A Human Resource Strategy for the Eastern Region
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Executive Summary

SUMMARY

A new five to seven year strategy for the Health Services in the Republic of Ireland is due for publication in the Autumn of 2001. Whatever the objectives of this strategy they will not become a reality unless the health service has the sufficient number of people, with the right skills and competencies, in the appropriate structures to deliver services of the highest quality.

The Eastern Regional Health Authority, which was established on March 1, 2000, is the statutory body with responsibility for health and personal social services for the circa 1.5 million people who live in Dublin, Kildare and Wicklow. The ERHA’s responsibilities include the strategic planning of services, commissioning of services and funding services through service agreements with the three Area Health Boards, the Voluntary hospitals and other Voluntary Agencies in the region. The ERHA is also charged with monitoring and evaluating the services provided by these agencies.

As the population it serves accounts for circa 36% of the total population of the Republic of Ireland the work of the ERHA will have a significant impact on the success of the overall National strategy. Human Resources has to be a priority item on the management agenda of every stakeholder in the Health and personal Services sector of the Eastern Region and the ERHA is in a key position to support this objective.

This report outlines: the current environment within which the Human Resources agenda for the Eastern Region has to be developed and managed, the key Human Resources issues to be addressed within the Region, a framework for the Regional Human Resources strategy and a blueprint for the way forward.

The Environment

There are a number of key issues at both National and Regional level which must be taken into account in the development of a Human Resources strategy for the Eastern Region.

- At a National level it must be aligned to the new Health Strategy for the Republic of Ireland, and to the Human Resources strategy developed by the Health Services Employers Agency (HSEA) and the Personnel Officer Groups.

- To ensure all stakeholders views are taken into account, it must be developed in conjunction with the variety of discrete Networks, Groups and Support Agencies in operation in the Health Service each of which fulfils a particular role in the delivery of a Human Resources Strategy. They are the Personnel Officer Groups, the Department of Health and Children, the HSEA, The Irish Business and Employers Confederation (IBEC) the Office for Health Management (OHM) and the wide variety of Professional Associations and Trade Union Bodies, which represent the employees of the Health Service.

- The process of developing the strategy and its content must reflect the commitment of all
of the stakeholders in the Health Service to the principle of working in partnership with the emphasis on consistency and fairness.

- The Programme for Prosperity and Fairness sets out a challenging agenda for the Health sector and promotes the need for flexibility in work patterns to enhance the delivery of service. However the ability for Service Providers and the ERHA to implement innovative practices or follow individual arrangements is curtailed by the existence of a number of agreements and practices at a National level within whose boundaries they are bound to operate (e.g. the restrictive practices regarding the common recruitment pool, the historical interdependency of reward packages, job evaluation systems which require updating and employment practices supported by the 10.71 circular). While steps are being taken to resolve these issues, their impact must be taken into account in the development of a Human Resources strategy at Regional level.

At a Regional level the Human Resources strategy must take into account a number of factors in the environment.

- The period of transition from the structures and working relationships of the Eastern Health Board to the new Eastern Regional Health Authority, creating three Area Health Boards and developing new working relationships with the thirty six (diverse) Voluntary Service Providers who retain their operational autonomy in the Region. In its first year this has posed considerable challenges to all stakeholders in terms of dealing with the impact of new structures, the need to fulfil the statutory obligations of the Authority and the need to develop clear lines of communication and accountability. Any Human Resources Strategy that is developed for the Region must take into account both the individual needs of the organisations in the Region and respect their operational autonomy, while supporting an integrated, coordinated approach to the development and implementation of people management strategies.

- The emerging role of the ERHA in response to the needs of the Health Services in the East must continue to be clarified for all stakeholders and continued emphasis placed on further developing channels of communication, clearly identifying lines of accountability and reviewing structures and procedures.

- The new organisational structures have also had an impact on the nature of working relationships with the unions. While a number of initiatives are in place to resolve such issues there will be a continued need for all stakeholders to focus on managing the communications process, and further developing relationships based on a pro active and partnership approach.
The current model of Human Resource Management in Service Providers which in many cases due to a variety of constraints, tends to be administratively focused with little link to the strategic formulation process.

Finally a major issue in the environment, which is of particular concern in the East, is the issue of workforce planning. Delivering high quality patient care requires Service Providers to have the correct staffing levels, the optimum skill mix and the most efficient and effective working practices. Therefore workforce planning is more than simply forecasting the future staffing needs to avoid shortages it is also about the debate on what skill mixes and competencies are required to meet future strategies on the nature of patient care. There are a number of challenges coming down the line in relation to this important area and it must be highlighted as a crucial element in the Human Resources agenda for the East.

The Way Forward

Therefore while a fit must be achieved with the environmental factors at both National and Regional level, this project is about developing a Human Resources strategy for the Eastern Region. The Consultants propose that the Human Resources strategy for the East must be about achieving the following three objectives,

• To get Human Resources on the strategic agenda for every Service Provider in the region.
• To define a new model for Human Resources Management in the region.
• To agree a framework for a Regional Human Resources Strategy.

Getting Human Resources on the Agenda

To make a Human Resources strategy a reality it is essential that Human Resources is high on the agenda in every Service Provider and within the Authority. To achieve this, the Consultants propose that the ERHA formally incorporate Human Resources into the Service Provider agreement and/or provider plans. In this way Human Resources issues are given a priority, which does not simply rely on the values and beliefs held by senior management as to their relevance but ensures their importance is recognised across the Region. The service planning mechanism is potentially the ideal framework to also;

• Identify the Human Resources agendas for the Eastern Region on an annual basis in terms of the provider plans and/or on a more strategic basis in terms of the service agreements, depending on how it is incorporated into the process.
• Agree a co-ordinated approach to their prioritisation and resolution.
• It also presents Human Resources Professionals with the opportunity to become fully involved in the service planning process and therefore strategy formulation.

Further work is required as to how exactly this process may be incorporated into the present model.

A Human Resources Model for the Future

So while the service planning process is the key to ensuring Human Resources play a role on the strategic agenda of all stakeholders, how can Human Resources functions in Service Providers, play a central role in implementing Service Providers and ultimately the Region’s objectives?

The proposed model is by David Ulrich. It states that Human Resources should not be defined by what it ‘does’ in the organisation but by what it ‘delivers’ – results that enrich the organisations (Service Providers) value to customers (patients, clients), investors (statutory and voluntary funding) and employees'. But how can this be achieved?

Human Resources should aim to deliver on its objectives by becoming;

• A **strategic partner** with senior and line management in strategy execution.

• An **administrative expert** in the way work is organised and executed, that accurate information is available for strategic decisions and that costs where possible are reduced and efficiencies introduced.

• A **champion for employees**, vigorously representing their concerns to senior management while working to increase their commitment.

• An **agent of continuous transformation** - shaping processes and a culture that together improve an organisations capacity for change.

This requires not only changes in how Human Resources professionals think and behave but also that senior executives change what they expect from the Human Resources function. Therefore the Consultants propose that Senior Management within Service Providers must begin to;

• Overtly communicate within their agencies the importance of cultural change, the value placed on its employees and the need for their commitment and retention.

• Explicitly define the deliverables from Human Resources and hold Human Resources accountable for the delivery of specific results.

• Invest in their Human Resources functions by upgrading skill mixes, restructuring the function to meet agreed deliverables and providing support to meet information requirements.

To meet these expectations the Consultants recommend that Human Resources professionals must undertake;
• A review or audit of how they deliver their services within their agencies to identify areas where greater efficiencies could be achieved.
• Focus on the deliverables of their work.
• Articulate their role in terms of the value they create.
• Review the activities with which they are involved and prioritise those which add most value in achieving their agencies objectives.
• Work to devolve responsibility for people management to their line Managers.
• Recognise they must take a regional perspective and a national one in relation to the management of Human Resources.
• View other Service Providers as 'benchmarks' and sources of information on innovative approaches.

This model is presented as a proposed way forward, the changes suggested will not be achieved overnight. They are the building blocks that will enable senior management not only to view employees as strategic assets, but also to invest in Human Resources capabilities so that Human Resources functions are in a position to leverage management's perspective.

Framework for Implementation

The third key element in the way forward is to develop a framework for the implementation of Regional Human Resources strategy. It is recommended that the Regional Human Resources Strategy must require all Service Providers to adhere to a consistent set of values, objectives, agendas, policies and practices that support the overall Regional strategy. This is driven by the need to operate within National agreements, pay policies and legislation (as mentioned earlier) which limit the possibility of individual arrangements as it would ultimately result in anomalies across providers. In addition as Partnership plays a major role in the development of these policies and agreements, consistency of implementation and fairness lies at the heart of this approach.

Having stated that there is a need for consistency the Consultants also recognise that given the complex and diverse nature of the Service Providers in the Eastern Region, there must be a degree of flexibility inherent in the way Human Resources is managed to allow each Provider tailor certain practices to meet the particular needs of their organisations.

So how can this potential conflict be resolved?

It can be resolved through a consultative process whereby Service Providers reach agreement on those areas where consistency must be achieved/followed and those areas where flexibility can be applied.

As a starting point the Consultants propose the following areas for consideration as requiring a consistent approach across the region;

• The guiding principles of the Human Resources Strategy and the role it should move
towards in the future.

- Adherence to legislation.
- Terms and Conditions of employment in the region (the HSEA is working on this).
- Pay Terms.
- Industrial relations procedures and collective agreements.
- Methodologies relating to workforce planning.
- In some recruitment and selection practices.
- The job evaluation process and grading issues.
- Agreement regarding relevant Human Resources competencies.

The following areas are proposed as ones where flexibility could be applied:

- The structure of Human Resources departments as they are subject to the specific needs of each service provider and to the level of investment they wish to make.
- The methods used to collect and manage Personnel Information, assuming they provide the nature of information required to support strategic decision making at Voluntary Service Provider level and at Regional level. Should be standardized.
- Recruitment and selection processes where each provider wishes to maintain 'full control' of this process. However full advantage should be taken of economies of scale and sharing successful methods.
- Training & Development initiatives.
- The design and timeframe for the introduction of a performance management system, assuming it will not be linked to pay.

Consultation

The process by which the Human Resources Strategy is developed over the next six months may be more important than the actual delivery on specific outcomes during that period. There needs to an extensive consultation process with key stakeholders. This report should form the basis of a consultation document for discussion with all of the stakeholders. The Consultants recommend that;

- The ERHA need to get the views of each stakeholder in the Region on the findings and recommendations of this report.
• A Working Group with representative(s) from each of the Service Provider groupings should be established to consider the views of the 'Region' and to develop an overall Human Resources Strategy.

• The findings of the Working Group should be published and followed-up by another phase of consultation with all of the stakeholders including unions, professional associations, the Department of Health and Children, the HSEA, Office for Health Management and all other appropriate statutory or non-statutory Agencies in the Health Services.

• The implementation of strategies should be done within a 'partnership' framework.

Further to the above process the ERHA Corporate need to consult with key stakeholders in the Region on an on-going basis to discuss and identify priority issues for the Region and to develop a coordinated approach to developing solutions.

In this regard the ERHA need to:

• Establish a Regional Human Resources forum for the Service Providers and

• Liaise closely with the Department of Health and Children, the HSEA and the Office for Health Management to ensure there is no duplication of work and that the Region's Human Resources initiatives are aligned to National strategies!

The Human Resources Agenda

During the research phase, a number of specific initiatives were identified by the stakeholders as requiring action. These are proposed by the Consultants as a set of specific initiatives, which should form the basis of an initial strategic human resources agenda. They are as follows;

• The Consultants strongly recommend that there is a role for a Human Resources and Workforce Planning Director in the ERHA Corporate organisation. This role should act as a facilitator for co-ordinating and driving the Regional Human Resources agenda. This is a challenging role that requires a person with considerable experience and should be filled as soon as possible. A full role description is in Appendix XI.

• In relation to Recruitment (Section 4.3) a number of recommendations are made;

  A It may be beneficial to review how effective the recruitment strategies used across the Region are in meeting their stated objectives.

  A Overseas recruitment has been fragmented. There is an opportunity to create a forum where information on the most effective practices can be shared and resources pooled. In addition a cost benefit analysis should be carried out to establish the actual value of this strategy.
In line with practices like that followed by the National Federation and the DATHS, the advertisement of vacancies within the National newspapers by Service Providers could be co-ordinated with the goal of a) minimizing cost and b) presenting a more professional image. A working group supported by the ERHA, should be created with representatives from the various groups of Service Providers operating against agreed frames of reference, to discuss the degree to which a common approach could be followed.

In relation to the design of the advertisements:

- A review should be carried out on the benefits of using a single advertising Agency versus a variety and to investigate the benefit of following such an approach

- Links should be forged with National groups re their findings on improving the advertising and marketing of the service and

- A concerted effort should be made to enhance the image of the Health Service through this medium and to gain maximum benefit in terms of attracting a suitable pool of candidates

The possibility of further developing the Eastern Region recruitment site on the Internet or creating a Regional job vacancy database could be investigated either on a stand alone basis or as part of the existing ERHA website.

Once again economies of scale could be achieved through negotiating with recruitment Agencies for better rates.

A number of issues emerged in relation to the Selection (Section 4.3) processes in operation:

- In some cases the length of time spent on the process was too long and unwieldy and a review of the methods used may be a way forward. In particular the guidelines outlined in Circular 10/71 in many cases are outdated and do not comply with current employment legislation. This is under review by the HSEA.

- The common recruitment pool is now seen as a barrier to the selection process and the HSEA is currently reviewing this issue.

- To gain maximum value, recruitment and selection processes should be amended to reflect the work carried out by the OHM in relation to competency analysis for each job family in the service.

- A review of the selection processes in operation across the Service Providers should be carried out to identify best practice approaches and to estimate areas where potential savings could be made and knowledge shared.

In addition to reviewing the validity and reliability of the selection methods in
operation an investigation could be made of other methods of selection/candidate assessment for example the use of Psychometric testing, assessment centres and structured interviewing.

- **Management of Workforce Planning** and how it can be supported in terms of information systems and resourcing (Section 4.2 and 4.7)

  - At a National level workforce planning should play a major role in the Human Resources Agenda in the new 'Health Strategy'.
  - It is proposed by the Consultants that workforce planning become a central part of every Human Resources Agenda.
  - Sufficient resources in terms of equipment staffing and training must be made available to support the collection and manipulation of workforce planning data, the determination of the quantity and nature of such investment should form the basis of a consultative process.

- **There is a need for a strategic approach across the region to Training and Development** (Section 4.5). Key issues covered in the section are:

  - The need to make available to all staff working in the health sector, accredited training and development programmes and a clear progression route to further education and career development.
  - Service Providers need to further clearly identify the development needs of their organisations, define the gaps that exist and develop appropriate training and development strategies that provide value for money both in terms of meeting individual needs and organisational needs.
  - Service Providers in the Eastern region, during the course of our research, identified a need to develop links, connections and partnership arrangements between different Hospitals, Health Boards, and other bodies in the region. This co-operative approach could take the form of:

    - The delivery of training programmes in a co-ordinated way for issues of mutual interest.
    - Staff rotation agreements.
    - The identification of Centres of Excellence in the region equipped to provide appropriate high quality training on specific issues.

  - At a strategic level the Consultants would advise that there is a need for a full assessment of training needs in the region, which should be followed by the development of a regional response that supports the objective of workforce planning strategies.
As Performance Management (Section 4.6) is one of the key elements, which (if designed and implemented effectively) can operate as a co-coordinating force in the integration of so many Human Resources initiatives, it plays a key role in any strategic Human Resources Regional Agenda. Service Providers should only consider its implementation when they are sure their organisation is in a position to gain maximum benefit from the process in relation to skill levels and a supportive culture.

The Voluntary Service Providers in Eastern Region and their Human Resources functions now require detailed workforce information (Section 4.7) to support their strategic and operational decision and planning activities. Therefore, a mutual approach must be followed which will benefit the information requirements of all parties concerned. The ERHA is currently driving an initiative to achieve consensus on a way forward.

The need to address equity in the application of the clerical/administrative grading system across the Service Providers in the short term. The ERHA are addressing this as a matter of urgency. Section 4.4 provides an overview of the issues.

The review of Human Resources Departments' structures and the resources is covered in Section 4.1. Key points are;

- It may be useful to review the dual structures in operation in a number of Agencies regarding the provision of Human Resources support to Nurses versus other job families. There may be scope for a more integrated approach.

- If there truly is a belief that the Human Resources function should focus on fulfilling more than an administrative role, then it must be an area for investment and/or restructure by each Service Provider. The level and degree of this investment must take into account the size and structure of each Provider. Opportunities should be looked at restructuring departments to support the delivery of an optimum service focusing on the delivery of results and in developing the skills and competencies both within the Human Resources function and at line management to deliver on their objectives.

- The Human Resources forums co-ordinated by the ERHA should consist of representatives from across both the Statutory and Voluntary Providers to support consistency and co-ordination across the region.

The Consultants believe that the development of a strategic human resources strategy on a Regional basis will ensure that there are a sufficient number of people, with the right skills and competencies, in the appropriate structures to deliver services of the highest quality to the population of the Eastern region.

This summary provides an overview of the findings and recommendations of our research. The remainder of the report provides the background, context and rationale supporting these results.
2. **INTRODUCTION**

In order to support the Human Resource Professionals of the Statutory and Voluntary Providers in the delivery of best practice Human Resource initiatives across the Eastern Region, the Eastern Regional Health Authority (ERHA) has identified the need for a Director of Human Resources and Organisational Development.

A suitably qualified candidate is currently being sought to fill this position. However while this process is taking place the ERHA Corporate recognised the urgent need to develop a Human Resources Strategy for the Eastern Region. To this end an independent Human Resources consultancy, Alpha Consulting was appointed by the Chief Executive of the ERHA, Donal OShea. The strategy has to take into account the framework of National agreements, relevant legislation, current Human Resources initiatives and the particular needs of each stakeholder (e.g. the Service Providers, Agencies, professional bodies, representative associations etc) which are involved in the operation of the Health Service in the Eastern Region.

2.1 **RESEARCH METHODOLOGY**

The approach taken to the research was based on the requirement not only to gather a wealth of information on Human Resources in the Region but also to develop a strong understanding of the Human Resources Agenda across the Service Providers.

2.1.1. **BACKGROUND RESEARCH**

Background research was carried out on an ongoing basis throughout the process. Key areas for investigation were;

- the guidelines (legislative, social and National policies) which provide the framework within which Human Resources activities must be managed within the Region.
- reports and findings from working parties and Expert Groups, set up to review various issues within and across job families.
- research on Human Resources initiatives in Health services in other jurisdictions.

For a full list of references see the Bibliography.

2.1.2. **STAKEHOLDER AUDIT**

In addition to background research, an in-depth 'stakeholder audit' of the Human Resources needs which exist across the range of Service Providers within the Eastern
Region and an audit of the views of key external stakeholders and influencers within the Health Sector was carried out.

The input of each of the stakeholders was paramount and to this end a highly consultative process was followed. Over 40 individual meetings and 2 workshops were held in addition to ongoing interaction with the ERHA Corporate itself. A list of participants is outlined on the following pages.

The aim of these meetings and workshops were to:

• Develop an understanding of each Provider in terms of its key drivers, business strategy, operational activities, structure, and the nature of jobs.

• Identify those areas in which Health Agencies and professional bodies are experiencing difficulties in relation to the management of their Human Resources (for example, the recruitment of particular professions, the retention of existing Staff, etc).

• Evaluate the impact of National policies, guidelines, legislation, working practices, union agreements etc, governing the management of Human Resources in each stakeholder’s area.

• Identify blockages to the implementation of solutions to these difficulties (e.g. National policies, pressure for resources and/or local issues).

• Identify 'Best practice' approaches and initiatives, which are currently in operation within the Eastern Region and at a National level.

A structured framework was used to guide the elicitation of information during these sessions.

We are conscious in this report that in the time available we cannot do full justice to the range of issues raised during the consultative process. We have however attempted to capture the themes which have emerged and either present or develop further the recommendations put forward under a number of broad headings within the Human Resources remit.

In addition a number of stakeholders were unable to take part in the consultative process therefore it must be highlighted that any process which results from this report should ensure their views are taken into account.
2.2.2.1. MEETINGS ON AN INDIVIDUAL BASIS

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<tr>
<th>ERHA CORPORATE</th>
<th>NAME</th>
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<tr>
<td>Chief Executive</td>
<td>Donal O'Shea</td>
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<td>Director Planning &amp; Commissioning</td>
<td>Pat Mc Loughlin</td>
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<td>Financial Director</td>
<td>Liam Woods</td>
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<tr>
<td>Director Monitoring &amp; Evaluation</td>
<td>Angela Fitzgerald</td>
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<td>Director Corporate Services</td>
<td>Martin Devine</td>
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<td>Director Public Health</td>
<td>Brian O'Herlihy</td>
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<td>Director Communications</td>
<td>Maureen Browne</td>
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<tr>
<td>Director of Nursing &amp; Midwifery Planning &amp; Development</td>
<td>Sheila O'Malley</td>
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<tr>
<td>Senior Human Resources Officer</td>
<td>Patricia Smith</td>
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<tr>
<td>Director Shared Services</td>
<td>Valerie Judge</td>
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<td>Head of Recruitment</td>
<td>Miriam Keegan</td>
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AREA HEALTH BOARDS

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<tbody>
<tr>
<td>Northern Chief Executive Officer</td>
<td>Maureen Windle</td>
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<tr>
<td>Area Health Board Director Human Resources</td>
<td>Mary Kelly</td>
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<tr>
<td>East Coast Chief Executive Officer</td>
<td>Michael Lyons</td>
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<tr>
<td>Area Health Board Director Human Resources</td>
<td>Pearse Costello</td>
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<tr>
<td>South Western Chief Executive Officer</td>
<td>Pat Donnelly</td>
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<td>Area Health Board Director Human Resources</td>
<td>Tony McMahon</td>
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### Dublin Academic Teaching Hospitals

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<tr>
<td>Mater</td>
<td>Chief Executive Officer</td>
<td>Martin Cowley</td>
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<td>Human Resources Manager</td>
<td>Mary Crowe</td>
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<td>St Vincent's</td>
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<td>St James's</td>
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<td>Tallaght</td>
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### Maternity/Pediatric

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<td>Our Lady's Hospital for Sick Children</td>
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<td>Human Resources Executive</td>
<td>Evelyn O'Neill</td>
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<td>Director of Nursing</td>
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<td>Paul Cunniffe</td>
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## TRADE UNION BODIES

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<td></td>
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<td></td>
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## DEPARTMENT OF HEALTH AND CHILDREN AND HEALTH SERVICE AGENCIES

<table>
<thead>
<tr>
<th>DOHC/AGENCIES</th>
<th>TITLE</th>
<th>NAME</th>
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<tbody>
<tr>
<td>Department of Health &amp;</td>
<td>Director Personnel</td>
<td>Frank Ahern</td>
</tr>
<tr>
<td>Children</td>
<td>Management &amp; Development</td>
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<td></td>
<td>Principal Officer</td>
<td>Bernard Carey</td>
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<td></td>
<td>Principal Officer</td>
<td>Larry O' Reilly</td>
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<td></td>
<td>Principal Officer</td>
<td>Feargal Lynch</td>
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<td></td>
<td>Assistant Principal Officer</td>
<td>Pat O'Byrne</td>
</tr>
<tr>
<td>Office of Health Management</td>
<td>Deputy Director</td>
<td>Laraine Joyce</td>
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<tr>
<td></td>
<td>General Manager</td>
<td>Alan Smith</td>
</tr>
<tr>
<td>Health Service Employers</td>
<td>Chief Executive Officer</td>
<td>Gerard Barry</td>
</tr>
<tr>
<td>Agency</td>
<td>Head of Employer</td>
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<tr>
<td></td>
<td>Advisory Service</td>
<td>Elva Gannon</td>
</tr>
</tbody>
</table>
2.1.2. GROUP MEETINGS AND WORKSHOPS

THE ASSOCIATION OF CHIEF EXECUTIVES OF VOLUNTARY HOSPITALS – EXECUTIVE COMMITTEE

<table>
<thead>
<tr>
<th>ORGANISATION</th>
<th>TITLE</th>
<th>NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incorporated Orthopaedic Hospital of Ireland</td>
<td>Chief Executive Officer</td>
<td>Michael Redmond</td>
</tr>
<tr>
<td>Royal Victoria Eye &amp; Ear</td>
<td>Chief Executive Officer</td>
<td>Aida Whyte</td>
</tr>
<tr>
<td>Cappagh National Orthopaedic Hospital</td>
<td>Chief Executive Officer</td>
<td>Aidan Gleeson</td>
</tr>
<tr>
<td>Royal Hospital Donnybrook</td>
<td>Chief Executive Officer</td>
<td>John Kennedy</td>
</tr>
<tr>
<td>St Lukes</td>
<td>General Manager</td>
<td>Donal Kelly</td>
</tr>
</tbody>
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THE ASSOCIATION OF VOLUNTARY HOSPITALS – WORKSHOP

WORKSHOP ATTENDEES TITLE NAME

<table>
<thead>
<tr>
<th>WORKSHOP ATTENDEES</th>
<th>TITLE</th>
<th>NAME</th>
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<tr>
<td>City of Dublin Skin &amp; Cancer Hospital</td>
<td>Personal Assistant</td>
<td>Carmel McKenna</td>
</tr>
<tr>
<td>National Rehabilitation Hospital</td>
<td>Chief Executive Officer</td>
<td>Derek Greene</td>
</tr>
<tr>
<td>St Michaels Hospital</td>
<td>Hospital Accountant</td>
<td>Seamus Murtagh</td>
</tr>
<tr>
<td>Our Lady’s Hospice</td>
<td>Human Resources Manager</td>
<td>Sandra Hannigan</td>
</tr>
<tr>
<td>Dublin Dental Hospital</td>
<td>Personnel Officer</td>
<td>Lauri Cryon</td>
</tr>
</tbody>
</table>

INTELLECTUAL DISABILITIES WORKSHOP

A Preparatory Meeting was held with Paul Ledwidge, Chief Executive, St.Michael’s House, Nessan Rickard, Personnel Manager, St.Michael’s House and Maura Donovan, Chief Executive Officer, Stewart’s Hospital.

The Workshop attendees were:
In addition a number of meetings were held in the United Kingdom, with representatives from the NHS specifically, the HR Director, Thomas Gateway, NHS Trust and the Chief Executive, East Sussex Hospital Trust.

2.2. STRUCTURE OF THE REPORT

This report is presented in three parts. Chapter 3 entitled the Environment presents an overview of the key factors which operate in the Health services environment and which must be taken into account in the development of a Human Resources Strategy for the Eastern Region. It covers the changing agenda of the Health services, the creation of the ERHA, the diverse nature of the Service Providers in the Eastern Region, the groups of Agencies and networks involved in Human Resources initiatives and the model of Human Resources Management currently in operation at Service Provider level in the Region. As they are such major considerations in the development of a Human Resources Strategy, a review of the Industrial Relations environment is also covered as are the challenges faced in the area of workforce planning.

Chapter 4 The Human Resources Agenda, is a review of particular issues within the Human Resources framework and presents recommendations on how their management could be improved. Areas covered are the structure of the Human Resources
Departments at Service Provider level in the region; the current state of play in relation to workforce planning and areas for attention, how recruitment and selection methods could be improved, issues in relation to pay and benefits in the region and suggested ways to move forward given the particular constraints in this area, the need for enhanced training and development initiatives, the nature of performance management and how it might be implemented within the region and finally the need for enhanced information systems to support strategic decision making at all levels.

The final Chapter entitled 'The Way Forward' presents a proposed Human Resources strategy for the Eastern Region, highlights key areas for attention and outlines the methodologies and processes by which it may be implemented. It is presented as a basis for discussion and review by members of the ERHA Corporate's senior management team, the Board of the ERHA, the Department of Health & Children and the Statutory and Voluntary Service Providers and other relevant agencies in the Health Sector.

2.3. CONSULTING TEAM

Due to the wide ranging nature of this project a team of Consultants were involved, who between them have the combination of public sector consulting experience and particular areas of expertise in Human Resource Management arena. They are Marian Bergin, Jenny Smyth, Conal Devine, Joanna Woodford and Emily O'Neill.

We would like to take this opportunity to thank all of those who participated in the meetings and workshops for the time afforded us and their willingness to contribute their thoughts and experiences and ideas for ways forward.

Project Manager

Marian Bergin
3. THE ENVIRONMENT

3.1 THE HEALTH SERVICES AGENDA

'\textit{Shaping a Healthier Future}', was published in 1994 as a strategy for effective health care in the Republic of Ireland in the 1990s. Its main theme was the orientation or reshaping of the Health Services so that improving people's health and quality of life became the primary and unifying focus of the work of health care policy makers and Providers.

It signalled a significant change in the direction of the service as it included a new emphasis on the achievement and measurement of health gain and a commitment to organise and manage the system as an integrated whole. The strategy was underpinned by three principles: equity, quality of services and accountability.

The new Health Strategy for the next five to seven years is in the process of being developed using an intensive consultation process with all the stakeholders in the Health Services. It is expected that the Strategy 2001 document will be published some time in the Autumn of this year.

It is envisaged that the new strategy will be shaped by the following types of issues:

- More people centred/consumer oriented system.
- Development of integrated sets of quality services, accessed on the basis of need.
- Strong focus on equity and fairness.
- An analysis of cross-sectoral issues affecting health status.
- A focus on prevention and health promotion/population health.

These objectives will require the reform and modernisation of the health and personal services. They will set a number of challenges for the services in terms of the scale of funding and resources required, the development of new information systems and e-health, the development of effective delivery systems and the effective management of a changing human resources agenda and in particular medical workforce planning.

3.2 THE EASTERN REGIONAL HEALTH AUTHORITY

3.2.1 THE OBJECTIVES OF THE ERHA

The Eastern Regional Health Authority (ERHA) is the statutory Body with responsibility for health and personal social services for the circa 1.5 million people who live in Dublin, Kildare and Wicklow.
The Authority is responsible for the:

- Strategic planning of integrated services in response to identified and measured need in the Region.
- Commissioning of services from both Statutory and Voluntary sectors through service agreements.
- Overseeing and evaluation of the services provided.

These services cover the full range of the care groups in both the Voluntary and Statutory sector.

In its commissioning of services and the associated allocation of resources the ERHA is charged with responsibility for deciding priorities on the basis of need and of ensuring efficiency, effectiveness and value for money (VFM) for the Region.

The Regional Chief Executive is responsible for the budget of the Region and is directly answerable under Section 13 of the Act to Dail Eireann.

3.2.2. THE STRUCTURE OF THE ERHA AND HEALTH SERVICES IN THE REGION

There are 55 members on the Board of the ERHA, consisting of 30 local public representatives nominated by the local authorities in the Region, 13 registered health professionals, nine representatives of the Voluntary Sector and three nominees of the Minister.

Under the Health (Eastern Regional Health Authority) Act 1999 (Appendix I), the Eastern Heath Board (EHB) was dissolved and the ERHA and four new bodies were established.

The three new Area Health Boards (Northern, South Western and East Coast) provide in their own areas the services previously provided by the former EHB. The ERHA, works with the three Statutory Providers (Area Health Boards) and a diverse range of 36 Voluntary Providers. (Appendix II).

The Office of the Regional Chief Executive (ERHA Corporate) consists of an Executive Body with the following management structure:

- Director of Planning and Commissioning
- Director of Monitoring and Evaluation
- Director of Finance
- Director of Human Resources (vacant)
- Director of Corporate Services
- Director of Public Health and
- Director of Communications

The Eastern Health Shared Service (EHSS) Centre replaced some of the Eastern Health Board (EHB) centralised support service. The EHSS is governed by a Board of Directors.
representing the ERHA and the three Area Health Boards. It was established to provide a wide range of contractually defined professional, technical and information support services to the Eastern Regional Health Authority and the three new Area Health Boards. The shared services model was chosen as an effective means of providing economies of scale, efficiency, service effectiveness and availability of expertise across the Region.

The ERHA commissions services from the new Area Health Boards and the thirty six Voluntary Bodies, on the basis of provider agreements that support a Regional service plan.

The Area Health Boards are responsible for the delivery of statutory services within their own areas as agreed in the service plans. They can be considered as equivalent in function to other Health Boards in Ireland but in addition have responsibility for the planning and co-ordination of all Health Services within their area, in co-operation with the local Voluntary Service Providers.

Voluntary Hospitals and Voluntary Agencies are guaranteed operational autonomy. The ERHA is required under legislation to have regard for the right of the Voluntary Bodies to manage their own affairs in accordance with their independent ethos and traditions, but they will be fully accountable to the ERHA for the public funds that they receive based on the provider agreements.

The introduction of provider agreements between the ERHA and the major Voluntary Providers means that the Voluntary Sector is now formally involved in the provision of integrated patient services within the Region in conjunction with the Area Health Board provided services.

The geographic structure and integrated planning process ensures that decisions about the provision of local services will be made closer to the point of delivery and will facilitate more involvement by local communities in the planning and organisation of their Health Services.

3.2.3. THE NATURE OF THE OPERATIONAL RELATIONSHIP WITH SERVICE PROVIDERS

The focus of the ERHA is significantly different from that of the Eastern Health Board. Under the Act (Section 9) the ERHA is not directly involved in service delivery.

The ERHA is responsible for the strategic planning of integrated quality services in response to identified and measured need, the commissioning and funding of services from both statutory and voluntary sectors and the overseeing and evaluation of the services provided.

In order to meet its governance obligations, the ERHA needs to understand the nature of the services provided and they also need accurate information to develop the Provider
plans, which feed back into the strategic planning process at Regional level.
The development of service agreements and Provider plans involves an intensive consultation process between the ERHA and each of the Service Providers.
The Service Provider is responsible for managing and delivering the agreed services.
To ensure compliance with the accountability legislation and issues of economy, efficiency and effectiveness the Authority monitors and evaluates the delivery of service against the agreements and plans and feeds the performance information back into the planning process for the following year.

3.2.4. OPERATIONAL CHALLENGES

It is not the remit of this report to investigate the nature of real or perceived problems with the new operational relationships in the Region. However, it is important to recognise any potential blockages or operational issues, which may impact on the development of a Human Resources Strategy and its successful implementation across the Region.

At the time of this report the ERHA, the three new Area Health Boards and the Shared Services Centre are just over one year in operation. The year was challenging in terms of defining corporate strategies, recruiting new teams and managing and developing the new organisation structures in the context of existing structures and the historical and cultural dimensions associated with some Health Service Providers in the Region.

The new structures of the Authority have posed considerable challenges to both the Statutory and Voluntary Service Providers in the Region. They have made demands, in terms of the need to access detailed information on all aspects of the service provision, the development of new channels of communications and new ways of working through the system to get things done. This has impacted not only on Chief Executive Officers/Secretary Managers but also management teams and Staff at all levels in the Service Provider organisations in the Region.

During our review a number of specific issues emerged:

- There is a strong sense across the Service Providers and other Agencies in the Health Services that the emerging role of the ERHA needs to be further defined. There are obvious sensitivities around the issues of operational autonomy but there is also a genuine confusion as to how the remit of the ERHA translates into day-to-day management of the Health Services.

- The Service Providers also see a need to clarify the role of the HR Director of the ERHA vis-à-vis the Department of Health and Children and other Health Service Agencies. The lack of an incumbent in the role has not assisted this understanding. However
this report and the current process in place to fill the role of HR Director, will clarify this issue.

- The direct linkage of budgets to each element of the service plans and the linkage of the ERHA’s monitoring and evaluation role to the service plans has posed a challenge to the Service Providers in terms of the new planning and funding arrangements.

- There is a requirement for Service Providers to provide higher levels of detailed information than previously required. The lack of sophisticated information systems has made this a difficult exercise and has stretched the resources of the Service Providers. There is also a difficulty in that it is not clear to the Service Providers as to why “so much” information is required. This relates back to a lack of understanding of the role and statutory obligations of the ERHA, where as previously mentioned in section 3.2.3, that in order to meet it’s governance/statutory obligations, the ERHA needs to understand the nature of the services provided and therefore must have detailed and accurate information with which to carry out the strategic planning and monitoring process at Regional level.

- Linked to the above point, there is a perception on the part of the Service Providers, that information flows tend to be ‘all one way’. Many Providers outlined the difficulties they had experienced in gaining responses from the ERHA to particular queries. It should be noted that communication problems are not new to the Region as the National College of Ireland (Sept 2000) study on “relationships between the former Eastern Health Board and Voluntary Organisations in the Eastern Region” reported that the:

“frequency of communication was found to be central to perceptions about the success of the relationship but more than half of respondents reported communications as infrequent or non-existent.” (page 5).

Our review would indicate that while communication channels at top management level between the ERHA and Service Providers may be relatively clear this may not be reflected in all cases at lower levels. Some blockages seem to exist within the system. This may be due to a resource issue within the ERHA as the level of correspondence and administrative work required to meet its objectives had not been anticipated in the original structure.

- Directly linked to this point is the perceived vacuum that has developed as a consequence of such a fundamental change in organisational structures, i.e. that the familiar working relationships of the Eastern Health Board have broken down and have not been replaced. A common theme from the interviews with the Service Providers was that;

“It is difficult to figure out who is responsible for what in the ERHA.”
As pointed out earlier, in any major transition phase such as has occurred in the Eastern Region, the fragmenting of relationships is inevitable due to the movement of staff, the learning curve for new employees entering into the health service, the creation of new posts and responsibilities and in many cases the difficulty in filling positions. However to ensure the maintenance and development of new working relationships, there is a need for lines of accountability and responsibility in the ERHA to be further visibly clarified for the Service Providers and an investigation as to how information transfer may be more effectively managed.

The key point arising from these issues in relation to the development and implementation of a Human Resources Strategy is that it is not simply the elements of the strategy that may be important but the nature in which it is developed and communicated which will be just as significant.

3.3 THE NATURE OF SERVICE PROVIDERS ORGANISATIONS

The new Health Service structure in the Eastern Region provides an opportunity to follow an integrated approach to people management among the Service Providers within the Eastern Region. However, there are a number of important points in terms of the nature of the organisations that must be taken into account when developing a Human Resources Strategy for the Eastern Region:

- Part of the new structure is the maintenance of the Voluntary Hospitals and Agencies operational autonomy.
- The Region is made up a range of highly diverse organisations ranging from complex structures like acute hospitals to smaller Agencies dealing with long stay low dependency care. As a result there are sharp differences in terms of size, structure and skill mixes.
- Despite the differences in structure these Providers must operate within a National Framework and therefore experience many of the same problems in terms of people management initiatives for example in the areas of the recruitment, development, management and reward of Staff.

Therefore any Human Resources Strategy that is developed for the Region must take into account both the individual needs of the organisations in the Region and respect their operational autonomy, while supporting an integrated, coordinated approach to the development and implementation of people management strategies.

3.4 HUMAN RESOURCES NETWORKS, GROUPINGS AND SUPPORT AGENCIES

There are a number of discrete Networks, Groups and Support Agencies in operation in
the Health Service both at a National level and on a Regional basis. These groups and Agencies fulfil particular roles in the delivery of a Human Resource Strategy and each one provides a piece of the jigsaw that makes up the Human Resources policies and practices in use in the Eastern Region.

As a consequence the ERHA needs to recognise the disparate groups impacting on Human Resource management issues.

The following section outlines the main groups that have an impact on the broader Human Resources agenda. For any Human Resources Strategy to be successful it must be developed in conjunction with these groups to ensure all stakeholders' views are taken into account.

3.4.1. PERSONNEL OFFICER GROUPS

Within the Eastern Region each of the Service Providers are affiliated to Human Resources Networks commonly called 'Personnel Officer Groups'. While in the past these have been quite informal, in recent years they have become more organised and are significant operating groups whose views must be taken into account in the development and implementation of Human Resources Strategies for the Region. The following groups exist and tend to meet/operate on an individual basis:

- The three Human Resources Directors of the Area Health Boards.
- Human Resources representatives from the Association of Voluntary Hospitals.
- Human Resources representatives from the Dublin Academic Teaching Hospitals (DATHS) and
- Human Resources representatives from the Federation of Voluntary Bodies Providing Services to People with Intellectual Disability (Mental Handicap), (the Federation).

In addition to the above groups the Association of Chief Executives of Voluntary Hospitals, the DATHS Chief Executive Group and the Federation frequently deal with a number of Human Resources issues as part of their remit.

3.4.2. THE DEPARTMENT OF HEALTH AND CHILDREN

The aim of the Department of Health and Children is to protect, promote and restore the health and well being of people by ensuring that health and personal social services are planned, managed and delivered to achieve measurable health and social gain and provide the optimum return on resources invested.

The Department is currently working on the development of a new Health Strategy to provide improved health status and the development, reform and modernization of the health and personal social services over the next 5 to 7 years.
The Department of Health and Children is divided into a number of divisions, each representing a key area of the Department's work. The Personnel Management and Development Directorate is sub-divided into Human Resources units based on a job family structure, each headed by a Principal Officer. They are the Medical Personnel Division, the Management, Professional and Support Divisions and the Nursing Policy Divisions. A fourth division looks after Medical Indemnity.

3.4.3. EMPLOYER REPRESENTATIVE BODIES AND HEALTH SERVICE AGENCIES

3.4.3.1. THE HEALTH SERVICE EMPLOYERS AGENCY (HSEA)

The HSEA is the representative Body for the Health Service Employers. A statutory Agency, it promotes the development of improved Human Resource practices within the Health Services. In fact it has reconfigured its committee system in order to provide for a greater involvement in and input on the part of the Personnel Officer Groups in all of its activities. It acts as a catalyst for greater efficiency and effectiveness in employment practice and provides a dynamic focus for the management of change consistent with changing service and operational requirements. It represents and supports employers in the management of Industrial Relations. In all of its activities the Agency works in close co-operation with IBEC.

3.4.3.2. THE IRISH BUSINESS AND EMPLOYERS CONFEDERATION (IBEC)

IBEC represent and provide economic, sectoral, Regional, commercial, employee relations, social affairs and information services to companies and organizations from all sectors of economic and commercial activity. A significant number of the Service Providers are members of both IBEC and the HSEA. The Association of Chief Executives of Voluntary Hospitals has recently re-negotiated their service contract with IBEC. Many Human Resources professionals use a combination of information from both Agencies.

3.4.3.3. THE OFFICE FOR HEALTH MANAGEMENT (OHM)

The Office for Health Management was established by the Minister for Health and Children to implement the Management Development Strategy for the Health and Personal Social Services in Ireland, published in 1997. The role of the Office is primarily a facilitative one, to commission management development programmes on behalf of employers for Staff in the health and personal social services where a gap is identified in existing service provision. The Office also seeks to identify and promote best practice in management development and management generally through its newsletter, website and management guidelines on selected topics.
3.4.4. THE TRADE UNION AND PROFESSIONAL ORGANISATION

The interests of employees in the health services are served by a wide variety of professional associations and trade union bodies. (See Appendix III). There is a high level of union membership across the service at all levels.

The representative organisations may collaboration on issues of common interest to their membership. The unions with significant membership numbers include; SIPTU, IMPACT, the Irish Nurse’s Organisation and the Irish Medical Organisation.

3.5. THE NATURE OF HUMAN RESOURCES MANAGEMENT IN THE REGION

Before looking to the future, it is imperative for an organisation to first review it’s current structures and approaches to people management as this:

- Influences the role of Human Resource management within the agency.
- Determines the scope of activities with which it can become involved and
- Determines which model of Human Resources is currently in operation.

This review is also necessary to establish the level of change that may be required and the barriers that may prevent or affect its implementation.

As part of our research agenda all stakeholders were asked to describe the role of Human Resource Management in their organisations. While recognition that Staff are one of the most important resources in the achievement of their objectives and that retention is a key issue, the majority answered this question by describing the activities of their Personnel Department/Human Resources Function. A consistent theme which emerged (with a few exceptions) is that the majority are involved in:

- Providing administrative support e.g. payroll, employee information, leave management etc.
- Dealing with the complex Industrial Relations issues prevalent in the health sector due to:
  - The number of unions which represent employees within the health sector as a result of the complex structures and skill mixes in operation.
  - The lack of ‘line management’ skills, leading to the production of IR problems rather than their reduction and
  - The requirement to implement National agreements at a local level.
- Responding to the manpower shortages through the management and implementation of recruitment and selection campaigns.
The following comments are representative of the responses received:

"We are constantly fire fighting and managing issues with the unions that should have been prevented through good management practice."

"The majority of our time is spent on recruitment and administration issues".

"Ours is a reactive administratively driven department".

3.5.1. LINK WITH ORGANISATIONAL STRATEGY

The level of involvement in the strategic formulation process tends to be limited to whether senior management view Human Resources as important to achieving the Service Provider's objectives or as a result of external pressures e.g. the staffing crisis. In a number of cases Human Resources professionals are not involved in the service planning process and do not sit on executive/management committees therefore limiting their involvement in the strategic planning activities of their organisations. Their role in general is to respond to the needs that emerge from the management agenda.

3.5.2. THE CURRENT MODEL OF HUMAN RESOURCES

Storey (1992) categorises Human Resources activities along two dimensions. The strategic/tactical dimension looks at the level at which the Human Resources function operates in making decisions or providing support in companies. The interventionary/non-interventionary continuum is the degree to which the function takes a 'hands on' approach to the management of the employment relationship. This results in a categorisation of four Human Resources function types, as shown in Figure 1 and detailed in Table 1.

Using Storey's typology to characterise the models of the Human Resources functions that are currently in operation in the Service Providers in the Eastern Region it would be fair to say that they fall into the range between Regulators and Handmaidens, as illustrated in Figure 1.
Figure 1: Storey's (1992) Human Resource Models using a two dimensional approach.

TABLE 1: THE CATEGORISATION OF THE FOUR HUMAN RESOURCES FUNCTIONS

<table>
<thead>
<tr>
<th>Function Type</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Advisor</td>
<td>Provides support to line and general management. While this function is carried out at a strategic level it is reactive and non-interventionist, providing specialist skills but in a consultancy capacity.</td>
</tr>
<tr>
<td>Handmaiden</td>
<td>Represents a subservient attendant relationship with Human Resources operating at a low-level in an interventionist capacity, reacting to the needs of line management in response to day-to-day operational problems. Indicative of a welfare and clerical role.</td>
</tr>
<tr>
<td>Regulator</td>
<td>Operates in an interventionist mode but rarely at the level of strategy formulation. This approach is representative of a traditional, Industrial Relations orientation with the senior Human Resources practitioners responsible for devising and negotiating policies &amp; procedures to ensure the smooth operation of the company. The Human Resources contribution is significant at an operational level rather than at a strategic level.</td>
</tr>
<tr>
<td>Change maker</td>
<td>Acts as a specialist and is highly interventionist and strategic in perspective. This represents the highest level of operation of the Human Resources function. In this model senior Human Resources practitioners are aware of both the 'soft' and 'hard' elements of Human Resources and employee relations practice.</td>
</tr>
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</table>
This is not to say that Human Resources professionals and senior management are unaware of the need for a more strategic proactive approach to people management and the majority highlighted the need for functions that could act as Advisor/Change Makers. Comments such as the following are reflective of general attitudes:

"We would like to develop and empower Managers, change the culture to one where Managers manage their people."

"We are looking at developing a more strategic approach to Human Resources and to devolve Human Resources responsibilities more and more to department Heads"

In response to the need for a strategic Agenda, The Personnel Officer Groups have, through the HSEA, developed "A People Strategy for the Health Service: A Human Resources framework for action" outlining a way forward.

3.6. INDUSTRIAL RELATIONS

The Health Services in the Eastern Region employ Staff across a wide range of skill mixes. They are represented by a large number of highly active unions (See Appendix III). This section outlines the nature of Industrial Relations in the Region at this time.

3.6.1 PARTNERSHIP

The Department of Health and Children, the Unions and the HSEA are strongly committed to the principle of working in Partnership to achieve the changes necessary to ensure a better quality service and one which provides value for money.

As stated in the Department's 'Working together for a better Health Service' document;

"Working together for a Better Health Service provides for a new active relationship in managing change characterised by employee participation and consultation, the development of joint objective, co-operation and trust and the delivery of patient-focused quality health Services."

The Partnership arrangements in the Eastern Region are either set-up or in the process of being established. The main focus of activity during 2000 was on the recruitment of Facilitators for the remaining sites. The Area Health Boards and the major hospitals will have facilitators in their own right while smaller Voluntary Hospitals have been grouped for this purpose. The ERHA recognise the need to develop a more proactive approach to partnership in the region.

3.6.2 THE PROGRAMME FOR PROSPERITY AND FAIRNESS

The Programme for Prosperity and Fairness (PPF) set a challenging agenda for the Health Sector. The primary focus was on:
• The service planning process as a means of creating the conditions, which will allow performance management systems to be put in place in the health sector.

• The need to create a shift in the way the service is delivered was noted, as traditional work patterns may not be appropriate for the delivery of a 24 hour service.

• The PPF also sets out a challenging agenda for change in the Health Sector (See Appendix IV). Items included on this Agenda are two of the key issues highlighted by the Service Providers in the Eastern Region; the recruitment pool and the circular (10/71) of October 1971.

3.6.3. PAY NEGOTIATIONS

The pay and grading structures in the Health Services are negotiated at National level between the government, unions and the HSEA. The HSEA also support, and where appropriate, represent the Health Service employers on local issues.

There are two primary processes in place for the negotiation of pay and grading claims at all levels. Since August 1998 all Health Service grades may process pay and grading claims through the Labour Relations Commission and ultimately the Labour Court (except for those grades under the remit of the Review Body on Higher Remuneration).

In the case of some grades, such as the Clerical/ Administrative grades pay has traditionally been determined in joint negotiation with that of their counterparts in the Local Authorities and having regard to developments in the Civil Service for similar grades. Other groupings have historical linkages with each other.

The Programme for Prosperity and Fairness provided for the establishment of the Public Service Benchmarking Body (PSBP) to undertake a fundamental examination of the pay of public service employee's vis-à-vis the private sector. The Body will produce a report by the end of June 2002 covering all grades, groups and categories within its terms of reference. The terms of reference for benchmarking are much more extensive than that of traditional arbitration. It is envisaged that matters such as pay structures and reward systems may feature. This process has put the majority of major pay claims on hold.

3.6.4. INDUSTRIAL RELATIONS IN THE EASTERN REGION

The establishment of the ERHA following the dissolution of the EHB has had a significant impact in terms of the working relationships between the unions and management within the Region.

The ERHA believe it is important to appreciate the complexities of managing industrial relations in the health services in the context of binding National agreements and directives from the Department of Health and Children. The ERHA and health service
employers would also contend that the obstacles placed by Trade Unions representing Health Services grades in the region to the implementation of productivity arrangements and change programmes (e.g. the continued existence of the recruitment pool) adds to this complexity.

From a union perspective the new regional structures have had a negative impact on the industrial relations environment in the region. Union officials representing health service employees in the region now deal with three Human Resources Departments as opposed to one. The impact of this structural change is further complicated by the lack of a visible coherent approach to dealing with industrial relations issues in the region and the breakdown of collective agreements on grievance procedures. Unions are also of the view that there is an "additional layer of bureaucracy" when dealing with industrial relations issues on behalf employees in voluntary bodies linked to the Area Health Boards.

There is a perception among both unions and some of the large Service Providers that there is a lack of line managers with Industrial Relations experience in the new regional structure. Managers are rotated around the system and where there are no clear supporting industrial relations procedures, this leads to inconsistencies in approach. From a Service Provider perspective there would also be issues in terms of the level of experience and skills of local union officials (i.e. at shop steward level) dealing with negotiations.

From a union perspective there is also an apparent lack of line managers in Area Health Boards with the accountability to make decisions on industrial relations matters. The experience cited by union officials would indicate that there is a pattern emerging of communications on minor issues being drawn out over extended periods of time with no resolution. These issues are now escalating and are being referred to third parties (e.g. Right Commissioners) for adjudication. The concern is that this is not only having an impact on time and resources for all parties concerned but also a more fundamental impact in terms of the possible loss of Staff over relatively simple Industrial Relations issues. (e.g. confirm if an employee's position is temporary or permanent).

The management of payroll for the ERHA Corporate and the three Area Health Boards is the remit of Eastern Health Shared Services (EHSS) Centre. Serious Industrial Relations issues have arisen out of problems experienced by the new Shared Services Centre in meeting its payroll obligations and the releasing and processing of funds for a variety of pay awards in the Eastern Region.

The EHSS experienced significant set-up difficulties and these difficulties were compounded by staff retention difficulties. An additional problem concerning the management of pay roll was the inaccuracy of information provided to the Shared
Service Centre by the local returning officers. This has highlighted a training need. A number of joint working initiatives between the EHSS and the Area Health Boards and the Unions are currently addressing this issue as a matter of urgency.

The Industrial Relations environment in the region is currently characterised by an apparent breakdown of collective agreements on grievance procedures, time consuming referrals to third parties on issues which it should be possible to address directly between the parties, a perceived lack of clear lines of accountability for decisions on industrial relations matters and inexperienced industrial relations practitioner in both union and employer organisations.

3.7. WORKFORCE PLANNING & THE CHANGING NATURE OF WORK

3.7.1. WHAT IS WORKFORCE PLANNING?

Delivering high quality patient care requires Service Providers to have the correct staffing levels, the optimum skill mix and the most efficient and effective working practices. Therefore workforce planning is more than simply forecasting the future staffing needs to avoid shortages it is also about the debate on what skill mixes and competencies are required to meet future strategies on the nature of patient care.

3.7.2. CURRENT APPROACH TO WORKFORCE PLANNING

In the past the general oversupply of skills in the labour market has allowed workforce planning to remain at the bottom of any Human Resources Agenda either at Government, Department or Service Provider level. However, staffing shortages now exist in every job family. Why has this happened? The reasons are many, but during our research the following issues were identified as those whose impact is keenly felt in the Eastern Region:

- Greater demands by patients for a higher level of service.
- Increased complexity in the nature of work, due in the main to the changes in work practices and in the ethnic mix that now populates the Health Service both from an employee and patient perspective.
- Insufficient training places which exist in some colleges to meet current demands and the time lag due to the length time required for professional education/training.
- Competition provided by the private sector in terms of levels of pay and working conditions.
- Lack of forecasting regarding the impact of strategies like reducing the number of training places or altering the content/design of professional education and training.
• The cost of living in terms of travel and accommodation, especially in the Dublin area.
• Constraints imposed by recruitment and selection practices inherent in the public service arena.
• The impression that working in the health sector is about long hours, poor working conditions and insufficient rewards.

Future Challenges which will add additional pressure on resources are the:
• Changes in legislation relating to working practices, for example the 48 hour working week for NCHD’s.
• Significant increases in consultant manpower numbers resulting in significantly increased workloads across a range of Staff.
• Changing nature of nurse training for example the four year degree course and less time spent on wards by students.
• Provision of more flexible services to patients e.g. twenty four hour cover, seven days a week.
• Need for an integrated seamless Health Service.
• Need to operate flexible working practices and support for the balance between work and family life which will have an impact on the availability of resources to provide sufficient cover and
• Impact of new technologies/medical techniques on the nature of work practices within health.

There is a recognition across the Health Service of the need for a formal approach to workforce planning in that any Expert Group or working party set up to review a job family has consistently recommended that this process be undertaken. As a result there are a number of initiatives/working groups either set up or in the process of being commissioned to look at such issues in for example; nursing, medical and paramedical job families. Appendix V contains further details.
4. THE HUMAN RESOURCES AGENDA
The following sections review particular issues within the Human Resources framework and highlights areas for attention.

4.1. STRUCTURE OF THE HUMAN RESOURCES DEPARTMENTS
This section covers the following points:

• Do Human Resources departments have the correct mix of skills and sufficient resources to deliver on a challenging Human Resources agenda?

• Do Human Resources functions receive enough support from their top management team to operate as strategic partners?

The structure of the Human Resources departments in the Service Providers within the Eastern Region differ widely depending on a number of factors:

• The size of the organisation in question.

• It's stage in the lifecycle (for example in the case of the Area Health Boards, new structures focused on role clarification and team building versus an emphasis on administration in the case of some of the older institutions).

• The activities with which the Human Resources function is directly involved.

• The degree to which Human Resources activities may be out-sourced to either an outside institution or the shared services centre and

• Whether it's remit covers nursing Staff. In a number of Service Providers, the Human Resources issues for nurses are dealt with by Nurse Managers/Directors.

One of the most consistent themes, which emerged among the Human Resources professionals within the Region during the course of this research, was that irrespective of their current size Human Resources Departments are under resourced in terms of staffing and in many cases the appropriate skill mix.

Section 3.5 outlines that as a result of the ongoing 'war for talent' Human Resources Departments are still spending a lot of their time on administration and recruitment issues. However, it also points out that Human Resources professionals and senior management recognise the need to focus on wider issues such as retention strategies, cultural change, internal communication and employee development.

As part of the People Strategy for the Health Service, the Personnel Officer Groups agreed a Human Resources Agenda comprising of a number of challenging elements. In order to deliver on this Agenda Human Resources Departments must be in a position to:

• Provide accurate workforce statistics and assist in their interpretation.

• Provide advice and assistance to line Managers in the interpretation of legal obligations and conditions of employment.
• Devise and support the management of flexible work arrangements.
• Operate recruitment, selection and induction campaigns to ensure the attraction and induction of the best qualified candidates.
• Support the needs of the organization and the individual through relevant training and development programmes.
• Support continuous improvement and personal development plans.
• Promote equal opportunities.
• Support a partnership approach to the implementation of Human Resources policies.
• Support the operation of grievance and disciplinary procedures and
• Ensure ‘best practice’ safety, health and welfare policies and procedures are in operation.

4.1.1. CONSTRAINTS

But what are the constraints that will impact on the delivery of the Human Resources Professionals Agenda?

Within the Service Providers:

• As mentioned previously the Human Resources departments are geared to deliver on administrative and recruitment processes with either the Personnel Officers or specific members providing specialist IR skills. Therefore, in many cases the departments are under resourced to deliver on the volume of work that these areas provide let alone contain the correct skill mix to deliver on a more strategic Agenda.

• The lack of ‘line management’ skills at every level in the Service Providers has also impacted on the nature of Human Resources for example it:

  △ Creates problems to which the Human Resources department must react e.g. local IR disputes.
  △ Reduces the chances of Human Resources devolving the responsibility for the operation of Human Resources policies to their rightful owners – the line Managers.
  △ Reduces the success of innovative management policies and practices as the line Managers themselves may be unable to support and drive their implementation.

• The lack of investment in Personnel Information Systems on the part of many Service Providers, to enable the management of employee information, prevents Human Resources Departments from being able to support such processes as service planning, throughout their current inability (in the majority of cases) to supply accurate workforce statistics.
Within the external environment the following constraints are in operation:

- The current process whereby Human Resources Professionals meet as separate groups does not support a co-ordinated approach within the Eastern Region.

- The lack of a co-ordinated approach to the management of Human Resources has led to the development of a number of inequities and inconsistencies across the Region. For example Section 3.6 highlights the breakdown of agreed IR structures, Section 4.2 outlines the fragmented approach to workforce planning, 4.4 illustrates the impact on grading structures as a result of this practice.

The continued lack of a Human Resources Director within the ERHA can only add to this inconsistency and valuable opportunities are being missed to support a co-ordinated approach to their resolution.

While there has been EU funding in the past for the investment in human resources. A greater emphasis must be placed on the ethos of providing specific funding for Human Resource management initiatives. Funding has traditionally been linked to service delivery rather than investing in people. As one respondent put it:

"There needs to be a balance between investing in people and services in order to ensure their (the services) delivery."

Human Resources issues are not perceived as high enough on the Agenda in many organisations and the lack of a 'champion' at ERHA Corporate level can only enhance this perspective.

**4.1.2. RECOMMENDATIONS**

Recommendations on the Human Resources Strategy for the region are covered in Chapter 5. The following recommendations refer to the structure of Human Resources departments in operation within the Region.

- It may be useful to review the dual structures in operation in a number of Agencies regarding the provision of Human Resources support to Nurses versus other job families. There may be scope for a more integrated approach.

- There is a need for Service Providers and Human Resources Professionals to jointly identify the competencies needed within the Human Resources function in today’s environment, to deliver effective and efficient Human Resources solutions in line with service delivery objectives and to facilitate the transition from an operational Human Resources role to a more strategic one. This may mean that Human Resources Professionals may need to develop new skills and competencies to deal with the many new challenges they face. The other half of this equation is to ensure that line management also have the skills to play their role in Staff management and development.
• If there truly is a belief that the Human Resources function should focus on fulfilling more than an administrative role, then it must be an area for investment and/or restructure by each Service Provider. The level and degree of this investment must take into account the size and structure of each Provider. Opportunities should be looked at restructuring departments to support the delivery of an optimum service focusing on the delivery of results. Until this happens, Human Resources Professionals will continue to be constrained by the need to deal with day-to-day operational matters.

• The Human Resources forums co-ordinated by the ERHA should consist of representatives from across both the Statutory and Voluntary Providers to support consistency and co-ordination across the region.

4.2. WORKFORCE PLANNING

4.2.1. ROLE IN HUMAN RESOURCES STRATEGY

Workforce planning is an integral part of any Human Resources Strategy. It is a highly complex process and is interlinked with almost every area of the Human Resources remit as the supply and retention of Staff are affected at a minimum by:

• The nature of pay policies, recruitment strategies, promotional structures, development opportunities.

• The degree to which people wish to work in a particular sector.

• The level of loyalty individuals have to their profession vs. particular Agencies.

• Good management practices.

• The availability of sufficient numbers of suitably qualified and trained Staff.

• The levels of demarcation and flexibility in the nature of work within and across professions.

• Team working across professional and organisational boundaries.

• Flexible working to make the best use of Staff skills and

• Removing barriers regarding which professions can fulfil which roles and deliver particular types of care.

At a National level workforce planning should play a major role in the Human Resources Agenda in the new ‘Health Strategy’. The ideal framework exists in the service planning mechanism, which allows workforce planning to be aligned with service planning at a local level, consolidated into a Regional level and submitted into a National strategy. The establishment of a National workforce planning committee is an item for consideration.
4.2.2. FUTURE CHALLENGES

At a National level as previously mentioned in Section 3.7, a number of expert groups have included workforce planning in their recommendations. However a strategy based on carrying out such exercises looking at each job family in isolation and potentially using different methodologies to reach their conclusions runs the risk of fragmentation and the danger that it will not be aligned towards the need for an integrated seamless service.

At a Regional level there is a clear need for a coordinated approach to workforce planning in order to highlight the particular needs and future challenges faced by Service Providers in the East. In addition this type of approach also strengthens the case when considered at a National level. However there are a number of barriers to be dealt with before this can become a reality:

- There are major weaknesses in the quality of the information available to support any workforce planning exercise. In certain job families this has been highlighted and actions are in place to review the systems (for example nursing). However at Service Provider level the support required to deliver such information is not only in the area of IT in the form of personnel information systems but also in terms of the resources to ensure the accuracy and timeliness of such information.
- In the management of Staff numbers and costs, there is little incentive to carry out workforce planning well due to the potential for a reduction in funding given the current arrangements whereby Staff costs drive the funding for so many initiatives.
- The lack of technical planning skills in relation to workforce planning in the Region.

4.2.3. RECOMMENDATIONS

- It is proposed by the Consultants that workforce planning become a central part of every Human Resources Agenda.
- Sufficient resources in terms of equipment staffing and training must be made available to support the collection and manipulation of workforce planning data, the determination of the quantity and nature of such investment should form the basis of a consultative process.
- Further investigation may be carried out to identify incentives to support effective workforce planning.

4.3. RECRUITMENT AND SELECTION

Recruitment is concerned with attracting candidates to apply for a given vacancy. Its primary functions are to attract a pool of suitable candidates, deter unsuitable
candidates from applying and to create a positive image of the organisation. Selection is the process of choosing the most suitable candidate from the pool. The two processes are tightly interlinked; the more effectively the recruitment stage is carried out the less important the actual selection process becomes. This distinction is reflected in the statement regarding recruitment and selection, which makes up the Strategic Human Resources Agenda signed off by the Personnel Officers groups through the HSEA.

"Candidates must be attracted from the widest possible pool of potential applicants and the best qualified candidates in terms of competencies and other relevant requirements must be recruited to the service. Our recruitment and selection policies must be designed to ensure this objective."

(A people Strategy for the Health Service 2000)

Up until quite recently, the recruitment and selection strategies utilised by Health Service Providers have been shaped by a number of factors in operation in both the internal and external labour markets. The historical emphasis on cost management within the Health Service resulted in the development of tight controls on staffing levels and procedures designed to prolong the recruitment and selection process. Within certain job families the implementation of protectionist measures such as the common recruitment pool reflected the buoyancy of the external labour market and the need to protect the internal labour market from such competition.

In the external labour market there was a plentiful supply of labour across every job family. When it came to attracting people into administrative and support roles, the aspect of job security, which is inherent in public sector jobs (given the economic climate prevalent over the years) often provided the competitive edge required to compete with similar positions in the private sector. In terms of the professions (medical, dental, nursing, allied health etc) there was no shortage of candidates. The numbers of qualified individuals produced each year often exceeded the demand, requiring people to emigrate to seek experience.

However, within a very short space of time, Health Service employers have found the external labour market has tightened up across the range of professions and skill mixes. The skills gap is spread across the entire spectrum of activities from catering and domestic Staff, to clerical/administration posts to the allied health professionals and most publicly recognised, the nursing profession and Non Consultant Hospital Doctor's (NCHD) positions.

These shortages, and the increased demands of the public on the level of service provided by the Health Sector, have resulted in the majority of Service Providers within the Eastern Region spending a significant proportion of their management time on recruitment and selection activities and in response to the challenge, a variety of strategies are being employed within the Region. Such strategies include:
• The use of media for example,
  △ Advertising in newspapers both local and National.
  △ Advertising in professional journals both National and international.
  △ The development internet sites both Service Provider specific and linked into National and international recruitment sites e.g. medical-posts.com and
  △ Commercials on the radio.
• Overseas recruitment, predominantly in nursing and Non-Consultant Hospital Doctors (NCHDs), though some evidence among the allied professionals.
• Linking into the FAS network.
• Attendance at recruitment fairs.
• The establishment of links with universities and academic institutions, schools and career guidance counsellors.
• Use of recruitment Agencies.
• Open days for school leavers to visit Service Providers and
• Mail shots.

4.3.1. WORKING PARTIES

In addition to the variety of recruitment activities there are a number of working parties or particular initiatives in operation in relation to recruitment and selection across the different Service Providers for example:

• A working group has been set up to review the Marketing and Advertising aspects of recruitment. The review is being carried out conjointly by the Health boards and the ERHA.
• The Federation has as part of its Recruitment, Retention and Promotion strategy identified a number of activities that will benefit member's actual recruitment processes.
• The DATHS and St Lukes as a result of their study, carried out in 2000, on Nursing Recruitment and Retention in the Dublin area have identified a number of areas for action within their recruitment strategies and
• The HSEA are looking at a number of initiatives to review selection procedures and the barriers to recruitment for example the common recruitment pool which places considerable restriction on the recruitment of administrative personnel.
4.3.2. NATIONAL STRATEGIES TO WIDEN THE RECRUITMENT POOL

While increasing the sophistication of recruitment practices may increase the numbers attracted to the Health Service, within each job family a number of barriers exist which have impacted on the success of recruitment strategies. Therefore numerous working parties and Expert Groups on a National level have begun to tackle the issues in each area. An overview of the work carried out by these groups can be seen in Appendix VI.

Two job families that were highlighted by Service Providers as proving difficult to recruit are the Clerical/Administration and the General Support Services (non Nursing Grades). Many called for measures to ease the shortages in these areas.

4.3.3. RECRUITMENT PRACTICES

While it is hoped that the strategies arising from the National Initiatives will increase the recruitment pool, a number of issues have emerged in relation to recruitment practices in the Eastern Region. In general a wide variety of recruitment practices are employed by Health Service Providers but an analysis of the most effective approaches in terms of reaching target audiences and providing the best response rate of suitably qualified candidates is not common practice.

4.3.4. RECOMMENDATIONS

Research in the UK has shown that the effectiveness of recruitment practices can vary significantly (Health Service Reports, 1999 & 2000). Therefore, it may be beneficial to review how effective the strategies in use in the Region are in meeting their stated objectives by asking the following questions:

- Are expensive recruitment campaigns in National newspapers the most effective method?
- Should the emphasis be on appealing to a broad range of potential applicants rather than specific posts?
- What kind of people do we want to recruit into the health sector?
- Are professional journals the optimum way to reach a target audience?
- Will overseas recruitment become a permanent part of this strategy rather than a short-term solution?
- What is the total cost of recruitment e.g. management time, recruitment costs etc?
- Should the emphasis be to spend more time and resources on retention strategies instead?

Overseas recruitment has been fragmented with Directors of Nursing and Human Resources professionals using a variety of recruitment methods for example, Agencies,
video conferencing, and personal visits. There is an opportunity to create a forum where information on the most effective practices can be shared and resources pooled for example sharing the cost of video conferencing. In addition a cost benefit analysis should be carried out to establish the actual value of this strategy.

The possibility of extending return to practice courses for other professions and administrative areas if not already in place, should be considered.

4.3.5. ADVERTISING

The Eastern Region is made up of a disparate group of Service Providers who are all competing for the same resources from the same talent pool. As a result, a trend has emerged whereby each Service Provider carries out their own recruitment campaigns often in direct competition with each other. The result has been spiralling recruitment cost both in advertising in the local and National press and in travel time and cost in the case of overseas recruitment campaigns.

In many cases the nature of advertisements placed in the newspapers leave room for improvement, many date back to a time when attracting people to posts in the Health Service was not an issue. When looking at the National papers and the Health Sector Appointments, the overall impression is highly fragmented. Some advertisements are hard to read and there is little evidence of a co-ordinated professional approach. It does not support one of the tenets of a recruitment strategy which is to present a positive image of the service.

There is little emphasis placed on marketing the Health Service as an employer of choice, outlining the full range of benefits available and the opportunities for development, which the Health Service offers.

A number of advertising Agencies are used by Service Providers to design and place the advertisements with varied success.

4.3.6. RECOMMENDATIONS

While it is impossible, given the competitive environment, which exists across Service Providers within the Eastern Region, to have a wholly integrated recruitment process. There are a number of initiatives, which could benefit from a co-ordinated approach. For example:

- In line with practices like that followed by the National Federation and the DATHS, the advertisement of vacancies within the National newspapers by Service Providers could be co-ordinated with the goal of a) minimizing cost and b) presenting a more professional image. A working group supported by the ERHA, should be created with
representatives from the various groups of Service Providers operating against agreed frames of reference, to discuss the degree to which a common approach could be followed.

- In relation to the design of the advertisements:
  - A review should be carried out on the benefits of using a single advertising Agency versus a variety and to investigate the benefit of following such an approach
  - Links should be forged with National groups re their findings on improving the advertising and marketing of the service and
  - A concerted effort should be made to enhance the image of the Health Service through this medium and to gain maximum benefit in terms of attracting a suitable pool of candidates.
- The possibility of developing an Eastern Region recruitment site on the Internet or creating a Regional job vacancy database could be investigated either on a stand alone basis or as part of the existing ERHA website.
- Once again economies of scale could be achieved through negotiating with recruitment Agencies for better rates.

4.3.7. SELECTION

As Staff are the most significant influence on the quality of patient care the calibre of those selected must remain high (A people strategy for the Health Service 2000). It can be argued that recruitment and selection decisions are among the most important decisions employers must make as they are a prerequisite to the development of an effective workforce. While the pressures of the external labour market make this increasingly difficult, employers in the Health Service must continue to ask themselves:

- What type of people do we want in the Health Services?
- Do our selection methods support the identification of the most suitable candidates?

4.3.8. RECOMMENDATIONS

Although the problems with recruitment emerged as a priority for the Service Providers in the Eastern Region, a number of issues emerged in relation to the selection processes in operation:

- In some cases the length of time spent on the process was too long and unwieldy and questions were raised about the effectiveness of the selection methods employed. There is no point improving the recruitment process if selection methods still cause problems. Therefore a review of the methods used may be a way forward.
4.4. In recent years there have been a number of working groups reviewing changes in the pay structures of selected job families in the Health Service (Appendix VII). The current focus in terms of pay at a National level is the examination currently being undertaken.

4.4.1. THE NATIONAL AGENDA

In recent years there have been a number of working groups reviewing changes in the pay structures of selected job families in the Health Service (Appendix VII). The current focus in terms of pay at a National level is the examination currently being undertaken.

particular the guidelines outlined in Circular 10/71 in many cases are outdated and do not comply with current employment legislation. This is under review by the HSEA.

• The Area Health Boards operate local and centralised recruitment and selection campaigns. The Shared Services Centre is currently reviewing its recruitment and selection methods with the intention of being recognised as the process experts and owners in this area, supporting the Area Health Boards in terms of local and central recruitment campaigns, providing administrative support and best practice advice.

• The common recruitment pool is now seen as a barrier to the selection process and the HSEA are currently reviewing this issue.

• Selection methods in the professions are guided by strict medical standards and criteria as set by Professional Bodies like the Health Education Authority. However, there is an increasing call for the inclusion of competency analysis in the selection procedure and the Office for Health Management are in the process of convening working parties to investigate this area for each job family in the service. Competencies have already been defined in the Nursing job family and for line management positions in the clerical administrative job family. The use of competencies can be highly effective in the selection process to aid in the matching of the candidate against the agreed criteria. Therefore, to gain maximum value, recruitment and selection processes should be amended to reflect this change.

• The involvement of management in both the recruitment and selection processes is vital in terms of the selection of the most appropriate candidates; this can be supported by training to ensure their skills are at optimum levels.

• A review of the selection processes in operation across the Service Providers should be carried out to identify best practice approaches and to estimate areas where potential savings could be made and knowledge shared.

• In addition to reviewing the validity and reliability of the selection methods in operation an investigation could be made of other methods of selection/candidate assessment for example the use of Psychometric testing, assessment centres and structured interviewing.

PAY AND BENEFITS
by the Public Sector Benchmarking Body (PSBB) of public service pay vis-à-vis the private sector. The PSBB is required to issue a single report covering all grades, groups and categories within its terms of reference by the end of June 2002. It is possible that there will be recommendations regarding changes in pay structures and reward systems in the Health Services.

There are number of issues that both Service Providers and unions identified as key issues. Some of these are within the National context and others are a Regional issue.

4.4.2. PAY PRESSURES AND INEQUITIES ACROSS THE REGION

It has become increasingly difficult for the Service Providers to compete with the levels of pay being offered by the education and the private sector for Staff in the Eastern Region. While there are recruitment and retention pressures across all of the grades in the Health Services, three groupings were identified by the Service Providers as requiring particular attention; clerical/administrative Staff, non-nursing support Staff and midwives.

These retention and recruitment pressures have influenced the manner in which the Service Providers manage pay and, in particular, manipulate the grading systems to arrive at the level of pay they need to attract candidates to a position or retain current employees.

- The level of pay and the degree of overlap between the grades at Clerical/Administrative level has caused difficulties for the Service Providers. The Benchmarking Body may address this in their recommendations as they are examining Grades III to VIII and the General Manager posts.

In the clerical/administrative grades a significant number of re-gradings have been carried out at local level over the past 2 to 3 years under new technology deals and in a bid to keep Staff. A significant number of these reviews upgraded Grade IIIs to Grade IV and Grade IVs to Grade V.

This re-grading has created a number of inequities between posts in the Area Health Boards, the Voluntaries and the Intellectual Disabilities. The smaller Voluntary and Intellectual Disability Providers have been placed at a disadvantage.

- Both the Service Providers and the unions recognise that there is a need to address the salary scales of care assistants and related grades.

Further to the recommendations of the Nursing Commission and the Working Group '7.63' a second Working Group '4.55' has been set-up to establish the standard criteria in relation to the entry requirements, educational qualification and training for Care Assistants, Attendants and other non-nursing employees. Parallel to this an agreement
between SIPTU and the Department of Health and Children has led to the establishment of a 'Profiling Body', under the auspices of a Joint Working Group chaired by the Labour Relations Commission, to carry out a detailed examination of the Pay/Reward structure and the conditions of employment issues for this grouping of employees. It is expected the work of the Body and the Joint Working Group will be concluded by December 2001.

4.4.3. **DEVOLUTION OF THE CLERICAL /ADMINISTRATIVE GRADING PROCESS IN THE EASTERN REGION**

In December 2000, the Department of Health and Children formally devolved the responsibility for the re-grading of clerical and administrative posts to the ERHA. The re-grading structures for clerical/administrative Staff and non-nursing Staff have been approved at National level with Union agreement. The categories covered include roles such as Medical Secretaries, Community Welfare Offices, Outpatient Department Personnel, Ward Clerks, Medical Records Personnel, Telephonist, IT Personnel, etc.

The job evaluation system, used as the basis for allocation of jobs to the grading structure, was developed in August 1971 by the working party on job evaluation and grading of executive and clerical jobs in Health Boards and local authorities.

The model has been approved at National level with union agreement, and any change would require a renegotiation at that level. However, it should be noted that the Consultants would advise that the system should be reviewed in light of the changes in the nature of work in the Health Services since the 1970s.

Given the inequities across the Region, a joint submission from the Maternity Hospitals and the flexibility proposals of the DATHs, the ERHA need to get procedures and systems in place to deal with the waiting list. The ERHA are addressing this as a matter of urgency and are in the process of agreeing a strategy to address this in the short term.

The Consultants noted that there was no adequate transitionary arrangements put in place in the course of the transfer by the Department of Health and Children of its responsibilities for carrying out evaluations in the Eastern Region to the ERHA. The Staff in the ERHA were charged with the responsibility of carrying out the evaluations without sufficient training at the time of the transition. This, together with the limited availability of union resources has impacted on the ERHA's ability to manage the process.

As noted, the Regional issues have to be addressed as a matter of urgency. However, the Consultants would query as to whether this role should be the formal responsibility of the ERHA in the long-term. At this point in time this has not been devolved in any other Region, it is a mechanism that needs to be managed consistently at a National level and there is the issue as to whether the ERHA should be involved at such an operational level.
4.4.4. CREDIT FOR PRIVATE SECTOR EXPERIENCE

On the 16 March 2000 the Labour Relations Commission granted full incremental credit for Paramedical, Clerical/Administrative and Analogous Grades on permanent appointment in respect of all previous relevant public sector experience whether in Ireland or, subject to certification, abroad. This new agreement also allowed temporary and part-time Staff progress beyond the 5th point of their scale.

Service Providers in the Region would argue that an employer should be in a position where they can also recognise a person's private sector experience and match that experience with an appropriate rate of pay.

4.4.5. PROCESSING OF PAY AWARDS

There has been a serious problem in terms of the releasing and processing of funds for a variety of pay awards in the Eastern Region.

The management of payroll for the ERHA Corporate and the three Area Health Boards is the remit of the Eastern Region Shared Services (EHSS) Centre. The EHSS have experienced significant set-up difficulties and these have been compounded by Staff retention difficulties. There are currently a number of joint working initiatives between the EHSS and the Area Health Boards and the Unions to try and address this issue as a matter of urgency.

There are a number of dimensions to this problem other than the structures and systems in place in the Shared Services Centre. This issue has highlighted the difficulties for the employee representative in terms of interfacing with the new Area Health Boards and the perception of a lack of accountability at lower levels in terms of Human Resources personnel. This relates back to the issues outlined in Section 3.6.

4.4.6. DUBLIN WEIGHTING ALLOWANCE

It is not the remit of this report to investigate the requirement for a Dublin weighting allowance. However, it is important to note that a number of unions within the Health Service are calling for the introduction of such a Dublin weighting. The Department of Health and Children have stated that the only form in which it can be dealt with is the Benchmarking Body.

4.4.7. PERFORMANCE RELATED PAY

The Public Sector experience of Performance Related Pay has been mixed and this was reflected in the views expressed by the Service Providers. The Consultants would advise that the Health Services in the Eastern Region are not in a position to implement
Performance Related Pay at the moment. Should a Performance Related Pay strategy ever be followed it would be imperative that it would be preceded by well established and successful performance management systems. The model for a linkage to pay would need to be consistent across the Region.

4.4.8. REWARD MANAGEMENT INITIATIVES

In recent years Health Service Providers have responded to recruitment and retention difficulties by reviewing both the financial and non-financial benefits that they offer to employees. The ‘reward’ strategies they have employed to attract and retain a work force that is characterised by an increasing number of women, part time Staff and a higher proportion of working parents are varied. The fundamental factor underpinning these strategies is the recognition that job satisfaction, quality of life and professional development are no longer of secondary or marginal importance to pay.

The Service Providers in the Eastern region are providing a number of benefits to employees that are over and above their statutory entitlements;

- Positive and attractive employment practices and conditions including; flexible working patterns, job-sharing, teleworking and flexible working hours.
- Some service providers offer a choice of rosters to Staff; full time over four days and flexi time is widely available to administrative Staff and teleworking has been piloted in a number of sites.
- Considerable flexibility in training and deployment of Staff (where possible).
- Career breaks and unpaid leave has been facilitated where possible.
- Retention bonuses – vouchers for spending on local activities/facilities.
- Tax efficient ‘recognition’ bonus vouchers to all Staff.
- Recognition of the canteen as a benefit and upgrading of facilities.
- Recreational Facilities for sports and leisure pursuits.
- Transportation to and from the hospital.
- Some organisations provide crèche facilities and others are carrying out feasibility studies including tax efficient methods for capital investment which benefit both employees and employers.
- Occupational Health programmes have been developed in various locations.
- Improvement of library facilities and some have developed ‘Learning Resources Centres’.

The next step for the health services employers would be to move to a ‘flexible benefits’ model - a type of plan under which employees select their benefits (up to an agreed IRE
value) from a menu of different benefits provided by the employer. While this would be desirable the Consultants would advise that the services do not have the administrative systems in place to manage such initiatives at this time. This is an issue that could be reviewed in the context of the PPARS information systems project.

4.5. TRAINING AND DEVELOPMENT

4.5.1. THE ROLE OF TRAINING AND DEVELOPMENT IN THE HEALTH SERVICES
The importance of training and development has been recognised in the reports of various Working Groups reviewing recruitment and retention issues in the Health Services. Effective training and development strategies are one of the most important tools the health system has to:

• Develop a positive managerial ethos throughout the health and personal social services, one that will support the goals of the new National health strategy.

• Ensure that the public service ethos and care ethic is maintained throughout the system.

• Support the development of career paths and personal development programmes as part of recruitment and retention practices.

• Break down barriers and promote understanding and communication across the different parts of the Health Services.

• Foster equal opportunities in the Health Services and achieve a more equitable gender balance in senior posts.

• Develop skills to work in a positive multicultural environment.

• Develop skills that enable members of the service to in a ‘partnership’ environment and initiate change.

4.5.2. THE FOCUS OF EDUCATION, TRAINING AND DEVELOPMENT
Education, training and development have not developed to the same extent across all of the job families in the health services. In recent years there has been a significant focus on the education and post-graduate training of medical professionals, nurses and some allied health professional groupings. The desired outcome of investment in these job families has been to reverse the trend of professionals leaving Ireland to gain international experience in a more supportive learning environment with clear career paths.

There has been progress in terms of management and personal development across a number of job families but the clerical/administrative grades and the non-nursing grades
have not benefited from similar training and development initiatives. A typical point made by that the Service Providers was that:

"There is funding for both management education and management development for medics, nurses and junior doctors what about the rest of them?"

However, the set-up of the Working Groups to address the issue of establishing standard criteria in relation to the entry requirements, educational qualification and training for Care Assistants, Attendants and other non-nursing employees is evidence of other 'non-professional' grades beginning to getting on to the training agenda. This is been driven by potential changes in the skills mix.

During the course of our review some of the Service Providers emphasised the need to provide all Staff with accredited training and development programmes and a clear progression route to further education and career development. A new emphasis needs to be placed on the training of all Staff working within the health sector.

4.5.3. MANAGEMENT DEVELOPMENT

In terms of training and development the Service Providers in the Eastern Region have recognised that it is important for employers to establish a clear link between the personal learning objectives of their Staff and the objectives of the organisation/service. They currently recognise the importance of (or are as mentioned previously are in the process of) implementing programmes in the areas of personal development and management development.

As a result of national initiatives pioneered by the Office for Health Management (OHM) there has been progress in terms of management development for senior and first line Managers, for nurses and for clinicians in management across the health care sector. See Appendix VIII & IX. To date the majority of these initiatives have focused at senior management/line management level and there is a significant need to progress further work at this level. The Service Providers have also identified a need to cascade these initiatives down to the next levels. This work is crucial to the development of working environments in the Health Services that are characterised by positive and progressive management.

The OHM have developed competencies for a number of job families. This is a significant step in setting up the building the blocks that will support personal development objectives, recruitment and selection process and performance management at all levels.

4.5.4. TRAINING NEEDS ANALYSIS

The majority of current training programmes implemented by the Service Providers in the Region focus on issues such as; health and safety, induction programmes, customer care for medical Staff, and information technology systems.
Training budgets tend to be devolved to Managers/Department Heads. The allocation of funds is currently driven by the nature of employees' interests and take-up depends on Managers and individuals.

"Training tends to be driven by Staff requests – not strategic or coordinated".

While it is important for managers to encourage individuals to take responsibility for their own development there needs to be a clear link between the training and the subsequent added-value contribution that will be made by the individual to the organisation.

Only a small number of Service Providers have developed a training needs analysis approach to developing their training and development strategies. There is a need for Service Provider organisations in the region to clearly identify the development needs of their organisations, define the gaps that exist and develop appropriate training and development strategies.

4.5.5. A CO-ORDINATED APPROACH

Under the Programme for Prosperity and Fairness each employer is to allocate 3% of their annual budget to training. According to the ERHA, training budgets in the Eastern region vary from between .5% to 4%. This indicates that there is a need to promote training and development not only across all job families but also across all Service Provider organisations in the region.

Training and development is a valuable tool in terms of attracting and retaining people in the health services. In this context the Service Providers in the Eastern region, during the course of our research, identified a need to develop links, connections and partnership arrangements between different Hospitals, Health Boards, and other bodies in the region.

This co-operative approach could take the form of:

• The delivery of training programmes in a co-ordinated way for issues of mutual interest.
• Staff rotation agreements.
• The identification of Centres of Excellence in the region equipped to provide appropriate high quality training on specific issues.

At a strategic level the Consultants would advise that there is a need for a full assessment of training needs in the region which should be followed by the development of a regional response that supports the objective of workforce planning strategies.
4.5.6. GETTING TRAINING AND DEVELOPMENT ON THE AGENDA

While Human Resources professionals in the Eastern region recognise that a strategic approach to training is a valuable tool in the recruitment and retention there are pressures on delivery of the training agenda.

The issues cited by Service Providers of both large and small organisations was the lack of resources to provide back-up cover for the trainee, the pressures on time, insufficient funding and cultures that are not supportive to a training and learning environment.

4.6 PERFORMANCE MANAGEMENT

The framework for the introduction of Performance Management in the Health Sector is clearly outlined in The Programme for Prosperity and Fairness (PPF). See Appendix IV. It put forward a clear set of design principles in that it:

- Recognises that the process of business/service planning results in individual and team objectives, which provides the basis for managing performance.

- Defines Managing Performance as "a continuous process directed at achieving the organisation's objectives by ensuring that Staff at all levels know what their role is and what is expected of them in terms of targets and standards, are aware of the progress being made and that they have, or can acquire, the knowledge, technical skills and other competencies they need to carry out their work in an efficient and effective manner”.

- Stresses the need for its implementation by stating that each sector will develop, as a matter of urgency, a performance management system relevant to its needs and circumstances and implement it over the period of this Programme.

- Provides guidelines on its design by highlighting that such systems will be based on; clarity of roles and responsibilities, developing the knowledge, skills and other competencies of individuals and teams and that implementation will be underpinned by:

  - An acceptable balance between meeting the objectives of the organisation and the development needs of Staff at all levels
  - Improved training and development focusing on enhancing management and Staff skills and competencies to facilitate career and personal development.
  - Improved measures to ensure equality of opportunity in recruitment, promotion and work practices and
  - Necessary measures to meet the needs of Staff with disabilities in line with the relevant codes of practice.
As a result of the PPF document, Service Providers have a set of guidelines with which to develop and implement performance management systems. As part of this research, it was found that the take up of the system is varied among Service Providers in the East. It ranges from those who have no formal system in place, to others who are in the design phase, to those who have operational systems in place.

An important consideration, which must be taken into account when reviewing the introduction of a performance management system is the impact it can have on those it seeks to support. In relation to Managers it, requires a completely new skills set. Undertaking performance management in an objective, sensitive and transparent manner requires careful preparation and considerable training and development of Managers prior to its implementation. It should be introduced in a culture where it is seen as a system to support Staff in the operation of their jobs rather than as a control or monitoring mechanism. If these two elements are not in place, its introduction can have a detrimental effect in terms of motivation.

4.6.1. RECOMMENDATIONS

• As Performance Management is one of the key elements which (if designed and implemented effectively) can operate as a co-coordinating force in the integration of so many Human Resources initiatives, it plays a key role in any strategic Human Resources Regional Agenda. Therefore, it should form an integral part of the National Human Resources Strategy going forward.

• In terms of a Human Resources Strategy for the Eastern Region it provides a perfect example of a system whose design and implementation, while remaining within the PPF guidelines, can be tailor made to suit the needs of individual Providers. However, this flexibility is only applicable in the absence of a direct link between performance management and reward. Should a Performance Related Pay strategy ever be followed it would be imperative that the system in terms of its design and implementation, be consistent across the Region.

• Service Providers should only consider it's implementation when they are sure their organisation is in a position to gain maximum benefit from the process in relation to skill levels and a supportive culture.

4.7. INFORMATION SYSTEMS

Ensuring that accurate workforce information is available for strategic decisions is one of the cornerstones of the Human Resources Agenda and is often one of the areas where its activities can truly be seen to add value in the achievement of an Agencies objectives.
In 'A People Management Strategy for the Health Services', this process is mentioned in the context that 'manpower planning should be an integral part of the Human Resources function and therefore must be informed by performance indicators e.g. turnover rates, absenteeism levels, age profiles of Staff etc'.

However as noted in section 4.2 the level and nature of the information necessary to support workforce planning is lacking throughout the Health Services. As part of our research, many Service Providers indicated there was room for improvement in the nature of information available regarding employees.

4.7.1. PAYROLL PERSONNEL ATTENDANCE, RECRUITMENT SYSTEM (PPARS)

At Health Board level, in response to such problems with workforce information, the (PPARS) project was initiated in 1998 and its headquarters are in Sligo. The SAP based package is a fully integrated Human Resources system inclusive of payroll and attendance/absence recording. The entire system is based on developing organisational charts for each Agency, identifying every post by its title and grade. The posts are then populated by individuals. The three Area Health Boards and St James Hospital in the Eastern Region are part of the National implementation programme.

At a Regional level, the ERHA requires a significant amount of highly detailed workforce information for a number of reasons to:

- Support the service planning process.
- Inform Regional and National workforce planning and forecasting activities and
- Aid in a variety of costing exercises.

The Voluntary Service Providers in Eastern Region and their Human Resources functions now require detailed workforce information to support their strategic and operational decision and planning activities.

Therefore, a mutual approach must be followed which will benefit the information requirements of all parties concerned. The Finance Directorate within the ERHA is currently driving an initiative to achieve consensus on a way forward.

Inherent in the success of any approach to collating and updating information are the following requirements;

- A system whose design allows the capture and manipulation of the information in a manner, which meets the particular Agencies needs.
- Sufficient resources to ensure information is regularly updated and maintained and
- Clear accountability at levels to follow the agreed steps, which will ensure information flows are maintained.
4.7.2. EXIT INTERVIEWS

On a broader level, information systems in the Agencies should not only be concerned with gathering demographic information on their employees but should also support the identification of relevant retention strategies and to measure organisational culture.

For example the process used by Service Providers for establishing individual's reasons for leaving their employment were varied. They range from one on one exit interviews with the relevant Manager/Member of Human Resources/ Nurse Manager to a request that leavers fill in particular forms which identify their reason for leaving. As part of the PPARS project, exit forms have been included for processing (their format is predetermined allowing no room for flexibility in response). In some Agencies, no formal process is carried out.

While exit interviews can be criticized in terms of the validity and reliability of the information they produce, ascertaining why people leave can be highly valuable in informing an Agencies retention and workforce planning strategies.

This is evidenced by the level to which information gathered from nurses who had exited the DATHS informed many of recommendations which made up the 2000 study on Nursing Recruitment and Retention.

4.7.3. CLIMATE SURVEYS

However, a more pro-active strategy to inform the Human Resources Agenda is that followed by a number of Agencies, which is to carry out climate or attitude surveys (the difference between these two is one of emphasis, attitude surveys tend to focus on the views of employees to specific initiatives, whereas climate surveys attempt to assess general morale within organisations - a combination of both can be used). Not only do these highlight certain issues as important, they also provide benchmarks against which to evaluate the success of particular initiatives.

While this information is invaluable at a local level, it may also feed into Regional information systems to support the identification of particular trends or issues among the Providers. The ERHA Corporate could carry out a review of common findings or particular traits for feeding into overall workforce management strategy.
5. THE WAY FORWARD

5.1. THE HUMAN RESOURCES STRATEGY FOR THE EASTERN REGION

This final chapter presents a strategic HR framework, which takes account of the environmental issues outlined in Chapter 3 and supports the resolution of the particular Human Resources challenges faced in the Eastern Region covered in Chapter 4.

At a National level the Human Resources strategy for the Eastern Region must be fundamentally driven by the:

- new Health Strategy for the Republic of Ireland which is currently being developed.
- work already completed by the HSEA and the Personnel Officers Groups outlining a strategic Human Resources Mission and from it strategic values, objectives and agenda at a National level.

However while a 'fit' must be achieved with these national initiatives, this project is concerned with developing a Human Resources Strategy for the Eastern Region which supports the objectives of the ERHA.

Therefore the Consultants propose that the Human Resources Strategy for the Eastern Region must be about achieving the following three key objectives;

- Getting Human Resources on the strategic agenda of every service provider in the region.
- Defining the Eastern Regional Human Resources model for the future.
- Agreeing the framework for the implementation of a regional Human Resources Strategy.

So how can this be achieved?

5.1.1. GETTING HUMAN RESOURCES ON THE AGENDA

Human Resources are not formally incorporated into Service Provider agreements or provider plans, rather they are assumed to underpin each Service Providers objectives in terms of meeting their obligations for service delivery.

Therefore in order to make a Human Resources Strategy a reality it is essential that Human Resources is high on the Agenda of every Service Provider in the Region. The Consultants propose that the way to achieve this is to incorporate it into the Service Planning process either as part of the three year service agreement and or the annual provider plan.

In this way Human Resources issues are given a priority, which does not simply rely on the values and beliefs held by senior management as to their relevance but ensures their importance is recognised across the Region.
The service planning mechanism is potentially the ideal framework to also:

- Identify the Human Resources agendas for the Eastern Region on an annual basis in terms of the provider plans and/or on a more strategic basis in terms of the service agreements, depending on how it is incorporated into the process.
- Agree a co-ordinated approach to their prioritisation and resolution.
- It also presents Human Resources Professionals with the opportunity to become fully involved in the planning process.

However there are a number of specific issues, which must be dealt with before such an approach is communicated to the Service Providers. It is vital to identify the mechanism by which Human Resources will be included in the service planning process. For example the following questions need to be considered:

- How will the Human Resources section ‘fit’ in relation to information requirements vis a vis those required by Planning & Commissioning and Monitoring & Evaluation?
- What are the lines of accountability and ownership for particular issues for example workforce planning information?
- On what basis will funding be available to Service Providers for Human Resources initiatives?
- What level of funding will be made for particular initiatives?
- What timeframe should be agreed to evaluate the success of particular strategies?

As a starting point the Consultants would recommend that the items which need to be included under the Human Resources heading are not just related to workforce numbers, but should include areas like:

- The structure and competencies of the Human Resources Department.
- Training and Development initiatives.
- Change Programmes.
- Special projects.
- Information systems requirements.
- Workforce planning information.

Once a template has been drafted it is recommended that in order to gain consensus to this approach that the input of the Human Resources Professional in the Service Providers be gained regarding issues like the nature of Human Resources inclusion and the resulting levels of information that may be required and the actions taken to support the achievement of its stated objectives.
5.1.2. A MODEL FOR THE FUTURE

The previous section outlines how Human Resources can be included on the strategic agenda. But how can Human Resources functions play a central role in implementing their Service Providers objectives? The Consultants propose that the model of Human Resources Management that will best meet the Human Resources needs outlined by Service Providers is based on the framework put forward by David Ulrich.

He states that 'Human Resources should not be defined by what it does but by what it delivers – results that enrich the organizations (Service Providers) value to customers (patients, clients), investors (statutory and voluntary funding) and employees'.

But how can this be achieved?

Human Resources should aim to deliver on its objectives by becoming;

• A strategic **partner with senior and line management** in strategy execution – Human Resources should be responsible for defining how the organisation is organised to carry out its strategy and identifying areas which require change or renovation.

• an **administrative expert** in the way work is organised and executed – HR should ensure information is available for strategic decisions and that costs where possible are reduced and efficiencies introduced.

• a **champion for employees**, vigorously representing their concerns to senior management while working to increase their contribution i.e. their commitment to the organisation and their ability to produce results.

• **an agent of continuous transformation** - shaping processes and a culture that together improve an organisations capacity for change.

This requires not only changes in how Human Resources professionals think and behave but also that senior executives change what they expect from Human Resources.

Therefore the Consultants propose that Senior Management within Service Providers must begin to;

• Overtly communicate within their agencies the importance of cultural change, the value placed on its employees and the need for their commitment and retention.

• Explicitly define the deliverables from Human Resources and hold Human Resources accountable for the delivery of specific results.

• Invest in their Human Resources functions by upgrading skill mixes, restructuring the function to meet agreed deliverables and providing support to meet information requirements.

To meet these expectations the Consultants recommend that HR professionals must undertake;
A review or audit of how they deliver their services within their agencies.

Identify areas where greater efficiencies could be achieved.

Focus on the deliverables of their work.

Articulate their role in terms of the value they create.

Review the activities with which they are involved and prioritise those which add most value in achieving their agencies objectives.

Work to devolve responsibility for people management to their line Managers.

Recognize they must take a regional perspective and a national one in relation to the management of Human Resources.

View other Service Providers as ‘benchmarks’ and sources of information on innovative approaches.

This model is presented as a proposed way forward, the changes suggested will not be achieved overnight. They are the building blocks that will enable senior management not only to view employees as strategic assets, but also to invest in Human resources capabilities so that Human Resources functions are in a position to leverage management’s perspective.

5.1.3. FRAMEWORK FOR IMPLEMENTATION

In developing a framework for the implementation of a 'Regional' Human Resources Strategy it would be tempting to compare the profile of the Eastern Region to that of a large multi-National made up of a number of diverse business units. In this type of model key decisions on the allocation of core resources are taken at the corporate level but it is the responsibility of business unit Managers (Chief Executives/Secretary Managers) to deal with the implications of these and to make appropriate operational decisions to satisfy corporate requirements.

Thus, this type of model would allow for different functional strategies to operate at the business unit (Service Provider) level to suit specific business (service provision) strategies. The Human Resources Strategies and decisions are an operational responsibility at the business unit (Service Provider) level. This implies that multi-business (diversified) companies (Service Providers) are likely to have considerable variation in their Human Resources policies to fit with their different business conditions and strategies.

At first glance, it would appear that the above model would be appropriate as a framework for a human strategy in the Eastern Region. However the Consultants would advise that this model is not appropriate. As noted throughout this report, there is a definite need for a Regional Human Resources Strategy, which requires all of the Service Providers to adhere to a consistent set of values, objectives, Agendas, policies and practices that support the overall Regional strategy.
In reaching this conclusion the Consultants took the following salient issues into account:

• As Bill Roche (1998) in his review of the Strategic Management Initiative (SMI) indicates; the model outlined above focuses on Human Resources theory as applied in commercial organisations, where business strategies are developed by senior management, sanctioned by boards and implemented sometimes in partnership with Trade Unions or in consultation with employees by Managers at different levels. However, as Roche points out when looking at Service Providers in the public sector, the model in the scenario outlined above, is incomplete. Where the public sector is concerned, strategies must be subject to political clearance and their implementation to political involvement of a kind seldom witnessed in commercial organisations. As Roche highlights, political brokerage complicates Human Resources Strategy and development especially where there is a well-established tradition of intervention in risky political areas such as health and education.

• National agreements, pay policies and legislation provide a framework within which each Service Provider must operate, therefore limiting the possibility of individual arrangements.

• Many systems such as the reward structures and grades are interdependent and for each Service Provider to implement them in a different way will ultimately result in anomalies across Providers. This will have implications for the areas of recruitment, retention and reward. For example; see Section 4.2 in relation to the fragmentation in workforce planning 4.4 for a review of the impact on grading structures as a result of this practice and 3.6 the breakdown of agreed IR structures.

• Partnership plays a major role in the development of these policies and agreements and consistent implementation and ‘fairness’ lies at the heart of this approach.

Having stated that there is a need for consistency the Consultants also recognise that given the complex and diverse nature of the Service Providers in the Eastern Region, there must be a degree of flexibility inherent in the way Human Resources is managed to allow each Provider tailor their own Agenda and certain practices to meet the particular needs of their organisations.

So how can this potential conflict be resolved?

It can be resolved through a consultative process whereby Service Providers reach agreement on those areas where consistency must be achieved/followed and those areas where flexibility can be applied.

As a starting point the Consultants propose the following areas for consideration as requiring a consistent approach across the region;

• The guiding principles of the Human Resources Strategy and the role it should move towards in the future.
• Adherence to legislation.
• Terms and Conditions of employment across the region (the HSEA is working on this).
• Pay Terms.
• Industrial relations procedures and collective agreements.
• Methodologies relating to workforce planning.
• In some recruitment and selection practices.
• The job evaluation process and grading issues.
• Agreement regarding relevant Human Resources competencies.

The following areas are proposed as ones where flexibility could be applied:

• The structure of Human Resources departments as they are subject the specific needs of each service provider and to the level of investment they wish to make.
• The methods used to collect and manage Personnel Information, assuming they provide the nature of information required to support strategic decision making at Voluntary Service Provider level and at Regional level.
• Recruitment and selection processes where each provider wishes to maintain ‘full control’ of this process. However full advantage should be taken if economies of scale and sharing successful methods.
• Training & Development initiatives.
• The design and timeframe for the introduction of a performance management system, assuming it will not be linked to pay.

5.1.4. THE HUMAN RESOURCE AGENDA FOR THE EASTERN REGION

A number of issues have been highlighted in this report and they are proposed by the Consultants as a set of specific initiatives, which should form the basis of an initial Strategic Human Resources Agenda. They are as follows:

• The Human Resources & Workforce Planning Director needs to be appointed immediately. The role and the necessary skills and background to meet such a demanding agenda is outlined in Section 5.2.3.
• The role of the ERHA needs to be further clarified as discussed in Section 5.2.1 and how communications should be managed is covered in Section 5.2.2.
• A consultative forum should be created to discuss the findings of this report and agree ways forward. This mechanism is further explored in the section 5.1.5 Consultation and Partnership.
• How Human Resources should be incorporated into the service planning process is covered in Section 5.1.1.
Specific objectives which should be the focus of immediate attention are the:

- The need for an updated and co-ordinated approach to Recruitment and Selection processes as outlined in Section 4.3.
- Management of workforce planning and how it can be supported in terms of information systems and resourcing as outlined in Section 4.2 and 4.7.
- The delivery of training across all job families, the level of funding available, the degree to which management development continues to be a priority and the need to co-ordinate training initiatives across Service Providers are outlined in Section 4.5.
- The need to address equity in the clerical/administrative grading system in Section 4.4.
- The review of Human Resources Departments structures and resources as covered in Section 4.1.

### 5.1.5. CONSULTATION AND PARTNERSHIP

The process by which the Human Resources Strategy is developed over the next six months may be more important than the actual delivery on specific outcomes during that period. There needs to be an extensive consultation process with key stakeholders. This report should form the basis of a consultation document for discussion with all of the stakeholders.

- The ERHA need to get the views of each stakeholder in the Region on the findings and recommendations of this report.
- A Working Group with representative(s) from each of the Service Provider groupings should be established to consider the views of the 'Region' and to develop an overall Human Resources Strategy.
- The findings of the Working Group should be published and followed-up by another phase of consultation with all of the stakeholders including unions, professional associations, the Department of Health and Children, the HSEA, Office for Health Management and all other appropriate statutory or non-statutory Agencies in the Health Services.
- The implementation of strategies should be done within a 'partnership' framework. Further to the above process the ERHA Corporate need to consult with key stakeholders in the Region on an on-going basis to discuss and identify priority issues for the Region and to develop a coordinated approach to developing solutions.

In this regard the ERHA need to:

- Establish a Regional Human Resources forum for the Service Providers and
- Liaise closely with the Department of Health and Children, the HSEA and the Office
for Health Management to ensure there is no duplication of work and that the Region's Human Resources initiatives are aligned to National strategies.

5.2. DEVELOPING A NEW ENVIRONMENT

5.2.1. CLARIFICATION OF THE NEW STRUCTURES AND WORKING RELATIONSHIPS

One of the issues in the environment as outlined in Chapter 3 is the lack of clarity around the emerging role of the ERHA.

The nature of both the legal and operational relationships between the ERHA and the statutory and non-statutory Service Providers needs to be clearly defined and communicated.

Similar to the recommendation in the study conducted by the National College of Ireland (Sept 2000) on relationships between the former Eastern Health Boards and the smaller Voluntary Organisations in the Eastern Region, the ERHA Corporate should develop a policy on its relationship with all the Voluntary organisations in the Region. The Consultants advise that this policy should extend to relationships with other stakeholders and that such a policy would define, articulate and clarify the role of both parties within the relationship. The policy could be defined in terms of a Service Charter. This needs to be worked through and communicated in consultation with the stakeholders.

There is also a perception that lines of accountability and responsibility could be further clarified and that the transfer of information within the system could be improved. A review of the new internal systems and procedures needs to be conducted to identify any blockages and to establish the degree of administrative support required to address these issues.

5.2.2. ERHA - HUMAN RESOURCES & WORKFORCE PLANNING DIRECTOR

As outlined in Chapters 3 and 4 the lack of a coordinated Human Resources Strategy in the Eastern Region has had a negative impact on the ability of both statutory and non-statutory Service Providers to attract and retain employees to deliver on the plans of the Health Services in the Region.

The Consultants strongly recommend that there is a role for a Human Resources and Workforce Planning Director in the ERHA Corporate organisation. This role should act as a facilitator for the co-ordination of the Regional approach to Human Resources.

The role should be responsible to the Regional Chief Executive Officer – ERHA Corporate
The main purpose of the role is as follows:
• To ensure that strategies are developed that provide for the availability and effective use of Human Resources in the Region so as to contribute to the delivery of service plans and

• To facilitate, on behalf of the Authority, the recruitment, development and retention of Staff of the highest quality in all professions and disciplines and to support the development of an organisational culture across all ERHA services that values Staff, develops them professionally and personally, enabling them to work more effectively.

• For a full role description see Appendix X.
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HEALTH (EASTERN REGIONAL HEALTH AUTHORITY) ACT, 1999

ARRANGEMENT OF SECTIONS

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2. Interpretation.
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22. Amendments to Second Schedule to Principal Act.

FIRST SCHEDULE

Functional Areas of Area Health Boards

SECOND SCHEDULE

Acts Referred to

- Comptroller and Auditor General (Amendment) Act, 1993 1993, No. 8
- Dentists Act, 1985 1985, No. 9
- Health Act, 1953 1953, No. 26
- Health Act, 1970 1970, No. 1
- Health Acts, 1947 to 1996
- Health (Amendment) (No. 3) Act, 1996 1996, No. 32
- Health (Corporate Bodies) Act, 1961 1961, No. 27
- Health (Provision of Information) Act, 1997 1997, No. 9
- Local Government Act, 1994 1994, No. 8
- Local Government (Dublin) Act, 1993 1993, No. 31
- Local Government (Superannuation) Act, 1980 1980, No. 8
- Medical Practitioners Act, 1976 1976, No. 4
- Nurses Act, 1985 1985, No. 18
HEALTH (EASTERN REGIONAL HEALTH AUTHORITY) ACT, 1999


[2nd June, 1999]

BE IT ENACTED BY THE OIREACHTAS AS FOLLOWS:

PART I

PRELIMINARY

1.—(1) This Act may be cited as the Health (Eastern Regional Health Authority) Act, 1999.

(2) The Health Acts, 1947 to 1996, the Health (Provision of Information) Act, 1997, and this Act may be cited together as the Health Acts, 1947 to 1999, and shall be construed together as one.

2.—(1) In this Act —

“the Act of 1993” means the Comptroller and Auditor General (Amendment) Act, 1993;

“the Authority” means the Eastern Regional Health Authority established under section 7;

“Dublin Corporation” means the Right Honourable the Lord Mayor, Aldermen and Burgesses of Dublin.
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''establishment day'' means the day appointed by the Minister under section 3 to be the establishment day;

''executive function'' shall be construed in accordance with section 4 (as amended by section 24) of the No. 3 Act of 1996;

''functions'' includes powers and duties, and reference to the performance of functions includes, as respects powers and duties, reference to the exercise of the powers and the performance of the duties;

''local authority'' means—

(a) in the case of an administrative county, the council of the county; and

(b) in the case of a county borough, the corporation of the county borough;

''local electoral area'' has the meaning assigned to it by section 13 of the Local Government Act, 1994;

''member of the staff'' includes an officer and servant;

''the Minister'' means the Minister for Health and Children;

''the No. 3 Act of 1996'' means the Health (Amendment) (No. 3) Act, 1996;

''prescribed'' means prescribed by regulations made by the Minister;

''the Principal Act'' means the Health Act, 1970;

''recognised trade unions and associations'' means the trade unions and staff associations recognised by the Authority for the purpose of negotiations which are concerned with the transfers of staff to the Authority as well as remuneration, conditions of employment or working conditions of officers and servants of the Authority;

''registered dentist'' means a person whose name is entered in the Register of Dentists, other than a person temporarily registered under section 28 of the Dentists Act, 1985;

''registered dispensing chemist and druggist'' means a person whose name is entered in the register of dispensing chemists and druggists maintained by the Pharmaceutical Society of Ireland;

''registered medical practitioner'' means a person whose name is registered in the General Register of Medical Practitioners, other than a person provisionally registered under section 28 of the Medical Practitioners Act, 1978, or temporarily registered under section 29 of the Medical Practitioners Act, 1978;

''registered nurse'' means a person whose name is entered in the register of nurses maintained by An Bord Altranais under section 27 of the Nurses Act, 1985;

''registered pharmaceutical chemist'' means a person whose name is entered in the register of pharmaceutical chemists maintained by the Pharmaceutical Society of Ireland;
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[1999.] "registered psychiatric nurse" means a person whose name is entered in the psychiatric division of the register of nurses maintained by An Bórd Altranais under section 27 of the Nurses Act, 1985:

"reserved function" has the meaning assigned to it by the No. 3 Act of 1996 (as amended by section 24):

"services" means health and personal social services which may be provided by a health board:

"voluntary body" means a voluntary body which provides or proposes to provide a service similar or ancillary to a service that a health board may provide:

"voluntary hospital" means a hospital which is substantially funded by means of an arrangement with the Authority or an Area Health Board under section 10 and the governing body of which is not the Authority or an Area Health Board or any committee of those:

"voluntary intellectual disability service provider" means a provider of intellectual disability services which is substantially funded by means of an arrangement with the Authority or an Area Health Board under section 10 and the governing body of which is not the Authority or an Area Health Board or any committee of those:

"voluntary service provider" means a voluntary body which provides a service by arrangement with the Authority or an Area Health Board in accordance with section 10.

(2) In this Act—

(a) a reference to a section or Schedule is to a section of, or Schedule to, this Act, unless it is indicated that reference to some other enactment is intended.

(b) a reference to a subsection, paragraph or subparagraph is to the subsection, paragraph or subparagraph of the provision in which the reference occurs, unless it is indicated that reference to some other provision is intended, and

(c) a reference to an enactment shall be construed as a reference to that enactment as amended, adapted or extended by or under any subsequent enactment including this Act.

3.—(1) The Minister shall by order appoint a day to be the establishment day for the purposes of this Act.

(2) Section 24 of the No. 3 Act of 1996 does not apply to an order made under this section.

4.—Every order made under section 5 and every regulation made under sections 11(2), 16(1) and 21(14) shall be laid before each House of the Oireachtas as soon as may be after it is made and, if a resolution annulling the order or regulation is passed by either such House within the next subsequent 21 days on which that House has sat after the order or regulation is laid before it, the order or regulation shall be annulled accordingly but without prejudice to the validity of anything previously done thereunder.
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5.—(1) The Minister may, after consultation with the Minister for the Environment and Local Government and the local authority concerned, by order amend the First Schedule.

(2) The Minister may, at the request of the Authority and subject to subsection (3), by order amend the Second Schedule by making additions or deletions therefrom.

(3) The Minister shall, before deleting reference to a person from the Second Schedule, consult with that person.

6.—(1) The following are hereby repealed, with effect from the establishment day—

(a) subsections (6) and (7) of section 13 of the Principal Act, and


(2) Regulation 4 of the Health Boards Regulations. 1970 (S.I. No. 170 of 1970), is hereby revoked, with effect from the establishment day.

PART II

THE EASTERN REGIONAL HEALTH AUTHORITY

7.—(1) There shall stand established on the establishment day a body to be known as the Eastern Regional Health Authority, and in this Act referred to as "the Authority".

(2) The Authority shall be a body corporate with perpetual succession and may sue and be sued in its own name and may acquire, hold and dispose of land and other property.

(3) The Authority shall provide itself with a seal and all courts of justice shall take judicial notice of the seal.

(4) The functional area of the Authority shall be the county borough of Dublin and the administrative counties of South Dublin, Fingal, Dún Laoghaire-Rathdown, Kildare and Wicklow.

(5) Subject to this Act, any reference to a health board, however expressed, in any Act, passed before the establishment day, or instrument made before such day under any such Act, shall be construed as including a reference to the Authority.

(6) Sections 4, 5 and 26(1) of the Principal Act and section 65 of the Health Act. 1953, shall not apply to the Authority.

8.—(1) The Authority shall perform the functions conferred on it under this Act and any other functions which are performable by a health board and such other functions as may be provided for by law.

(2) The Authority shall, having regard to the resources available and as it sees fit, plan, arrange for and oversee the provision of services in its functional area.
(3) In performing its functions under this section, the Authority shall—

(a) make arrangements under section 10 with persons for the provision of services,

(b) co-ordinate the provision of services,

(c) put in place systems, procedures and practices to enable it to monitor and evaluate services provided in accordance with arrangements made under section 10,

(d) provide in its annual report an account of measures taken to monitor and evaluate services and an account of the outcomes of such measures,

(e) have regard to the advice (if any) tendered to it by each of the three Area Health Boards, and

(f) have regard to the right of voluntary bodies who provide services in accordance with arrangements made under section 10 to manage their own affairs in accordance with their independent ethos and traditions.

(4) Nothing in this Act shall be construed as prejudicing the performance by the Adelaide and Meath Hospital, Dublin, incorporating the National Children's Hospital of its functions under its Charter.

9.—(1) The Authority shall provide in writing for such of its reserved functions in relation to the provision of services which, immediately before the establishment day, were performed by the Eastern Health Board, to be exerciseable on its behalf, in relation to the functional area of an Area Health Board, by that Area Health Board.

(2) Notwithstanding subsection (1), the Authority may, from time to time, and where it considers such action would secure the most beneficial, effective and efficient use of resources, provide in writing for such of its reserved functions as it may determine to be exerciseable on its behalf, in relation to the whole or part of its functional area, by a specified Area Health Board and where the Authority does so, any provision made under subsection (1) in relation to those functions shall cease to have effect.

(3) The performance of its functions under subsections (1) and (2) shall be a reserved function of the Authority.

10.—(1) Subject to subsections (2) and (4), the Authority shall, having regard to the resources available to it, make one or more arrangements with one or more persons for the provision of services within its functional area.

(2) (a) Subject to section 9(2) and subsection (3), the Authority shall, having regard to the resources available to it, make and carry out an arrangement with each Area Health Board for the provision within the Area Health Board's functional area of services which, immediately before the establishment day, were provided by the Eastern Health Board.
(b) The Authority may make arrangements with an Area Health Board for the provision of services other than those specified in paragraph (a).

(c) Paragraph (a) shall not be construed as preventing the Authority or an Area Health Board from discontinuing or curtailing any service.

(3) The Authority may determine an arrangement or any part thereof made under subsection (2)(a) in relation to the provision of a service and make and carry out an arrangement in lieu thereof with a voluntary body for the provision of the service.

(4) An arrangement made under this section shall include the following:

(a) a written agreement between the Authority and the person who proposes to provide the services, covering a period of not less than 3 years and not more than 5 years and specifying—

(i) the principles by which both parties agree to abide for the duration of the agreement, and

(ii) such standards relating to the efficiency, effectiveness and quality of the services to be provided as may be agreed between the parties,

and

(b) a written agreement, to be renewed annually, between the Authority and the person who proposes to provide the services specifying—

(i) the services to be provided, and

(ii) the funds to be made available therefor.

(5) The Authority may delegate its power to make an arrangement under subsection (1) to an Area Health Board, other than where:

(a) the arrangement is with any one of the persons specified in the Second Schedule, or

(b) the arrangement is with another Area Health Board.

(6) A person (not being an Area Health Board) who provides services in accordance with an arrangement made under this section shall keep, in such form as may be approved by the Authority, all proper and usual accounts and records of all income received or expenditure incurred by it.

(7) Accounts kept in pursuance of subsection (6) shall be submitted annually for audit and a copy of the accounts and the auditor's certificate and report thereon shall be presented to the Authority within such period as may be specified by the Authority.

(8) The expense of an audit carried out under subsection (7) shall be paid for by the person keeping the accounts.
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II.—(1) The Authority shall consist of 55 members.

(2) Of the members of the Authority—

(a) 30 shall be appointed by the local authorities whose functional areas are included in the functional area of the Authority, of whom—

(i) 10 members of Dublin Corporation shall be appointed by Dublin Corporation, and

(ii) 4 shall be appointed by each of the councils of the counties of Fingal, South Dublin, Dún Laoghaire-Rathdown, Kidare and Wicklow, and the members appointed by the council of a county shall be members of that council.

and the persons so appointed shall, where so prescribed, include such numbers of persons from such local electoral areas as may be prescribed.

(b) 13 shall be members of registered professions appointed by election, of whom—

(i) 9, including not less than 2 consultants in general hospitals, not less than one consultant psychiatrist, not less than 2 general medical practitioners and not less than one registered medical practitioner with special knowledge or experience in preventive medicine, shall be appointed by election by registered medical practitioners practising in the functional area of the Authority,

(ii) one shall be appointed by election by registered dentists practising in the functional area of the Authority,

(iii) one shall be appointed by election by registered nurses (other than registered psychiatric nurses) practising in the functional area of the Authority,

(iv) one shall be appointed by election by registered psychiatric nurses practising in the functional area of the Authority, and

(v) one shall be appointed by election by registered pharmaceutical chemists and registered dispensing chemists and druggists practising in the functional area of the Authority.

(c) 9 shall be representative of voluntary service providers, appointed by the Minister, of whom—

(i) 3 shall be nominated for appointment by such persons or organisations as the Minister considers to be representative of the voluntary hospitals in the functional area of the Authority.

(ii) 3 shall be nominated for appointment by such persons or organisations as the Minister considers to be representative of the voluntary intellectual disability service providers in the functional area of the Authority, and
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(iii) 3 shall be nominated for appointment by such persons or organisations as the Minister considers to be representative of other voluntary service providers in the functional area of the Authority.

and

(d) 3 shall be appointed by the Minister.

(3) The Authority shall hold at least 6 meetings in each year and such other meetings as may be necessary for the performance of its functions.

(4) Subject to subsection (3), the rules set out in the Second Schedule (as amended by section 22) to the Principal Act, shall apply in relation to the Authority.

Regional Chief Executive.

12.—(1) Subject to subsection (3) and notwithstanding any other enactment, the Authority shall, pursuant to a recommendation from the Local Appointments Commissioners, appoint a person who shall act as the chief executive officer of the Authority and such person shall be known and in this Act referred to as the Regional Chief Executive.

(2) Subject to this Act, any reference to the chief executive officer of a health board in any Act, passed before the establishment day, or instrument made, before such day, under any such Act shall be construed as including a reference to the Regional Chief Executive.

(3) Notwithstanding section 15(1) of the Principal Act, the Minister may, before the establishment day, appoint a person who, on the establishment day, shall be deemed to have been appointed to be the Regional Chief Executive and that person shall, unless he or she otherwise dies, resigns or is removed by the Minister, hold the office for a period not exceeding 3 years.

(4) The Minister may remove a person appointed under subsection (3).

(5) Section 13(1), (3) and (8) of the Principal Act shall not apply to the Regional Chief Executive.

(6) The appointment of the Regional Chief Executive in accordance with subsection (1) shall be a reserved function.

13.—(1) The Regional Chief Executive shall, whenever required by the Committee of Dáil Éireann established under the Standing Orders of Dáil Éireann to examine and report to Dáil Éireann on the appropriation accounts and reports of the Comptroller and Auditor General, give evidence to that committee on—

(a) the regularity and propriety of the transactions recorded or required to be recorded in any book or other record of account subject to audit by the Comptroller and Auditor General which the Authority or the Area Health Boards are required by or under statute to prepare.

(b) the economy and efficiency of the Authority and the Area Health Boards in the use of their resources.

(c) the systems, procedures and practices employed by the Authority and the Area Health Boards for the purpose of evaluating the effectiveness of their operations, and
(d) any matter affecting the Authority or any Area Health Board referred to in a special report of the Comptroller and Auditor General under section 11(2) of the Comptroller and Auditor General (Amendment) Act, 1993, or in any other report of the Comptroller and Auditor General (in so far as it relates to a matter specified in paragraph (a), (b) or (c)) that is laid before Dáil Éireann.

(2) In the performance of his or her duties under this section, the Regional Chief Executive shall not question or express an opinion on the merits of any policy of the Government or a Minister of the Government or on the merits of the objectives of such a policy.

PART III

AREA HEALTH BOARDS

14.—(1) On the establishment day, there shall stand established 3 boards, which shall be known, respectively, as—

(a) the Northern Area Health Board,
(b) the East Coast Area Health Board, and
(c) the South-Western Area Health Board,

and referred to collectively in this Act as ‘the Area Health Boards’.

(2) Each Area Health Board shall be a body corporate with the power to sue and be sued in its own name and may acquire, hold and dispose of land and other property.

(3) Each Area Health Board shall provide itself with a seal and all courts of justice shall take judicial notice of the seal.

(4) The functional area of each Area Health Board shall be as described in the First Schedule.

15.—(1) An Area Health Board shall perform, with respect to its functional area and on behalf of the Authority, such functions as are specified by the Authority in accordance with section 9(1) and shall carry out such other functions as provided by this Act or as may from time to time be conferred on it by the Authority.

(2) An Area Health Board shall, with respect to its functional area—

(a) provide, or arrange for the provision of, such services as may be specified in any arrangements entered into with the Authority in accordance with section 10(2),
(b) plan and co-ordinate the provision of services, in co-operation with persons providing services in the area and with such other persons as it may see fit, and
(c) advise the Authority on the provision of services generally.

(3) An Area Health Board shall—

(a) carry out its functions subject to any general directions which may be given by the Authority, and
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[No. 13.] Health (Eastern Regional Health Authority) Act, 1999.

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(b) co-operate with the Authority and with other Area Health Boards in the co-ordination of services in such manner as the Authority may from time to time determine.

(4) Where an Area Health Board makes an arrangement with a person for the provision of services, it shall put in place systems, procedures and practices to enable it to monitor and evaluate the services so provided.

(5) An Area Health Board shall, notwithstanding that it is exercising functions on behalf of the Authority under this section, be entitled to enforce any rights acquired and shall be liable in respect of any liabilities incurred (including liabilities in tort) in the exercise of those functions in all respects as if it were acting as a principal, and all proceedings for the enforcement of such rights or liabilities shall be brought by or against the Area Health Board in its own name.

(6) Sections 3 and 4 of the No. 3 Act of 1996 (as amended by section 24) shall apply to an Area Health Board as if it were a health board and references in those sections to a chief executive officer shall be construed for the purposes of this subsection as including references to an area chief executive.

16.—(1) The Minister shall, in accordance with this section, specify in regulations the membership of an Area Health Board.

(2) Subject to subsections (4), (3) and (6), the Authority shall appoint the members of the Area Health Boards.

(3) The Authority, when appointing a member of an Area Health Board, shall fix such member’s period of membership which shall not exceed 5 years.

(4) Each member of an Area Health Board shall be a member of the Authority and where a member of an Area Health Board ceases to be a member of the Authority he or she shall also cease to be a member of the Area Health Board.

(5) Membership of an Area Health Board shall include at least one member of the Authority who has been appointed by each of the following, namely—

(a) the local authorities mentioned in section 11(2)(a),

(b) the registered professions mentioned in section 11(2)(b),

(c) the Minister, on the nomination of each of the voluntary service providers mentioned in subparagraphs (i), (ii) and (iii) of section 11(2)(c), and

(d) the Minister under section 11(2)(d).

(6) With respect to each Area Health Board, persons appointed to the Authority under section 11(2)(a) and subsequently appointed by the Authority to an Area Health Board shall exceed the total number of other members of that Area Health Board and be from local electoral areas within the functional area of the Area Health Board.
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(7) A member of the Authority who has been appointed to the Authority in accordance with section 11(2)(b), other than subpara-graph (i), shall be entitled to attend a meeting of an Area Health Board of which he or she is not a member and to participate in the deliberations at such a meeting, but shall not be entitled to vote on any question arising at such a meeting.

(8) The Authority may make payments to a member of an Area Health Board or to a member of the Authority referred to in subsection (7) in respect of travelling and subsistence expenses incurred in attending a meeting of an Area Health Board or otherwise in the pursuance of the business of an Area Health Board in accordance with a scale determined by the Minister, with the consent of the Minister for Finance.

(9) The Authority may, with the consent of the Minister, pay an allowance to the chairman and the vice-chairman or an Area Health Board in respect of expenses (other than expenses referred to in subsection (8)) incurred by him or her in relation to the business of the Area Health Board.

(10) Rules 7, 10, 11 (as amended by section 22, 15 and 17 to 32 of the Second Schedule to the Principal Act, shall apply in relation to an Area Health Board and, accordingly, references therein to the board shall be construed as including references to an Area Health Board.

(11) An Area Health Board shall hold at least 9 meetings in each year and such other meetings as may be necessary for the performance of its functions.

17.—(1) Subject to subsection (2), the Authority shall, pursuant to a recommendation from the Local Appointments Commissioners, appoint 3 persons to be chief executive officers of the Area Health Boards, and shall assign them to the 3 Area Health Boards as it sees fit and each of these persons shall be known and in this Act referred to as an area chief executive.

(2) The Minister may, before the establishment day, pursuant to a recommendation from the Local Appointments Commissioners, appoint 3 persons to be area chief executives of the Area Health Boards, and shall assign them to the 3 Area Health Boards as he or she sees fit, and those persons shall be deemed to have been so appointed on the establishment day.

(3) A person appointed under subsection (1) or (2) shall hold office for a period not exceeding 7 years under a contract of service in writing with the Authority upon such terms and conditions (including terms and conditions relating to remuneration and expenses) as may be determined by the Minister, with the consent of the Minister for Finance, and specified in the contract.

(4) An area chief executive shall act as the chief executive officer of the Area Health Board.

(5) Where the Authority delegates a function to an Area Health Board in accordance with section 8, the corresponding executive functions of the Regional Chief Executive shall be deemed to have been delegated to the area chief executive of that Area Health Board.

(6) The Regional Chief Executive shall delegate in writing to each area chief executive such of his or her functions in relation to the provision of services within the functional area of the relevant Area Health Board which, immediately before the establishment day, were performed by the chief executive officer of the Eastern Health Board.

(7) Notwithstanding subsection (6), the Regional Chief Executive may, from time to time, and where he or she considers such action would secure the most beneficial, effective and efficient use of resources, provide in writing for such of his or her functions as he or she may determine to be exercisable in relation to the whole or part of the Authority's functional area by a specified area chief executive and where the Regional Chief Executive does so, any delegation made under subsection (6) in relation to those functions shall be revoked.

(8) An area chief executive shall exercise the functions delegated to him or her under this section in accordance with such general directions as may from time to time be given by the Regional Chief Executive.

(9) An area chief executive may delegate, in accordance with subsections (2) to (5) of section 16 of the Principal Act, his or her functions to another member of the staff of the Authority who has been assigned to the Area Health Board concerned and references therein to the chief executive officer of a health board shall be construed for the purposes of this subsection as references to an area chief executive.

(10) An area chief executive may be removed from office by the Authority, with the consent of the Minister, in accordance with the terms and conditions of his or her contract of service.

(11) The appointment under subsection (1) and the removal under subsection (10) of an area chief executive shall be reserved functions of the Authority.

18.—(1) An Area Health Board shall keep all proper and usual accounts of all moneys received or expended by it including an income and expenditure account and balance sheet and, in particular, shall keep all such special accounts as the Authority or the Minister may, from time to time, direct.

(2) An Area Health Board shall prepare annual financial statements in accordance with the accounting standards specified by the Minister for the purposes of section 11(2) of the No. 3 Act of 1996 and shall submit such financial statements to the Comptroller and Auditor General for audit on or before the 1st day of April in the year following the year to which they relate.

(3) Upon completion of the audit referred to in subsection (2), the Comptroller and Auditor General shall draw up a report in writing in relation to the financial statements and shall submit a copy of the financial statements together with his or her report thereon to the Authority, which shall submit them to the Minister.

(4) The annual financial statements of an Area Health Board shall form part of the consolidated annual accounts of the Authority.

(5) The consolidated annual financial statements of the Authority shall be prepared in accordance with accounting standards specified
by the Minister and shall be adopted by the Authority and submitted to the Comptroller and Auditor General for audit on or before the 15th day of April in the year following the financial year to which they relate.

(6) Subject to subsection (5), the consolidated annual financial statements of the Authority shall be audited in accordance with section 6 of the Act of 1993.

(7) The annual financial statements of the three Area Health Boards, together with the reports of the Comptroller and Auditor General thereon, shall be appended by the Minister to the annual financial statements of the Authority (as submitted to the Minister by the Comptroller and Auditor General in accordance with section 6 of the Act of 1993) and the consolidated annual financial statements of the Authority (as submitted to the Minister by the Comptroller and Auditor General in accordance with subsection (6) and section 6 of the Act of 1993) and laid before each House of the Oireachtas.

(8) An area chief executive shall assist the Regional Chief Executive in carrying out his or her duties under section 13 in such manner and at such times as the Regional Chief Executive may from time to time direct.

PART IV
Dissolution of Eastern Health Board and Transfer of its Staff to Authority

19.—(1) On the establishment day, the Eastern Health Board shall stand dissolved.

(2) On the establishment day, all land which, immediately before that day, was vested in the Eastern Health Board and all rights, powers and privileges relating to or connected with that land, shall, without any conveyance or assignment, stand vested in the Authority.

(3) On the establishment day, all property other than land, including choses-in-action, which, immediately before that day, was the property of the Eastern Health Board shall stand vested in the Authority without any assignment.

(4) All rights and liabilities of the Eastern Health Board arising by virtue of any contract or commitment (express or implied) entered into by that body before the establishment day shall on that day stand transferred to the Authority.

(5) Every right and liability transferred under subsection (4) may on or after its transfer be sued on, recovered or enforced by or against the Authority in its own name and it shall not be necessary for the Authority to give notice to the person whose right or liability is transferred.

(6) Final accounts of the Eastern Health Board shall be drawn up in accordance with the accounting standards specified by the Minister for the purposes of section 11(2) of the No. 3 Act of 1996 and shall be audited by the Comptroller and Auditor General in accordance with section 6 of the Act of 1993.

(7) Any legal proceedings pending on the establishment day in any court or tribunal to which the Eastern Health Board is a party
Appendix I

Pr.IV S.19 shall continue with the substitution of the name of the Authority for that of the Eastern Health Board and shall not abate by reason of such substitution.

(8) Any reference to the Eastern Health Board in an order made by a court before the establishment day shall, on the establishment day, be construed as a reference to the Authority.

(9) Any resolution passed, order made or notice served by the Eastern Health Board before the establishment day shall, on or after that day, continue in force and have effect as though it was a resolution passed, order made or notice served by the Authority.

(10) Any rule or regulation made by the Eastern Health Board which was in force immediately before the establishment day shall, on or after that day, continue in force and have effect as though it was a rule or regulation made by the Authority, and every such rule or regulation may be continued, varied or revoked, and penalties and forfeitures arising thereunder may be recovered and enforced by the Authority.

(11) The Authority may, subject to this Act, in writing transfer to an Area Health Board any land, other property, right or liability transferred to it under this section.

20.—(1) Every person who immediately before the establishment day is a member of the staff of the Eastern Health Board shall, on that day, be transferred to and become a member of the staff of the Authority.

(2) Save in accordance with a collective agreement negotiated with any recognised trade unions or staff associations concerned, a person referred to in subsection (1) shall not, while in the service of the Authority, receive a lesser scale of pay or be made subject to less beneficial terms and conditions of service (including those relating to tenure of office) than the scale of pay to which he or she was entitled and the terms and conditions of service (including conditions relating to tenure of office) to which he or she was subject immediately before the establishment day.

(3) Every contract of service, express or implied, which is in force immediately before the establishment day between the Eastern Health Board and any person to whom subsection (1) applies shall continue in force on and after the establishment day, but shall be construed and have effect as if the Authority were substituted therefor the Eastern Health Board and every such contract shall be enforceable by or against the Authority accordingly.

(4) A person transferred to the staff of the Authority under this section or appointed as an officer or servant of the Authority in accordance with section 14(1) of the Principal Act, may be assigned from time to time by the Authority to an Area Health Board.

(5) Every person assigned under subsection (4) shall continue to be an officer or servant of the Authority, as the case may be, but shall, while so assigned, be subject to the directions of the area chief executive of the Area Health Board to which he or she is assigned, subject to such arrangements as may be made between the Regional Chief Executive and that area chief executive.

(6) For the purposes of any enactment relating to superannuation, the office of an officer who on the establishment day was an officer
Appendix I


of the Eastern Health Board shall be deemed not to have been Pr.IV S.20 abolished.

PART V

THE HEALTH BOARDS EXECUTIVE

21.—(1) There shall stand established, on the appointed day, an agency to be known as the Health Boards Executive and in this section referred to as “the Executive”.

(2) The Executive shall be a body corporate with the power to sue and be sued.

(3) The Executive shall provide itself with a seal and all courts of justice shall take judicial notice of the seal.

(4) The Executive shall perform, on behalf of the health boards—

(a) such executive functions of the health boards as may be specified, from time to time, by the members of the Executive, and

(b) such other executive functions in relation to improving the efficiency and effectiveness of the health and personal social services as the Minister may, from time to time, direct.

(5) The members of the Executive shall be the chief executive officers of the health boards and the area chief executives.

(6) (a) The expenses of the Executive, in so far as not met from other sources, shall be met by the health boards in such proportions as the members of the Executive may agree upon from time to time, or, failing such agreement, in such proportions as may be determined by the Minister.

(b) In default of payment by a health board of the amount payable by it under paragraph (a), the amount involved may be deducted from any moneys payable to the health board by the Minister for any purpose whatsoever and shall be paid to the Executive by the Minister.

(7) The Executive shall keep all usual and proper accounts of its income and expenditure and of the sources of such income and of the subject matter of such expenditure and of the assets and liabilities of the Executive.

(8) The annual financial statements of the Executive for each year shall be prepared in accordance with accounting standards specified by the Minister and shall be submitted to the Comptroller and Auditor General for audit within 3 months of the end of the year to which they relate and an audit shall be carried out by the Comptroller and Auditor General in accordance with section 5 of the Act of 1993.

(9) Upon completion of the audit under subsection (8), the Comptroller and Auditor General shall draw up a report in writing in relation to the accounts and shall submit a copy of the accounts together with his or her report thereon to the Minister, each health board and the Area Health Boards, and the Minister shall, as soon as may be, cause a copy of the report and a copy of the accounts to which the report relates to be laid before each House of the Oireachtas.
Appendix I

[No. 13.] Health (Eastern Regional Health Authority) Act, 1999.

(10) The Executive shall, not later than the 31st day of March in each year, make a report on its activities during the preceding year and shall submit a copy of the report to the Minister, each health board and the Area Health Boards.

(11) (a) The Executive may, with the consent of the Minister and the concurrence of the Minister for Finance, appoint such and so many persons to be members of the staff of the Executive as it may determine and in appointing any such person the Executive shall comply with any directions given by the Minister relating to the procedure to be followed.

(b) Every member of the staff of the Executive serving in a permanent capacity shall cease to be such a member on attaining the age of 65 years.

(c) The Executive shall, with the consent of the Minister and the concurrence of the Minister for Finance, determine the remuneration and conditions of service of each member of its staff.

(d) The Executive shall, from time to time, assign such duties as it considers appropriate to each member of the staff of the Executive and each such member shall perform the duties so assigned to him or her.

(e) Schemes and regulations made under the Local Government (Superannuation) Act, 1980, shall apply to the members of the staff of the Executive appointed in a permanent capacity as if the Executive were a health board.

(12) For the purpose of the performance of its functions, the Executive may, subject to such terms and conditions (if any) as the Minister may specify—

(a) purchase or take on lease any land or other property.

(b) sell, exchange, let or otherwise dispose of any land or other property vested in it.

(c) make arrangements with another person for the use by the Executive of premises or equipment belonging to that person or for the use by the Executive of the services of employees of that person or body.

(d) accept gifts of money, land and other property upon such trusts and conditions, if any, as may be specified by the donor, save that the Executive shall not accept a gift where the conditions attached by the donor to its acceptance are not consistent with the functions of the Executive.

(13) (a) The Executive shall not borrow money without the prior consent of the Minister, given with the concurrence of the Minister for Finance.

(b) The borrowing of moneys by the Executive shall be subject to such terms and conditions (if any) as may be specified by the Minister with the concurrence of the Minister for Finance.
Appendix I


(14) The Minister may make regulations in respect of all or any of the following—

(a) the terms and conditions of the membership of the Executive;

(b) rules and proceedings at its meetings;

(c) the establishment of committees of it;

(d) the payment of expenses to its members.

(15) The Minister shall by order appoint a day to be the appointed day for the purposes of this section.

(16) Notwithstanding section 4(1) (inserted by section 24) of the No. 3 Act of 1996, the chief executive officer of a health board may require the Executive to carry out a function on his or her behalf and, where the officer makes such a requirement, he or she shall, as soon as may be, inform the health board concerned.

(17) In this section a reference to a health board includes a reference to the Authority and a reference to a chief executive officer of a health board includes a reference to the Regional Chief Executive.

PART VI

AMENDMENT OF PRINCIPAL ACT. HEALTH (CORPORATE BODIES) ACT, 1961. AND NO. 3 ACT OF 1996

22.—The Second Schedule to the Principal Act is hereby amended by—

(a) the insertion in Rule 5 after “section 4(2)(a)(ii)” of “or section 11(2)(b) of the Health (Eastern Regional Health Authority) Act, 1999,”;

(b) the insertion, after Rule 11(2) of the following:

“(2A) Where a member of the board appointed other than by the council of a county or the corporation of a county borough has not, for a consecutive period of 6 months, attended a meeting of the board, he or she shall cease to be such a member and the Minister shall, as soon as may be, appoint a person to fill the vacancy.”;

(c) the insertion, after Rule 11(3) of the following:

“(4) This Rule shall not apply where a member of the board can demonstrate, to the satisfaction of the chairman of the board, that his or her absence has been due to illness.”;

(d) the insertion in Rule 12 after “section 4(2)(a)(ii)” of “or section 11(2)(b) of the Health (Eastern Regional Health Authority) Act, 1999,” and

(e) the insertion in Rule 17 after “an officer or servant of the board” of “or an employee of a voluntary hospital, voluntary intellectual disability service provider or voluntary service provider”.

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Appendix I


23.—Section 6 of the Health (Corporate Bodies) Act, 1961, is hereby amended by the substitution of the following paragraph for paragraph (d):

"(d) the furnishing from time to time by the body to the Minister, or to such other body as the Minister may specify in the order, of information regarding the performance of its functions and the furnishing of such information to the Minister or to the other body at any other time on request."

24.—The No. 3 Act of 1996 is hereby amended—

(a) in section 1(1), by the substitution for the definition of "reserved function" of the following definition:

‘reserved function’ means—

(a) a function of a health board specified in a section mentioned in column (3) of the First Schedule opposite the Act mentioned in column (2) of that Schedule, and

(b) any function of a health board which is specified as a reserved function in the Health Acts, 1947 to 1999, or any other enactment.

(b) by the substitution for section 3 of the following section:

"3. (1) A reserved function shall be performed directly by a health board.

(2) A health board shall not take any decision or give any direction in relation to any function of a health board that is not a reserved function.

(3) The chief executive officer shall assist the board in the performance of a reserved function in such manner (if any) as the board may require."

and

(c) the substitution for subsection (1) of section 4 of the following subsection:

"(1) A function of a health board that is not a reserved function shall be performed by the chief executive officer unless otherwise provided for and such a function shall be an executive function."
FIRST SCHEDULE

FUNCTIONAL AREAS OF AREA HEALTH BOARDS

1. In this Schedule—

the "county of Kildare" means the administrative county of Kildare;
the "county of Wicklow" means the administrative county of Wicklow;
the "city of Dublin" means the county borough of Dublin;
"Dun Laoghaire-Rathdown County" means the administrative county of Dún Laoghaire-Rathdown;
"Fingal County" means the administrative county of Fingal;
"South Dublin County" means the administrative county of South Dublin.

2. Boundary of functional area of Northern Area Health Board.

That part of the functional area of the Authority which corresponds with the following:

That part of the city of Dublin which is situated north of the River Liffey, and
Fingal County.

3. Boundary of functional area of East Coast Area Health Board.

That part of the functional area of the Authority which corresponds with the following:

The local electoral area of Pembroke in the city of Dublin,
Dún Laoghaire-Rathdown County, and
the county of Wicklow (except for the local electoral area of Baltinglass).

4. Boundary of functional area of South-Western Area Health Board.

That part of the functional area of the Authority which corresponds with the following:

That part of the city of Dublin which is situated south of the River Liffey (except for the local electoral area of Pembroke),
South Dublin County,
the county of Kildare, and
the local electoral area of Baltinglass in the county of Wicklow.
Appendix I


SECOND SCHEDULE

Section 10.

St. James's Hospital
Beaumont Hospital
Mater Misericordiae Hospital
St. Vincent's Hospital, Elm Park
The Adelaide and Meath Hospital, Dublin, incorporating the National Children's Hospital
St. Michael's Hospital, Dún Laoghaire
Royal Victoria Eye and Ear Hospital
Coombe Women's Hospital
National Maternity Hospital
Rotunda Hospital
Our Lady's Hospital for Sick Children, Crumlin
The Children's Hospital, Temple Street
St. Luke's and St. Anne's Hospital
Hume Street Hospital
Cappagh Orthopaedic Hospital
Incorporated Orthopaedic Hospital of Ireland, Clontarf
National Rehabilitation Hospital
Our Lady's Hospice
Royal Hospital, Donnybrook
Dublin Dental Hospital
Central Remedial Clinic
Leopardstown Park Hospital
Federated Dublin Voluntary Hospitals
Drug Treatment Centre, Trinity Court, Pearse Street
St. Vincent's Hospital, Fairview
St. Mary's Hospital and Residential School, Baldoyle
Stewart's Hospital
Hospitalier Order of St. John of God Services, Stillorgan
Children's Sunshine Home
St. Michael's House
Daughters of Charity of St. Vincent de Paul, Navan Road
Sisters of Charity of Jesus and Mary, Mooreabbey, Co. Kildare
Cheeverstown House Limited
K.A.R.E.
Peamount Hospital
Sunbeam House Services
## Voluntary Providers

<table>
<thead>
<tr>
<th>Voluntary Provider</th>
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<td>Adelaide &amp; Meath Hospital incorporating the National Children's Hospital</td>
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<tr>
<td>Beaumont Hospital</td>
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<td>Dublin Dental Hospital</td>
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<td>Leopardstown Park Hospital</td>
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<td>National Maternity Hospital</td>
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<td>Our Lady's Hospice</td>
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<td>Our Lady's Hospital for Sick Children</td>
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<td>Rotunda Hospital</td>
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<td>Royal Victoria Eye and Ear</td>
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<td>St. Michael's Hospital, Dun Laoghaire</td>
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<td>St. Michael's House</td>
<td>St. Vincent's Hospital, Elm Park</td>
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<td>St. Vincent's Hospital, Fairview</td>
<td>Stewart's Hospital</td>
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<td>Sunbeam House Services</td>
<td>The Children's Hospital, Temple Street</td>
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## Trade and Professional Organisations

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<td>ACBI (The Association of Clinical Biochemists in Ireland)</td>
<td><a href="http://www.iol.ie/deskenny/acbi.html">www.iol.ie/deskenny/acbi.html</a></td>
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<td>AEEU (The Amalgamated Engineering Electrical Union)</td>
<td><a href="http://www.aeeu.org.uk/indexj.htm">www.aeeu.org.uk/indexj.htm</a></td>
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<tr>
<td>AHCP5 (Association of Higher Civil and Public Servants)</td>
<td><a href="http://www.ahcps.ie">www.ahcps.ie</a></td>
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<tr>
<td>ATGWU (Trade and General Workers Union)</td>
<td><a href="http://www.tgwu.org.uk">www.tgwu.org.uk</a></td>
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<tr>
<td>BATU (Building and Allied Trades Union)</td>
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<td>BEAI (Biomedical Engineering Association of Ireland)</td>
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<td>IASW (Irish Association of Social Workers)</td>
<td><a href="http://www.iasw.eire.org">www.iasw.eire.org</a></td>
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<tr>
<td>IDA (Irish Dental Association)</td>
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<td>IENA (Irish Emergency Nurses Association)</td>
<td><a href="http://www.eire.org/iena">www.eire.org/iena</a></td>
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<td>IHCA (Irish Hospital Consultants' Association)</td>
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<td>IIPMM (Irish Institute of Purchasing and Materials Management)</td>
<td><a href="http://www.iipmm.ie">www.iipmm.ie</a></td>
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<td>IMO (Irish Medical Organisation)</td>
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<td>IMPACT (Irish Municipal, Public and Civil Trade Union)</td>
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<td>INO (Irish Nurses Organisation)</td>
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<td>ISOM (Irish Society of Occupational Medicine)</td>
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<td>MLTA (Medical Laboratory Technologist's Association)</td>
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<td>PSI (Pharmaceutical Society of Ireland)</td>
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<td>SIPTU (Services, Industrial, Professional &amp; Technical Union)</td>
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<td>TEEU (Technical Engineering and Electrical Union)</td>
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<td>UCATT (Union of Construction and Allied Trades)</td>
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Extract: Programme for Prosperity and Fairness

Section 1.4.3

Modernisation in the Health Sector

INTRODUCTION

The Health Strategy, *Shaping a Healthier Future*, launched in 1994 had at its core the principles of:

- Equity
- Quality and
- Accountability.

While very significant progress has been made towards achieving these principles through major initiatives such as the Cancer Strategy, Cardiovascular Health Strategy and the establishment of new organisations with defined roles (OHM, HSEA, ERHA), there is still significant work to be done to deliver the remaining areas.

The health care area is quite different from the commercial sector. The relationship between the patient and the health care institution or provider is usually much different to that of the customer in the commercial area who can often make choices and 'shop around'. These important differences underline the need for a conscious patient-focused approach to realigning services in a way that puts patients first.

The emphasis on patient care is an accepted cultural ethos of health service staff. A performance management approach to building on the quality of service for patients, utilising partnership structures, will be a unifying force for both management and staff.

Service Planning/Business Planning is an essential element of any system of performance management. As a first step, therefore, it will be necessary to ascertain the views of the public regarding their experiences of the health service. This will focus on the users of the service.

Service Delivery Plans for the health service have been in use for some years. Significant work has been done in improving the service planning process and current plans are now suitable for the creation of conditions which will allow performance management systems to be put in place.

Aside from setting out the high-level objectives of the organisation, the service planning process will allow team objectives to be set which will reflect what the patients require from the unit and from the organisation. In order to guide the preparation of future plans, it is essential to validate the improvements made.

Service Plans should lend themselves to being used as a management tool for monitoring the performance of the organisation.
Appendix IV

It is also essential, when drawing up the Service Plans, to involve staff at every level of the organisation so that they can have a meaningful input into the process at unit level. Advancing these objectives will require working through the partnership process at both national and local level. The Service Plan process should therefore be significantly improved through the contribution of staff who are in closest contact with members of the public.

Traditional work patterns in what is a 24 hour service have grown up around normal office hours attendance regimes. There is a need to create a shift in the way the service is delivered. We must move from the present position where institutions are often configured around the way people have traditionally done things to one where the patient is at the centre of how the service is organised. There is a need to develop performance standards against which the level and quality of service to members of the public can be measured.

KEY ELEMENTS OF A CHANGE PROGRAMME FOR THE HEALTH SECTOR

The next phase of implementation will require a carefully co-ordinated and focused change implementation programme which would have within it, for example, a number of elements, as set out below:

- Extending hours of service to the public
- Co-ordinated action across a broad range of disciplines to achieve specified targets for reduction of waiting times and numbers of people waiting for procedures
- Introduction of a strengthening of audit of patient satisfaction within the health care system and the establishment of measurable standards for patient satisfaction
- Improved communication between patients and providers in relation to information on treatment processes, updating of current status, and other relevant information sought by patients and their families
- Working in partnership with the Service Planning process and co-operating with the ongoing measurement and validation of performance indicators as agreed by each agency
- Achieving a greater flexibility of skill mix by utilising a continuum of health care competencies (e.g. developing role of nurse practitioners, nurse-led clinics, etc.)
- Setting up clear and measurable targets for the uptake of vaccination/immunisation programmes
- Co-operation in the introduction of information systems in the areas of personnel, payroll, attendance, recruitment and superannuation (PPARS)
- Agreed human resource measures for a more open recruitment system (as per paragraph 21 of Section 1.4), improvements in staff retention, effective deployment of staff, speed of vacancy filling and staff absenteeism, and workforce planning and
- Co-operating with a comprehensive overhaul of the provisions of personnel policies (circular 10/71) to progress positively the HR agenda in the health service.
Appendix IV

These are practical examples of areas in which real progress, resulting in improvements in services for patients, can take place.

Any of these performance measures must, of course, be agreed between the social partners at health sector level. The most suitable vehicle for this would be the partnership arrangements which are now being developed both nationally and locally.

Performance management systems would then operate at agency level where senior management and staff would agree arrangements for setting targets and monitoring outcomes.
### Groups whose recommendations specifically mention workforce planning

<table>
<thead>
<tr>
<th>Group</th>
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<tr>
<td>Bacon: Report on Therapy Professions</td>
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<tr>
<td>Expert Group on Medical Laboratory Technicians</td>
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<td>Expert Group on Paramedical Grades</td>
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<td>Expert Group on Radiographers</td>
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<td>Expert Group on Social Workers</td>
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<td>Medical Manpower Forum</td>
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<td>Nursing and Midwifery Resource Group</td>
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Appendix VI

NATIONAL WORKING GROUPS TO WIDEN THE RECRUITMENT POOL

MEDICAL

The Medical Manpower Forum has completed its deliberations and have made a number of recommendations regarding the required change in work practices and skill mixes needed to deliver an effective service to patients. Its recommendations are being reviewed at Government and Departmental levels.

NURSING & MIDWIFERY

- The promotional structure within nursing has been significantly improved on foot of the recommendations of the Commission on Nursing and the 1999 Nurses pay settlement.
- In an effort to increase the annual intake of nursing students, the overall number of training places in the country have been increased and a national student nursing recruitment programme is in place with the aim of encouraging school leavers to enter training in all areas of nursing, general, mental handicap and psychiatric.
- The Nursing & Midwifery Resource Group resulted from the need to for an enhanced focus on workforce planning and the interim report is a first step towards the establishment of a system for forecasting future requirements for nurses and midwives in the Irish Health care system.
- The Nursing & Midwifery Planning & Development Units being established in each health board area will have a key role in preparing and monitoring human resource forecasts and strategic plans for nursing and midwifery services within their region.
- Back to nursing courses have been operated by a number of hospitals around the country.
- A working group is being set up in relation to recruitment and retention of nursing staff in the Dublin area. The group will be composed of representatives of Health Service employers (ERHA, Department of Health & Children and the HSEA) and the four nursing unions. It will have the following terms of reference:

"to examine factors affecting the recruitment and retention of nursing and midwifery staff in the Dublin area and to recommend innovative ways in which the situation might be improved".

- A number of proactive measures to support recruitment into the service have also been put in place like flexible working, educational support, further career development opportunities, and enhanced financial support for students,
- Discussions will open between the National Federation of Voluntary Bodies providing services to people with Mental Handicap and Trinity University to explore how the University's requirement for quality clinical placements might be met by Service Providers. The wider Federation membership will be asked to assist the Intellectual Disability Nursing School in providing appropriate placements for trainee nurses as required.
ALLIED HEALTH PROFESSIONALS (PARAMEDIC) GRADES

There are recruitment difficulties right across the therapy professions and during our research these posts were highlighted as problem areas for Service Providers in the Eastern Region. In an attempt to expand the recruitment pool a number of National initiatives have been undertaken:

• The Expert Group on Various Health Professions issued their report in April 2000 and the Government accepted their findings. Among the findings were to address anomalies in pay scales, introduction of a new Therapy Assistant Grade and a review of grading structures, incremental credit for previous experience and recognition of temporary contracts, restricting staff employed on a temporary basis. Fixed term contracts should be available and adequate back up facilities should also be provided e.g. clerical and IT support.

• Manpower planning and forecasting was identified as a major requirement in this area. Studies are being carried out by Peter Bacon and Associates on the future requirements in the Speech and Language Therapist, Physiotherapist and Occupational Therapist professions. While the Department of Health and Children has succeeded in increasing the number of third level places within the grades requiring professional qualifications, it is expected that the Bacon Report will recommend a further increase in these places.

• Similar studies for the Dietetics and Chiropody professions are planned. In relation to Chiropody work is taking place to review the difference in qualifications required to practice in the Public Sector versus the Private and the need to have a school of Chiropody in Ireland.

• The National Federation of Voluntary Bodies providing services to people with Mental Handicap has highlighted that further research will be conducted into the reasons for the ongoing difficulties which Service Providers’ experience in recruiting certain paramedical grades. This research will include detailed discussions with the relevant professional bodies. They have also sought a meeting with the Minister for Education and Science with a view to discussing their needs.

• The establishment of an Advisory Unit for the therapy professions in the Department of Health and Children will lead to therapy professionals having a more significant and enhanced influence on the wider planning of the Health Services.

MEDICAL AND LABORATORY TECHNICIANS

The Expert Group on Medical and Laboratory Technicians/Technologists has recommended action in relation to better planning in this area.

RADIOGRAPHERS

In relation to Radiographers it is anticipated that, as a result of talks with the Department of Education and Science and the Higher Education Authority, the number of training places may be increased.
Appendix VI

SOCIAL WORKERS

• A National Social Workers Forum was established by the Minister in Autumn 2000. Among the issues covered are recruitment and retention, workload management, manpower planning and back up support e.g. IT and clerical.
• The National Federation of Voluntary Bodies providing services to people with Mental Handicap have stated that dialogue will be entered into with the appropriate Institutes of Technology with a view to having designated Intellectual Disability modules included in Applied Studies in Social Care Courses Syllabi.

CHILD CARE

A review of Child Care Worker training is currently being carried out and among other issues it is considering the issue of the appropriateness of both the training provided and the number of graduates being trained.

CLERICAL/ADMINISTRATION

The clerical/administrative job family has during our research consistently been identified as a problem area across the service providers. The following Initiatives have been undertaken to improve the situation:
• Revise the entry qualifications for the basic recruitment grade
• Remove age related pay scales, which has allowed for a substantial rise in the first 3 points in the scale for those under 21 years
• Revise incremental credit arrangements for temporary and part time staff, allowing for all previous relevant experience to be taken into account and
• The establishment of grade VIII in order to allow further promotional opportunities.

However, despite these initiatives, this job family still provides most of the Health Service employers the greatest difficulty in terms of recruitment and retention. On the recruitment side the common recruitment pool mentioned before severely limits the opportunities of Health Service employers in the labour market and needs to be reviewed. In addition, the pay scales lack of competitiveness with the private sector and the promotional ban until 2 years service has been completed, have also been highlighted as barriers.

CARE ASSISTANTS

This group emerged as an issue for many employers. The 4.55 group has been set up to establish standard criteria in relation to the entry requirements, educational qualifications and training for Care Assistants, Attendants and other non nursing employees across the services. It has been highlighted as vital that this job family be integrated into the service as it will free up the skill mix in other areas.

In relation to other groups of employees in this grade, it is proving difficult to recruit and in some cases turnover is increasing. While the improvements in the clerical/administrative Grades have a
Appendix VI

knock on effect to these roles, employers still point out the constraints are uncompetitive pay scales, poor working conditions and the lack of promotional opportunities. These problems are particularly acute in the Intellectual Disability agencies, who have a higher proportion of general support staff employed.
Appendix VII

Working groups reviewing job family changes in the pay structure

Medical and Dental grades

- Non consultant Hospital Doctors (NCHDs) over the past 2-3 years. The principal area of contention has been the working hours and overtime payments. A major study of NCHDs working hours etc.
- Significant improvement in overtime rates for NCHDs.
- Senior Manager to be appointed in each major hospital to manage NCHD hours.
- Dental grades a thorough restructuring has been agreed and is being introduced following detailed discussion on implementation of the Dental Action plan as developed by the Department of Health & Children and agreed by the Government. This covers a number of areas including extension of eligibility criteria for free dental treatment and care.

Nurses

- Further to the 1997 settlement with the nursing unions and the review of the profession conducted by the Commission on Nursing, the Labour Court made recommendations on pay adjustments for promotional grades together with the introduction of a new Senior Staff Nurse position were implemented.
- Annual maintenance grant for nursing students increased to IRE3,325 from 1 April 2000
- New arrangements introduced for better starting pay, standardised overtime working arrangements and a significantly improved regime of allowances.
- Commission on Nursing Pay settlements.

Various Health Professionals

- The recommendations of the Expert Group on Various Health Professionals with regard to the Therapy grades and consequent pay and grading improvements are now implemented. The term Therapy Grades is also used to cover six of the ten grades involved: therapy grades are Physiotherapists, Occupational therapists, Speech & Language Therapists, Dieticians, Orthopaedists and Chiropodists.
- A range of retention measures have been initiated in the context of the EG on VHP including improvement in incremental credits, fixed term contracts, employee benefits, overtime payments and back-up facilities/clerical support
- Paramedics 1997?
- Expert Group on Medical Laboratory Technicians/Technologists has just been completed.
Appendix VII

and makes a series of recommendation in relation to both pay and grading adjustments. Discussions will be commencing with the representatives of these grades on the implementation of the Report shortly.

- The Expert group on Radiology grades has not, as yet, been finalized. It is anticipated that it be finalised shortly.

General Support Services (Non Nursing Grades)

- Care Assistants etc.
- Ambulance personnel: The implications of up-skilling and training have been reflected in recent pay agreement adjustments for ambulance personnel.
- Clerical Administrative Grades
  - Revision of entry qualifications for basic recruitment grade – clerical officer allows satisfactory relevant experience as an alternative to the prerequisite of the leaving cert.
  - The removal of the age related pay scales allows a substantial rise in the first 3 points in the scale for those under 21 years.
  - Previous public sector experience is taken into account
  - Establishment of Grade VIII
Appendix VIII

Education, training and development

MEDICAL AND DENTAL
The Medical Manpower Forum, in association with the various medical interests is addressing:

- A system of structured rotations that include training in the larger teaching Hospitals as well as smaller general hospitals
- Revised arrangements for medical training and the need to take account of the requirements of female doctors
- Institutional structural reform to allocate clear responsibility for ensuring the quality of training in Irish hospitals.
- Further to the agreement with the Non-Consultant Hospital Doctors (NCHDs), an additional training fund of IRC10million has been established. IRC3,000 will be made available for NCHDs per annum for approved activities associated with their medical training, plus allowances for travel and subsistence in relation to training programmes.
- Significant increases have been made in the financial assistance provided to the Royal College of Physicians of Ireland, the Royal College of Surgeons in Ireland and to the College of Anaesthetists to enable them to improve the administration of their postgraduate training schemes. This funding has been used to provide for postgraduate Deans in Medicine and Anaesthetics and a Director of Surgical Affairs. In addition the appointment of over 20 National Speciality Directors in various medical facilities have been made. These Directors act as executive officers to the relevant Speciality Training Committees
- The Postgraduate Medical and Dental Board has commissioned the RCS/IPA to run a series of professional development workshops for NCHDs. IRC150K has been allocated for this initiative.
- The Board has also recently allocated IRC60K to subsidise doctors undertaking a Certificate Course in Health Care Informatics run by UCD.

NURSING EDUCATION / TRAINING ISSUES

- Some 11 hospitals around the country provided ‘back to nursing’ courses in 1999 for nurses wishing to return to the workforce. The expansion of these courses is aimed at maximising the available nursing workforce.
- During 1999/2000 sixteen new post-registration programmes were developed. Five of the 16 new programmes are in the Dublin area.
- A priority action plan was agreed with the Nursing Alliance as part of the settlement of the nurses’ strike and additional funding of IRC1 Million has been provided this year for initiatives in the Action Plan.
- From January of this year, nurses working in the Public Health Service who want to undertake nursing and certain other undergraduate degree courses on a part-time basis
have had their fees paid in full by their employing agencies. Fees are paid in return for a commitment on the part of the nurses to continue to work in the Public Health Service for a period of up to two years after the completion of the degree course. This fees initiative will continue until at least the year 2005.

- From this year, all students studying for the Higher Diploma in Public Health Nursing (PHN) in both University College Cork and University College Dublin have been paid a salary while studying and will have their fees refunded. This is in return for a commitment on the part of Student PHNs to work as Public Health Nurses for at least two years with the sponsoring Health Board.

- An enhanced support package for Student Midwives has been introduced with effect from this academic year. Student Midwives will now have fees refunded and will receive increased remuneration.

- Under an agreement between the Department and the Nursing Alliance, an additional 300 training places were provided this year, bringing to 1,500 the total number of training places available. The intention is that the level of intake will be maintained in 2001 and 2002.

- There are currently some 3,720 nursing students at various stages of training, the target being 4,500 students in training by the year 2002.

- The annual maintenance grant for nursing students, which is not subject to a means test, was increased to IR£3,325 with effect from 1 April 2000. The grant is now almost double the maximum grant for which other third level students may qualify. In addition, allowances for external clinical placements, books and uniforms have also been increased.

ALLIED HEALTH PROFESSIONALS (PARAMEDIC) GRADES

Some significant progress has been made recently in relation to increasing the number of training places for allied health professionals. Main details are:

- An additional 51 places for physiotherapy from October 2000.

- The HEA is also establishing a group comprised of representatives from each of the three physiotherapy schools to investigate the establishment of a ‘fast-track’ physiotherapy programme to begin in each school from October 2001. The first graduates from these programmes should be available in 2003.

- A similar exercise can also be undertaken for Speech and Language Therapy and Occupational Therapy. An additional five places have been created for speech and language therapy and three for Occupational Therapy.

- The number of entrants to the three approved Medical Laboratory Science courses in Ireland has been increased by 20 per annum since October 1999.

- The creation of a new Student Medical Laboratory Technician post is also being funded by the Department of Health and Children. Entrants to this grade have completed a degree programme but lack the required clinical placement. This programme addresses that lack by providing a one year placement.
Appendix VIII

- A review of Psychology Services in the Health Boards was undertaken and IRE725,000 per annum has been allocated to address this issue.
- The Clinical Measurement Diploma Course at Kevin St DIT produces technicians, vascular, cardiac etc. The Department are currently working with the DIT to introduce a degree level programme from October 2001.

GENERAL SUPPORT SERVICE WORKPLANNING

The Department of Health and Children continues to work with Health Agencies on the development of a suitable training course for Care Attendants and has made good progress in developing an accreditation course with the NCVA (National Council for Vocational Awards).

In line with the Report of the Commission on Nursing the Department has already established a group to:

"examine opportunities for the increase use of Care Assistant and other non-nursing personnel in the performance of other non-nursing tasks".

This group, known as the '7.63 group' after the paragraph to which it relates in the Report, includes representation from the four constituent unions of the Nursing Alliance. However, the PNA (Psychiatric Nurses Association) has withdrawn from the process.

The findings of this group, which were expected by October 2000, were fed into a second group (the "4.55" group) which was also recommended by the Commission.
Appendix IX

Office for Health Management Initiatives

The Office for Health Management was established by the Minister for Health and Children to implement the Management Development Strategy for the Health and Personal Social Services in Ireland, published in 1997. The key initiatives undertaken by the Office of Health Management include:

MANAGEMENT PROGRAMMES

TOP/SENIOR MANAGEMENT DEVELOPMENT

The OHM has established a strategy group for at the development of top and senior managers within the health and personal social services. The strategy group recognized:

- The variations in backgrounds, skills and experience of managers
- The time constraints under which they operate

The strategy group met with all senior managers within the Health Boards and the large Voluntary Hospitals and conducted a pilot exercise:

- Managers were split into one of two pilot development initiatives
- One group worked with an executive coach on one-to-one personal development initiatives
- The other group worked on real life work problems

The initiatives were evaluated and one-to-one coaching has now been extended to further senior managers nominated by their Chief Executive Officers. In addition the strategy group is also considering extending the initiatives to the academic teaching hospitals regarding their development needs.

PERSONAL DEVELOPMENT PLANNING

A Personal Development Planning Strategy Group was established to:

- Identify resource materials and tools
- Facilitate personal development planning

The approach was piloted on a number of schemes comprising multidisciplinary staff in diverse health and personal social service settings. From this process a series of critical success factors were identified. A second wave of pilot schemes has been launched to test the validity of these factors. Research will also be carried out to demonstrate that this type of staff development has a measurable improvement on the service being provided and on the individuals' themselves.

LEADERSHIP DEVELOPMENT

In 1999 two leadership development programmes ended. The following areas were covered in the training:

- Mentoring
Appendix IX

- Learning sets
- Shadowing
- Personal development planning

An independent evaluation of the two programmes concluded that they had been worthwhile. As a result two further courses have been commissioned.

FIRST TIME MANAGERS

In 1999 a pilot scheme was developed aimed at addressing the development needs of first-time managers. The training focuses on the provisions of key information and skills to support the transition to management. The training is now available to employers and may be delivered by their own staff or alternatively they may engage consultants to deliver it.

MANAGING CAPITAL PROJECTS TRAINING AND DEVELOPMENT PROGRAMME

Due to the funding available under the National Development Plan, the above programme for project managers was run from September to November 2000.

MASTER CLASS PROGRAMME

The Office for Health Management provides a programme for managers facing a demanding and challenging agenda. The training involves making people who have recognised expertise in areas relevant to health service management available to a group of managers in the master class format.

A number of master classes have been presented since the establishment of the Office for Health Management and topics fall into the following broad subject categories:

- Leadership Quality
- Strategic Management
- Performance management
- Management structures and process Governance Teamwork
- Management development
- Organisation development

FINANCIAL LITERACY

A training manual in financial literacy, launched in 1999, has been substantially revised on the basis of feedback from managers. It will be made available to health service employees towards the end of this year.

REGIONAL MATERIALS MANAGERS

In 1999 a seven day programme was held as part of a dissemination process. The programme consisted of seven days of development, which covered many issues including role clarification, team working and personal development planning.
Appendix IX

GENERAL MANAGERS, COMMUNITY SERVICES
A development programme for general managers in community services commenced in 1998. The programme aimed at enabling general managers in the development of personal development plans for themselves, to network and to share experience of best practice. Two further development workshops were held in 2000 for this group.

CHILD CARE MANAGERS
The Office for Health Management commissioned a two day development workshop for Child Care Managers in December 1998. This was followed by a Master Class for Child Care Managers in February 1999. In addition, this group requested a further one-day workshop with an outside facilitator to enable them to review the work done and the issues identified during their previous work together. This workshop took place in October 1999 and the Child Care Managers prepared a plan for presentation to the Programme Managers, Community Care. In addition, the Office commissioned a diagnostic workshop and a subsequent two-day management workshop for the supervisors of inter-country adoptions.

OD NETWORK
In 1999 a cross-service network was developed to share experience and learning of organizational change and to further develop organizational development skills. Ultimately, the network aims to heighten awareness of the benefits of OD for the health and personal social services.

TRAINING PACKAGE FOR FRONTLINE SUPERVISORS IN THE ANCILLARY SERVICES
In 1999 the Office for Health Management at the request of the Dept. of Health and Children and SIPTU, as part of a partnership initiative, was requested to commission a training package and pilot programmes for frontline supervisors. The package was piloted with two cohorts of 15 frontline supervisors. As a result of this exercise it was developed further and piloted again, in 2000.

GUIDELINES ON MANAGEMENT TOPICS
Since the Office was established guidelines on the following topics have been prepared and published:

• Preparing a CV
• Preparing for Interview
• Job Analysis
• Coaching & Mentoring

NURSING PROGRAMMES
The Office has been hugely involved in commissioning management development programmes for nurses. As part of the partnership programme, the Department of Health and Children and
The Irish Nurses Organisation has co-funded the following pilot management development programmes for nurse managers.

**MANAGING AND LEADING NURSING**

This programme for nurse managers of medium sized hospitals aimed at exposing nurse managers to new frameworks, understandings and experiences in order to develop their capacity to lead and manage change. The programme included study visits to hospital sites in the UK. It concluded in November 1999. Participants continue to meet periodically under the auspices of the Office for Health Management.

**ACTION LEARNING PROGRAMME**

This programme was designed for nurse managers from smaller hospitals and welfare homes. The programme used an action learning approach to enable participants to establish and implement action plans for the improvement of their skills and their capacity to develop their staff. The Office for Health Management evaluated the programme and is committed to providing further development opportunities for this group.

**CHANGING FROM WITHIN**

This pilot management development programme was provided to all the nursing staff of one hospital. It was therefore designed to enhance the effectiveness of the entire nursing resource. The site chosen for this pilot was Longford/Westmeath General Hospital, Mullingar. Individual nurses undertook action learning projects centering on patient care and service development. The programme was completed in 1999.

**PUBLIC HEALTH NURSING LEADERSHIP PROGRAMME**

This programme was designed to develop the leadership skills of a cohort of Superintendent and Senior Public Health Nurses within two neighbouring health boards, the North Eastern and the North Western Health Boards. These boards were chosen to facilitate the development of networking opportunities with nurses in Northern Ireland for the sharing of best practice and leadership skills and knowledge.

**PROGRAMME FOR 2000**

Discussions were held regarding a future programme for the year 2000 and a request for proposals was issued for training addressing three levels of nurse managers:

- Assistant Directors of Nursing
- Clinical Nurse Managers 3
- Clinical Nurse Managers 2

These proposals have been integrated into the work of the Empowerment of Nurses and Midwives Steering Group and it is expected that pilot programmes leading to training packages will commence in early 2001.
Appendix IX

NURSE MANAGEMENT COMPETENCIES

A Blueprint for the Future recommended that the Office for Health Management commission a study of nurse management competencies at three levels; director of nursing, assistant director of nursing and ward sister. This study was commissioned during 1999. It involved an examination of the existing nurse manager’s role and how these roles needed to evolve in the future. Methods used included workshops, questionnaires and interviews. The identification of these nurse management competencies will guide the recruitment, selection, appraisal and development of nurse managers in the future.

SENIOR NURSE MANAGERS

The Office for Health Management sponsored a visit to two London Hospitals for five directors of nursing of teaching hospitals. Following the visit they shared their findings and their insights with their fellow directors of nursing at a Shared Learning Workshop organised by the Office for Health Management. At a further consultative workshop the establishment of learning sets for directors of nursing was discussed.

Clinicians in Management

As a wide spread imitative to improve the level of management clinicians have been involved in a facilitative process. The CIM initiative provided development programmes to address the needs of individuals, teams, their organisations and the health system as a whole.

DISCUSSION PAPERS

In 1999 the Office for Health Management commissioned two discussion papers on Clinicians in Management from international consultants. The first paper, "Clinicians in Management: Introduction and Case Studies" provides a broad introduction to the concept of CIM. It provides background and rationale, several participant case studies and a checklist of critical success factors. The second paper "Clinicians in Management: A Framework for Discussion" provides healthcare organisations with an outline of how to introduce a CIM initiative for the first time.

MEETINGS WITH PROJECT LEADERS

The Office for Health Management holds regular consultative meetings of CIM project leaders. These meetings enable the Office to support and facilitate the CIM initiative by keeping in touch with what is happening on the ground. As well as providing a consultative forum regarding training and development initiatives the meetings enable project leaders to share experience and pool ideas. The meetings take place every two months and a representative from the Department of Health and Children attends occasionally.

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REVIEW EXERCISE

The review exercise has been commissioned by the Office for Health Management and has the following objectives:

- To assess progress with regard to the involvement of clinicians in management in each CIM pilot site
- To decide on the best way forward, and
- To identify the support and development needs of each site, differentiating between those needs that are best addressed locally and those that can be met centrally by the Office for Health Management

EQUAL OPPORTUNITIES FOR WOMEN IN MANAGEMENT

The management development strategy identified the need for Health Service employers to provide opportunities for women to develop their careers within the health and personal social services. To address this the Office for Health Management has been promoting and facilitating equal opportunities through the following initiatives.

REGIONAL NETWORKS

Since June 1998 the office for health management has been supporting the formation and development of regional women's networks. The Office funds professional facilitation for the first four meetings of each regional group. Some groups have requested additional facilitation and this was provided for a further four sessions. At the end of the professional facilitation each network was been requested to submit an action plan to their employer and the Office for Health Management.

NORTH/SOUTH CONTACT

Throughout 1999 links were forged with the Health and Personal Social Services in Northern Ireland. By the end of the year, areas of common interest were identified and this has led to the co-hosting of a conference to consider Cross-Border initiatives within each organisation's strategic agenda. The joint conference "Embracing Diversity -the Development Agenda" took place in October 2000.
Role Profile for the Director of Human Resources and Organisational Development

Responsible to:
Chief Executive Officer – ERHA Corporate

MAIN PURPOSE:
To ensure that strategies are developed that provide for the availability and effective use of human resources in the region so as to contribute to the delivery of service plans.
To facilitate, on behalf of the Authority, the recruitment, development and retention of staff of the highest quality in all professions and disciplines and to support the development of an organisational culture across all ERHA services that values staff, develops them professionally and personally, enabling them to work more effectively.

Key Responsibilities:

CORPORATE ORGANISATION
ERHA CORPORATE HUMAN RESOURCES AND ORGANISATION DEVELOPMENT
Responsible for the:
• development and implementation of human resource strategies and policies for the ERHA Corporate organisation.
• effective management of human resources in the ERHA Corporate organisation and the development of the most effective organisation structure and processes.

CORPORATE MANAGEMENT
Responsible to:
• play a full role in the Corporate Management of the Authority.
• share with corporate management and staff of the responsibility for the effective management and performance of the Authority and its obligations in terms of the service plan.

REGIONAL FOCUS
DEVELOPMENT OF HUMAN RESOURCES STRATEGY FOR THE EASTERN REGION
Responsible to:
• collaborate with all statutory and voluntary service providers, health agencies, professional bodies, academic institutions, staff representative bodies and other relevant organisations on the development, maintenance and review of human resources strategies for the region.
• encourage and collaborate with all stakeholders in the process of change management in the health services.
Appendix X

• ensure that the human resources strategy represents the interests of all service providers in the region. Ensuring equity across the region in terms of access to people resources and the capacity to develop and implement effective human resources strategies and practices at local level.

DEVELOP COMMUNICATION CHANNELS/FORUMS TO ADDRESS REGIONAL ISSUES

Responsible to:

• establish and maintain an effective system of communications with individual human resources professionals in all statutory and voluntary service providers, Personnel Officer. Groups, the Department of Health and Children, health agencies, professional bodies, academic institutions, staff representative bodies and other relevant organisations.
• set-up stakeholder working groups to address human resources issues specific to the region.
• ensure that the views of all service providers in the region are either directly or indirectly communicated and taken into account where the Authority has input to human resources or industrial relations initiatives at national level.
• Put in place arrangements and communications processes in the area of employee relations with the objective of securing harmonious relations between the Authority, providers and their staff.

TO BOTH UTILISE AND SUPPORT THE DEPARTMENT OF HEALTH AND CHILDREN AND VARIOUS STATUTORY AGENCIES AT NATIONAL LEVEL.

Responsible to:

• prepare reports on the Eastern region, as requested, for submission to the human resources/industrial relations planning process at national level either by the Department of Health and Children or specific Task forces/Review Bodies/Agencies (e.g. HSEA) with regard to manpower planning, grading structures, pay and retention strategies.
• support effective implementation of national partnership arrangements or other initiatives.
• encourage and support service providers to work in line with best human resources practices. Liasing with the Health Services Employers Agency on various initiatives.
• encourage staff development in provider organisations by ensuring arrangements are in place for professional and managerial training and the development of staff. Liasing with the Office for Health Management, academic institutions and other training/development agencies.

INPUT TO REGIONAL PROVIDER AND SERVICE PLANS

• Responsible to provide Human Resource input to the Authority's regional service plan and associated provider plans with the aim of ensuring human resources strategies and policies support the business/service objectives.
Appendix X

- Working in conjunction with all service providers to research, monitor, assess and interpret the future people requirements for the region in terms of the numbers of staff in all relevant professions and disciplines and of a skills mix and cost that is consistent with the Authority's service requirements.

TO UNDERTAKE ANY OTHER DUTIES/FUNCTIONS COMMENSURATE WITH THE ROLE AS DESIGNATED BY THE CHIEF EXECUTIVE.

KNOWLEDGE & EXPERIENCE

- A proven track record in the management of people and change over a number of years, not less than five.
- An appropriate third level qualification, preferably a post-graduate degree in a relevant discipline;
- Previous work in the health services or public sector would be a distinct advantage or knowledge of the key concepts and critical issues that define the health services.
- Experience of change management is essential along with working knowledge of some or all of the following would be an advantage; manpower planning techniques, job evaluation, employee relations and training and development.

The person appointed must be able to demonstrate maturity of judgement, have experience of successfully managing other professionals, and have effective presentation, communication, information technology and negotiating skills.
Appendix X

Key competencies include:

| Focus on Results | Sets personal goals and develops an overall plan. Works to immediate and longer term time-frames, adjusts goals and plans as the Authority's needs change.
|                  | Takes responsibility for delivering committed results to meet the Authority's needs even when faced with obstacles or delays. Demonstrates initiative, energy and determination to achieve their goals. |
| Flexibility      | The ability to handle a variety of situations and demands; and to adapt one's approach as the requirements of the situation change. |
| Diagnosis        | Having range of frameworks and models for understanding individuals, groups and organisations. Maintaining a critical approach to models. Ability to construct own models. Encouraging joint diagnosis with stakeholders. |
| Active Listening | Attending to the content and process level in communication. Being attuned to non-verbal signals and their possible meaning. Ability to draw others out. Diagnosing possible underlying feelings, concerns and motivations |
| Relationship Building and Influence | Building and maintaining open collaborative relationships. Exchanging feedback in a timely and constructive way. Being assertive, when appropriate. Balancing support and challenge in relationships. Ability to influence others and gain commitment. Being open to influence from others. Earning trust by managing expectations, which cannot be met. |
| Understanding the Nature of change | Ongoing development of an intellectual and experiential understanding of change processes - how and why people change, how and why they avoid change, how larger systems change or avoid changing. The ability to understand and use power relationships and culture to get things done. Encouraging widespread participation in the design and implementation of change. Supporting others through the stress of transition. |
| Team working & collaboration | Works effectively with other people from own and other teams to achieve the team and the Authority's goals. Solves issues and problems, works to improve team effectiveness and works with respect and consideration for the needs of other team members. Participates in team activity, and commits to team decisions. |
| Conflict Handling | Valuing and exploring differences. Ability to challenge without alienating. Maintaining flexibility choice and self esteem when faced with conflict and hostility. Having the personal courage to open up potentially difficult areas. |