Report of the Expert Group on

Various Health Professions

April 2000

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Introduction

Establishment of the Expert Group

1. In April 1997, the Labour Court investigated a claim from the trade union IMPACT on behalf of the members of ten health professions. The union was seeking the maintenance of pay links with nursing grades. In its recommendation (LCR 15515), the Court recommended the same level of pay increases for all the ten professions. It also recommended the establishment of an Expert Group to examine a number of issued raised in the course of the Court's investigation. The Group comprised an independent chairperson and one representative each from the health employers and the staff trade union. The members of the Expert Group were:

Mr John O'Connell	(Chair and Retired Deputy Chairperson of the Labour Court)
Mr Peter McLoone	(General Secretary of IMPACT)
Mr Alan Smith	(General Manager, Office for Health Management).

Terms of Reference

2. The terms of reference for the Expert Group were agreed as follows:

   "The terms of reference of the Expert Group will be to examine and report on the issues raised in LCR 15515 including:

   Changes that have taken place in the relevant professions and in this context to address the anomalies that have arisen.

   Career structures

   Problems relating to recruitment and retention

   The role of each profession

   Training and education requirements

   Management structures and development within each profession

   Interaction with other disciplines

   Development plans for delivery of services

   Any other issues which the Expert Group considers relevant to its task."

3. There are ten professions covered by the Expert Group study: audiologists, biochemists, care workers, chiropodists, dietitians, occupational therapists, orthoptists, physiotherapists, social workers, speech and language therapists.

Method of Inquiry Used by the Expert Group

4. The Expert Group first met the management, represented by the Health Services Employers Agency (HSEA) and IMPACT, together with representatives from each of the ten professions, on 10th November 1997 to agree the process for examining the issues set out in the terms of reference and an order of business. It was agreed to hold a separate hearing for each profession, and it was decided that the staff and management sides would each prepare written submissions in advance of each hearing.

5. The Expert Group convened a further meeting with the parties on 26th March 1998 to discuss the delay in getting the process underway. A schedule of meetings was agreed and the Expert Group was asked to make site visits to a number of workplaces before reaching its conclusions. It was agreed that the professions would

draw up a schedule for the site visits, which subsequently gave an extremely useful insight into the roles and responsibilities of those working in the services, and the pressures and constraints that exist at the point of delivery.

6. The formal hearings commenced in May 1998, and the Expert Group heard presentations relating to occupational therapists on 27th May and physiotherapists on 28th May 1998. The Expert Group heard submissions relating to biochemists, chiropodists, dietitians, orthoptists and speech and language therapists in June 1998. Submissions relating to audiologists were heard on 3rd September 1998 and those for child care workers and social workers were heard on October 29th and 30th 1998 respectively.

7. The submissions presented on behalf of the professions were comprehensive and addressed in some detail each issue covered by the terms of reference.

8. The detailed management submissions presented to the Expert Group adopted the same approach to each staff side submission, in general addressing the issues in the terms of reference as policy issues. The management submission strongly argued that the Expert Group be aware of the wider organisational and structural changes within the health service contained in the 1994 health strategy document.

9. Most of the submissions were able to draw on previous research and policy reports, including the 1994 health strategy document, which previously addressed a number of the matters raised during this exercise. The staff side submissions contained detailed descriptions of the developing role of each profession in modern health care, and, apart from their principal purpose they should also serve as important tools for the development of the professions into the future. They should also contribute enormously to the understanding of the role of the professions by other health professionals, managers and policy-makers. For this reason, the Expert Group has included in this report extracts from these submissions relating to their role as described by the professions themselves.

10. At the conclusion of the hearings, the Expert Group requested additional information from both parties and supplementary submissions were received from many individuals and groups, and from the Department of Health & Children.

11. The Expert Group decided to look at the organisation and delivery of services in two other countries. It visited Scotland on November 1998 and Finland in May 1999, where it met practitioners from a wide range of professions.

12. The Expert Group met with managers from a wide range of services on 2nd February 1999, and discussed their views on service plans, staffing shortages, grading structures and other issues raised in the staff side submissions.

13. At the request of the professions, the Expert Group made a number of site visits which were not completed until the end of 1999. The Expert Group was impressed with the level of professionalism demonstrated by the staff in the workplace and by the range of diagnostic and specialist therapeutic skills employed in the treatment of clients. The management at these sites were also very helpful in making the necessary arrangements to ensure that these visits were productive.

Acknowledgements

The Expert Group wishes to put on record its gratitude and appreciation for the assistance given by the following:

Site Visit to Scotland

Mrs Marilyn Barrett, Directorate of Nursing, Scottish Office
Ms Sonya Lam, Project Manager, PAMS
Ms Dave Carroll, Clinical Director for Professions Allied to Medicine together with their colleagues
in Edinburgh and Scotland.

Site Visit to Finland

Mauno Konttinen, Deputy Director General, and Hannu Uusitalo, Deputy Director General, Stakes (National Research and Development Centre for Welfare and Health)
Marja Liisa Niemi, Senior Adviser, The Ministry of Education
Martti Lahteinen, Special Adviser, and Pirju Marjamaki, Senior Researcher, The Ministry of Social Affairs and Health
Hannele Kerosuo, Planner, The Espoonlahti Centre for Social Welfare and Health Care
Tuula Hurnasti, Soile Tammisto (Occupational Therapists Association).

Finally, particular thanks are due to Mrs. Sirkku Grierson of Stakes whose assistance to the Group during the course of the visit was invaluable.

Ms Eilis Walsh, Director, National Social Work Qualifications Board
Ms Noirin Hayes, Head of School of Social Sciences, D.I.T.

The Group would also like to record an appreciation to the many individual members of the professions involved together with managers and administrators who met with the Group during the course of its work. These discussions helped to ensure that the Group had a greater understanding of the issues as they affect people in their everyday work.

The conclusions drawn from what was elicited are however entirely the responsibility of the Group.

Finally the Group wishes to put on record its very special thanks to our Secretary, Ms Anna Marie Killilea, for all she contributed throughout the work of the Expert Group and in the preparation of this Report. We also wish to thank Ms Orla Tierney for her patience and diligence in typing the many drafts of this Report.

The Therapy Professions

14. Although there are differences in the functions carried out by the main therapy professions, which are reflected in their separate roles within the health services, it is nevertheless possible to deal with a wide range of issues covered by the terms of reference within a common set of recommendations, for these professions.

15. Accordingly, the recommendations that follow apply to the major therapy professions: dietitians, occupational therapists, physiotherapists and speech and language therapists. Where relevant, the recommendations will also apply to chiropodists and orthoptists.

16. The submissions from the professions highlighted the development needs in each of the services under review. It is clear from each of the submissions that these professions are making an increasingly important contribution to the health services.

17. The 1994 health strategy document acknowledged that *"The development of services and the trend towards specialisation has created a demand for a wide range of skills in many of the other professions in the health and personal social services. The output of many of these from the education/ training system has not kept pace with demand. This has led to shortages in many areas. This will be examined in co-operation with the education authorities and professional bodies concerned with a view to increasing the numbers in training."*

18. The Expert Group believes that one of the reasons for the lack of influence of these professions is their limited input into the wider planning of health services.

    As an immediate first step to rectifying this, the Expert Group recommends the establishment of a Unit in the Department of Health & Children, which would advise the Minister, health and educational authorities and others in the sector on staffing levels and development of services.

    This Unit would be staffed by professionals with a background in the area and would liase with appropriate professional bodies. It would make policy inputs in a wide range of areas such as children's health and the treatment of the elderly and people with disabilities.

19. It was evident from the submissions made that these professions share a very wide range of common interests. The influence of the therapists generally is likely to be dissipated if each profession seeks individual representation. The Expert Group is of the view that their common interests would be better served and their influence enhanced at the higher levels of health care management were a committee to be established representative of all the therapy professions. The Expert Group met and had discussions with members of the PAM Committee in Scotland as well as representatives of the professions at institutional and community level. Though not considered ideal by any of the therapists concerned, it was generally agreed that it does afford the therapy profession a voice in policy-making.

    The Expert Group, therefore, recommends that the various professions establish such a committee amongst themselves.

    The Expert Group further recommends that employers establish a corresponding committee of health care managers who have direct responsibility and interest in the provision of therapy services.

The Expert Group recommends that these committees work together on a partnership basis to deal with issues of concern to the professions and the service providers consistent with corporate goals and client needs. The Expert Group recommends that the committees work in close liaison with the new Policy Unit in the Department of Health and Children. The Expert Group further recommends that, if necessary, appropriate training/facilitation be provided to assist the participants in managing collaborative working relationships.

The composition of these two committees should be discussed and agreed by each party in respect of its own committee.

Changes in the professions

20. The last decade has seen massive changes in these relatively new health professions and the pace of change is likely to continue and increase in the coming years. Extensive changes have included:

- A substantial widening of the scope of the professions with the development of new services and new forms of treatment, and a trend towards specialisation, which have created new demands for a wide range of services.
- A shift towards diagnostic (as well as therapeutic) responsibilities for many of the professions.
- An increase in the contribution of the professions to health care strategies and outcomes.
- The development of new skills and specialisation which require ongoing education and training of the professions throughout their careers.
- Significant changes in the level of educational attainment necessary to enter the professions, most notably the shift from diploma to degree status in most areas under consideration.
- Substantial development of best practice, which has put additional responsibilities and pressures on staff
- Developments in social, public and health policy, as well as development in lifestyles and expectations, that have increased demand on service providers.
- Cumulatively these changes have resulted in therapists achieving a level of autonomy well beyond that available to other health care workers. This transformation is very clearly illustrated by the table below which formed part of the physiotherapist submission to the group.

Comparitor of Role of Chartered Physiotherapist - 1978 to 1998 to 2010

Past (1978) **Prescriptive**	**Present (1998)** **Referral**	**Future (2010)** **Diagnostic**
Skill based profession	Knowledge based profession	Knowledge based profession
Medical profession demand led service	Profession led Planning services	Profession led
Treatment rendered following diagnosis and referral by medical practitioner	Client can self-refer Referrals from medics/other professionals - consultative Physio assessment and clinical differential diagnosis	Self-referral normal
Referral specified treatment practice regime in specific terms	Selection & implementation of treatment programme	Outcomes-driven
Any change in patient's condition/lack of progress required doctor's attention	Re-assess, monitor progress, adapt treatment as necessary	Evidence-based practice
Referred back to doctor on completion of treatment general programme	Discharges patient Written report to referee/ solicitor	Discharges patient Written report to practitioner/solicitor
Had regard at all times to the clinical responsibility of the doctor for the patient	Diagnostic profession with medico-legal responsibilities	Increased medico-legal responsibilities
Physiotherapists sent report to doctor who represented patient	Physiotherapist may represent his/her own opinion professionally in court	Listed as medico-legal expert witness in court
Self-employment in private involved practice very rare medical service	Private practice — self-employed/employer other physios Number: 23% '94	Private practices in general work
Postgraduate statutory usual degrees are	Postgraduate degrees usual MA, BA, MSc. (in Physio-therapy, Education, Sports Medicine, Medical Science, by Thesis) PhD	Postgraduate degrees
Specialisation by experience	Diplomas recognised by HEA, NCEA or CNA reciprocity with UK. (Lifting/Handling techniques, Acupuncture, Obstetrics, Neurodevelopmental, etc.)	PhDs & evidence-based research will become more normal

Anomalies

21. In Recommendation 15515, the Labour Court found *"that there are some surprising anomalies between the pay scales of the various disciplines that are included in this claim"* and the terms of reference for this Group asked it to address these.

22. In the light of all the submissions made to it, the Expert Group is of the view that the major anomaly to be dealt with is in fact the myriad differences arising from the discrepancies in the salary scales - both basic and promotional - which have arisen between the therapy professions.

23. This view is supported by the significant similarity in terms of entry requirements, the levels of academic and practical training and the relative development and standing of the professions within the health service. In the submissions relating to therapists the health service employers also recognised that *"a case may exist for a more rational pay structure"*

24. **Accordingly the Expert Group recommends that with effect from 1st April, 2000 the following common scales be established for the following professions.**
Chiropodist, Dietitian, Occupational Therapist, Orthoptist, Physiotherapist and Speech & Language Therapist.

    19,069 19,708 20,249 20,809 21,362 21,930 22,495 23,059 23,654 24,279 24,904 25,404. [L.S.I.]

    The Expert Group further recommends that the overlap between grade scales should be eliminated by expressing the Senior grade's salary as a plus of £4,200 over the individual's service point on the basic scale.

    The salary progression for the Senior grade may be shown by the following set of figures:

    25,009 25,562 26,130 26,695 27,259 27,854 28,479 29,104 29,604.

25. The salary progression recommended for a therapist who accepts the duties and responsibilities appropriate to the Senior grade recognises:

    (a) That a minimum of three years' post qualification experience is an essential requirement for appointment at senior level.

    (b) That senior salary, depending on the professional service is that figure which is £4,200 over the individual's service point on the basic scale.

Career Structures

Existing Career Structures

26. The career structure of dietitians, occupational therapists, physiotherapists and speech and language therapists derives from a number of joint union-management working party reports in the late 1970s and early 1980s. The structure in each case has a number of tiers and provides for basic, senior and in-charge/principal/head levels.

Recommendations

Basic grade

27. **The Expert Group recommends retention of the basic grade, with a common pay scale as set out in the section dealing with anomalies.**

    The Expert Group also recommends the continuation of the present system of rotation of new graduates over the full range of basic professional tasks.

Senior Grade

28. The current structure for physiotherapist is based entirely on numbers. The number of senior posts in the hospital or community care area or service is determined solely by reference to the number of physiotherapists employed.

29. In the case of dietitians, occupational therapists and speech and language therapists, a senior post exists where the person is working single handed in a designated area or in charge of a department that is a distinct entity, in which at least two others are employed.

30. The structure for these professions also provides that in exceptional circumstances, where the holder of a basic grade is carrying out individualised specialised work demanding a high degree of responsibility and technical skill, the post could be upgraded to a senior level. The specific approval of the Department of Health & Children is required in such cases. There was little evidence that many senior posts have been established through this process.

31. The Expert Group has concluded that the criteria for the establishment of posts at senior level is inflexible and inequitable in its application. The site visits confirmed that the present system for determining the basis on which posts should be at senior level is creating problems, not resolving them.

    For their part the employers frankly acknowledged the shortcomings of the present numbers based system.

32. All the professions taken together represent a comparatively small number of people. Despite the recent growth of interest in their skills, the major sources of employment are the health agencies. Within this narrow field, these professions which are widely dispersed in small groups, have limited opportunities for professional advancement. This is so compared with other numerically larger groups in which there are greater opportunities and wider scope for advancement. In these circumstances the current system has been inequitable and is in fact a disincentive to remaining in the profession.

Accordingly the Expert Group recommends

- **That the current system for determining senior grade should continue where applicable.**

- **That senior grade apply where a therapist is working single handed.**

- **That senior grade apply where a therapist is carrying out work of a specialist nature.**

33. The Expert Group is satisfied that with the scientific development of the therapy professions and the growing trend towards specialisation, an increasing number of therapists are doing work which should qualify for senior grade. Difficulties that may arise from the implementation of this recommendation should be dealt with in accordance with the provisions in paragraph 45.

In-charge/Principal/Head grade

34. The current structure for physiotherapist provides for the establishment of a post at 'in-charge' level in a hospital or service in which a total of five physiotherapists are employed.

35. There are three levels of In-charge

* *Grade I* - hospital with five but less than 12 physiotherapists

* *Grade II* - hospital with 12 but less than 20 physiotherapists

* *Grade III* - hospital with 20 or more physiotherapists.

36. In the case of dietitians, occupational therapists and speech and language therapists, the structure provides for the establishment of a post at principal/head level in a hospital or community care area in which a total of at least three others are employed.

37. There are two levels of principal/head

* *Level 2* - hospital or service with three but less than six (five in the case of dietitians).
* *Level 1* - hospital with at least six therapists employed (five in the case of dietitians).

38. With regard to the grade of in-charge/ principal/head, the Expert Group does not consider that differentials within this grade related solely to numbers managed is warranted.

39. **The Expert Group recommends the establishment of a single physiotherapist manager post to replace levels 1 and 11 in the existing structure, with effect from 1st April, 2000.**

40. **The Expert Group recommends that the overlap between grade scales be eliminated expressing the In-charge salary as a plus of £4,200 over the senior scale [£8,400 over the basic scale] with effect from 1st April, 2000.**

    The salary progression for the In-charge grade may be shown by the following set of figures:

    30,330 30,895 31,459 32,054 32,679 33,304 33,804.

    The salary progression recommended for a therapist who accepts the duties and responsibilities appropriate to *In-charge* recognises that -

    (a) A minimum of five years' post qualification experience is an essential requirement for appointment at In-charge level.

    (b) The in-charge salary depending on the professional service is that figure which is £8,400 over the individual's service point on the basic grade salary [£4,200 over the service point on the senior grade salary progression].

41. **The Expert Group recommends that the In-charge 111 be retained and the salary progression with effect from 1st April, 2000 will be:**

    34,530 35,095 35,659 36,254 36,879 37,504 38,004.

42. **The Expert Group recommends the establishment of a single manager level to replace the existing Principal/Head 1 + 11 posts for Dietitians, Occupational Therapists and Speech & Language Therapists, with effect from 1st April, 2000.**

    The Expert Group recommends that the overlap between grade scales be eliminated by expressing the Principal/Head as a plus of £8,400 over the individual's service point on the basic grade salary [£4,200 over the service point on the senior grade salary progression].

    The salary progression for the Principal/Head may be shown by the following set of figures:

    30,330 30,895 31,459 32,054 32,679 33,304 33,804.

    The salary progression recommended for a therapist who accepts the duties and responsibilities appropriate to Principal/Head recognises that:

(a) A minimum of five years' post qualification experience is an essential requirement for appointment to Principal/Head level.

(b) That Principal/Head salary is that figure which is £8,400 over the individual's service point on the basic grade salary [or £4,200 over the service point on the senior grade salary progression].

43. The salary scale proposed for basic, and the salary progression proposed for senior and head will eliminate the considerable overlapping problem within the existing scales and provide incentives for those who undertake positions of responsibility.

    Existing post holders should be assimilated to the scales on the basis of corresponding points.

Implementation

44. The Expert Group recognises that the above recommendations represent a change from the rigidity of the existing system. It has been devised particularly with the circumstances of therapists in mind.

45. It is anticipated that the implementation of these recommendations will involve a great deal of work by all concerned. In particular, it is to be expected that a large number of applications will be received from therapists seeking upgrading to senior level on the basis of specialist work.

    The Expert Group acknowledges that the parties now have full access to the Labour Relations Commission and Labour Court to assist in resolving differences which may arise from the implementation of this Report.

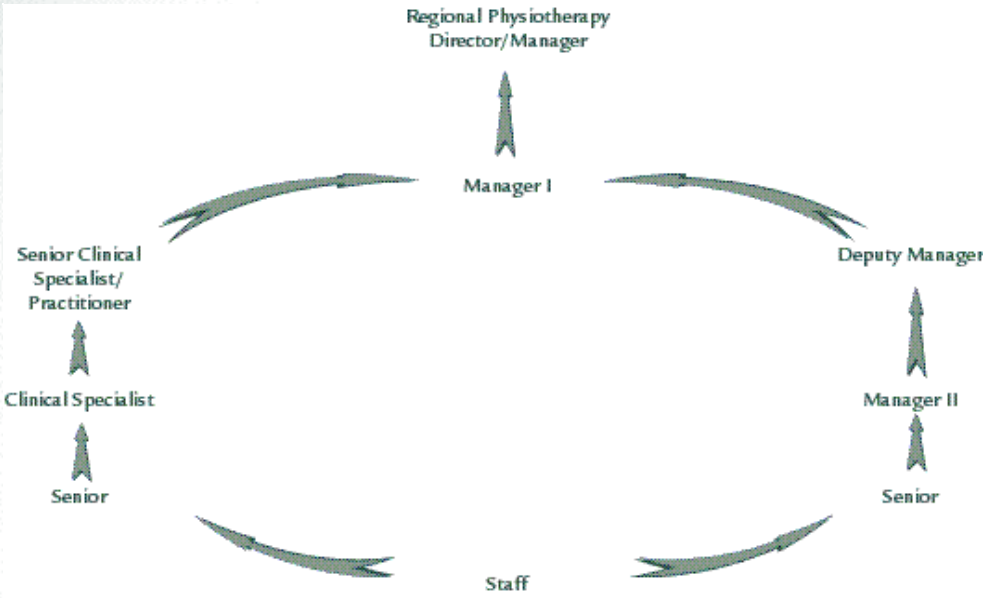
    However, for an initial period of two years, it is recommended that an agreed Adjudicator be appointed to chair a process to deal with such applications as are in dispute. During this period a set of criteria should emerge by which these issues will thereafter be determined.

46. **The Expert Group formally endorses and recommends the proposals in the employer's submission that the manager's role should develop in a more structured way to allow the person to become more involved in the management of the service. The managers, as heads of service, should continue to distance themselves from day-to-day work with clients and patients and focus on the broader issues outlined in the specification of their role. However, the Expert Group recognises that the clinical role will continue to feature in the work of managers.**

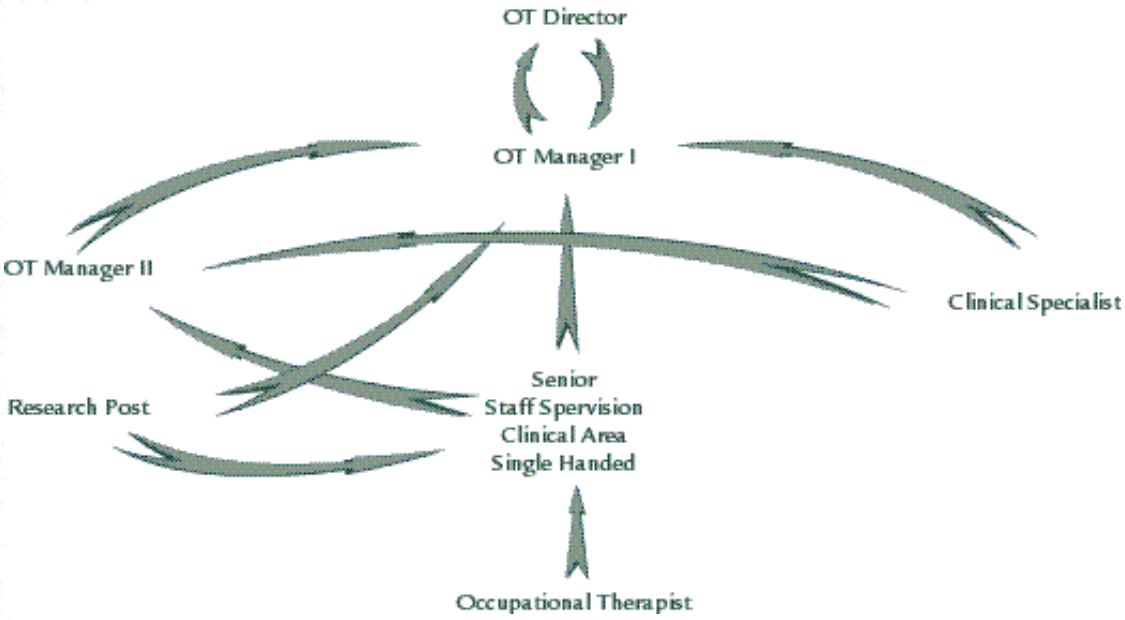
Future Career Structure

47. All submissions approached the development of a new career structure from slightly different angles but arrived at markedly similar consensus as illustrated by the following charts:

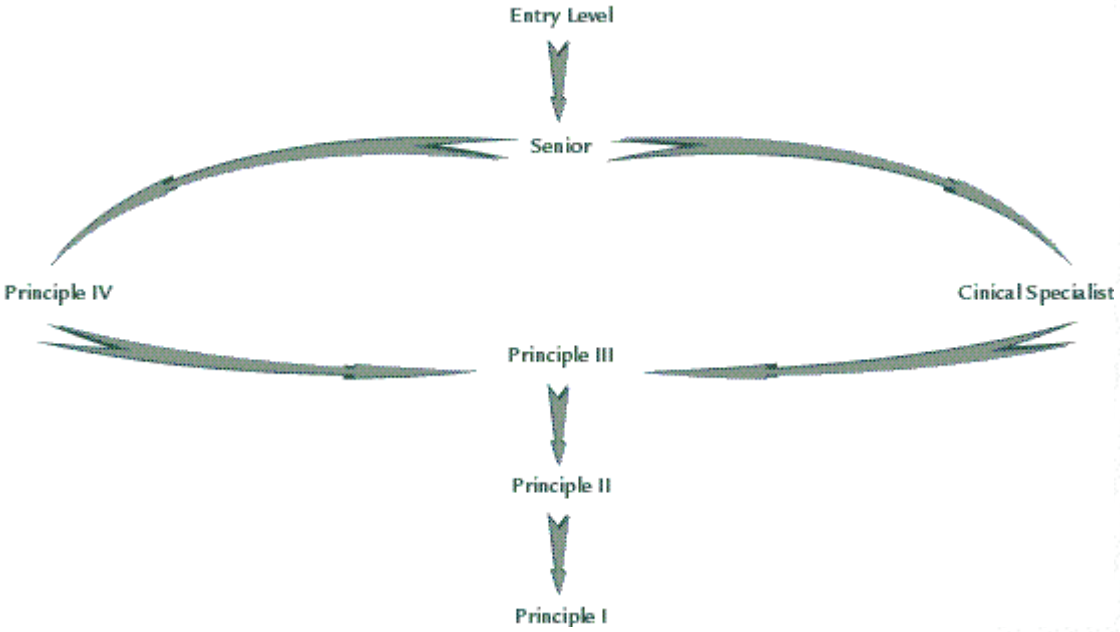
Physiotherapist



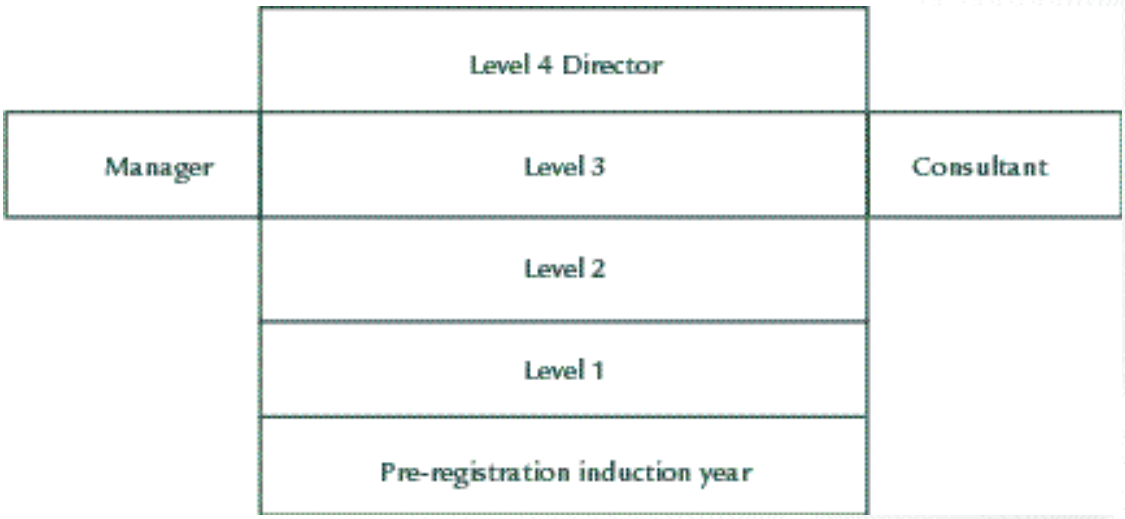
Occupational Therapists



Dietitians



Speech & Language Therapists



48. The employers were in favour of changing the structure and argued that any alternative to the existing arrangements must be capable of meeting the following principles

- *Transparency*
- *Equity*
- *Responsive to the needs of the service*
- *Predictability for budgetary control purposes.*

49. The framework put forward by the employers provides for

- *Regional managers*
- *Therapist in-charge/manager*
- *Senior grade*
- *Staff grade*
- *Intern post*

50. The employers proposed that, *"in the context of an integrated, seamless and inter-disciplinary service, a post of regional manager could be established with hospital/ community responsibilities."*

51. The employers suggested the new grading structure should

- *Vary between community areas and hospital settings*
- *Reflect workload and outcomes and not necessarily numbers employed.*

52. **The Expert Group recommends, subject to what follows, that the parties meet to examine the requirements for the future, taking account of the principles set out in the employers submission.**

53. **The Expert Group does not recommend the establishment of an intern grade as proposed by the employers.**

54. The establishment of senior managerial/ advisory posts should only be developed by reference to service needs at area or regional health board level, e.g. elderly, child care, disability, mental health and so on.

    For this reason the Expert Group does not recommend the establishment of a post at regional health board level for each of the professions.

55. The Expert Group has considered both the proposal made by staff for the establishment of a new grade of clinical specialist and in this context the changes in the provision of health services as envisaged in the employers' submission.

    "While these structures worked well and have allowed significant increases in the level and range of services over the years, there are now new and emerging ways of thinking about healthcare and re-orientating to improve its delivery, effectiveness and quality. Programmes are also being developed for specific types of illness, e.g. mental health, cancer, etc. Such re-orientation is likely to impact on the way occupational therapists are deployed and utilised in the future."
    [Para 7.1 of employers' submission re occupational therapists and others].

    Clearly a great deal of detailed consideration needs to be given by the parties as to the place such a grade would occupy in a more flexible service.

    For these reasons, the Expert Group sees merit in the staff side proposal but is of the opinion that as of now, it can do no more than recommend that discussions start on these matters at an early date.

56. **The Expert Group recommends that the task of overseeing and co-ordinating undergraduates during their practical courses and arranging rotation of new graduates should be formally recognised.**

In the immediate future, it is envisaged that such responsibilities would be expanded to include the provision of refresher courses for former therapists.

The Expert Group recommends that an annual allowance of £1,800 be paid to the therapist with responsibility for such training.

57. Although there was evidence relating to a pilot project for Speech & Language Therapy services in the Mid-Western Health Board and that a grade of Therapy Aide exists in certain Physiotherapy and Occupational Therapy Departments, the issue of skill mix in the health professions is one that has not been fully developed in the past.

    The Expert Group is satisfied that the introduction of therapy assistants has the potential to provide the very necessary practical support for therapists in the delivery of an efficient and effective service and accordingly recommends that a grade of Therapy Assistant be introduced where appropriate.

    Such a development is intended to enhance the quality of care being provided to clients and as such, a suitably accredited training programme should be established for these assistants in order to provide them with the necessary skills for the job. The role of such assistants in service provision is an issue that must also be addressed so as to ensure that it adequately supports and complements the role of the therapist.

    The introduction of such assistants into the service is not intended as a substitute for existing therapists but rather to complement the role of the therapist and ensure that patient care is maximised.

Problems Relating to Recruitment & Retention

58. Although the parties did not agree on the precise level of staffing required in each of the professions there was no disagreement that,
    for most, there exists a serious deficit in staff numbers. Addressing the shortfall in staff numbers would unquestionably improve the delivery of service and enhance the health and social gain of clients. It is likely that investment at this stage would also bring overall savings for the health services as it would allow much earlier intervention, preventing deterioration in clients' conditions and avoiding wider adverse effects on clients in areas where early intervention is crucial.

59. The staffing problem was recognised in the 1994 health strategy document when it acknowledged that the output of education and training establishments was not keeping pace with demand. The Strategy contained a commitment to examine the problem and increase the numbers in training, in co-operation with the education authorities and professional bodies concerned. **The Expert Group recommends that this should be implemented as a matter of urgency.**

60. The deficit between the number of people employed and the number required to provide effective, equitable service across hospital and health board regions is caused by a variety of factors. **The development of a strategy for manpower planning is a necessary pre-requisite for arranging the increased number of therapists required to improve the quality of service and the Expert Group recommends that the parties meet to address this issue as a matter of urgency in accordance with the recommendations contained in paragraphs 18 - 19.**

61. **The Expert Group recommends that a therapist forms part of the interview board for the filling of therapy posts particular to his/her profession.**

62. Staff and management identified a number of other elements in the current employment conditions which gave rise to difficulties both in recruiting and retaining staff.

    The Expert Group recommends the following changes in employment practices to eliminate some of these disincentives.

- **In all cases newly recruited therapists be given full incremental credit for previous professional experience, at home and subject to certification, abroad.**
- **Active measures should be taken to restrict the employment of staff on temporary contracts to a minimum period. Any post that has been filled on a temporary basis for more than 11 months should be examined with a view to establishing the reason the post cannot be filled on a permanent basis.**
- **In any event, therapists employed on temporary contracts should be treated as permanent employees for the purposes of incremental progression and other appropriate benefits which may accrue to permanent staff.**
- **For staff who seek them, fixed term contracts are an alternative way to deal with locum requirements.**
- **In all cases, employee benefits should be available to part-time employees on a pro rata basis.**
- **Overtime worked should be recompensed as a cash payment or time off in lieu and should always be the choice of the employee.**
- **The Expert Group recommends that employers should ensure that adequate back up facilities are available including investment in information technology and proper communication systems and the provision of clerical support.**

63. The Expert Group has been assured that a number of therapists who have for one reason or another retired or resigned, but who feel they are out of touch with up-to-date practice would be willing to return to work if refresher courses were made available.

    The Expert Group recommends that employers establish initiatives to facilitate therapists who wish to return to the health services.

64. **The Expert Group further recommends that the parties at local level consider the establishment of "out of hours" clinics.** Essentially, this suggestion means that an employer makes available facilities to allow therapists who wish to do so to provide clinics either in the evening or at weekends.

    The Expert Group realises that much of the work of therapists is both physically and mentally strenuous and is not recommending that overtime should be a major element in the provision of therapy services but if on a voluntary basis therapists were to undertake additional sessions on a regular basis, the advantages would be as follows:

    A marginal easing of the daytime workload - a decrease in work intensity.

    A financial benefit to therapists taking part. The form of payment would be subject to negotiation.

    Such clinics would be client-friendly.

    It would facilitate the employment of additional part-time staff.

Role of the Therapy Professions

65. Each submission by the individual professions provided a detailed description of its role in various sectors of the health service. Set out hereunder is a summary of each:

Dietitians

The role of the nutritionist/dietitian

"The role of the nutritionist/dietitian is that of an authority in the application of nutrition and dietetic knowledge for the benefit of patients and of the general public. Nutrition/dietetic interventions have positive effects on the health and wellbeing of individuals or groups within the population. A nutritionist/dietitian is also an expert nutrition resource for other health professionals and industry.

The functions of the nutritionist/dietitian are very diverse and are dependent on his/her particular sphere of influence.

In the health service, nutritionists/dietitians are primarily employed in hospitals or in the community/public health."

Occupational Therapists

66. *"The purpose of occupational therapy is to maximise the "fit" between what an individual wants and needs to do and his/her ability to achieve this.*

Occupational therapists have an intricate knowledge and understanding of the physical sciences, including anatomy, physiology and kinesiology, as well as the human sciences of psychology and sociology. All these essential elements combine to provide an occupational therapist with a unique understanding of occupational performance which includes:

Knowledge and understanding of the importance and relevance of 'occupation' to the wellbeing of an individual.

Knowledge and understanding of 'occupational science' which includes an understanding of performance components and the influence of environmental factors on occupational performance.

Knowledge and understanding of practice models and frames of reference.

In addition to the above, occupational therapists have knowledge and understanding of health management and administration."

Speech & Language Therapists

67. *"The speech and language therapy services provide assessment, diagnosis, treatment, advice and counselling to people of all ages with communication disorders and feeding/swallowing disorders. Communication disorders may be associated with a wide variety of medical factors, e.g. cleft palate, hearing impairment, strokes, brain injury, neurological disorders, etc. They may also be associated with social, cognitive or linguistic impairment, e.g. learning disabilities, intellectual impairment/mental handicap, specific language impairment, etc. Speech and language therapists are clinically accountable for acceptance of clients for assessment, diagnosis of disorder and for the provision of therapy."*

Chartered Physiotherapists

68. *"Physiotherapy is a health care profession with an emphasis on analysis of movement based on the structure and function of the body and the use physical approaches for the promotion of health and the prevention, treatment and management of disease and disability. Physiotherapy as a profession in health care examines, assesses, plans and implements treatment programmes, monitors and evaluates patient responses, counsels and advises patients and carers.*

Physiotherapists work in both the private and the public sector in Ireland. Traditionally, physiotherapy has been a hospital-based service, providing care for in-patients and out-patients.

Physiotherapy as a profession covers many areas of specialisation which range from respiratory care in the acute medical setting, to sports and fitness evaluation and training. The treatment of neurological conditions, both developmental and acquired, forms an important part of physiotherapy in the hospital, clinic and community setting. Orthopaedic, rheumatological and musculo skeletal conditions are treated in most out patient departments. In recent years, many more physiotherapists have been employed in the community by some health boards where they mainly provide a service for the very young and very old."

Orthoptist

69. *"An orthoptist is involved in the assessment, diagnosis and treatment of various disorders of the eyes, extra-ocular muscles, (e.g. squint) and anomalies of vision (amblyopia (lazy eye)). Orthoptists work in close liaison with ophthalmologists.*

    Orthoptists make a significant contribution to visual health. An ocular disability, perhaps initially slight, can become a major visual handicap if not promptly identified and treated. Preventative screening is particularly important. Quality of vision is an important factor in leading a full and useful life at all ages. It is crucial to infant development, to a child's education, to employment prospects, to the pursuit of leisure activities, and to the enjoyment of retirement.

    In many centres the orthoptist makes the initial contact with the patient and carries out a detailed examination. Having taken a precise ocular and general medical history, the orthoptist selects the appropriate diagnostic techniques.

    These include tests to assess the visual levels, the relative position of the eyes, the ability to move the eyes and the degree to which the input from each eye can be combined by the brain.

    The interpretation of the results enables the orthoptist to diagnose the extra-ocular motility (eye movement) disorder, and so judge the patient's ability to interpret visual information and maintain eye control, with the two eyes working in unison. The orthoptist also establishes whether the defect is long-standing or of recent onset, and if it has neurological implications."

Chiropodist/Podiatrist

70. *"The essence of the chiropodist/podiatrist's clinical work is to assess, diagnose and treat diseases and abnormalities of the foot. The chiropodist/ podiatrist is an autonomous clinician to whom the patient/client may self-refer. Patients/clients usually present with some degree of pain as in the foot. Each patient has to be assessed and the protocol for this process is described later. As a clinician the chiropodist/podiatrist practices mainly in isolation. Although team working, (unidisciplinary and multidisciplinary) has been developing in recent years, much patient contact continues to be on a one to one basis. Because of this, the undergraduate education emphasises the ability of the clinician to arrive at an accurate assessment and diagnosis of the signs and symptoms from which the patient seeks relief.*

    In broad terms the assessment of the patient is designed to arrive at a definite (or at least a differential diagnosis) by identifying the cause of the problem. In addition other factors are identified which may influence the choice of treatment including the patients vascular status, neurological status, systemic conditions and the current drug regime, the latter being cross-referenced with MIMS or BNF. Drug toxicity is an important issue when treating patients with chronic illnesses, skin rashes, fungal infections, and delayed wound healing may become evident. An assessment is also made of the extent of pathological changes, local and general, which have taken place and whether a prognosis can be made on the basis of the information as to whether the condition is improving or deteriorating. In a limited number of cases other opinion may be sought to ensure accurate diagnosis and effective management and the best outcome for the patient."

Employers' Response

71. The employers have given a standardised response describing in broad terms the structures within which they envisage the professions.

    The submission reads as follows and is the same in respect of all therapy professions:

    "The health strategy demands that services be more responsive to the needs of patients and clients. To ensure this objective, decisions which affect patient care must be taken as near to the point of service as possible. It is essential that the organisational structure in the health service provides for the proper assignment of decision making. While strategic policy indicators may emanate from central level, i.e. Government or Department of Health & Children, operational decisions are best taken locally, having regard to local service needs and knowledge.

    In addition to assigning decision-making to the appropriate level, it is also essential that the responsibilities of agencies and individuals at all levels are clearly stated and understood. While continuing to be clinically responsible to referring medical practitioners, such devolution of other responsibilities will obviously impact on the role of therapists."

72. From all the documentation supplied, it may readily be deduced that no real conflict exists as to the roles of the professions in question. For the employers part, their description of the element of management and its responsiveness, together with new forms of service provision, are clearly based upon the level of professional autonomy now clearly established within the therapy professions.

73. All the evidence offered - the growth in the knowledge base, a greater general awareness of the benefits to patients deriving from such knowledge properly applied - all point to a wider role likely to be played by the growing influence of therapists. There is no reason to believe that this influence will decline. It is much more likely to increase.

Training & Education Requirements

74. It is agreed by all concerned that, at present, the general shortage of therapy staff is due in some measure to the small number of college places available for undergraduate education. This shortage is such that certain employing authorities have had to refuse to accept student placements due to the pressure of work on a much depleted staff. The Expert Group accepts that there is no simple solution to this problem. It notes the employers have suggested in this context a manpower planning exercise. This is an initial and important step that the Expert Group readily endorses. But the Expert Group felt that, to be useful, the exercise must be on a national basis over all therapy professions and, most usefully, the manpower plan should relate not just to immediate needs but to the future development of the therapy services.

    The Expert Group recommends that this exercise begin as soon as possible and be overseen by a body representing the academic institutions, health care management and the therapy professions.

75. **The Expert Group also recommends that any additional educational places which may become available prior to the completion of the exercise should of course be taken up.**

76. The personal and professional development of therapists is vital to maintain a high quality of service. **For this reason, the Expert Group recommends that employers establish a training budget which should be largely devolved to the head of the particular profession to identify and arrange for appropriate training and development programmes.**

Whilst local priorities should influence the manner in which the budget is spent, some effort should be made to make payment of travel, accommodation and other expenses involved in such training more equitable.

77. **In relation to the training budget the Expert Group recommends that where appropriate a system be introduced to provide guidelines on priority areas for spending at local level and to indicate the level of spending required.**

78. **The Expert Group recommends that the position and work of the therapist in charge of undergraduate clinical placement be formally recognised and has dealt with this in paragraph 56.**

79. **The Expert Group recommends that the employers' proposals for the establishment of joint academic/service posts be implemented.**

80. **The Expert Group does not recommend that the attainment of additional qualifications, of itself, merits additional remuneration.**

81. **The Expert Group believes that the official registration of the therapy professions would greatly assist in the development, maintenance and monitoring of educational and training standards. It notes the successful implementation of registration in Finland and recommends the establishment of Statutory Registration for Irish therapists. This matter is dealt with in the final section of this report.**

Management and Development within each Profession

82. The Expert Group recognises from the written submissions and meetings with management and representatives of the professions that both management and staff agree on the need for a planned personal and management development programme for the therapy professions. This is particularly true for the management grades.

83. The difficulties experienced by members of the professions in the transition to management positions is accepted and the Expert Group fully endorses the view expressed in the 1997 'Management Development Strategy for Health and Personal Social Services' which, when referring to this transition states:

"The entry to management often involves distancing themselves from day-to-day work with patients and clients and focussing on what may seem to be quite separate set of issues. Making this transition, from concern with the individual to concern for a service or client group can be stressful."

84. **In the light of the above, the Expert Group recommends that the Office for Health Management commissions a survey into the competencies required for management positions within these professions.** Once these competencies are identified, they should be used in the recruitment, selection and development of managers within the professions. This survey should be informed by the submissions made by both sides on the developing management role of the professions.

85. The Expert Group is also aware of a programme developed by the Office for Health Management directed at first-time managers. **The Expert Group recommends that employers ensure that appropriate personnel from professions participate in this programme.**

86. **The Expert Group recommends that the Office for Health Management pilots personal development planning exercises with each of the professions to test out an approach to linking personal development needs to organisational objectives and to help members of the professions prepare realistic and achievable plans to meet those needs with a view to all health service employers introducing this developmental approach for all grades in the therapy professions.**

Interaction with Other Discipline

87. Each submission by the therapists described the range of other professions with which they work on a regular basis. The employers gave no indication that any difficulties were being experienced at present. However, it seems clear that changes in clinical practice and the extension of care into the community will give rise to the composition of team work procedures. **Whilst it is right that employers should expect the co-operation of professions in the formation and operation of such teams, the Expert Group recommends that they are established after full consultation with the professions concerned.**

Developement Plans for Delivery of Services

88. Under this heading, employers once again commented in a standardised way, outlining the policies that they envisaged would apply at all levels of management in the health services in future.

"Therapists will be expected to participate in management development programmes with a view to developing and improving their managerial skills to better meet the needs of their service. Therapists will form part of the recruitment pool from which health service employers will recruit general management grades such as general managers, district managers and care group directors.

For multi-disciplinary teamwork to be effective, it demands ongoing commitment. Services must be needs led and this requires ongoing review and evaluation of the day-to-day service delivery. As part of these ongoing review measures, therapists will be expected to manage waiting lists. Services should not be developed in isolation from each other, but must be needs-led, holistic and consumer-based. Services must be developed in the context of health service employers' strategies and in the wider national context of the health strategy, both in terms of health and social gain.

Service plans will be the vehicle for the introduction and agreement of development plans for delivery of service. The service planning process is expected to move over time from an annual to a multi-annual basis. The plans must also include a consumer feedback mechanism as a service evaluation measure.

Health service employers will continue with the process of devolving resource budgets. This is in line with the accountability principle contained within the health strategy and in keeping with best management practice."

89. The professions, for their part, interpreted what was required of them under this heading in different ways. Their various comments are summarised hereunder:

- Gaps in the provision of services due to staff shortages and organisation flaws
- Areas in which services have still to be provided
- Likely extension of demand for new or additional services due to demographic and other changes
- Variations in the provision of service due to clinical and technological advances.

90. The Expert Group assumes this to mean that there is no fundamental conflict of interest to be resolved. But the underlying theme of each submission demonstrates that major flaws relating to the organisation and provision of therapy services will require attention if the employers' plans are to be realised. The implementation of these plans will, of course, require detailed consultation at all levels to ensure the areas of interest of the therapists are taken into account. In this context, as well as on the issue of inter-disciplinary teamwork, the establishment of a Policy Unit in the Department of Health & Children will be of considerable assistance.

Chapter 3 Recommendations Specific to Orthoptists and Chiropodist/Podiatrist

Orthoptists

91. The Expert Group notes the extent to which the academic and professional development of orthoptists has paralleled that of the major therapy professions. It also notes their concerns that career structures, salaries and other conditions of employment should equate to those professions.

    The Expert Group recommends, to the extent that it is possible to apply them, that the various changes proposed for the therapy professions should be extended to the orthoptists.

92. The current geographical distribution of orthoptists does not, in the view of the Expert Group, allow for the construction of any form of management role even under the terms of the promotion by numbers system. However, the need for management positions may arise when the profession is extended.

    The situation does have a major advantage for orthoptists insofar as the majority, if not all full-time staff should qualify for senior grade by reason of working single-handedly or being engaged in work of a specialist nature. **Accordingly the Expert Group does not recommend any change in the present career structure for orthoptists.**

93. **The Expert Group recommends that the common pay scale recommended for the basic post will apply with effect from 1st April, 2000.**

Basic grade

19,069 19,708 20,249 20,809 21,362 21,930 22,495 23,059 23,564 24,279 24,904 25,404. [L.S.I.]

94. **The Expert Group further recommends that the overlap between the basic and senior grade scales be eliminated by expressing the senior grade salary as a plus of £4,200 over the individual's service point on the basic scale. The salary progression for the senior grade may be shown by the following set of figures.**

    25,009 25,562 26,130 26,695 27,259 27,854 28,479 29,104 29,604.

95. The salary progression recommended for the orthoptist who accepts the duties and responsibilities appropriate to the Senior grade recognises:

    (a) That a minimum of three years' post qualification experience is an essential requirement for appointment at senior level.

    (b) That senior salary, depending on the professional service is that figure which is £4,200 over the individual's service point on the basic scale.

96. The Expert Group is clearly not in a position simply to recommend that the health agencies increase the number of orthoptists employed, but given the variation in the numbers employed it would seem that overall, an additional six orthoptists might usefully be absorbed. Similarly, given the number of single-handed posts, there would seem to be places for further full-time work to cover annual or other leave.

    Since there is no educational facility in the State, the Expert Group recommends that the new Policy Unit in the Department of Health & Children arrange with the employing authorities for the provision of three places in the UK universities for the academic year 2001, providing financial assistance to students. This exercise should be repeated in 2002 to provide yet again for three places.

Any developments thereafter should take place in the context of a review designed to plan for the future of the orthoptic service within the health service as a whole.

Chiropodist/Podiatrist

97. **The chiropodist/podiatrist has no grading structure and the Expert Group recommends the establishment of a post at senior level. The common pay scale recommended for the basic post will apply with effect from 1st April, 2000.**

Basic Grade

19,069 19,708 20,249 20,809 21,362 21,930 22,495 23,059 23,654 24,279 24,904 25,404. [L.S.I.]

The Expert Group recommends that the senior scale be expressed as a plus of £4,200 over the individual's service point on the basic scale. The salary progression for the senior grade may be shown by the following set of figures.

25,009 25,562 26,130 26,695 27,259 27,854 28,479 29,104 29,604.

98. The salary progression recommended for the chiropodist/podiatrist who accepts the duties and responsibilities appropriate to the senior grade recognises:-

    (a) That a minimum of three years' post qualification experience is an essential requirement for appointment at senior level.

    (b) That senior salary depending on the professional service is that figure which is £4,200 over the individual's service point on the basic scale.

99. The geographical distribution of chiropodist/podiatrist does not, in the view of the Expert Group, allow for the construction of any form of management role even under the terms of the promotion by numbers system. However, the need for management positions may arise when the profession is extended.

    The situation does have a major advantage for chiropodist/podiatrist insofar as the majority, if not all full-time staff will be at senior grade by reason of working single-handedly or being engaged in work of a specialist nature.

100. The Expert Group is satisfied that major advances have been made by the profession in clinical and general health care. It also accepts it is important for the population generally that an adequate corps of properly qualified chiropodists/podiatrists exist.

The Expert Group therefore recommends that the new Policy Unit in the Department of Health & Children initiate a manpower planning exercise to determine the number of additional chiropodists/podiatrists required and in that context the need for the establishment of a School of Podiatry, which apparently has been under consideration for some time.

Child Care Workers

101. The role of the child care worker is primarily concerned with the social and emotional welfare of children in their care. The care worker provides a specialist caring service to children with special needs, which if not responded to would leave the development of the child at risk.

The context in which the child care worker provides this service is in a residential setting (including Special Care Units) or in a community based service.

In the past, non custodial residential child care was largely provided on behalf of health boards by voluntary bodies and religious organisations.

The majority of residential homes were managed by a Resident Manager. Below the manager, the child care worker was graded as house parent, assistant house parent or trainee house parent.

102. As a result of legislative changes and a number of high profile reports which highlighted issues requiring attention, major changes are taking place in the organisation and delivery of child care services.

Recent developments include:

- Raising the legal definition of a child from 16 to 18 years.
- The requirement that Health Boards develop care plans and undertake regular reviews of children in their care.
- Increased responsibility on each Health Board to promote the welfare of children in its area who are not receiving adequate care and protection.
- Raising the age of criminal responsibility from seven to ten years.

As a result, health boards are now more extensively involved in the establishment of new child care services and enhancement of services available in residential units.

103. The staff side submission highlighted the increasing professionalisation of child care services and the high standards demanded in the provision of therapeutic support to meet the needs of a highly complex and ever changing client group.

The Expert Group accepts that to meet the challenges presented by new legislation and related developments, the skills required by child care workers will continue to evolve.

104. It is clear that the work of child care workers is distinguishable from other professions:

a) By duration and intensity of the relationships with the client.

b) The range of ages and the variety of needs of the clients within such a long term context.

c) The extension of this work into the family and community.

The Expert Group recommends that child care workers be accorded formal professional status and as a consequence recruitment of non-qualified personnel must eventually cease.

105. **Having regard to the implications of the recommendation at paragraph 104, the Expert Group recommends that a joint committee be established whose terms of reference should be to deal with issues arising from recognition of the autonomy of the child care workers profession including:**

- The setting up of a proper career structure for both the residential and community child care workers.

- The changes required in general management of child and family services and in case management arising as a consequence.
- The management of changes arising from the ending of recruitment of non-qualified child care workers.
- A complete review of the training available to child care workers, with a view to the introduction of a nationally recognised professional qualification and the provision of regular in-service training.
- The arrangements for training of unqualified staff to an acceptable standard.

106. **Given the extent of this agenda, the Expert Group recommends that the proposed committee should have eighteen months to conclude its business. In the event that agreement cannot be reached on particular issues it is recommended that they be referred in the first place to the Labour Relations Commission and if necessary to the Labour Court.**

107. **The Expert Group recommends that the premium payments in respect of unsocial hours work done by child care workers should with effect from 1st April, 2000 be as follows:**

- **The premium for Saturday work should be increased to £8.50 in line with nursing grades.**
- **The Sunday premium payment is double time and no change is recommended.**
- **The Labour Court Recommendation 14787 concerning the payment of a double time premium for work on Public Holidays should be fully implemented in all areas.**
- **The Unsocial Hours Premium conceded to Nurses in the Labour Court Recommendation 16330 of time and one-sixth for hours worked between 6.00 p.m. and 8.00 p.m. to apply where there is an 8 hour shift or more worked by the individual.**
- **A payment of £25 for "sleeping in" should apply. Sleeping in time to be a continuous period of 8 hours between 8 p.m. and 8 a.m. and outside of the normal 39 hours duty. Staff in receipt of such payment should be deemed to be on call and the payment should only apply to staff specifically requested to sleep in for duty purposes.**
- **Unsocial hours premiums should apply to resident managers where the manager is rostered to work such hours.**

108. **The Expert Group recommends that active measures should be taken to fill temporary posts on a permanent basis.**

- **The Expert Group recommends that in any event child care workers employed on temporary contracts should be treated as permanent employees for the purpose of incremental progression and other benefits which may arise for permanent staff.**
- **The Expert Group recommends that newly recruited child care workers should be given full incremental credit, subject to verification for all previous relevant service.**

109. **The Expert Group recommends that holiday entitlements should be standard for all child care workers.**

Social Workers

Pay & Anomalies

110. The Expert Group has examined the claim made by social workers for salary scales equivalent to psychologists and executive engineers. The Expert Group is satisfied that this does not constitute an anomaly as defined by the Labour Court. It is rather, a claim based on relative comparability and as such is outside the terms of reference of the Expert Group.

- The recent pay history of social workers demonstrates that the Health Services/Local Authority Arbitration Board reviewed it in December 1990. As a result the pay of all social worker grades was increased by 25%.
- The Labour Court in Recommendation 15515 awarded social workers the same increase as the other health professions. It is not considered therefore that there are anomalies in the social worker scales with those of the various other professions that need to be addressed by the Expert Group.

Career Structure

111. The existing grading structure for the profession is as follows:

Community Care	**Hospital**
Senior Social Worker	Head Medical Social Worker
Team Leader	Senior/Single Handed
Professionally Qualified Social Worker	Medical/Psychiatric Social Worker

112. The career structure for community care social workers was reviewed in 1994.

As a result the post of team leader was introduced as an intermediate grade between the social worker and senior social worker.

The purpose of the team leader post is to act as support to the senior social worker whether by assuming supervisory responsibility for a particular geographic area and/or leading a number of social workers dealing with a specific service area e.g. adoption services, fostering resource units, young homeless.

The Expert Group is advised that additional posts at team leader level continue to be created in response to specific service developments.

113. The staff side submission put forward the following proposal on a future grading structure.

Particular emphasis was placed upon the position of the social work practitioner as a means of retaining a higher proportion of skilled experienced personnel in the position of practitioners.

TITLE	QUALIFICATION	MAIN FUNCTION
Professionally Qualified Social Worker	National Qualification in Social Work (N.Q.S.W.) or equivalent.	Responsible for an assigned workload and access to regular planned supervision and unplanned consultation.
Senior Social Work Practitioner	N.Q.S.W. or equivalent, plus three years post qualification experience. Proven effectiveness as a professional Social Worker.	Responsible for an assigned workload involving cases of particular complexity or specialist tasks with access to regular planned supervision. Provision of consultation/ skills.
Team Leader	N.Q.S.W. or equivalent plus three years post qualifying experience. Capacity to lead a team.	Responsible for the supervision of the professional practice of a teamof social workers and ensuring a good professional standards of practice.
Senior Social Worker	N.Q.S.W. or equivalent plus five years post qualification experience. Managerial experience preferred.	Manager of a social work team and related services in an area or institution. Responsible for ensuring effective interdisciplinary and interagency working.
Director of Social Work	N.Q.S.W. or equivalent plus seven years post qualification experience, at least two of which to have been at management level.	Responsible for service and policy development within the agency and in collaboration with other agencies. Preparation of service plans and negotiation and control of budgets.

114. **The Expert Group recommends the following approach to the grading structure for social workers employed in community care and hospital services.**

- **The Expert Group recommends retention of the basic professionally qualified social worker, medical social worker and psychiatric social worker.**
- **The Expert Group recommends retention of the team leader grade in community care and recommends that senior medical/single handed medical social workers be paid at the same level.**
- **The Expert Group recommends the following salary for the team leader with effect from 1st April, 2000:**

  28,887 29,737 30,587 31,437 32,287 33,137 33,987
- **The Expert Group recommends that the ratio of senior social worker/team leader and basic social worker posts should be a matter for ongoing direct negotiations between the parties having regard to service needs and the need to provide adequate supervision/support and provide for more efficient caseload management.**
- **The Expert Group recommends that the senior social worker and head social worker be replaced by the title principal social worker. The Expert Group also recommends the following salary for principal social worker with effect from 1st April, 2000:**

  33,137 33,987 34,837 35,687 36,537 37,387
- **The Expert Group formally endorses the proposals in the employer's submission that the manager's role should develop in a more structured way to allow the person to become more involved in the management of the service.**
  The managers, as heads of service, should continue to distance themselves from day-to-day work with clients and patients and focus on the broader issues outlined in the specification of the role. However, the Expert Group recognises that the clinical role will continue to feature in the work of managers.
- The establishment of senior managerial posts should continue to be developed at Area/ Health Board level by reference to service needs e.g. Child Care Manager, Care Group Directors, District Managers. **For this reason the Expert Group does not recommend the establishment of a post of Director of Social Work.**
- **The Expert Group has considered both the proposal made by staff for the establishment of a new grade of senior social work practitioner, and in this context changes in the provision of health services as envisaged in the employers submission.**

  "While these structures worked well and have allowed significant increases in the level and range of services over the years, there are now new and emerging ways of thinking about healthcare and re-orientating to improve its delivery, effectiveness and quality. Programmes are also being developed for specific types of illness, e.g. mental health, cancer, etc. Such re-orientation is likely to impact on the way social workers are deployed and utilised in the future."

  Clearly a great deal of detailed consideration needs to be given by the parties as to the place such a grade would occupy in a more flexible service.

- **For these reasons, the Expert Group sees merit in the staff side proposal but is of the opinion that as of now, it can do no more than recommend that such discussions start on these matters at an early date.**

115. **The Expert Group recommends that employers should ensure that adequate back-up facilities are available to social work services, including investment in information technology and proper communication systems, and the provision of clerical support.**

Training & Education

116. The Expert Group met with the National Social Work Qualification Board (N.S.W.Q.B.) which is an independent body corporate established by the Minister for Health & Children in 1997.

The main function of the N.S.W.Q.B. is to accredit courses that lead to a national qualification in social work.

117. Although the N.S.W.Q.B. is responsible for advising the Minister on content and standards in the training of social workers, its functions do not appear to explicitly extend to the identification of education and training needs for qualified and practising social workers, or to the regulation or accreditation of such training. Yet the need for continuing training and education in a fast-changing professional setting is clearly evident to the Expert Group. Indeed, the role of the N.S.W.Q.B. in regularly reviewing and updating course content for students of social work indicates the importance of updating the skills and knowledge of social workers in general.

The staff side submission to the Expert Group identified a number of areas where recently qualified and experienced social workers required ongoing training in order to maintain the quality of existing services and meet changing professional and public expectations. These included professional development (particularly in specialist areas), legislative changes, new technologies, courtroom skills, management skills and training for practice teachers.

The need for a system of student placements and induction for newly qualified staff is also important in creating the blend of theoretical and practical knowledge necessary to the service.

The Expert Group recommends that the employers and staff meet with the N.S.W.Q.B. as soon as possible to discuss the difficulties in relation to acquiring an adequate number of suitable practice placements for students of social work in community care areas, and to deal with the provision of adequate induction activities at commencement of employment.

The Expert Group also recommends that the need for, and resource implications of, practice teachers be recognised in the forthcoming N.S.W.Q.B. manpower survey.

118. **The Expert Group further recommends that the employers and staff meet with the N.S.W.Q.B. to discuss the possibility of its developing a role in the identification of training needs for practising social workers, and the regulation and accreditation of such training. This might be incorporated into the existing N.S.W.Q.B. function of reviewing and updating course content for students of social work.**

The staff side submission also raised the question of management provision of training resources, time-off for training, and cover for staff undergoing training. While it would be inappropriate for the Expert Group to make recommendations in this area, it is clearly important for the development of the service that all parties contribute to an environment in which ongoing education and training is facilitated. **The Expert Group, therefore, recommends that the employers and staff explore the scope for drawing up agreed 'best practice' recommendations for the provision and resourcing of vocational training for serving social workers, with the advice and input of the N.S.W.Q.B.**

119. **The Expert Group recommends that the employers proposal for the establishment of joint academic posts be implemented.**

Recruitment & Retention

120. Social workers are employed to provide a range of services to a wide variety of client groups including children, families, the elderly and disabled.

In practice most of the social work resources are concentrated in Child Protection Services. This aspect of the work has shown a steep rise in recent years, because of the increased number of suspected child abuse cases referred for social work intervention.

The rapid developments arising from legislation changes in the last decade and the implementation of a number of major reports has led to a growing demand for greater investment in services which rely heavily on social workers. This in turn has created a significant increase in manpower requirements.

Although there was evidence of a substantial increase in the number of social worker posts in recent years, the staff side submission made strong pleas for additional social workers to deal with clients with learning difficulties, short-term fostering, drug abuse, physical and sensory disability, as well as more posts for child protection services.

The submission stated that the social work process is becoming more concentrated on crisis intervention at the expense of preventative and therapeutic work. The staff side argued that many social workers carry unrealistic caseloads and that waiting lists are on the increase.

At the meeting with the N.S.W.Q.B. the Expert Group was informed that there is a current lack of comprehensive information relating to manpower planning.

The Expert Group welcomes the decision of the N.S.W.Q.B. to embark on a manpower survey initiative to identify numbers of social work posts and any planning and recruitment issues arising.

The findings of this survey will provide a basis for evaluating the effectiveness of existing services and will assist the parties in developing a strategy for manpower planning which would make a substantial difference to service delivery and the quality of services.

The Expert Group recommends that this initiative be fully supported and resourced.

Management & Development Within Social Work

121. The Expert Group recognises from the written submissions and meetings with management and representatives of the professions that both management and staff agree on the need for a planned personal and management development programme for the social worker profession. This is particularly true for the management grades.

122. The difficulties experienced by members of the social worker profession in the transition to management positions is accepted and the Expert Group fully endorses the view expressed in the 1997 'Management Development Strategy for Health and Personal Social Services' which, when referring to this transition states:

"The entry to management often involves distancing themselves from day-to-day work with patients and clients and focussing on what may seem to be quite separate set of issues. Making this transition, from concern with the individual to concern for a service or client group can be stressful."

123. **In the light of the above, the Expert Group recommends that the Office for Health Management commissions a survey into the competencies required for management positions within the social worker profession.** Once these competencies are identified, they should be used in the recruitment, selection and development of managers within the professions. This survey should be informed by the submissions made by both sides on the developing management role of the professions.

124. The Expert Group is also aware of a programme developed by the Office for Health Management directed at first-time managers. **The Expert Group recommends that employers ensure that appropriate personnel from the social worker profession participate in this programme.**

125. **The Expert Group recommends that the Office for Health Management pilots personal development planning exercises with the social worker profession to test out an approach to linking personal development needs to organisational objectives and to help members of the profession prepare realistic and achievable plans to meet those needs with a view to all health service employers introducing this developmental approach for all grades in the social worker profession.**

Audiologists

126. A great number of the procedures carried out by audiologists, especially those of an objective electrophysiological nature, have only been introduced over the past ten years. Thus, the role of the audiologist has changed significantly over this period. This has led to a greater involvement of the audiology department in the assessment and treatment of a wider range of patients, which previously was the responsibility of other specialists. Prior to the introduction of the above, there existed no reliable method for the assessment of young infants, the severely mentally handicapped and other difficult to assess patients. As a result of the changing role it is now possible to assess all patients and instigate treatment of hearing aid where indicated, thus providing a comprehensive service.

    It is clear from the submission that the range and complexity of the work of the service has increased considerably over recent years. Insofar as the name audiologist does denote this change from the narrow definition implicit in the term audiometrician, **the Expert Group recommends that this service be entitled Audiology Service and the providers be named Audiologists.**

127. The current grading structure provides for basic and senior levels.

    The Expert Group was informed of a recommendation put forward within the Department of Health & Children in December 1997 to improve the career structure for audiologists, either by the establishment of a post at 'chief' level or another method.

    The recommendation proposed that a chief grade should:

- Have at least 10 years' clinical diagnostic experience
- Have a qualification [BAAT 1,2 and in the future MSc.]
- Be performing in their Department the full range of diagnostic assessments.

    The recommendation was that posts at 'chief' level might be located in regional/teaching E.N.T. Units provided they are using the full range of technology.

128. **The Expert Group recommends that a 'Chief' post should be established in each E.N.T./Hospital Audiology department, but that the criteria set out above be amended to allow an audiologist who has five years' clinical diagnostic experience to be eligible to apply.**

    The salary recommended for the chief post with effect from 1st April, 2000 is:

    24,092 24,942 25,792 26,642 27,492 28,342.

    Taking account of the distribution of audiologists throughout the health services, the Expert Group does not believe it is necessary to construct a more elaborate grading structure.

129. **The Expert Group recommends that the proposal made by the staff side for the establishment of a 'student' grade be considered favourably.**

130. **The Expert Group recommends that the Department of Health & Children should work with the profession to address the issue of training, the related issue of the development of audiology services and how to ensure that overseas audiologists seeking employment are fully qualified.**

131. **The Expert Group recommends that holiday entitlement should be standard for all audiologists.**

132. **The Expert Group recommends that an audiologist forms part of the interview board for the filling of audiology posts.**

Biochemist

Pay & Anomalies

133. The Expert Group has examined the claim made by biochemists for a pay relationship with medical physicists. The Expert Group is satisfied that this does not constitute an anomaly as defined by the Labour Court. It is rather a claim based on relative comparability and as such is outside the terms of reference of the Expert Group.

The Labour Court in Recommendation 15515 awarded biochemists the same increase as the other health professions. It is not considered, therefore, that there are anomalies in the biochemist scales with those of the various other professions that need to be addressed by the Expert Group.

Career Structure

134. The current grading structure for biochemists and the number employed in each level is as follows:

Top Grade	6
Principal	23
Senior	29
Basic	22

Future Staffing Structure

135. The staff side submission proposed a new career structure as follows:

The establishment of a trainee clinical biochemist post to replace the existing basic grade position, and its function to be solely for training for entry into the career grades.

The staff side submission also proposed a phased reduction in the number of existing basic and senior grade posts, and the creation of additional posts at top grade and principal grade to provide for:

Teaching Hospitals

One top grade biochemist in each training hospital and one principal grade in each main area of the biochemistry department.

Large Non-Teaching Hospitals

One top grade biochemist and one principal grade biochemist in each hospital.

Smaller Hospitals

One principal grade biochemist in each hospital with specialist cover from within the health board area.

The staff side argued that these proposals were in line with the training and career structure for clinical biochemists in the U.K., and that the proposed scheme is necessary to train biochemists to the level needed for higher level scientific posts and will facilitate European Registration of clinical biochemists and accreditation of clinical biochemistry laboratories.

136. The employers also favoured a change in the structure but put forward a fundamentally different approach.

The management submission proposed a common entry grade for *"two distinct professional groups of employees whose duties overlap significantly"* i.e. biochemists and medical laboratory technicians/ technologists.

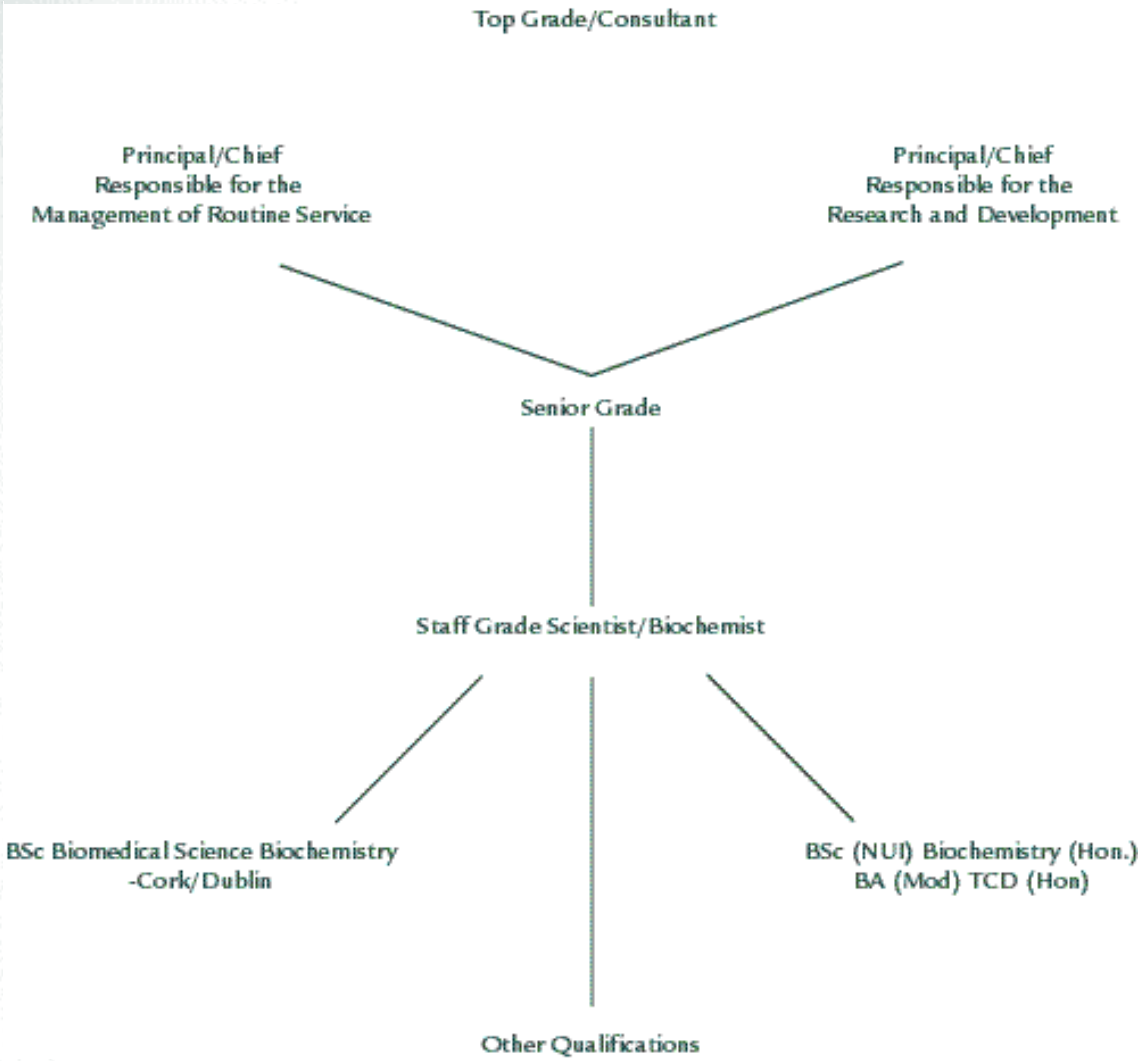
The Expert Group met the parties to discuss this proposal. The employers made an additional written submission on the future staffing of biochemistry laboratories.

The employers proposed that - with a common entry point for the service, two significant benefits would accrue from a service perspective; the potential to recruit from a number of different sources provided the qualifications meet basic criteria to be agreed; the admission of suitably qualified non-national graduates who presently are precluded from applying for basic grade posts in medical laboratories.

The employers also proposed that promotion to the post of senior would normally be by competition and eligibility would be based on post-graduate qualification and/or publications in addition to adequate experience in the service at the lower grade. Similarly, promotion to the posts of principal/chief would be based on qualifications, appropriate experience and perhaps publications.

The employers' proposal is illustrated by the following chart:

Proposed Staffing Structure



138. The proposal was rejected by the staff side.

In a further written submission to the Expert Group, as recently as March 10th, 2000 the biochemists outlined the reasons why the management proposals were totally unacceptable. The following is a summary of the reasons given for rejection:

- *the position of top grade (consultant) biochemists and of principal biochemists would be undermined. The quality of candidates for consultant biochemist posts and their contribution to the service would be diminished,*
- *the long-term quality of the clinical biochemistry service would be adversely affected,*
- *the education and training of trainee biochemists would be further jeopardised and impeded,*
- *the standing and status of the profession would be lowered,*
- *recognition (and registration) of Irish biochemists would suffer, (for example, European Registration would be very difficult),*
- *Irish biochemists might not be able to compete for jobs with their colleagues in Northern Ireland, U.K. and European countries and*
- *they might not even be able to compete on level terms for posts in Ireland with candidates from N.I., U.K. and Europe.*

139. **The Expert Group does not find it possible at this stage to make any recommendation on the future staffing structure for biochemistry laboratories because of the wide divergence of views.**

- **In these circumstances the Expert Group recommends that the staff side and the Department of Health & Children resume direct discussions to establish if a new policy on training and career structure for biochemists can be agreed.**
- To assist the discussions the Expert Group recommends that all professions in the medical laboratory service be involved and, if necessary, that an independent exercise be carried out to:
  - Evaluate the academic standing of the different degree programmes [B.Sc and BMS degrees].
  - Determine the differences in the role of biochemist and that of medical laboratory technician, at basic, senior and principal/ chief levels.
  - Determine the requisite qualifications and experience needed for promotion to senior and principal biochemist posts.
- **The Expert Group also recommends that the individual claims for upgrading of posts, within the existing criteria on specialist work, be included in the discussions.**

Other Issues

Statutory Registration

140. A number of the submissions sought the introduction of legislation providing for the regulation of the various professions.

The main purpose of statutory registration is to protect the public, and to provide a structure for the appraisal and approval of training courses, examinations, qualifications and institutions, thus ensuring the proper development of education and training for certain health professions.

The main functions of a Registration Body would relate to

- The maintenance of a register of each profession covered by the legislation
- The control of education and training of students and post-registration training of the professions
- The operation of fitness to practise procedures
- The administration and implementation of EC Directive on the Mutual Recognition of Third Level Qualifications in EC Member States

The Expert Group recommends the introduction of legislation which will provide a framework for the regulation of health professions.

The Personnel Management & Development Directorate in the Department of Health & Children in a supplementary submission to the Expert Group stated that *"the introduction of statutory registration for these professions is one of the Directorate's key strategic goals for 2000 and is receiving priority in the Directorate at present."*

The Department plans to progress this issue in consultation with all of the professional bodies. The Expert Group endorses and recommends this approach.

Pension Scheme

141. A number of staff side submissions included claims for early retirement. Comparisons were made with public service groups which already have provisions for retirement earlier than the public service norm.

The Government established a Commission on Public Service Pensions in February 1996 to examine and report on the occupational pension arrangements of public servants. The issues referred to the Commission included early retirement and other improvements in pension arrangements which a number of groups are seeking.

The Expert Group was advised that no claim for the improvement of existing pension schemes shall be submitted or processed further pending the report of the Commission. **Accordingly the Expert Group considers that claims for improvements in pension arrangements must await the final report of the Commission.**