the backfill arrangement to all directors of nursing/midwifery.

The INMO Executive Council considered the proposal from the HSE at its October meeting and agreed to support the Peer Flu Vaccination Programme 2017 on the understanding that the above commitments are honoured fully.

This agreement means that replacement is provided to allow the release of peer vaccinators. The terms of this agreement will be notified to DON/Ms and the INMO has made it clear to management that if nurses/midwives are absent, without replacement, for the periods in questions the INMO will consider it a breach of the agreement and withdraw support. The INMO and the HSE will meet to review the entire Peer Flu Vaccination Programme 2017.

Separately, the INMO Executive Council considered a request from the HSE to lend its support to the flu vaccine programme. The Executive Council agreed to remind members to avail of the flu vaccination, following any necessary medical advice.

Retrospective application of injury allowance

THE INMO is happy to report that after pursuing the retrospective application of the injury allowance (degree of impairment), the HSE has issued HR circular 013/2017 and HR circular 029/2017.

Circular 013/2017 sets out the revised arrangements for the calculation of injury allowance to apply with effect from March 16, 2017. Approval has been granted to apply the arrangements as set out in circular 029/2017 on a retrospective basis to employees whose injury occurred on or after June 17, 2015 and who were temporarily incapacitated. Therefore, HR circular 29/2017 deals specifically with the issue of granting retrospective payment to employees whose injury allowance payment had been subject to a degree of impairment assessment rating. This only affected those employees in the pre-existing pension scheme.

A separate circular is being prepared to extend the injury allowance scheme to Single Scheme members and will include clarification sought by the INMO regarding the vesting period.

It was confirmed at the NJC meeting of September 26, 2017 that the Department of Health is currently engaging with DPER in relation to any legislative amendments which may be required under the Public Service Pensions (Single Scheme and Other Provisions) Act 2012, to give effect to the injury allowance for Single Scheme members in the health sector.

In the interim, a memorandum was issued by Anna Killilea, of Corporate Employee Relations on August 3, 2017 dealing with the issue of a vesting period. The circular clarified that "there is no requirement for the employee to have completed the ill health vesting period for the purposes of determining if the employee satisfies the eligibility criteria for payment of the injury allowance." Therefore, in accordance with the arrangement for employees in the pre-existing schemes, there is no qualifying period for access to the injury allowance and an employee may be eligible for payment at any stage, following commencement of his or her employment.

on current national IR issues

National WRC conciliation conferences

Health Service National Joint Council

THE primary forum for the management of industrial relations in the health service is the National Joint Council (NJC). The purpose of this council is to oversee the conduct of good industrial relations in the employments covered and to decide on an efficient method to deal with matters arising with the objective of ensuring co-operation between employers and eligible trade unions for the better delivery of a modern health service.

The NJC is chaired by a conciliation officer of the WRC and has trade union and management side representatives. The management side represents all health service employers, the Department of Health and recognised employers' representative bodies. Other agencies form part of the NJC including the HSE, public/voluntary hospitals, intellectual disability sector and other specialist agencies.

The NJC meets every two months. The trade union side has expressed concern about how the NJC operates and the behaviour of the employer. As a result, a WRC advisory service is due to meet with HSE management and the staff panel of trade unions on October 19, 2017 to discuss these concerns.

It is hoped that the involvement of the WRC advisory service will ensure that issues raised by the trade unions, either collectively or individually, will be dealt with in an effective manner thus ensuring that the forum fulfils its purpose. The INMO will be a full participant at the meeting and it is hoped that these matters can be resolved.

National ED agreement

A WRC conciliation conference on the implementation of the nationally agreed ED agreement is due to take place on November 13, 2017. While individual hospitals and hospital groups have made considerable progress on reducing the number of patients on trolleys waiting for a hospital bed, this continues to be a national scandal. In September 2017, the number of persons on trolleys again hit record levels *(see page 10)*.

As part of the national agreement, local engagement should be taking place at every acute hospital and regular meetings should be taking place between the INMO and the CEO/COO/CNO of each of the hospital groups. It is particularly important that these meetings take place on a regular basis heading into the winter months.

The INMO will be raising the concerns of frontline ED nursing staff at the meeting on November 13.

National Safeguarding of Vulnerable Adults

As we went to press, a national conciliation conference was also due to take place on October 23, 2017 to ensure the implementation of the WRC agreement of July 2017 on the safeguarding of vulnerable adults policy 2014.

Separately, members will be aware that a national working group is working to revise the 2014 policy and many focus groups, surveys and public consultation have already taken place on this.

Legal supports for breastfeeding and employment

MARKING National Breastfeeding Week 2017, which took place from October 1-7, the INMO reiterated its support for breastfeeding, and outlined the many benefits and legal provisions set out for breastfeeding mothers in the workplace.

While breastfeeding and employment can be challenging at first glance, the benefits are clear. For employers, facilitating breastfeeding ensures reduced absenteeism, increased productivity, improved staff morale, lower staff turnover, cost benefits and a positive corporate image for the employer.

From a societal point of view, breastfeeding reduces healthcare costs, is environmentally friendly, has economic value and ensures a healthier workforce into the future.

The health benefits listed in the literature for the infant are enormous, including protection from asthma, eczema, diabetes and obesity. Furthermore, research has shown in longitudinal studies that later in life, the risk from high blood pressure and heart disease is lower for those who were breastfed as infants.

There are clear provisions set out for mothers to breastfeed in the workforce as outlined in the Maternity Protection (Amended) Act 2004. The Act is further strengthened by the Maternity Protection (Protection of Mothers who are Breastfeeding) Regulation 2004, S.I. 654 of 2004.

These pieces of legislation outline that certain women in employment who are breastfeeding are entitled to take time off work each day in order to breastfeed. It applies to all women in employment who have given birth within the previous six months. The women may therefore opt to either breastfeed in the workplace or express breast milk where facilities are provided by the employer, or have their working hours reduced (without loss of pay) to facilitate breastfeeding where facilities are not made available.

Women in employment who are breastfeeding are entitled to take one hour (with pay) off work each day as a breastfeeding break. The Act outlines that this time can be taken in one 60-minute break, two 30-minutes breaks or three 20-minute breaks. The breaks may be longer and more frequent if agreed between the woman and her employer. Part-time workers are entitled to breastfeeding breaks calculated on a pro rata basis.

Women who wish to exercise their right to breastfeed in employment must notify their employer at least four weeks before the date they intend to return to employment from maternity leave.

The INMO supports breastfeeding and champions breastfeeding in the workplace. Please log on to **www.inmo.ie** to view articles and research.

– Tony Fitzpatrick, interim director of industrial relations

• *Further details on National Breastfeeding Week on page 65*

Elizabeth Adams is new EFN president

ELIZABETH Adams, INMO director of professional development and the new Richmond Education and Event Centre, was elected president of the European Federation of Nurses Associations (EFN), at the 106th meeting of the General Assembly in Brussels last month.

Ms Adams has extensive international experience working in various senior positions across the world. This has included being an adjunct associate professor at Curtin University, Western Australia and University College Dublin, while also being a fellow of the Faculty of Nursing and Midwifery at Royal College of Surgeons of Ireland (RCSI). Ms Adams has also held the post of consultant in nursing and health policy with the International Council of Nurses in Geneva. Prior to this she served as director of nursing and midwifery for the Health Service Executive, while also holding senior nursing posts in the departments of health in Ireland and Western Australia.

In the course of her work in Ireland, she led and implemented nurse and midwife prescribing nationally, while also co-researching the first national study of the nursing and midwifery resource. While in Australia Ms Adams managed significant health reform and was instrumental in establishing the nurse practitioner role in Western Australia. In addition, she has had significant clinical and management experience with the Mater Misericordiae Hospital, Dublin.

The EFN was established in 1971 and is a strategic international organisation representing over three million nurses across the continent of Europe. Issues concerning health, patient care, mobility of health professionals, working environments, pay and conditions, education, technology and health funding are central to EFN.

Since 2013, Ms Adams has been a vice-president and an elected member of the Executive Committee (Governing Body). Ms Adams was elected president, by the EFN General Assembly, comprising 36 European member organisations,

Elizabeth Adams elected president of the European Federation of Nurses Associations

at its meeting in Brussels last month.

Speaking after her election, Ms Adams said: "Nursing is central to the delivery of healthcare to the 508 million people in the EU. It is a privilege to witness the extraordinary contribution made every day by nurses across the continent and to see how nurses make a real difference to the lives of those they meet. While nursing plays a key role already, health systems have not fully recognised the potential of nurses and the EFN has been and will be pivotal in ensuring that the voice of nursing is at the centre of every discussion around healthcare. I am honoured to have been chosen by representatives of nursing associations across Europe to lead their great organisation. I will make full use of this privilege to drive forward and strengthen EFN's influence at a political level in the EU so as to support nurses and midwives and thereby enhancing the health of the populations in all European countries."

INMO general secretary Liam Doran said: "The INMO is delighted that our colleague Elizabeth Adams has been elected to the critical post of president of EFN. Elizabeth has worldwide experience and will bring to this role confidence, experience and a breadth of knowledge, of all issues facing nursing, which is unparalleled. EFN will go from strength to strength, with Elizabeth as its leader, over the next two years. This is a very proud moment for the INMO, and is tangible recognition of Elizabeth's commitment to excellence in nursing practice which she has held throughout her distinguished career to date."

WRC agreement on weekend essential work

INMO members assigned to the HSE Dun Laoghaire Community Care Area have reached agreement at the Workplace Relations Commission regarding planned essential calls at weekends.

The attendance pattern resulted in nurses working 12 consecutive days without a rest day. As a result of the new agreement, nurses will now access paid days off in lieu of working weekends. The regular premium earnings will apply to weekend shifts. Payment for weekend work will now be pensionable.

Expressing satisfaction with the outcome of the intensive negotiations at the WRC, INMO IRO Philip McAnenly said: "PHNs and community RGNs will now be remunerated properly for the onerous liability of weekend work. Our members are delighted with the outcome that will deliver rest days and pensionable earnings.

"The previous attendance pattern was a deterrent to nurses being available for weekend work. Already, an increasing number of staff have volunteered to access the improved terms and conditions now attached to planned

WRC agreement on planned essential calls at weekends: *Pictured outside the Workplace Relations Commission were (l-r): INMO IRO Philip McAnenly with Marie Lucey O'Connor, CRGN, Dermot Coleman, CRGN, Eileen Grehan, DPHN and Una O'Neill, PHN*

essential calls at weekends."

Mr McAnenly paid tribute to the commitment of the INMO reps for the area – Marie Lucey O'Connor, Una O'Neill and Dermot Coleman – in bringing this dispute to a satisfactory conclusion.

Give peace a chance

With recent atrocities around the globe, attacks on healthcare workers and patients are at a record high, writes **Dave Hughes**

OCTOBER 1: *I read the news today, oh boy!*

On the streets of a major European city which once hosted the Olympics, in full view of the world's media, police violently attacked people attempting to vote on a sunny Sunday in Barcelona. Media footage showed mature older people physically beaten and literally thrown down stairs by officers of the state normally expected to protect them.

Then in Las Vegas on the night of October 1, 2017, a gunman opened fire on a crowd of concert-goers at the Route 91 Harvest music festival on the Las Vegas strip in Nevada, leaving 58 people dead and 546 injured. Between 10:05 and 10:15pm a 64-year-old fired hundreds of rifle rounds from a suite on the 32nd floor of the nearby Mandalay Bay Hotel.

About an hour later he fired his last shot, he was found dead in his room from a self-inflicted gunshot wound. His motive is unknown. The shooter used bump firing, a method used to allow semi-automatic rifles fire at a rate similar to that of fully automatic weapons.

Turn to another page and US president Donald Trump has warned that military action is a possibility, and has agreed to work with President of Russia Vladimir Putin to solve the "very dangerous" situation with Kim Jong-un, the North Korean president, who was threatening to conduct a sixth nuclear weapons test. The US president had already moved an anti-missile system, submarines and aircraft carriers into South Korea in a major show of military might. Could this be real? Vladimir Putin?

Pondering whether this was a nightmare from which awaking from sleep would provide release, the lyrics of one hit wonder Barry McGuire come to mind – "You don't believe we're on the eve of destruction".

Back in work and an update arrives from our colleagues in Physicians for Human Rights: "Over the past week, Syrian government forces or their Russian allies have launched at least five aerial attacks on three of the main hospitals in Syria's Idlib governorate, the most concentrated string of hospital attacks Physicians for Human Rights (PHR) has verified in Syria since April. The three facilities came under fire on the same day, September 19, and two of those hospitals came under separate attack just days later. PHR said that all five attacks likely constituted war crimes, either because they were targeted attacks on operating medical facilities or indiscriminate strikes in violation of international law."

Breaches of international law are carried out with impunity when those who do it are super powers or supported by them. Regrettably attacks on nurses, midwives, doctors and patients are now at record levels. In Syria alone 830 medical personnel have been killed between March 2011 and August 2017. They lost their lives delivering care without judgement, but based on human conditions and their need for care. They were killed by official forces of Syria, Russia, international coalition forces, Kurdish forces and Islamic State (IS) or terrorist organisations.

But attacks on health workers are not confined to Syria. They have happened in Palestine and 21 other countries during the past two years. The Safeguarding Health in Conflict coalition report *'Impunity Must End'* documents the scale of this staggering phenomenon.

The weapons industry profits from war, and with over 20 currently raging and civilisations being obliterated the industry is making mega profits. We must question why any business should be allowed to make money from the killing of innocent people and health workers. The National Rifle Association in the US is already out influencing with its trite proposition that 'weapons don`t kill, it's people who do".

INMO delegates to this year's Global Nurses United conference will seek support for a worldwide network to lobby for health workers' safety in conflict zones.

All we are saying is give peace a chance!

– Dave Hughes, INMO deputy general secretary

Reimbursement of class 2 insurance loading for PHNs

THE INMO has been engaged in ascertaining why CHO 8 Laois/Offaly had refused to reimburse PHNs who have an extra loading to pay for class 2 motor insurance due to the use of their cars for work purposes.

The management stated that National Financial Regulations allow it to do this, however the INMO argued that:

- A local internal memo states that all PHNs must produce class 2 insurance
- Nationally it is accepted that PHNs would be reimbursed.

After much debate it has been confirmed that PHNs will be reimbursed for extra loading as per Circular 03/2008. This will involve PHNs providing written evidence of the increase to their employer.

– Dean Flanagan, INMO IRO

Happy Retirement to Kay Garvey:
The INMO extends best wishes to INMO stalwart Kay Garvey on her recent retirement. Kay has spent many years working hard for her colleagues in the Athlone Branch and has served several terms on the INMO Executive Council. Kay is pictured above (centre) with (l-r): Dean Flanagan, INMO IRO, Ann Marie McDonnell (front), and three Athlone Branch officers Joan Scanlon, Patricia Hayes and Julie Molloy

Northern Irish experience can provide roadmap for RNID role in Republic

THE RNID Section officers were delighted to attend the RCN NI Learning Disability Network conference recently. The conference was entitled 'Celebrating excellence in person-centred care in learning disability nursing'.

The conference was opened by Prof Charlotte McArdle, chief nursing officer of the Northern Irish Department of Health. Her main message was that the "sky is the limit for learning disability nursing".

There are learning disability nurses to be found in all aspects of care access in the UK and Northern Ireland, including in prison services, maternity care, sexual health, community leadership and primary care. The UK 2026 strategy epitomises person-centred care.

Janice Smyth, director of the RCN NI, celebrated the learning disability nurse, praising ambassadors in learning disability nursing and their value, however she cautioned that a failure to fund structures and planning was not a pathway towards best practice.

Damien Hughes, consultant psychiatrist at the Belfast Health and Social Care (HSC) Trust, presented on the value of the RNLD and multidisciplinary team in the care of people with learning disability.

Muckamore Abbey Hospital in Belfast is a centre that provides specialist treatment plans for people with such issues as mental illness, autism and epilepsy. Referring to care in Muckamore, Dr Hughes said it is often suggested that it must be the 'magic dust' phenomenon at work when treatments are successful, however the truth is that "it's really about good quality nursing care".

Dr Hughes spoke about the need for specialisms in learning disability nursing in mental health, autism and Alzheimer's disease. He believes that the LD nurse is the glue of the multidisciplinary team as they are hugely influential at ward level and in the boardroom. He recommended that LD nurses should continue to develop as professionals together, stating that "teams learning to assimilate together" is the direction we should go.

A presentation by Carline Donaldson, a behavioural specialist nurse, and Eadoin Donaldson, an occupational therapist, who came together to provide a person-centred service for a young man with Pradar Willi syndrome, highlighted effective discharge using a person-centred approach. Andrew's story, told by his mother, laid out clearly how it took many years to receive person-centred care and how this makes such a difference in his life.

Pictured at the RNID learning disability forum were (l-r): *Anne Marie O'Reilly, INMO RNID Section; Ailish Byrne; RNID Section; Janice Smyth, RCN NI director; Wendy McGregor, RNLD, lead, RCN NI Learning Disability Nursing Network; Prof Charlotte McArdle, chief nursing officer, NI; Rhona Brennan, RNLD, deputy lead, RCN NI Learning Disability Nursing Network; Patricia McCartney, RNID Section; Siobhan Rogan, ANP, RNLD, team manager; Rosaline Kelly, senior professional development officer, RCN NI*

Tommy Whitelaw, from the organisation Dementia Carer Voices, gave an inspirational talk on caring for his mum Joan, telling those at the conference that each of us "could make a difference". He left us with lots to reflect on such as "the standard you pass is the standard you set".

In the afternoon, panel interviews of the learning disability nurses of 2017 were provided the Telling it Like it is (TILI group), followed by talks on topics such as 'Making sure to hear the every patient's voice' by Clare Mcgee, a senior practitioner at the Child and Adolescent Mental Health Service s, and the 'Critical contribution of learning disability nurse' by Maurice Devine, assistant head of the HSC Clinical Education Centre.

The officers of the RNID Section agreed that the career pathways and full development of the learning disability nurse's role in Northern Ireland should be mirrored in the Republic of Ireland by the RNID and allied professionals, to create a person-centred approach in providing services for person with intellectual disability ensuring highest quality of care.

-Ailish Byrne, chairperson
RNID Section

Education and networking top TT conference agenda

MORE than 75 triage nurses met for their annual conference in Portlaoise at the end of September. The topics covered included headaches and migraines, domestic abuse, pyrexia, vomiting and diarrhoea, flu management, epilepsy and legal updates.

The conference provided a great opportunity for nurses working in the out-of-hours setting to network and gather for CPD education updates. The conference carried five NMBI CEUs and all delegates had their on-line professional portfolios updated accordingly.

The speakers received very positive feedback, with the majority of delegates feeling that they exceeded or met their expectations. We received some really useful feedback from those attending on possible topics for next year, ranging from child protection, to gastro conditions, to psoriasis, to spinal first aid.

All these suggestions, and more, will be considered at the next meeting of the telephone triage section which is set to take place on Wednesday, January 24, in the Midland Park Hotel, Portlaoise at 11am. All members are welcome to attend.

Pictured at the TT Section's annual conference in Portlaoise were: *Hazel James, TT Section; Kathleen Mooney, speaker; Noelle Collingwood, speaker; Dr Orla O'Leary, speaker, Martina Harkin-Kelly, INMO president; Carmel Murphy, TT Section; Ger Byrne, TT Section; Breege Clarke, TT Section; and Esther Tomkins, speaker*

EFN assembly told of roadmap for new directive

Elizabeth Adams reports from the 106th general assembly of the European Federation of Nurses Associations in Brussels

THE European Federation of Nurses Associations (EFN), former Standing Committee of Nurses of the European Union (PCN) held its 106th general assembly in Brussels on October 12 and 13. With over 70 participants, the INMO was represented by myself as director of professional development and Edward Mathews, director of regulation and social policy.

Established in 1971, the EFN represents over three million nurses across 36 European countries represented by National Nursing Associations. The EFN is the independent voice of the nursing profession at European level (further information is available at: **http://www.efnweb.be**).

The INMO has been a member of the EFN since its inception. The EFN is an important international organisation representing nurses and nursing concerns across wider Europe. There are a number of significant projects and policy developments that the INMO is central to due to being a member of EFN.

Issues concerning health, patient care, mobility of health professionals, education, terms and conditions, working environments, technology and health funding continue to be central to the European Union debate and the culmination of these debates result in legislation which all member states have to implement. It is therefore imperative that the EFN, in representing 36 EU countries' national nursing associations, is strengthened and empowered to influence the EU political agenda, particularly in the current economic climate.

Member associations shared information regarding the effects of the economic crisis on healthcare. The impact has led to the closure of hospital units and other healthcare facilities, reduced salaries, deteriorating conditions of employment, reduced number of health professionals, particularly nurses, increasing workload and consequent uncertainty about the quality and safety of healthcare delivery.

This exchange of information is essential to the strategic policy and lobbying activities of EFN, in portraying the difficulties facing nurses in providing a safe and quality service and the inequalities of citizens in regard to nursing services in the EU.

Update on the Proportionality Directive

The European Commission, Martin Frohn, head of unit, DG GROW and Alma Basokaite presented to the general assembly on one of the most significant and currently relevant topic items, the Proportionality Directive. DG GROW develops and carries out the Commission's policies on the single market and business and industry. DG GROW, through Mr Frohn and Ms Basokaite, has a very positive relationship with EFN.

As part of the roadmap set out in the single market strategy, the European Commission proposed several initiatives aiming to simplify procedures for cross-border service providers and to subject regulation in the services to EU scrutiny. The European Commission published a *Proposal for a Directive of the European Parliament and of the Council on a proportionality test before adoption of new regulation of professions* in early 2017.

According to Mr Frohn, there are 47 million professionals regulated which accounts for 22% of EU total employment. The Commission estimated that through improvements in professional regulation there is a potential job creation of 700,000 approximately. The EFN general assembly was informed by Mr Frohn of the extensive consultation and discussions undertaken by the Commission with several hundred stakeholders on the proposed Directive, and a proportionality test has been developed.

The key features of the proposed proportionality test are informed by European Court of Justice rulings. The criteria are based on existing case law, so there is nothing new being introduced in that regard. It simply asks member states to do this assessment consistently and transparently. This is a methodology that incorporates a tool and a process of evaluation, it does not dictate the outcome.

It ensures the assessment is done in a systematic, inclusive and transparent manner. Any proposed regulation change or new initiative will need to be underpinned by the public interest objective and purely economic reasons are not adequate justifications.

The Commission, in working with member states, identified the variation in national practices and regulations regarding the implementation of Directive 55. In some member states there is evidence of over-regulation, and in others of under-regulation. Identification of risk also varied, in relation to the effects of such regulation on professional practice and quality of care.

Since the variation in regulations across the EU potentially obstructs free movement of health providers, the provision of the Treaty on the Functioning of the European Union (TFEU 2012), on the freedom of establishment or freedom to provide services may apply. Given the role of health professionals in protecting human life and health, they have been singled out in the Treaty for special treatment. Therefore, Article 53 (2) of the TFEU specifies that "in the case of medical and allied pharmaceutical professions, the progressive abolition of restrictions shall be dependent upon coordination of the conditions for their exercise in the various member states".

The EU has already established a regulatory framework guaranteeing minimum qualifications to be met by health care professionals (Directive 2005/36/EC on the recognition of professional qualifications). The proposed Directive sits in the policy context of Directive 55, which is focused on high quality healthcare and patient safety, therefore, it is important to ensure regulation is fit for purpose.

The draft Proportionality Directive for European professionals, such as nurses, midwives, dentists, doctors and pharmacists on proposed proportionality tests, aims to make it easier for companies and professionals to provide services across the European Union.

Member states must provide evidence that measures are necessary to protect a public interest objective and that they do not exceed what is necessary to attain this objective. The regulations referred to in the proposal include the following issues: continuous professional development; language knowledge; reserving specific activities for professionals with a particular professional title; rules relating to the organisation of the profession and professional ethics, registration or authorisation schemes and requirements limiting the number of authorisations to practice.

EFN Executive Committee 2017-2019 *Pictured (l-r) were: Paul de Raeve, EFN secretary general; Janet Davies, RCN (UK); Roswitha Koch (Switzerland); Elizabeth Adams, EFN president (INMO, Ireland); Milka Vasileva, EFN treasurer, (Bulgaria); Jana Slováková(Slovakia); and Veronica Di Cara, (Czech Republic)*

European Commission at EFN: *Pictured (l-r) were: Elizabeth Adams, EFN president (INMO, Ireland); Alma Basokaite, DG GROW European Commission; Paul de Raeve, EFN secretary general; Marianne Sipilä, former president (Finland); and Martin Frohn, head of unit, DG GROW, European Commission*

The package of measures includes a proposal for a Directive on a proportionality assessment of the rules of competent authorities. The European Commission has stated that regulation is often warranted for a number of professions, for example, those linked with health and safety, but that there are many cases where unnecessarily burdensome rules can make it difficult for qualified candidates to access jobs.

The European Commission has confirmed that it does not regulate or deregulate professions – this remains a national prerogative of member states. However, unlike EU law, a member state needs to establish whether new national professional requirements are necessary and balanced. The draft Directive would compel competent authorities to undertake a proportionality test before adopting or amending any legislation. There is no exemption for regulators in the field of health or patient safety. Member states would then have to assess the proportionality of the proposed measure and inform relevant stakeholders before the new legislation could be adopted. The draft Directive continues to be discussed with MEPs and member states.

Elizabeth Adams is INMO director of professional development and the Richmond Education and Event Centre

INMO's Elizabeth Adams elected as EFN president

AT THE European Federation of Nurses Associations general assembly last month, Elizabeth Adams, INMO director of professional development, was elected as the federation's new president with over 90% of the votes from 36 member countries (with 100% of the membership voting).

With extensive international experience working in various senior positions across the world, the general assembly recognised Ms Adam's strategic expertise and track record in delivering excellence for nurses and midwives. *See news page 18* for more details of Ms Adam's appointment.

Become the best leader that you can be

Mary Leahy reports from a recent conference on how compassionate and effective leaders make a difference in the health service

"IF WE get it right for staff, we get it right for patients" were welcome words from Rosarri Mannion, HSE national director of HR, as she addressed participants at the HR in Health conference, *The compassionate and effective leader – making a difference*, recently.

I am confident that every nurse and midwife, having endured an extremely challenging decade in the workplace, will relate positively to these words.

These were certainly not the only welcome words on the day, as HSE director general Tony O'Brien, in his opening address, acknowledged the "self harm and self vandalisation that occurred in our health service throughout the hardship years of recession".

Mr O'Brien acknowledged that experienced leaders were incentivised to leave while others were acting up reluctantly, without support, recognition or remuneration. Nurses and midwives will especially relate to the profound damage and regression that our professions sustained throughout the unmanaged exodus and subsequent moratorium, which negatively impacted our ability to provide compassionate care or leadership.

The need for dramatic change within our health service has now been recognised and acted on by HSE HR, with the very welcome introduction of the Leadership Academy. The Leadership Academy promises to develop the type of leadership that our patients, carers, communities and staff deserve by supporting leaders at every level and across every sector in healthcare.

Leading Care 1 (Diploma) and Leading Care 11 (Masters) are the first in a suite of programmes that will be offered to staff through the Leadership Academy. Mr O'Brien also alluded to the soon to be published First National Patient Experience Survey and said that the results of the survey will be an important narrative in how we deliver services going forward.

One of the keynote speakers, Judith Glaser, focused on the theme, *'How great leaders build trust and get extraordinary results'*. Ms Glaser, an organisational anthropologist, has been listed in the top 10 consultants globally in the Excellence Top 100 Consultants and is one of the Top 100 Thought Leaders globally on the subject of leadership. She is a best-selling author of seven business books and a world leading authority on conversational intelligence.

She said 'trust' lies in the prefrontal cortex of the brain while 'distrust' lies in the primitive lower brain. We all toddle back and forth between trust and mistrust depending on the conversation we are having. The more we trust, the more oxytocin is produced and the more beautiful we feel. This possibly accounts for why nurses and midwives haven't been feeling too 'beautiful' throughout this past decade! Buckminster Fuller, inventor and visionary, was aptly quoted: "You never change things by fighting the existing reality. To change something, build a new model that makes the existing model obsolete".

Ms Glaser affirmed that leadership is not about having power and pushing it down on others, but is about having power *with* others. "It is all about conversational intelligence… listen to connect, not judge or reject." In advocating for compassionate leadership, she said that compassion takes us to a higher level within the brain than empathy. Caring, compassion and concern for other people increases oxytocin – the feel good hormone. Exciting new research where oxytocin spray is allowing children with autism to 'cross the bridge' was referenced. Heartmath, Heart-Brain communication was also discussed and Ms Glaser said that the heart sends far more information to the brain than the brain sends to the heart. When we distrust, we see reality through threats and fear and close down. Trust on the other hand allows us to see clearly and engage openly.

The second keynote speaker, Chris Roebuck, spoke about optimising patient care through compassion and effective leadership. With his research showing that current leadership is broken, he developed a new approach I-Care Leadership, where leaders use a more humane leadership style that is proven to inspire and unleash hidden potential that is otherwise wasted.

At the recent HR in Health conference were (l-r): Mary Leahy, INMO first vice-president; Valerie Madigan, HSE HR manager, Bray, and Madeline Spiers, INMO past-president

Mr Roebuck has worked with many organisations across the world, including the NHS. He made a particularly relevant point that has been argued by nurses/midwives time and time again, "successful compassion requires *time* to deliver"… *Time* is required to deliver compassion".

Aspirations to deliver compassionate care will be realistically realised when nurses and midwives are afforded sufficient time to carry out the professional role that they are educated to do.

Members will be more than aware that our current determination to realise this time will be directed through the Public Service Pay Commission. It is our expectation that this Pay Commission will address pay disparity, which in turn will positively influence recruitment and retention, which in turn will provide us with the time to deliver compassionate care.

The Leadership Academy is a welcome and innovative move and HSE HR is to be commended for this initiative. I would encourage nurses and midwives to consider undertaking a programme through the Health Service Leadership Academy that will assist you in becoming the best leader that you can be (**see www.hse.ie**).

Mary Leahy is first vice president of the INMO

Q and A Bulletin Board

With INMO director of industrial relations Tony Fitzpatrick

Query from member

I am currently working in the public health service. I applied for a career break but have been refused. I am considering resigning as a result. How will this affect my pension?

Reply

A career break is an opportunity to take unpaid leave for an agreed period. All nurses and midwives who have satisfactorily completed their probationary period may be granted a career break for a minimum period of one year and a maximum period of five years. Career breaks may be availed of for domestic reasons, education and to travel abroad. Time spent on career break does not count as service for any purpose.

An employee on a career break is required to give at least three months' notice of their intention to either extend their career break or to resume duty.

"In the event that a suitable fillable vacancy does not arise in the employing agency on the termination of the period of the career break, staff are guaranteed re-employment within the public health services within 12 months of the date which had been notified to the desired date of termination of the career break." (Department of Health Circular S146/99, dated August 1987)

However, if you resign from your employment for a period of more than 26 weeks then this is regarded as a break in service. If you return to the public health service you will enter into the Single Public Service pension scheme. What you have already contributed to your defined benefit scheme will be preserved. Therefore, I advise that you talk to your director again seeking that they grant the career break scheme to you. This would be mutually beneficial as it ensures the service retains you at a time of severe nursing shortage and have a job to return to while retaining your pre-2013 pension scheme.

Query from member

I currently work in ICU and I am in receipt of the location allowance. I have now obtained my higher diploma in intensive care nursing. Does this entitle me to the payment of both allowances, the location and now the qualification allowance?

Reply

The answer to your question is, no, you are not entitled to receive two allowances. Location allowances are valued at €1,858 and this applies to registered nurses employed on duties in specific locations. These locations are listed on the INMO website **https://inmo.ie/salary_information**. However, registered nurses employed on duties in specialist areas, with the appropriate category 2 qualification are entitled to receive a qualification allowance. As you can only receive one allowance, you would receive the higher of the two allowances, which would, in this case, be the qualification allowance. The qualification allowance is worth €2,791. Therefore, a staff nurse working in ICU would receive a location allowance if they did not have the category 2 qualification relevant to that area. Once you receive the category two qualification relevant to that area, you should notify the HR department/salaries department to ensure you are then paid the qualification allowance, which would be higher than the location allowance. Once you are in receipt of the qualification allowance, the payment of the location allowance to you would cease.

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

Quality & Safety

A column by Maureen Flynn

Improvement knowledge and skills guide

THIS month our column focuses on a new resource, developed by the HSE Quality Improvement Division called the improvement knowledge and skills guide.

The guide is a developmental assessment tool that can help nurses and midwives to self assess their current knowledge and skills in improvement and identify areas for learning and development for current or future roles. The overall aim of the guide is to support ongoing learning and professional development of all staff by providing an inventory of improvement knowledge and skills on how to deliver improvement in the health service.

Using the guide

The improvement knowledge and skills are structured around the six drivers of the Framework for Improving Quality (HSE 2016). The six drivers are required to successfully implement and sustain improvement in healthcare. It is the combined force of drivers working together that creates the environment and acceleration for improvement (*see Figure 1*).

The learning and development journey in improvement for everyone working in the Irish health service is illustrated in *Figure 2*. The improvement knowledge and skills apply to four levels: (i) everyone; (ii) improvement team; (iii) improvement champion; and (iv) improvement advisor. Your manager, clinical team lead or colleague may support you in assessing your knowledge and skills for improvement and in planning your learning and development needs as you progress along your journey.

An embedded development assessment tool and scale to assess your learning and development needs are incorporated. You decide which applies (*see Box*).

At the end of each section there is a space called 'Areas I require development in' to note actions that may be included within an action plan or personal development plan. This helps in the identification of HSE or external resources, education and training courses that best meets your development needs. To aid your learning and development, many of the knowledge and skills listed have active links to resources which will provide you with more information

Development assessment tool

Confident: I feel confident about my knowledge and skills in this area
Consider:
- I understand and know the knowledge and skill
- I can give an example of when I successfully applied the knowledge and skill

Some development: I require some development in my knowledge and skills in this area
Consider:
- A knowledge and skill that needs strengthening

A lot of development: I require a lot of development in my knowledge and skills in this area
Consider:
- I don't understand or know the knowledge and skill
- I can't give an example of when I successfully applied the knowledge and skill

Benefits

There are a number of potential uses of the guide, to:
- Assess yourself against the knowledge and skills listed to identify areas for development
- Identify resources, tools, education and training programmes that would support your knowledge and skills development and your personal development plan
- Use in conjunction with performance achievement to identify continuous professional development objectives
- Become skilled and proficient in improvement

Get involved

The guide is accessible at http://hse.ie/eng/about/Who/QID/Improvement-Knowledge-and-SkillsGuide. If you are interested in using or championing the guide within your area please contact us by email to: nationalqid@hse.ie or see www.qualityimprovement.ie for more information.

Figure 1: Framework for improving quality

Figure 2: Learning and development journey in improvement

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

Acknowledgements
Thank you to Paul Marley, Paul Rafferty and Dr Mary Browne and the Quality Improvement Division teams for making this guide available and sharing information. We would also like to thank members of both the steering and advisory groups for their valued input during the design and development process

Student reps get organised

INMO organiser **Albert Murphy** focuses on recent rep training courses held in HQ and in Donegal

THE first ever INMO industrial relations training course held specifically for student and new graduate reps took place in September. Such was the demand for the training that the INMO organised two back to back courses in HQ.

In addition to the normal course content which was provided, the reps were given training in relation to trade union democracy and also on the role of the student rep.

The student reps also took the opportunity to visit the INMO library in HQ, which is the largest nursing library in Ireland. Head librarian Niamh Adams showed the students around the library and signed them up to both the library and to the INMO's online library for nurses and midwives, **nurse2nurse.ie**

During the course two of the participants, Tara Moran and Aisling Byrne, received their final exam results and they were absolutely over the moon. The INMO wishes them every success in their future nursing careers.

The student reps were also given a tour of the media facilities in HQ.

At the INMO training course for student reps held at HQ (day 1) were *(back, l-r): Tara Moran, Yewande Ogunnaike , Liam Conway, INMO Student and New Graduate Officer, Diana DeCadogan, Anthony Mullins, Mary Olabode, Albert Murphy, INMO Industrial Relations Officer; (front): Dave Hughes, INMO deputy general secretary; Claire Kane, Beibhinn Ryan, Aisling Byrne, Liam Doran, INMO general secretary*

At the INMO training course for student reps held at HQ (day 2) were *(l-r): Albert Murphy, INMO Industrial Relations Officer, Cliona Gildea, Aaron Doyle, Mary McGovern, Emma McGorman, Nokuthula Ncube, Niamh Donohue, Liam Conway, INMO Student and New Graduate Officer*

Three in a row for Letterkenny

A rep training course was held in Letterkenny for reps from throughout the county. This was a highly successful training course and is the third year in a row that the INMO has organised rep training in Letterkenny.

INMO IRO Maura Hickey said: "The reps found the course really beneficial and empowering. Our reps are now taking action locally and I'm looking forward to offering advanced rep training in Letterkenny early next year, which will build on the training which has taken place here over the past few years."

If you are interested in becoming a rep in your workplace, or doing a refresher course if you are already a rep, see *page 20* for details and apply to Martina Dunne at martina.dunne@inmo.ie

Group Scheme competition

As part of the INMO campaign to give you greater value for your INMO subscription, members are eligible to join the INMO Group Scheme which offers a range of discounts on a wide variety of goods and services.

For the months of July, August and September a competition was held whereby anybody who signed up for Group Scheme or clicked on to the Group Scheme was entered into a draw. Five winners were drawn, each of whom have been sent their prize of a €100 gift card from the INMO Group Scheme.

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

Making sense of your payslip

Student and new graduate officer, **Liam Conway**, explains how to understand your payslip

THIS month I want to bring you through the main components of your payslip so you understand how we arrive at net pay. Payslips can vary, but all provide information about your gross earnings, gross deductions, hourly rate/ increment on the pay scale and your class of PRSI. I hope this handy guide will assist you when examining your payslip in future.

Payslips

If you are a student/graduate working in the public or private sector, your payslips will have a similar format and similar deductions. The only difference in public versus private sector payslips are the pension contributions – or the absence of same in the private sector.

You may receive your payslip electronically or on paper. Payslips are confidential documents and you should always keep them safe. Your payslip will contain certain basic information every month. You will be able to locate your PPS number, staff number and the period (week of the year of payment if paid weekly/fortnightly or monthly, eg. Period 9, September). Your grade can be displayed, eg 'staff nurse', which can be displayed in abbreviations or numbers depending on where you work. Basic rate/hourly rate will often be displayed – This is your salary, eg €28,483 on first point of scale, which can be displayed as an hourly rate of €14, and your PRSI class.

It is important to know your increment point on the scale and to keep an eye that this rises every 12 months. Your employer should automatically ensure this happens but it is important to check your payslip thoroughly every month. New graduates should ensure to check that they receive their second (graduate) increment 16 weeks after commencing work, including pre-registration time worked. It is a good idea to keep a reminder in your diary.

You can view INMO salary scales and allowances on the INMO website: **www.inmo.ie/salary_information**.

Payments

When looking at payslips, you will see that there are two sides. Payments are on the left side and then deductions are on the right.

Firstly, we will look at the left side displaying payments. The big figure will be displayed as 'salary'. If you are paid monthly your salary is divided up into 12 payments. So, for example the first point of the scale €28,483 will spread over 12 months in and around a figure of €2,374. This is your basic pay. If you are paid fortnightly then your annual salary figure is divided by 26 payments. You will find additional payments underneath this for any premium hours worked and entitled allowances.

Premium pay is displayed as follows: Sunday/Bank holiday (Double time, this is your hourly rate x 2); Saturday (Any Saturday worked entitles you to an allowance of €15.30); Unsocial hours (Time and one-sixth is paid for any hours worked between 18:00-20:00; Nights (paid at a time and one-quarter = hourly rate + one-quarter of your hourly rate); Sunday night premium can be displayed and this is double time + one-quarter of your hourly rate. This will all add up to your gross pay or total pay.

Some nurses/midwives will receive additional pay due to them qualifying for a location allowance. The location allowance entitles nurses/midwives working in a specialised area such as ED or ICU to an additional €1,858 per year. Nurses/midwives who hold a level 9 postgraduate course in a specialised area that they are working in can claim €2,791 per year. These payments will be spread out equally over your pay periods.

Deductions

Tax and PRSI

The dreaded deductions are on the right side of your payslip. Firstly, you will see tax, which everyone pays. This is calculated on your gross earnings. To examine your own tax and tax credits, have a look at our article on managing your tax at: **www.inmo.ie/New_Graduates**.

Next you will see PRSI. Again, this is mandatory. These contributions are recorded to determine future entitlements to social welfare benefits such as the state pension. The following payments depend on your PRSI contribution record and other qualifying conditions: Jobseeker's Benefit; Illness Benefit; Maternity Benefit; Adoptive Benefit; Health and Safety Benefit; Invalidity Pension; Widow's, Widower's or Surviving Civil Partner's (Contributory) Pension; Guardian's Payment (Contributory), State Pension (Contributory); Treatment Benefit; Occupational Injuries Benefit; and Carer's Benefit. You pay 4% PRSI on all your earnings.

USC: Universal Social Charge

The rate paid is based on gross earnings:

- First €12,012 – 0.5%
- Next €6,760 – 2.5%
- Next €51,272 – 5%.

However, USC itself and rates, bands may change depending on budgets.

Pension levy/PRD

The public service pension-related deduction (PRD) is a deduction from the pay of pensionable public servants. It is provided for under the terms of the Financial Emergency Measures in the Public Interest (FEMPI) Act 2009. However, this is set to be reduced and renamed as part of the new Public Service Stability Agreement in 2019.

With effect from January 1, 2016 the rates of the deduction and the bands of remuneration to which these rates apply are as follows: Pay up to €26,083 is exempt and any excess over €26,083, but not over €60,000, incurs a 10% deduction.

You can read all about the Single Service Pension Scheme and how this is calculated and what it means to you here: **www.inmo.ie/New_Graduates**.

Union fees

Finally, if you pay for your membership through salary deduction, this will be displayed as 'INMO' or 'UNION'.

If you have any issues or queries please don't hesitate to contact me. If you have any queries related to pay, please contact your payroll/salaries initially.

Liam Conway is INMO student and new graduate officer
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Infantile colic

In the latest clinical update in this continuing professional development series, **Catherine Lewis, Nina Thirlway** and **Gerry Morrow** examine the management of infantile colic

INFANTILE colic is a self-limiting condition, which can be defined as 'repeated episodes of excessive and inconsolable crying in an infant who otherwise appears to be healthy and thriving'[1] or 'episodes of irritability, fussing or crying that begin and end for no apparent reason and last at least three hours a day, at least three days a week, for at least one week, in an infant up to four months of age with no evidence of faltering growth'.[2]

The worldwide prevalence of infantile colic is estimated as occurring in 20% of all children.[3] Colic occurs equally in breastfed and bottle-fed infants, and equally in both sexes. Infantile colic usually improves by three to four months of age, and resolves by six months of age.[3]

Typically, an infant with colic presents with excessive, inconsolable crying that starts in the first weeks of life and resolves by three to four months of age. The crying most often occurs in the late afternoon or evening and the baby may draw its knees up to its abdomen or arch its back when crying.[3]

Possible causes

The cause of infantile colic is not known. Some experts suggest it may be a 'normal' pattern of infant crying. Other possible causes include:

- Abnormal gastrointestinal motility and pain 'signals' from the gut
- Inadequate amounts of *lactobacilli* and increased amounts of coliform bacteria in the intestinal microflora, which influence gut motor function and gas production
- Psychosocial factors, such as family tension, parental anxiety, inadequate parent-infant interaction, overstimulation of the infant, or misinterpretation of crying.

Complications

Possible complications of infantile colic include parental or carer stress, anxiety, depression and sleep deprivation, family tension and parent-infant attachment difficulties, premature cessation of breastfeeding, or premature weaning onto solid foods. There is also an increased risk of child maltreatment.[4,5,6]

There is conflicting evidence from small studies as to whether infants with colic are at increased risk of developing psychological, behavioural or medical problems such as allergic or functional gastrointestinal disorders in later life.[3]

Assessment

If infantile colic is suspected, the diagnosis should be made following exclusion of other possible causes of symptoms, and assessment should include taking a history and examination of both the infant and the mother.[1,4,5,6]

The questions should include asking about the onset, duration, frequency, and timing of crying episodes, change in tone or pitch of crying, and any alleviating or exacerbating factors. In addition, information about the pregnancy, any birth trauma or known medical conditions or congenital abnormalities, such as ankyloglossia (tongue-tie) or cleft lip and/or palate, which may affect breastfeeding should be recorded.[1,4,5,6]

Ask the parent about the child's birth weight, weight gain, general health and behaviour. Look for any associated red flag symptoms such as apnoeic episodes, cyanosis, respiratory distress, bile-stained or projectile vomiting, or blood in the stool, which may suggest a more serious underlying cause. Associated symptoms such as reflux, constipation, or rash may also suggest another underlying physical cause for excessive crying and distress.[1,4,5,6]

Determine the current feeding pattern – frequency, duration, night feeds –and if there are any feeding problems; ask about timing between crying and feeds; method of reconstituting formula feeds, if used, and winding technique. Check if other fluids or foods are being given, when started, quantity, and frequency. Ask about the use of a dummy or pacifier and the baby's sleeping pattern/routine.[1,4,5,6]

Determine the parental/carer history by asking about parental responses to crying, including coping strategies, and impact on the parents and family including siblings, if appropriate.

Ask if there is associated parental insomnia, stress, anxiety, depression, or postnatal depression. Discuss the parent/carer's beliefs, ideas, concerns, and expectations about infant crying, feeding, and sleep and whether they have family or other support available, including health visitor and/or social worker input. Determine if there is a family history of atopy or allergies and the alcohol and smoking history of the parents/carers.[1,4,5,6]

If breastfeeding, ask about any maternal breast and/or nipple pain, and use of nipple shields or breast shells; maternal diet, for example excessive coffee, tea, or soft drinks that contain caffeine, or excessive alcohol or spicy food.

Examination of the infant

Examine the infant for suitability of clothing to maintain appropriate body temperature. Look for signs of fever, dehydration or raised intracranial pressure. Check weight and serial measurements of weight gain or loss. Look for skin rash or signs of itch that may cause discomfort.[1,4,5,6]

Check the oral anatomy (ankyloglossia, palate, jaw, and lips), and assess for signs of oral Candida infection or nasal congestion that may affect sucking and swallowing. Assess muscle tone, neurological maturity and behaviour. Examine for signs of bruises, petechiae, or trauma which may suggest child maltreatment.[1,4,5,6]

Examination of the woman

Observe the woman's interaction with the infant and handling. If there are concerns about breastfeeding problems ensure that a person with appropriate training and expertise, such as a health visitor or breastfeeding specialist, observes the woman breastfeeding and expressing milk check the feeding technique. Be aware that signs of organic disease in infants can be non-specific. Other possible causes of excessive, inconsolable crying include:[1,4,5]

If symptoms started suddenly and recently

- Intussusception or volvulus which is suggested by bile-stained (green or yellow-green vomit), blood in the stool, and

abdominal distension, tenderness, or a palpable mass
- Pyloric stenosis which is suggested by frequent, forceful (projectile) vomiting in infants up to two months of age
- Incarcerated/strangulated hernia or torsion of the testis
- Infection or sepsis
- Corneal abrasion, such as from a scratch from the infant's nails
- Accidental trauma or child maltreatment.

If symptoms are more persistent because of discomfort from
- Hunger or dehydration.
- Excessive heat or cold.
- Skin rash or itch, for example caused by eczema, itchy clothes or clothes labels or nappy rash
- Wind, may be due to inadequate winding technique
- Constipation
- Gastro-oesophageal reflux disease (GORD)
- Cows' milk protein allergy (CMPA) or transient lactose intolerance (rare)
- Seizures, infantile spasms (rare)
- Congenital or metabolic disorders, chromosomal abnormalities (rare).

Advice and support

Reassure the parents/carers that infantile colic is a common problem that should resolve by six months of age.[1]

Advise on strategies that may help to soothe a crying infant, such as holding the baby through the crying episode, trying gentle motion, such as pushing the pram or rocking the crib, or 'white noise', for example a vacuum cleaner or hair-dryer. Bathing the infant in a warm bath may help. Ensure an optimal winding technique is used during and after feeds.[1,4,6]

Encourage parents/carers to look after their own wellbeing by asking family and friends for support, if possible. Meeting other parents/carers with babies of the same age, can help to share experiences and access peer support. Advise the parents/carers to rest when the baby is asleep and to put the baby down in a safe place, such as their cot, if they feel unable to cope with the crying for a few minutes, to allow 'time out'. If the mother is breastfeeding, encourage her to continue wherever possible. Arrange for follow-up of the infant and family, depending on clinical judgement.[1,4,6]

Do not recommend the following management strategies, as there is insufficient good-quality evidence for their use:[4]
- Simeticone or lactase drops
- Maternal diet modification if breastfeeding, or changing the infant milk formula preparation
- Probiotic supplements
- Herbal supplements
- Manipulative strategies, such as spinal manipulation or cranial osteopathy.

If symptoms are severe or persist after four months, consider an alternative underlying cause for symptoms.

Seek specialist advice from a paediatrician or arrange referral, depending on clinical judgement, if parents/carers feel unable to cope with the infant's symptoms despite reassurance and advice in primary care, the infant is not thriving, or symptoms are not starting to improve or are worsening after four months of age, or there is a suspected underlying cause for symptoms that cannot be managed in primary care.

Provide sources of information and support, such as a public health nurse. Information from the HSE is available at: **www.hse.ie/eng/health/az/C/Colic/Symptoms-of-colic.html** and a UK-based self-help support group called Cry-sis is available for families with excessively crying or sleepless children: **www.cry-sis.org.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. Colic is defined as:
A) Episodes of irritability, fussing, or crying no apparent reason which last at least one hour a day, at least one day a week, for at least one week
B) Any cause of crying in a baby
C) Episodes of irritability, fussing, or crying no apparent reason which last at least three hours a day, at least three days a week, for at least one week
D) Sudden episodes of crying in an infant over six months of age

2. Colic occurs:
A) More in breastfed babies
B) More in bottle-fed babies
C) Equally in breastfed and bottle-fed babies

3. 'Infants with colic are at increased risk of developing psychological, behavioural or medical problems such as allergic or functional gastrointestinal disorders in later life'. True or false?
A) True
B) Uncertain
C) False

4. Other causes of excessive crying include:
A) Torsion of the testicles
B) Excessive heat/cold
C) Infection
D) Corneal abrasion

5. Strategies which may help to soothe a crying infant include:
A) Gentle motion
B) White noise
C) Warm baths
D) Herbal supplements

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**

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

Preventing pneumococcal infection

Pneumococcal disease is largely preventable by optimal use of vaccination programmes, especially for those at high risk, writes **Ruth Morrow**

PNEUMOCOCCAL disease is a bacterial infection caused by streptococcus pneumoniae of which there are more than 90 strains. The organism is commonly found in the respiratory airway of healthy individuals.[1] The incidence and burden of pneumococcal disease have been significantly reduced since the introduction of the pneumococcal conjugate vaccine in the national immunisation programme in 2008.[1]

Transmission

It is estimated that the pneumococcus bacteria is carried in 10% of adults to 50% of children attending day care facilities. Transmission is from person to person, usually by respiratory droplet infection , but may be spread by direct oral contact or indirectly through articles contaminated with respiratory secretions. The *S. pneumoniae* bacteria are spread through contact between those who are ill or who carry the bacteria in their throat wh0 are often asymptomatic. The incubation period varies by the type of infection and can be as short as one to three days.[3]

High risk groups

The very young and the very elderly are most at risk of pneumococcal infections. Those with the following conditions are particularly vulnerable and the National Immunisation Advisory Committee (NIAC) recommends pneumococcal vaccines to the following individuals:

- Persons 65 years of age or older
- Children under five years of age
- Asplenia (no spleen) or severe dysfunction of the spleen, including surgical splenectomy
- Chronic renal disease or nephrotic syndrome
- Chronic heart, lung or liver disease, including cirrhosis
- Diabetes mellitus
- Sickle cell disease
- Weakened immunity (due to disease or treatment)
- Complement deficiency
- Patients with CSF leaks, either congenital or complicating skull fracture or neurosurgery
- Individuals with cochlear implants
- Smokers and alcoholics
- Individuals with occupational exposure to metal fumes (ie. welders).

Prevention and vaccination

The most common strains *S. pneumonia* can be prevented by vaccination. Some strains which are not covered by the vaccines will occur despite vaccination. Vaccination is recommended for those most at risk of disease (*Table 1*). Previous pneumococcal infection does not protect individuals from future infection and therefore, vaccination is still recommended for children and adults who have a history of pneumococcal disease.

Pneumococcal vaccines

There are two different types of pneumococcal vaccines:

- Pneumococcal Polysaccharide Vaccine (PPV23). This incorporates 23 of the most common capsular types which account for up to 90% of all serious pneumococcal infections. It is only suitable for use in those two years of age or older as there is an inadequate antibody response in children under two years of age
- Pneumococcal Conjugate Vaccines (PCV 7, 10 and 13) contain polysaccharide antigens from 7, 10 or 13 serotypes conjugated to a protein (*see Figure 1 for details on which serotypes are contained in each vaccine*). These vaccines provide protection against 75-90% of serotypes causing invasive disease, including a significant number of penicillin-resistant strains. The number of doses required for optimum immune response depends on the age at which the vaccine is given.

Figure 1: Serotypes covered by the different vaccines

The following serotypes are contained in pneumococcal vaccines	
PCV7	4, 6B, 9V, 14, 18C, 19F, 23F
PCV10	1, 4, 5, 6B, 7F, 9V, 14 18C, 19F, 23F
PCV13	1, 3, 4, 5, 6A, 6B, 7F, 9V, 14, 18C, 19A, 19F, 23F
PPV23	1, 2, 3, 4, 5, 6B, 7F, 8, 9N, 9V, 10A, 11A, 12F, 14, 15B, 17F, 18C, 19A, 19F, 20, 22F, 23F, 33F

Recent changes in vaccines used in childhood immunisation programme

In 2002, PCV7 was introduced for at risk children. In September 2008, PCV7 was recommended for all infants, along with a catch up programme for all children under two years of age. In December 2010, PCV13 vaccine replaced PCV7 in the Irish childhood immunisation programme. In 2013, NIAC recommended the use of PCV vaccination for older children and adults at high risk of invasive pneumococcal disease (*see Table 1*).

Pneumococcal vaccines and babies

Two doses of the pneumococcal conjugate vaccine are recommended in infants

less than one year of age. The doses are given at the ages of two and six months with a booster at 12 months of age. In December 2016, the introduction of Men B vaccine in to routine immunisation the third dose of PCV 13 was shifted from 12 months of age to 13 months of age for children born on or after October 1, 2016. Some children are at particularly high risk of pneumococcal infection (see conditions listed above) and it may be recommended either additional doses of either the PCV13 and/or the polysaccharide vaccine (PPV23) to provide broader protection.

Booster doses of the PPV23

The Pneumococcal Polysaccharide Vaccine (PPV23) is recommended for individuals at increased risk of pneumococcal disease as previously outlined. Booster doses are not routinely recommended for immunocompromised people as there is a lack of evidence of improved immunity and an increased incidence of local side-effects after repeated doses.

In individuals whose antibody levels are likely to decline more rapidly, (eg. those with no spleen, with splenic dysfunction, and immunosuppression) one booster should be given five years after the first dose. Adults 65 years or older should receive a second dose of PPV23 if they received vaccine more than five years before and were less than 65 years of age at the time of the first dose. Those who received one dose of PPV23 at age 65 or older do not require any further dose regardless of immune status.

Clinical syndromes associated with *S. Pneumoniae*

The most common types of infections caused by *S. pneumoniae* include:

- Middle ear infections (acute otitis media), particularly common in children
- Pneumonia – the most common presentation of pneumococcal disease among adults
- Bacteraemia (blood stream infection)
- Sinus infections
- Meningitis

Clinical features

Pneumonia – abrupt onset of fever, chills or rigors, pleuritic chest pain, cough with purulent rusty sputum, dyspnoea, tachypnea, hypoxia, tachycardia, malaise and weakness. Patients may also present with nausea, vomiting and headaches. Complications of pneumococcal pneumonia include empyema, pericarditis and respiratory failure.

Bacteremia can occur without a known site of infection and is the most common invasive clinical presentation of pneumococcal infection in children two years old or younger and accounts for approximately 12-16% of invasive pneumococcal disease in children in this age group.[3]

Meningitis – clinical features include headache, lethargy, vomiting, irritability, fever, nuchal rigidity, cranial nerve signs, seizures and coma. The mortality rate is approximately 8% in children and 22% among adults. Neurological sequelae are common after infection.[3] Acute otitis media – pneumococci are a common cause of acute otitis media and are detected in 28-55% of middle ear aspirates.[3] Complications of pneumococcal otitis media include mastoiditis and meningitis.

Diagnosis and medical management

A definitive diagnosis of infection relies on isolation of the organism from blood or other sterile body sites.

Pneumococcal disease is treated with a broad-spectrum antibiotic. In recent years many pneumococci have become resistant to some of the antibiotics used to treat pneumococcal infections. In 2014, 17% of samples tested by the National Pneumococcal Reference Laboratory were non-susceptible to penicillin. Pneumococcal disease is a notifiable disease.

In summary, this article has focused on the transmission, high risk groups, prevention, vaccination, clinical features and treatment of pneumococcal disease. Pneumococcal disease is largely preventable through optimising vaccination programmes. Vaccination programmes have been developed and implemented to ensure access to vaccination for all those at high risk, namely the very young and the older population.

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Table 1: Recommendations for pneumococcal vaccination[1]

Group A Those at high risk	Group B Children at medium risk	Group C Adults at medium risk
• Asplenia, hyposplenia (including splenectomy, sickle cell disease, haemoglobinopathies, and coeliac disease)[1] • Complement deficiency (particularly C1-C4) • Immunosuppressive conditions (eg. some B- and T-cell disorders, HIV infection, leukaemia, lymphoma,) and those receiving immunosuppressive therapies[2] • CSF leaks (congenital or complicating skull fracture or neurosurgery) • Intracranial shunt • Candidates for, or recipients of, a cochlear implant • Post haematopoietic stem-cell transplant • Solid organ transplant	• Chronic renal disease or nephrotic syndrome • Chronic heart, lung, or liver disease • Diabetes mellitus requiring insulin or oral hypoglycaemic drugs • Down syndrome • Children under five years of age following invasive pneumococcal disease	• Chronic renal disease or nephrotic syndrome • Chronic heart, lung, or liver disease • Diabetes mellitus requiring insulin or oral hypoglycaemic drugs • Smokers and alcoholics • Individuals with occupational exposure to metal fumes (ie. welders)
Vaccines recommended by age group and risk group		
Group A Those at high risk	**Group B Children at medium risk**	**Group C Adults at medium risk**
Children 2 to <5 years: PCV and PPV23 Children 5 to <18 years: PCV and PPV23 Adults ≥ 18 years: PCV and PPV23	Children 2 to <5 years: PCV and PPV23 Children 5 to <18 years: PPV23	Adults: PCV and PPV23

1 Require two doses of PCV two months apart
2 Individuals with primary immunodeficiency may have a suboptimal response to all vaccines. Pneumococcal vaccines are unlikely to be immunogenic in children with primary immune deficiencies involving significant B cell compromise who are receiving regular IVIG replacement therapy. However vaccination should be given as it may have some effect.

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Diabetes: the right approach

Audits show that a structured multifactorial approach to diabetes is the right care model

OPTIMAL management of type 2 diabetes needs an organised integrated primary/secondary care approach, which is far removed from the traditional opportunistic, episodic and largely hospital-based care model. The preferred approach encompasses patient registration, recall and regular review, protected time and adhering to a standard care protocol.

A pioneer of the preferred approach has been the Midland Structured Care Diabetes Programme, which was introduced in 1998 for patients in Longford, Westmeath, Laois and Offaly and led by Dr Velma Harkins. A new audit report on this programme from the HSE provides a good evidence base for the success of a structured care approach to type 2 diabetes.[1]

The audit results suggest that if a structured programme is implemented, encompassing an agreed number of visits, processes and added resources – such as nurse specialists, chiropody and dietetics – improvements can be made in the care and clinical status of people with diabetes.

While there are caveats about some of the findings, the audit overall shows that the midlands programme has demonstrated that over the past 17 years there have been significant improvements in terms of recording care processes and in achieving reductions in blood pressure, HbA1c and lipids.

The audit results tend to back up evidence that structured care, coupled with encouragement of lifestyle changes, has positive implications for morbidity and life expectancy and particularly in terms of reducing diabetes complications.

The commentary on the audit notes that while the Cycle of Care initiative is welcome, it only covers two primary care review visits per year, which is regarded as less than optimal, and at this stage does not include private patients. The midlands programme provides for three review visits per year and includes both medical card and private patients. However, the hope clearly is that the programme will help inform an eventual fully structured, comprehensive, and integrated type 2 diabetes care system nationally.

The report notes that the structured care model based almost solely in primary care can be considered as an interim between the models of 'shared care' and a formal chronic disease programme integrated within the wider health system. Such a programme sits further along the spectrum from shared care, which focuses on joint primary/secondary care, the report says.

It also points to resource deficits in terms of some of the supports available, for example, in the area of nutrition and dietetics, and indeed a decline in dietetic screening was reported in the audit, reflecting a need for proper resourcing in key areas of structured diabetes programmes.

Audit

The latest audit covers 2015/16 and it is a follow-up to three previous audits.

Patient profile

To date, 3,797 patients have been enrolled in the programme, which is delivered across 30 GP practices in the midlands. In the latest audit, 94% of patients had type 2 diabetes. The median age of patients was 68 (65 in 1999 and the majority of patients controlled their diabetes with diet and medication. There was increase in the combined approach to diabetes control involving diet, tablets and insulin among patients with type 2 between the two audits (5% increasing to 13%).

Processes of care

Process of care recording exceeded 97% for HbA1c, BP, total cholesterol and triglycerides among patients. Smoking status and BMI recording were 79% and 71% respectively. There were significant improvements in care process recording across most clinical parameters for both type 2 and type 1 diabetes. HbA1c recording remained stable over time.

Process of care recording in 2016 was comparable on HbA1c, BP and total cholesterol with the National Diabetes Audit for England and Wales 2015-16 and the Scottish Diabetes Survey of 2015. Recording of BMI and smoking status were the exception.

Prescribing

It was found that aspirin prescribing for patients with type 2 diabetes declined between 2009 and 2016 from 75% to 60%, which may reflect changes in prescribing guidance, recommending that aspirin not be given to adults with type 2 not at risk of CVD.

Screening

It was found that 76% of patients attended for annual review in 2016, a decline from 90% in 2009. Attendance at podiatry services declined from 57% to 51% and the proportion of patients with foot assessment recorded also declined, from 78% to 54%, during the same period. The proportion of patients who had a foot assessment in the previous 12 months was well below that recorded in diabetes programme audit in England and Wales (NDA). Eighty per cent of patients attended RetinaScreen or specialist eye services in the previous year, although attendance at dietetic services declined between 2009 and 2016.

Outcomes of care

- Smoking prevalence was 16% 2016 compared to 21% in 2009
- Over half of patients with type 2 diabetes were classified as obese in 2016, similar to the figure for 2006 but greater than the figure in 1999 (42%)
- In 2016, most patients achieved clinical targets in line with current national guidelines: BP ≤140/80mmHg (62%); HbA1c ≤53mmol/mol (57%); total cholesterol <4.5mmol/L (60%) and triglycerides <1.7mmol/L (65%)
- The percentage of patients with type 2 diabetes achieving a blood pressure <130/80mmHg increased significantly from 8% in 1999 to 21% in 2016. Significant increases too were seen in target attainment for total cholesterol <4.5mmol/L (23% vs 70%) and triglycerides <2.0mmol/L (46% vs 76%) over the same period
- The proportion achieving HbA1c, 6.5% has remained stable over time (38% in 1999 vs 34% in 2016
- The percentage of patients with type 2 meeting the target HbA1c ≤58mmol/mol (≤7.5%) was comparable with the NDA (66%) as was the percentage of patients meeting a total cholesterol target <5.0mmol/L. Patients with type 2 diabetes meeting the target BP ≤140/80mmHg (60%) was less than the proportion in the NDA.

Complications

The percentage of patients with retinopathy increased from 13% in 1999 to 33% in 2016, while there were significant

decreases in macrovascular and microvascular complications in patients with both type one and type 2 diabetes.

In conclusion, the audit noted that most patients in the midlands programme with type 2 diabetes achieved the updated HbA1c target of ≤7.0% (57.4%) and the proportion achieving the older target (≤6.5%) remained stable over time (34%-38%). Given the increasing age profile of the cohort and longer duration of diabetes among the enrolled patients, the fact that the proportion under the 7% target remained stable can be seen as an improvement, the audit stated.

The audit noted that among patients enrolled in the programme in 1999 who were followed up in 2016, the percentage with HbA1c less than 6.5% has decreased. This could reflect the changing age profile of these patients, making the more stringent target less feasible (a relaxed target of 8% is now considered more acceptable in older or frail adults. The audit also noted that 25.7% of patients with type 2 and over half with type one remain in the high risk category, defined according to the latest guidance as >58mmol/mol (>7.5%).

The report noted that updated BP targets were met and the CVD risk profile of the midlands patients appears to have improved over time. Improvements in LDL cholesterol and BP improvements would be expected to translate into a reduction micro and macrovascular complications and mortality, it stated.

Improvements in total cholesterol likely reflect the high level of statin prescribing in type 2 patients, the audit says.

The audit noted the reduction in smoking levels to lower than the smoking prevalence in Ireland, although the smoking rate is higher among type one diabetes patients, albeit at a reduced level since 2009.

On BMI levels, the audit found the 51.5% rate of obesity among diabetes patients was higher than the recent national estimate of an overall 23% adult obesity rate. This was obviously a cause for concern as these patients are at an increased risk of cardiovascular and cerebrovascular mortality. However, it was noted that the median BMI of the cohort remained stable between 2009 and 2016 – a positive given background national trends of rising obesity rates.

On foot care, while most type 2 patients at high or moderate risk had been referred to and attended foot services over the previous 12 months, of concern was a high proportion of patients with type 2 diabetes with high risk foot who had not been referred. While the percentage of patients with retinopathy in the midlands programme had increased over time, 61.3% of those with type 1 and 33% of those with type 2 diabetes had retinopathy detected in 2016 – much higher than the national prevalence among over 50s with type 2.

Progress

The audit noted the progress made in diabetes care in the region since its initiation in 1999. The programme is delivering care in line with national standards and compares well with UK programmes, particularly in terms of process of care recording and clinical outcome targets. It says there are some areas in need of improvement, particularly attendance at screening services. Also, BMI and smoking recording remain lower than other parameters and this requires attention.

The full report is available to read on **www.lenus.ie**

– Niall Hunter

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Changes afoot for patient radiation protection

Janet Wynne outlines the current framework for patient radiation protection and highlights how this will be affected by the new European Directive coming into Irish law in February 2018

THIS article outlines the current legislative framework and national arrangements for patient radiation protection and aims to highlight areas of practice that will be affected by the transposition of the European Basic Safety Standard Directive 2013/59[1] into Irish law in February 2018.

The Department of Health is the designated competent authority, under statutory instrument (SI) 478 (2002), for regulating medical ionising radiation in Ireland and the National Radiation Safety Committee (NRSC) is the statutory committee established under this legislation. The responsibility for patient radiation protection has been delegated to the director general of the HSE who nominates relevant experts in radiation safety to become members of the NRSC and provide advice on matters pertaining to medical ionising radiation exposure.[2]

The HSE Medical Exposure Radiation Unit (MERU) was established to regulate patient radiation protection practices in both public and private radiological facilities, and is the executive, administrative and advisory unit for the NRSC. MERU has an important national role in monitoring and trending patient radiation safety incidents, commissioning audits, producing guidance documents and representing the Department of Health at international forums.

Under the current legislation, MERU does not have the authority to compel radiological facilities to accept and implement patient safety guidelines or recommendations. However, the unit does have the authority to publish its findings.

The current legislative framework for medical ionising radiation practices in Ireland is outlined in *Figure 1*.

International Atomic Energy Agency

In 2015, at the request of the Irish government, the International Atomic Energy Agency convened an international team of safety experts to conduct a review of the Irish regulatory framework for radiation safety.[3] While largely positive, this review identified the following areas that are in need of urgent attention:

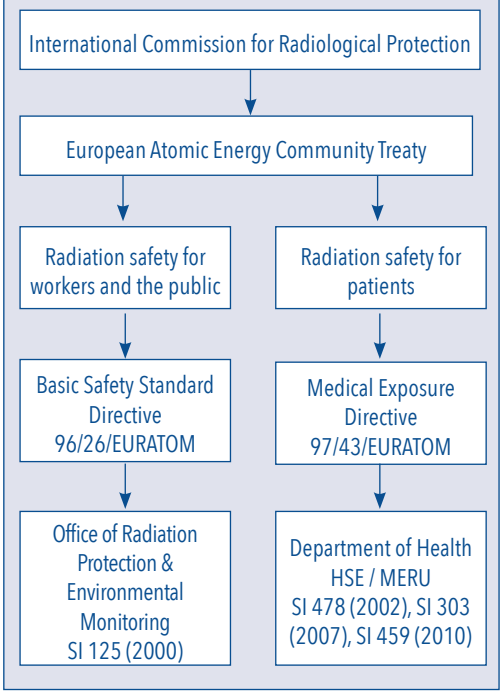
- The requirement for an effective legal framework to facilitate inspection and enforcement by the regulator to ensure patient protection
- The requirement for an independent regulatory body for patient protection which does not have responsibilities for, or interests in, providing medical ionising radiation to patients
- The requirement to ensure effective coordination between the Office of Radiation Protection and Environmental Monitoring (ORPEM) and the regulatory body for patient protection
- The requirement to establish policies and the processes on development and updating guidance documents and a code of practice for radiation safety.

These gaps in practice were accepted by the Department of Health and the forthcoming legislative changes offer a unique opportunity to address the issues raised.

The European Basic Safety Standard Directive 2013/59

In February 2018, the Medical Exposure Directive 97/43/EURATOM and the Basic Safety Standard Directive 96/26/EURATOM will be replaced by the revised European Basic Safety Standard (BSS) Directive 2013/59. This will necessitate the enactment of new Irish legislation for radiation safety. This process is being led by the Department of Environment, Community and Local Government, with assistance from the Department of Health on the patient safety aspect, and is being supported by various stakeholders including MERU, the ORPEM and the Health Information and Quality Authority (HIQA).

Figure: Current legislative framework for radiation protection in Ireland[4]



The five priorities for patient radiation protection that will be affected by the BSS Directive are: governance, justification, optimisation, education and training, and incident reporting.

Governance of patient radiation safety

Currently, the competent authority for medical ionising radiation is the Department of Health, and the HSE acts as both provider and regulator of patient radiation

safety. Agreements have been put in place between the Department of Health, the HSE and HIQA to transfer the competent authority and regulatory functions to HIQA in February 2018. This will ensure an independent regulator for patient radiation protection and it is anticipated that the new statutory instrument will give the regulator inspection and enforcement powers.

Principle of justification

Justification requires that the benefit of each procedure outweighs the possible risk caused by radiation exposure. Under current legislation, the referrer (a medical specialist, dentist or appropriately trained nurse specialist) making the referral, the practitioner accepting the referral (typically a radiologist) and the professional (usually a radiographer) undertaking the procedure have a role in the justification process.

The Medical and Dental Councils are responsible for regulating the justification process. Although the Dental Council reviews justification, the Medical Council Ionising Radiation Committee, established in 2004, is not active. Consequently, there is no formal governance structure to review generic justification, no process to assess new practices involving medical ionising radiation and no specific requirements for justifying procedures for asymptomatic individuals.

Robust governance and clear lines of accountability are required to enforce a culture of patient radiation safety. It is anticipated that the new legislation will require the roles and responsibilities of each practitioner involved in justification to be clearly defined and documented.

Principle of optimisation

Optimisation is where medical radiation exposures are kept as low as reasonably achievable to obtain the required diagnostic outcome for the patient. For patients requiring radiation therapy, exposures of target volumes are individually planned and maintained as low as reasonably achievable to be consistent with the intended radiotherapeutic purpose of the exposure.

Existing legislation relating to optimisation is clear on responsibilities and delegation in relation to practical aspects. The radiation protection adviser and/or medical physics expert have a responsibility for developing and implementing a quality assurance programme. The practitioner in charge is responsible for ensuring that the radiation dose delivered is at the lowest practicable level while achieving the optimum outcome for the patient.

However, there is no mandatory requirement for the practitioner in charge to have written records to demonstrate that advice received had been considered, approved and implemented. This is expected to be addressed in the new legislation, together with a requirement to develop specific optimisation protocols and to maintain documented records of medical exposures to patients and carers for a specified period.

In addition, it is anticipated that the forthcoming legislation will make it mandatory for the principle of optimisation to be considered in the procurement of new radiological equipment and dose monitoring software, or the upgrade of existing equipment and software.

Education and training

It is best practice, but not mandatory, that all staff working with medical ionising radiation are appropriately trained and competent in patient radiation protection. This includes staff making a referral, those responsible for maintaining radiological equipment, those who administer the radiation dose and those who assess the patient outcomes. However, there is no system to determine what an appropriate patient radiation safety training programme entails.

Currently, patient radiation protection training for medical and dental practitioners is mandatory but it does not require oversight from professional bodies or governance from employers. There is no requirement for continuous professional development for medical specialists in relation to patient radiation safety. There is no recognised patient radiation safety training programme for non-radiographers operating equipment, and chiropractors and sports scientists administer ionising radiation without being recognised under SI 478 (2002). Radiographers and nurse specialists must register with their respective professional bodies in order to practise and they must demonstrate continuous professional development. Medical physics experts can voluntarily register with a professional body, which includes a framework for continuous professional development, but this register is not recognised by the competent authority.

In the BSS Directive, there is a requirement for ongoing training and development in radiation protection. It is expected that the chief executive officer at each radiological facility will be responsible for ensuring that all staff involved in the use of medical ionising radiation are appropriately trained and competent. Documented training records may be required by the regulator. Evidence based training programmes on radiation safety may need to be agreed and developed nationally by the relevant professional bodies, in consultation with the competent authority.

Accidental exposures/incident reporting

Currently, all public and private radiological facilities report and manage patient radiation safety incidents locally and report to MERU, where appropriate. This is self regulated and MERU has no inspection or enforcement authority. The MERU Patient Radiation Protection Manual offers guidance but is not mandatory.

Under the BSS Directive, it is mandatory to report, analyse and record unintended radiation exposures in radiology, nuclear medicine and radiotherapy. The new legislation will transfer regulation to HIQA and is expected to give inspection and enforcement powers. Thus, all locations that administer medical ionising radiation to patients will be required to demonstrate compliance.

Post February 2018

Following the transposition of the BSS Directive into Irish law in February 2018, the role of the competent authority for patient radiation protection will transfer from the Department of Health to HIQA and the NRSC and MERU will be stood down. The HSE may maintain a national unit to monitor patient radiation protection practices in public facilities but this has yet to be confirmed. Almost half of all radiological locations that engage with MERU are privately managed and currently fall under the remit of the NRSC, but post transposition, this will change.

The promotion of best practice in relation to patient radiation safety and maintaining the continued delivery of a safe and effective service during this transition period, and thereafter, is essential. Engagement between the HSE, ORPEM, HIQA and the Department of Health is ongoing and will continue post transposition to ensure a smooth transition and the best outcomes for patients and those who work with medical ionising radiation.

Janet Wynne, Manager of HSE Medical Exposure Radiation Unit, Quality Assurance and Verification Division, Health Service Executive

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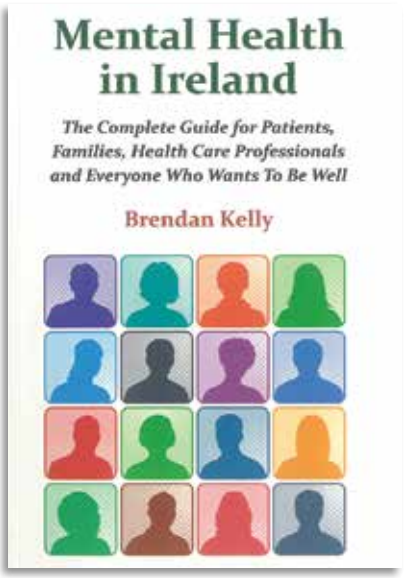
Mental health matters

ONE in four Irish people develop mental illness – why? Ireland's suicide rate has fallen steadily for the past six years – why? Suicide is more than four times more common in men than in women – why? The rate of involuntary psychiatric care in Ireland is less than 50% of that in England – why? There is still widespread stigma associated with mental illness in Ireland – how can we correct this?

Written by one of Ireland's leading psychiatrists, *Mental Health in Ireland* explores these questions.

Each year, hundreds of thousands of people attend general practitioners for mental health problems; tens of thousands attend community mental health teams; and there are over 17,000 admissions to inpatient psychiatric facilities in Ireland, of which over 2,000 are involuntary admissions under the Mental Health Act 2001.

While statistics such as these are essential for service planning, they only tell part of the story, according to the author, Brendan Kelly, who is professor of psychiatry at Trinity College Dublin and a consultant psychiatrist at Tallaght Hospital. "Behind each admission and attendance is an individual human



story, and each story affects not just one person, but a network of family, friends and colleagues, as well as the broader community."

He goes on to say that "ultimately, it is the patient who guides diagnosis and treatment. People matter most. Diagnoses matter substantially less."

Mental Health in Ireland provides a clear, authoritative overview of mental health, mental illness and mental wellbeing in Ireland. It is a clear guide to common mental illnesses, including depression, schizophrenia, bipolar disorder, anxiety, dementia, eating disorders, suicide and self-harm. For each condition, four questions are answered: What are the signs and symptoms? How common is it? What are the causes? What are the treatments?

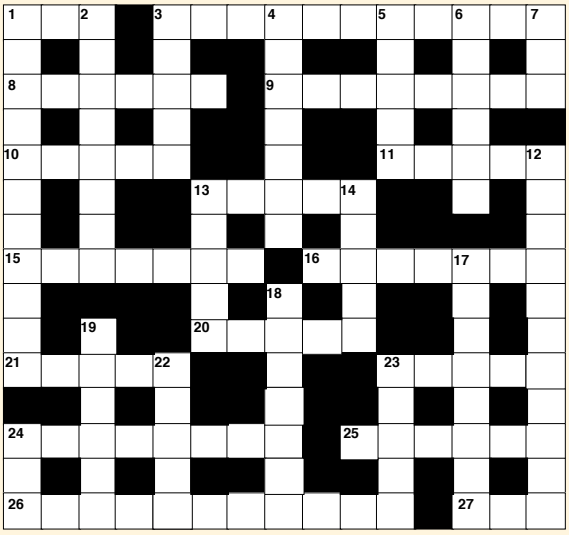
The book also explains mental health policy and services in Ireland, how to access care and community support, the rules governing involuntary care, and the underpinnings of happiness and well-being in Ireland today. The issue of suicide is also examined in detail and there is guidance on 'how to be happy'.

In clear, accessible language, *Mental Health in Ireland* offers a unique guide for patients, families, carers, mental health professionals and anyone with an interest in mental health and illness. It is intended as a pragmatic guide to mental health problems and their solutions, and is aimed at anyone who has ever felt overwhelmed by their situation, has looked at mental health services and been entirely confused by them.

Mental Health in Ireland is published by The Liffey Press (Oct 2017). Price €29.95.ISBN 978-0-9957929-1-5 (paperback)

Crossword Competition

WIN A €30 BOOK TOKEN



Across

1 Anger (3)
3 Make Batman cheer up in the waiting room (11)
8 & 20a Gibberish (6,5)
9 Powered cutting implement (5-3)
10 Sounds of astonishment (5)
11 & 14d Ireland's largest lake (5,5)
13 The Southern chessman has a mass of eggs (5)
15 Stress, anxiety (7)
16 There's space for a raincoat here in Cork, it seems (7)
20 See 8 across
21 The Umbilicus (5)
23 Name shared by cities in Scotland and Australia (5)
24 To put a broken gun in the middle of showy jewellery is so clumsy! (8)
25 Rodent kept as a pet (6)
26 That sour teacher may be untrustworthy (11)
27 The hour of one's anticipated appearance (1.1.1.)

Down

1 The idiot ensign might suffer from this stomach problem (11)
2 Liquid preparation or type of paint (8)
3 Book of maps (5)
4 & 24d Betteb, as you might place with a bookie (4-3,3)
5. Spirit in Shakespeare's Tempest, or Disney's Little Mermaid (5)
6. Thick, creamy shellfish soup (6)
7 Uncooked (3)
12 Oil him a heap to shift this bloody disease! (11)
13 Berate (5)
14 See 11 across
17 Bale rope problem? Surgery may help (8)
18 Reel, walk unsurely (7)
19 Take retribution (6)
22 Shade of purple, or a flower (5)
23 They write in verse of the making of pesto (5)
24 See 4 down

Name: .....
Address: .....
.....
.....

The prize will go to the first correct entry opened.
Closing date: Thursday, November 30, 2016
Post your entry to: Crossword Competition, WIN, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Co Dublin

Solutions to October crossword:

Across:
1 Hop 3 Gingerbread 8 Leered
9 Uncouple 10 Troon 11 Moose
15 Formula 16 Panacea 20 Drone
21 Tryst 23 Hyena 24 Stagnant
25 Skills 26 Gatecrashed 27 Wed

Down
1 Hold the fort 2 Premolar
3 Green 4 Gruyere 5 Broom
6 Employ 7 Due 12 Embarrassed
13 Piled 14 Spare parts
17 Coleslaw 18 Colitis 19 Tyrant
22 Tunic 23 Hired 24 Sag

The winner of the October crossword is: Chris Roche Fermoy Co Cork

What does Budget 2018 mean for you?

Ivan Ahern outlines the key changes to your income following Budget 2018

This short guide to Budget 2018 and what it means for nurses and midwives, as a public sector employees, has been created by Cornmarket.

The key changes include:

- USC rates for lower to middle income earners to be reduced by 0.5%
- Income tax standard rate band to increase by €750
- Welfare payments to increase by €5 per week
- Pension payments to increase by €5 per week

Budget highlights

USC

- €0-€12,012 @ 0.5% (remains at 0.5%)
- €12,012-€19,372 @ 2% (cut from 2.5% and ceiling raised from €18,773 to €19,372)
- €19,372-€70,044 @ 4.75% (cut from 5%)
- Medical card holders and people aged 70 and over whose total income does not exceed €60,000 will now pay a maximum USC rate of 2% (cut from 2.5%).

Income tax

There has been an increase of €750 in the income tax standard rate band for all earners from €33,800 to €34,550 for single individuals, and from €42,800 to €43,550 for married, single-income couples.

Home carer tax credit

Budget 2018 introduced an increase in the home carer tax credit from €1,100 to €1,200.

Self-employed

An increase in the earned income credit from €950 to €1,150 will be applied.

Mortgage interest relief

There will be a scaled back extension of mortgage interest relief for owner-occupiers who took out qualifying mortgages between 2004 and 2012 – 75% of the existing relief continued into 2018, 50% into 2019 and 25% into 2020. The relief will cease from 2021.

Rented residential property

Deduction for pre-letting expenses on a property that has been vacant for 12 months or more, up to a maximum of €5,000 per property.

Social welfare

- Welfare payments up by €5 per week
- Christmas bonus payment of 85% to remain.

Medical prescriptions

- Prescription charges reduced by 50 cents for all medical card holders under 70 (cut from €2.50 to €2)
- Maximum monthly prescription charge cut from €25 to €20
- Threshold for the Drugs Payment Scheme reduced from €144 to €134.

Other

- Cigarettes – up by 50 cents per packet
- Sugar tax – a new tax of 30 cents per litre on drinks with more than 8gms of sugar/100ml
- Benefit-in-kind on electric vehicles at 0% for one year.

Economy and jobs

- 9% VAT rate for tourism and hospitality industry to remain
- 12.5% corporation tax rate to remain
- €300 million Brexit loan scheme for SMEs
- Public service employment:
  - 800 additional gardaí and 500 additional civilian members
  - 1,280 new teachers and 1,000 new special needs assistants
  - 1,800 additional staff in frontline services across acute, mental health, disability, primary and community care sectors.

Examples of Increase in disposable income per annum

Single income household

Total income	Single, no children	Married one income, no children	Married one income, two children
€25,000	€66	€66	€66
€35,000	€241	€91	€191
€45,000	€266	€266	€366
€55,000	€291	€291	€391
€70,000	€328	€328	€428
€100,000	€328	€328	€428

Two married PAYE employees with two children

Total combined income	Increase in disposable income
€50,000	€132
€70,000	€482
€90,000	€532
€110,000	€582
€140,000	€657
€200,000	€657

Ivan Ahern is a director of Cornmarket Group Financial Services Ltd

Please note: there may be further changes to the above following the Finance Bill. Every effort has been made to ensure that the information provided here is accurate and up-to-date (October 10, 2017). The information provided is of a general nature and may not address the specific circumstances of a particular individual. Cornmarket does not accept any liability arising from any errors or omissions.

Cornmarket Group Financial Services Ltd is regulated by the Central Bank of Ireland. A member of the Irish Life Group Ltd which is part of the Great-West Lifeco Group of companies

Cornmarket consultants are highly trained experts in public sector finance. If you require additional advice on your finances following the Budget, contact Cornmarket at Tel: 01 420 6757.

500K at risk of pneumococcal disease

One in 10 of those over 65 in Ireland will die from the infection

MORE than 500,000 people age 65 and older in Ireland are at risk of getting pneumococcal disease this winter. *S. pneumoniae* bacteria can cause serious illness including meningitis, pneumonia and septicaemia. Of those who get infected, one in four will develop meningitis, one in four will develop pneumonia and one in 10 will die. Currently, 84% or more than 500,000, of over 65s are not protected against the disease.

Those aged 65 and over are at increased risk of infection, however children under the age of five and people with weakened immune systems also have a higher risk of infection. It has been estimated that 10% of adults may carry the bacteria while that figures ranges up to 50% of children attending day care facilities.

Those who are officially at-risk according to Irish immunisation guidelines include people with diabetes, asthma and heart disease, as well as those with chronic renal disease and chronic lung problems.

GP Dr Andrew Murphy, said: "It is disappointing that there are more than half a million 65-year-olds and over in Ireland who have not been vaccinated against or pneumococcal disease. A pneumo infection can cause serious illness and even result in death. We know the introduction of a nationwide vaccination programme for pneumococcal disease almost a decade ago has resulted in a 90% fall in cases. It is important to maintain that success rate and continue to protect at-risk groups.

Neil Johnson, CEO of Croí, the West of Ireland Heart Charity, said: "Winter months are a prime time for those with weakened immune systems, including people with heart disease, to catch infection that can cause serious illness. Know that you can be and should be protected against pneumococcal disease this winter."

Averil Power, CEO, Asthma Society of Ireland, said: "Prevention is better than cure and the first step towards prevention is awareness. The pneumo bug is spread like the common cold, through coughing, sneezing and by close contact, and like the common cold, it can be hard to avoid."

Dr Anna Clarke, health promotion and research manager at Diabetes Ireland, said: "We are all aware of meningitis, pneumonia and even septicaemia, but often we are not aware of one of the causes of these serious illnesses. I would urge those with diabetes to know the impact it can have on your health and wellbeing and talk to your diabetes team."

The Immunisation Guidelines for Ireland recommend that infants, official at-risk groups and everyone aged 65 years or older should be offered pneumococcal vaccination.

Flighting Blindness makes urgent call for funding of clinical genetic services for people with inherited retinal conditions

FIGHTING Blindness has urged the government to prioritise the funding of clinical genetic services, including clinical consultant geneticists and genetic counsellors, for people with inherited retinal conditions. Such funding is fundamental to the diagnosis, care and treatment of the estimated 5,000 people living with genetic sight loss in Ireland.

The call came against a backdrop of Ireland having among the lowest numbers of genetic staff per 100,000 population in Europe. As a result, current waiting lists for clinical genetic services in Ireland stretch up to 18 months and longer, meaning families affected by genetic sight loss are unable to access timely diagnosis, treatment and counselling. The lack of investment in ophthalmology services is also exemplified in latest figures from the National Treatment Purchase Fund which show that:

- Ophthalmology had the second highest in-patient/day case waiting list at 12,025 at the end of September, with one in five patients (21%) waiting more than a year
- Ophthalmology out-patient waiting list numbers climbed 21% from 31,4973 to 38,094 in the 12-month period to end September, with almost one in three (32%) waiting more than a year.

There are an estimated 225,000 people living with low vision and sight loss in Ireland, including approximately 13,000 blind people. These figures are projected to increase to 272,000 and 18,000 respectively.

Reinventing leadership tops agenda at IADNAM annual conference

THE IADNAM annual conference was a two-day event in the Galway Bay Hotel with an overall theme 'Beyond perfection – Re-inventing leadership through honest conversation and networks of peer support'.

Phil Ní Sheaghdha, INMO general secretary designate, and Elizabeth Adams, INMO director of professional development, attended the conference.

Speaking after the conference, INMO president Martina Harkin-Kelly said: "It is my firm belief that nursing and midwifery leaders hold a privileged position, as we are charged with ensuring that the core values of nursing and midwifery are not lost to the pursuit of singular goals. Talk is one thing but the true patient advocacy conversation must also involve the front-line nurse and midwife."

Last year's conference in the Radisson also carried the theme of leadership but this year's had the added dimensions of authenticity and mastering conversation.

INMO/RCM joint midwifery conference: *pictured (l-r) were: Gill Walton, RCM CEO; Breedagh Hughes, RCM director; Martina Harkin-Kelly, INMO president; Una Tubritt, assistant director of public health nursing for children and young people, Northern Ireland; Kilian McGrane, national programme director, Women and Infants Health Programme*

Keynote speakers at the conference included Dr Siobhan O'Halloran, chief nurse, Department of Health, and Mary Wynne, director of the Office of Nursing and Midwifery Services, HSE.

INMO/RCM Joint All Ireland Midwifery Conference

With over 170 delegates in attendance and the theme of 'Actions Speak Louder than Strategies' the joint All Ireland Midwifery Conference was a huge success.

Speaking at the conference in Armagh, Kilian McGrane, director of the National Women's and Infant Health Programme, emphasised importance of the National Maternity Strategy and gave assurance of the commitment to implement it. The Strategy was officially launched, on October 19 by the Health Minister Simon Harris and can be accessed at this link: **http://health.gov.ie/wp-content/uploads/2016/01/Final-version-27.01.16.pdf**

Irish breastfeeding rates increasing

Data shows age, income and nationality influence breastfeeding rate

A NEW all-island report published by the Institute of Public Health in Ireland (IPH) highlights that breastfeeding rates are increasing steadily in Ireland but the gap between North and South is getting wider. In addition, the data shows a steep decline in breastfeeding rates in the early weeks after birth.

Dr Helen McAvoy, IPH director of policy, explained that in the Republic of Ireland between 2006 and 2015, breastfeeding rates at discharge from hospital increased from 49% to 58% – a nine percentage point rise. In the same period in Northern Ireland, breastfeeding rates at discharge increased by five percentage points – from 40% to 45%.

The report – *Breastfeeding on the island of Ireland* – highlights that:

- 58% of babies in the Republic of Ireland received any breast milk at discharge from hospital
- Among all babies in the Republic in 2015, 53.7% were still receiving breast milk at first PHN visit (within 72 hours of discharge) and 35.4% at three months
- In Ireland, Irish mothers were the least likely of all nationalities to start breastfeeding.

"Rates of starting breastfeeding have increased over the island of Ireland in the last ten years although Northern Ireland was starting from a lower point than the Republic and the gap between North and South has widened. However, across the island there is a steep decline in breastfeeding in the early weeks after birth," Dr McAvoy said.

Dr McAvoy pointed out that these rates matter because breastfeeding makes a significant contribution to population health by protecting infant health and contributing to maternal health. Research published in *The Lancet*, last year, estimated that, globally, over 22,000 children's lives could be saved each year if breastfeeding maintenance was significantly increased from present levels, while 20,000 deaths from breast cancer could be prevented.

Dr McAvoy said that older mothers and those in the highest socio-economic groups were the most likely to initiate breastfeeding and to continue with it.

"Mothers from 'higher professional' and 'skilled manual workers' occupations (65.6% and 63.5% respectively) were more than twice as likely to exclusively breastfeed as mothers who are unemployed (28.6%). Likewise, breastfeeding rates among younger mothers were persistently low, so it's clear that significant inequalities persist in relation to breastfeeding initiation and duration" she said.

The report highlighted that society as a whole must continue to focus on how we create a more breastfeeding supportive environment to improve initiation and duration of breastfeeding. In this context, Dr Joanna Purdy, IPH public health policy development officer, added that breastfeeding is a collective responsibility which bestows shared rewards on our children, their mothers and wider society.

"Creating environments and communities where women feel supported and empowered to both start and maintain breastfeeding is essential. In this context, we're very much looking forward to the establishment of a working group on culture change – including experts from outside the health sector – under the HSE's Breastfeeding Action Plan and the Healthy Ireland framework."

Special Olympics 2018 needs you

THE 2018 Special Olympics Ireland Games are returning to Dublin next summer, taking place from June 14-18, 2018. Staging these will require the enthusiasm, skills, knowledge, support, and commitment of over 2,500 volunteers. Our athletes deserve the best and that's why we are asking you to help us. Special Olympics Ireland is looking for nurses who would like to be involved in the planning stage of Games as part of the medical services team. We also require registered nurses to volunteer to provide nursing support in sports and accommodation venues from June 14-17, 2018.

If you are interesting in joining the team, please visit **www.specialolympics.ie** from and click on 'Ireland Games 2018'.

New bus for Holy Cross Day Centre in Killarney with help from INMO members

Holy Cross Day Centre, Killarney: *Pictured (l-r) were: Sheila Dickson former INMO president; with community nurses Astrid Weisse; Karen Villing; and Stephanie Levan; and Sheila McGillycuddy, nurse manager on a recent visit to the day centre. The Holy Cross Day Centre was built in 2003 and provides a welcoming,warm and safe environment for the older person living in the greater Killarney area. The Centre recently took delivery of a new wheelchair accessible bus to bring clients to and from their homes to the day centre and for outings to local sights. This bus was purchased entirely from sponsorship, flag days, church gate collections and a busking festival on August bank holiday weekends over the past 10 years. The Centre is very grateful to the INMO members who donated €3,000 to the bus fund from the proceeds of the quiz held at the ADC when last held in Killarney*

National campaign highlights key benefits of breastfeeding

OCTOBER 1-7 was National Breastfeeding Week and many events took place around the country to support the *'Every breastfeed makes a difference'* campaign.

The week began with a reception hosted by Sabina Higgins in Áras an Uachtaráin on Monday October 2.

During National Breastfeeding Week, the major health and nutritional benefits for both mother and baby were celebrated. The many social and financial benefits of breastfeeding were also highlighted through a national media campaign. See **www.breastfeeding.ie** for news, resources and media articles from National Breastfeeding week.

The Department of Health recommends that mothers exclusively breastfeed their infants for the first six months and after that combine breastfeeding with solid foods until two years of age. Indeed, the benefits of breastfeeding are so great, as supported by the research, that it should be better supported.

Breastfeeding education

There are many supports in place for breastfeeding mothers, including:

- Accredited lactation consultants and public health nurses and community RGNs
- Voluntary breastfeeding groups, including Cuidiú (www.cuidiu.ie), La Leche League (www.lalecheleagueireland.com) and Friends of Breastfeeding (www.friendsofbreastfeeding.ie/wp)
- Online supports such as **www.breastfeeding.ie**, which has a live expert on hand to offer on-the-spot advice.

Centres of nurse education also run information seminars, training days etc, which are co-ordinated by the national breastfeeding co-ordinator Siobhan Hourigan, who is based in National Maternity Hospital, Holles Street. She can be contacted at email: siobhanhourigan@hse.ie

HSE launches annual flu vaccine campaign for health workers

The HSE has urged all healthcare workers to get the flu vaccine as figures show that seasonal flu vaccine uptake rates among staff working in the health services last year were at the highest levels ever.

Flu is responsible for between 200 and 500 deaths each year in Ireland and in a severe season it can cause up to 1,000 deaths, according to HSE Assistant National Director for Health Protection, Dr Kevin Kelleher.

"The best way to prevent flu is to get the flu vaccine. Flu vaccine is a safe, effective a way to help prevent flu infection, avoid hospitalisation and flu related deaths and illnesses. The flu vaccine is the only defence against the flu, yet many healthcare workers fail to get vaccinated and put themselves and patients at risk of serious illness. Getting protected from flu with the flu vaccine is an important duty for any healthcare worker, because for them, or for their patients, it is a life-saver. Many of the people in our care are vulnerable to the life-threatening complications of flu – like people with long-term illnesses and conditions, pregnant women, and anyone aged 65 and over. The simple fact is that if we cannot get the flu, we cannot pass it on to them - it's their best shot," he said.

Dr Anna Clarke, HSE National Immunisation Office, flu vaccine lead said: "Overall uptake rates for flu vaccine among healthcare workers working in the acute hospital sector reached 31.9% during last year's flu season, up from 22.6% during the 2015/2016 season. Uptake among healthcare workers in long-term care institutions also increased to 28.1% up from 24.4% in the 2015/2016 season.

"The increase is very welcome but we need to make sure that this positive development continues and that every healthcare worker considers getting vaccinated this year. Basically, if you can't get the flu, then you can't spread the flu so it is important that those working in frontline healthcare protect themselves from getting the flu to prevent spreading the flu to vulnerable patients," she said.

Health Minister launches national ICU planning initiative

Simon Harris, Minister for Health, recently launched the new national ICU nursing workforce planning initiative – Career Pathway. Career Pathway is an exciting and innovative critical care nursing workforce planning initiative which has been set up by the Critical Care Programme and is funded, approved and supported by HSE Office of Nursing and Midwifery Services Director ONMSD and by HSE Human Resources as an integrated workforce planning initiative. For the first time in Ireland, immediately or at any time following graduation, graduate nurses can access Career Pathway and commence in full-time full-pay permanent pensionable employment

Pictured (l-r) at the launch of the National Foundation Education Module in Critical Care Nursing were: (Back row) Derek Cribbin, nurse lead, Critical Care Programme; Dr David Honan; Dr Catherine Motherway; Dr Geraldine Shaw; Margaret Jenkinson, chief operations officer; Dr Jeanne Moriarty, dean, Joint Faculty of Intensive Care Medicine; Una Quill, programme manager – National Clinical Programme for Anaesthesia; Martin McCormack, CEO CAI; Dr Colm Henry, national clinical advisor and group lead, acute hospitals, HSE; (Front row): Dr Michael Power, clinical lead, Critical Care Programme; Simon Harris, Minister for Health; Mary Wynne, director, Office of the Nursing & Midwifery Service

November

Saturday 11
PHN Section meeting. INMO HQ. From 11am-1pm. Contact jean.carroll@inmo.ie for further details. Community RGN Section meeting. INMO HQ. From 11am – 1pm. Contact jean.carroll@inmo.ie for further details

Wednesday 18
CNM CMM Section meeting. INMO HQ. From 11am -1pm. Contact jean.carroll@inmo.ie for further details

Wednesday 22
ED Section meeting. 12.30pm. Venue to be confirmed. Contact jean.carroll@inmo.ie for further details

Thursday 23
ADON Section meeting. INMO Head office. 11am – 1pm. Teleconferencing facilities available for this meeting. Contact jean.carroll@inmo.ie for further details

Friday 24
Beaumont Hospital 6th Annual Transplant & Nephrology Conference. Venue: The Hilton Dublin Airport Hotel, Northern Cross. Theme : The Next Generation of Renal Care. Price €40 www.beaumont.ie/kidneycentre Email: tunconference@beaumont.ie

Wednesday 29
CPC Section meeting. 10.30-12.30 INMO HQ. Contact jean.carroll@inmo.ie for further details

December

Thursday 07
Retired Section Bi-Annual Conference, INMO HQ. See page 70 for full details or contact helen.oconnell@inmo.ie for further details

Wednesday 6
RNID Section meeting. INMO HQ. 10am. Contact jean.carroll@inmo.ie for further details

January

Wednesday 03
International Nurses Section AGM. INMO HQ. Time TBC. Contact jean.carroll@inmo.ie for further details

Tuesday 09
Dublin East Coast Branch (DECA) meeting. 7pm in St Michael's Hospital, Dun Laoghaire

Saturday 20
ODN Section AGM. Naas General Hospital. 11.30am. Contact jean.carroll@inmo.ie for further details. School Nurses Section AGM/ meeting. INMO HQ. From 10.30am Contact jean.carroll@inmo.ie for further details

Wednesday 24
Telephone Triage Section AGM. 11am. Midland Park Hotel, Portlaoise. Contact jean.carroll@inmo.ie for further details

Thursday 25
Retired Nurses Section AGM. 11am. INMO HQ. Contact jean.carroll@inmo.ie for further details

INMO Membership Fees 2016

A Registered nurse *(Including temporary nurses in prolonged employment)*	€299
B Short-time/Relief *This fee applies only to nurses who provide very short term relief duties (ie. holiday or sick duty relief)*	€228
C Private nursing homes	€228
D Affiliate members *Working (employed in universities & IT institutes)*	€116
E Associate members *Not working*	€75
F Retired associate members	€25
G Student nurse members	No Fee

Condolences

❖ On behalf of Executive Council, management team and staff, INMO president Martina Harkin Kelly offers heartfelt sympathy to Geraldine Talty, former first-vice president, on the sudden and sad loss of her husband Michael. Words cannot express how we all feel, and no words will ever describe Geraldine's loss. *Ar Dheis Dé go raibh an anam dilis*.