Sectoral Social Dialogue Committee for the Hospital Sector
Working Group Meeting 2/2015
Brussels, 15 June 2015
Draft Notes

MORNING SESSION

08.45 – 09.15 HOSPEEM – EPSU Steering Committee

09.15 – 10.15 Separate trade unions' and employers' group meetings

10.15 – 12.30 Plenary

Chair: Kirsi Sillanpää, Tehy, Finland – Vice-President of EPSU SC HSS

1. **Follow-up to the Framework of Actions on Recruitment and Retention four years after its adoption**
    - Presentation of the draft joint report on the use and implementation of the Framework of Actions
    - Demands for amendments or additions
    - Exchange on how to best use the report
    - Exchange amongst HOSPEEM and EPSU members on future challenges and possible future priorities for joint action for the social partners

Mathias Maucher, EPSU Secretariat, provided an update on the revisions of the draft joint report on the use and implementation of the FoA R&R [=> draft report as of 4 June 2015]. The section on the challenges employers and trade unions are confronted with and on drivers of R&R (e.g. measures to reconcile work and family life and to increase the workforce diversity or the need/demand for CPD and LLL) has been extended. He pointed out that as in December 2014, when an earlier draft was presented, the examples contained in the report were not geographically balanced. Both secretariats thus renewed their call for input and illustrations of R&R measures from under-represented countries/regions in view of the final revision of the report. Mathias Maucher underlined that the report DG SANTE had commissioned (see 2.) largely elaborated on the same issues as covered in the HOSPEEM-EPSU report. A reference to the European Semester and country-specific recommendations (CSR) also for health services has been added to the report as the CSR are expected to be an additional layer to "frame" and determine future R&R policies and measures. He also pointed out the range of actors involved in R&R policies/initiatives in the hospital sector in addition to the social partners, namely governments, national health and safety institutes, and different types of observatories. The report contains examples on how they work together or have developed R&R measures that are interrelated (see e.g. measures in The Netherlands listed under section 4.2 in the Annex).

The following elements arose from the debate:

- The chairperson considers that the structure of the report well reflects the key challenges to R&R, being rooted in the work organisation (including working time), pay and working conditions, availability and access to CPD/LLL, health and safety at the workplace and more broadly speaking the working environment. In Finland one important focus has recently been put on the ethical recruitment of health workers

and another on increasing the attractiveness of the sector for young workers. Both points should be well identifiable in the report. Tjitte Alkema, Secretary General of HOSPEEM, also considers the collection of good practices aimed at recruiting skilled young people into the labour market and retaining them particularly useful for hospital employers and the workers concerned.

- Not least as a response to announced or implemented cuts in health budgets in a number of countries across Europe, a strengthening of the social dialogue to reduce possible negative repercussions on the workforce is needed and possible. The independence in collective bargaining has to be ensured. German trade unions have benefited from collaboration and common campaigns on R&R with employers and other stakeholders, and this in a context of an important staff shortage the German health care labour market is currently facing and that endanger the quality of care.
- A French EPSU colleague reported that even without salary cuts in France, the safety of workers and patients was jeopardised due to increased workload and stress and that burnout of staff constituted a high pressure for the remaining workers. This makes effective R&R and the setting of adequate staffing levels to safeguard the safety of workers and patients and the quality of the health services provided all the more important. This statement was underpinned by trade union colleagues from Germany – referring to the key ver.di campaigns on “quality work” and “safe staffing levels” (that should be mentioned in the joint report as one illustration of R&R measures) – and Ireland (where the EPSU member organisations represented at the meeting called for mandated nurse-patient ratios).
- In Ireland tax incentives [= tax back compensation for expenses certain employees are paying, for example for buying and laundering their own uniforms, like nurses, physiotherapist, pharmacists, other hospital staff] are considered as one useful tool for staff retention.
- Tjitte Alkema stressed that the context when the FoA was adopted was different than the current situation. Due to crisis the context is now different. Some countries are still facing job losses whereas others are facing shortages. The starting point is thus different according to the countries. It has to be the right staff and the appropriately qualified staff. Tjitte Alkema questioned the systematic link between the number of health workers and the quality of the care provided and warned about a too quantitative approach to staffing. He put the emphasis on the importance of qualitative approaches (looking at the skills mix).
- As to the use of the R&R report he and other speakers suggested to include a maximum of good practice examples and to use it in the communication on the outcomes of the SSDC and politically towards DG SANTE and the EC in general. According to Tjitte Alkema, the good examples listed could function as a source of inspiration for countries. It is therefore important to see how HOSPEEM and EPSU can disseminate them. According to Kate Ling, it would be helpful to make a connection between the DG SANCO and the HOSPEEM-EPSU reports in order to make best use of them. Several speakers suggested to better “carve out” and put the focus in the report on social partner-based initiatives.
- From the trade union side the need to work longer in order to get a decent pension was mentioned as another challenge for R&R as the privatisation of hospitals and their operation by commercial enterprises is identified as a “hurdle” for social dialogue activities.
- A French TU colleague supported the reference in the report to the process of European Economic Governance and the CSR for health care as they indeed will have a stronger influence on national, sectoral and organisation level based R&R measures in the future.
- The same colleague also suggested to more clearly elaborate in the joint report on the link to insights from the DG SANTE report on CPD.
- One challenge for effective R&R in the health sector in the Czech Republic is that access to further training/CPD/LLL is dependent on the fact of being employed. One other for Romania (and other countries) is the R&R in rural areas (while there is a concentration of workers in urban areas). Staffing levels are also needed to better address the consequences of cross-border migration or perhaps to prevent it already

(as the health sector then might become more attractive). The challenges of trans-border mobility should be better mentioned in the report.

It was agreed that both secretariats would recirculate the report to their members and that the final deadline for demands for revision and provision of additional examples would be the end of September 2015 to allow the last round of revision of the report during October 2015 and its adoption during the December meeting of the SSDC HS

2. DG SANTE Study *"Effective Recruitment and Retention Strategies for Health Workers"*

- Short report from final project workshop to discuss the study, 10 and 11 March 2015, Leuven
- Presentation of main contents and conclusions of study

Emilie Sourdoire, HOSPEEM Secretariat, summarised the context and content of the final workshop on the study commissioned by DG SANCO on "Effective Recruitment at Retention Strategies for health workers in the EU" organised in Leuven on 10 and 11 March 2015 and in which EPSU and HOSPEEM participated [=> programme]. The aim of the seminar was to share the main findings from the literature review and from the about 40 case studies around 8 "fields of action" for R&R and to present and receive feedback on the policy recommendations the research team drew from the study. She specified that during this event HOSPEEM and EPSU had shown their involvement in R&R issues and referred to their own work in this field and had highlighted the crucial role played by social partners in this regard. The final report will be presented at the Expert Group European Health Workforce on 17 June 2015 (see for the programme here) and then published soon (see for the report here).

Mathias Maucher then shortly introduced some key outcomes of the study, on the basis of the executive summary circulated to the participants of the final workshop in Leuven (see also here), and compared them to the "findings" of the HOSPEEM-EPSU joint follow-up report and to the examples respectively reported by HOSPEEM and EPSU members . The executive summary refers to the setting up of an EU-level repository of good practices in R&R, a proposal that social partners could take up and seek cooperation on with DG SANTE. It also speaks about the need for identifying criteria for the effectiveness and sustainability of the measures. He informed the participants that HOSPEEM and EPSU would have a time slot to present their work on R&R and the draft report at the Expert Group on European Health Workforce on 17 June 2015.

Tjitte Alkema added reflections about the opportunities (and "caveats") of a possible future cooperation between the social partners and DG SANTE on this issue, e.g. by using the announced "database"/web-based repository and by bringing in their competence and experience from the ground as the Commission Services and researchers tend to focus on governments and competent authorities or look at existing research. He recalled their initial scepticism towards the DG SANCO approach to R&R and underlined that the parallel work EPSU and HOSPEEM had taken up again about a year ago on R&R was a good choice as it helped to come up with own "updated" and "practical" evidence.

3. Updates on other issues

3.1 Joint HOSPEEM-EPSU project *"Assessing health and safety risks in the hospital sector and the role of the social partners in addressing them: the case of musculoskeletal disorders (MSD) and psycho-social risks and stress at work (PSRS@W)"*

- Short report on first conference on the issue of musculoskeletal disorders, 25 March 2015, Paris

- Updates from meeting of Steering Group of 4 June 2015 in view of the preparation of the second conference focusing on psycho-social risks and stress at work, 10 November 2015, Helsinki

Emilie Sourdoire gave a summary of the first conference organised by HOSPEEM and EPSU with the support of FEHAP on 25 March 2015 in Paris, which brought together around 90 participants from 16 EU Member States, mainly from trade unions' and employers' organisations. The focus was on fact finding in order to advance a common understanding of this occupational hazard and provide social partners with a clear picture of measures they could take to reduce and prevent MSDs. The programme was built around four cornerstones, with expert inputs and practical examples [=> programme]. The interactive roundtable discussions over lunch were considered as an interesting opportunity for the participants to exchange knowledge and good practice. The presentations of all the speakers can be found on the dedicated webpage of the EPSU and HOSPEEM websites. HOSPEEM prepared a special newsletter on the event, already shared with EPSU.

Mathias Maucher reported back from the second meeting of the Steering Group of the OSH project held on 4 June 2015 in Brussels. This meeting provided the occasion to make an overall assessment of the organisation and the results of the first conference (in view of possible improvements for the second event) and to work on a draft agenda for the second conference on ways to best address PSRS@W, organised on 10 November 2015 in Helsinki. Invitations and a draft programme were to be circulated in early July. It was agreed that aspects of the broad and complex topic of PSRS@W that could not be covered during the Helsinki conference could be brought up during the regular meetings of the SSDC HS in 2016 (with the joint project also still running until June 2016) [for more info => minutes of meeting].

3.2. Action Plan EU Health Workforce; Joint Action on Health Workforce Planning, EU Health Policy Forum (19 March 2015); EP Seminar "Mobility of Health Professionals in the EU – Ethical recruitment and policy coherence" (5 May 2015)

Mathias Maucher gave a short update on recent activities and publications in the context of the Joint Action on Health Workforce Planning and Forecasting, focusing on the issue of (ethical) cross-border recruitment. He specified that HOSPEEM and EPSU received regular updates on the related work package, focusing on the improvement of data collection and the evaluation of the use and impact of the WHO Code of Practice on the International Recruitment of Health Workers in a European Union context (based on a report).

He also referred to the on-going revision of the mandate, function, operation mode and membership of the European Health Policy Forum (2001-today) dealing with a broad range of topics DG SANTE is responsible for. He pointed out that EPSU had been involved so far, not HOSPEEM. He informed the participants about the reflection on the role of this forum, i.e. whether it should become more than a consultative body or an online platform for targeted exchanges on specific topics. He said that as the European Health Policy Forum was a place of "programmatic" discussions on topics under the remit of DG SANTE, including the health workforce, the social partners might like to exert an influence.

Kate Ling, NHS Employers, then referred to the European Commission Feasibility Study on a Common Training Framework for Health Care Assistants for which a Dutch research institute (NIVEL, Utrecht) was selected by DG SANTE. Up to now they have shown some reluctance to share information on the work plan and about how the social partners could be updated or possibly involved in the project activities. It was agreed that if appropriate, the project coordinator could be invited to the Plenary Meeting of the SSDC HS on 10 December 2015.
In the meantime NIVEL published a first News Bulletin (July 2015) on the "CC4HCA Project".

AFTERNOON SESSION

Chair: Tjitte Alkema, NVZ, the Netherlands – Secretary General of HOSPEEM

14.00 – 16.15 Plenary (cont.)

4. **Joint HOSPEEM-EPSU Working group on Life-Long Learning (LLL) and Continuous Professional Development (CPD)**
   - Reporting back from the exchange of views between HOSPEEM and EPSU (and the meeting planned on 27 May 2015) to identify the cornerstones and deliverables for the work of the joint working group
   - Identification of relevant existing material/experience (studies, social partners' agreements, etc.)
   - Revisiting the main findings and recommendations of DG SANCO study (http://ec.europa.eu/health/workforce/docs/cpd_mapping_report_en.pdf) presented in December 2014 to identify relevant elements for our own work
   - Agreement on points to be covered in a joint statement on LLL and CPD for healthcare staff in the EU

Tjitte Alkema reported back from a preparatory meeting organised in Brussels on 27 May 2015 in order to identify the cornerstones of the planned joint declaration of HOSPEEM and EPSU on access to CPD for all health workers in the EU, to reflect on the structure and the main contents and to come up with a suggestion on the work process. [for more info => notes of meeting, to be read with the notes of the last meeting of the SSDC HS of 6 March 2015 when the issue was first dealt with]. This document and the notes of the WG 1/2015 have been distributed and are the starting point for today's exchange.

The following points were raised during the discussion:

- There is a clear difference – in terms or scope, entitlement to, funding basis, workers' responsibility, etc. – between CPD and LLL for the different professions and professionals/workers in the health sector. E.g. in Germany CPD ("*Berufliche Fort- und Weiterbildung*") falls into the responsibility of the employer that also has to pay for it (fully or to a large share). There are also collective agreements dealing with the access to CPD in large companies. On the other hand LLL is defined as an element of adult education which implies a funding responsibility from public authorities and covers contents that are not only related to the professional qualifications needed for a certain (current or future) "job" or function". CPD and LLL are broader than formal education. What is meant by CPD and LLL needs to be clarified in the joint declaration. Moreover, the distinction between CPD and LLL as to different dimensions needs to be fully reflected in the future HOSPEEM-EPSU joint work that should focus on CPD.
- There are different sources of funding for CPD and LLL according to the Member States. Funding can be provided by the governments, hospital budgets and/or be "defined" in collective agreements. There is a difference between the responsibility for CPD and its financing. The financing of mandatory CPD is a responsibility of employers and competent authorities.
- Access to CPD is also often linked to the performance of a worker (related questions are then e.g.: how is the assessment of the performance being done and who then decides on the access to CPD for a particular worker?) and based on an employment contract. It is also "conditioned" by the demand of a particular professional training in the context of CPD. The responsibility of workers to participate in training also needs to be highlighted.
- There are different forms of professional and formal CPD and LLL. We can distinguish academic/theoretical and participatory CPD. This also needs to be reflected in the joint work and joint declaration. This also holds for the distinction between work-related and job-related CPD. CPD for teams is also important.

- The issue of time availability is crucial. A replacement for employees on training is necessary.
- Various countries have regulation requiring regular upgrades ("fit for practice") for different health professions such as nurses, midwives and doctors for them to be entitled to continue exerting their profession. Qualifications upgrading should be directly linked to the position a worker is currently active in or the position he/she is preparing himself/herself for.
- This aspect is linked to one purpose of CPD important for employers, workers and patients, namely the quality of the services provided. CPD insofar contributes to a quality assurance policy in hospitals (as one important field of action for hospital employers in terms of HRM). CPD and quality of care are interrelated.
- Another aspect that needs to be covered in the HOSPEEM-EPSU joint work (and tackled in practice at national level) is the access to CPD across all age groups (also for workers 45+) and across all professions/functions. It is necessary to invest in qualifications in the long run.
- The joint declaration should highlight the key role of access to CPD for effective retention and recruitment policies in the sector. Investing in CPD can help creating attractive career pathways.
- It should also underline – and underpin – with good practice examples the role of social partners in the design, delivery and evaluation of CPD. Trade union colleagues from France underline divergent opinions on the roles and responsibilities vis-à-vis CPD with orders of medical professions, a current topic of debate with high priority for them. The role of professional organisations vis-à-vis trade unions in the field of CPD needs to be carefully looked at.
- The purpose of the joint document is also to influence future policy initiatives of the EC as a possible follow-up e.g. to the DG SANTE CPD Study (published in December 2014, together with an Executive Summary in all EU languages).

Points agreed/Action points/Deliverables:
- It was agreed that the points raised, in addition to what was already discussed and "concluded" in the meetings of 6 March 2015 and 27 May 2015, should be summarised in a paper that would serve as starting point for the working group members. This is a task for both secretariats. This document would then be circulated, with indications on how to proceed and to start the work, by the two secretariats.
- Both secretariats were asked to see with their "delegates" in the joint WG which of the colleagues would be interested and available to form a "core" group to start with the concrete drafting of the joint statement. This work would be done in English only. A meeting of this small steering group could take place at the end of September or beginning of October.
- A first draft of the joint declaration should then be presented and discussed at the Plenary Meeting of the SSDC HS 2015 on 10 December 2015.
- HOSPEEM members and EPSU affiliates were requested to send in relevant examples and good practices (also involving social partners) to improve the access to and outcomes of CPD to take along in the joint declaration.

Mathias Maucher informed EPSU had reached out to researchers at the European Centre for Vocational Education and Training (CEDEFOP) working on CPD to see to which extent their work could be used when drafting the joint ESPU-HOSPEEM statement and also if they were interested in being informed about our work and even possibly "involved" at some point. The CEDEFOP expert on CPD could not join the meeting due to other professional obligations but had shared publications with the EPSU Secretariat (passed on to the HOSPEEM Secretariat) [=> publications] that could be "exploited" where appropriate by the Working Group on CPD.

5. AOB

Stefano Martinelli, DG EMPL, briefly informed the participants about the adoption of the "Better Regulation Agenda" by the European Commission on 19 May 2015 and about its link with European social dialogue. He explained that one major change for future autonomous agreements would be the obligation to make the text of the agreement available on the websites of the social partners signing it. He specified that this was asked for by the European Council concerned with the representativity of social partners, being regarded as a crucial issue. He then stressed that with the adoption of the "Better Regulation Package" the European Commission had reaffirmed its recognition of the specificity of the European social dialogue.

ANNEX

Colleagues from The Netherlands, Norway and the United Kingdom gave joint presentations on different aspects of VTE/CPD policies in their countries and the role of social partners. The slide sets of the presentations have been shared with/circulated to the members by both secretariats. Key points also taken up in the discussion (see above) are summarised below.

Presentation NL (Jeanne Antoinette de Graauw, NVZ / Marco Borsboom, FNV Z&W)

- Political aim of CPD: Maintaining and optimising patient safety and quality

1. Collective labour agreement in hospitals
   - Non-mandatory CPD and LLL right for all employees
   - 3 percent of the average wage-budget per hospital is spent on CPD, taken out of available care budget
   - Formal procedures: 1) Access to/participation in CPD is monitored by works councils; 2) There is a complaint procedure for workers in case of non-selection; 3) Organisation of an annual performance review

2. Collective grant for general hospitals
   - Starting point: Non-mandatory CPD for all employees – Output-centrered system – Objective: Incentive to increase the level of competence of all healthcare professionals to better prepare them and the health system in view of future demands
   - Procedure: Employer requests training for the employee which is approved by the works councils and the board (thus it is linked to demand of/in a concrete health care institution).
   - Amounts: The amount of EUR 450 million € earmarked for CPD, based on an agreement between the government and the social partners for 2014-2017, is evenly distributed between hospitals by the Ministry of Health when an employer applies for the grant. This grants was also used as a "sticking plaster" to partly compensate cuts decided by the Health Ministry.

3. Quality assurance systems for nurses and health care assistants
   - A programme of "mandatory" CPD for nurses and health care assistants was negotiated between the Ministry of Health and the professional organisation of nurses.
   - This programme is only mandatory within the own professional group, but not legally mandatory
   - It's a "conditional sales" programme, i.e. membership in the professional organisation was required to have access to the courses)
   - The programme introduced training/educational courses with examinations and is organised alongside the professions. There is no direct link with job requirements.
   - There are also no quality assurance checks. Social partners try to work on quality assurance systems for CPDs. A Strategic Training Plan per health care institution has to be submitted by the employer. The lacking link to the quality requirements is contented and criticised by both sides of the social partners. Social partners have no influence in this scheme.

Presentation N (Signe Hananger, Fagforbundet & Trond Bergene, Spekter)

Vocational Training and Education

Norway has a long tradition of social dialogue. There has been a cooperation between the social partners, among others via joint conferences, to achieve common objectives, e.g.:

a. Ensure that Norwegians receive high quality care in hospitals.
b. Share good practices on interoperability, encouraging full time work, education and training, attractiveness.
c. Uncover – together with a research institute – the reasons behind young people's education choices. This is particularly important, because Norway is expecting to have a severe shortage of nurses/nursing staff in 10-15 years. The possibility for have better access to CPD was found to be central, also vocational training was necessary.

The social partners are involved in tripartite structure with the national government and in a joint advisory group that has a strong mandate for upper secondary education.

The social partners are striving to reinforce the cooperation, both bipartite and tripartite, on tertiary vocational education and training.

N.B.: It is noteworthy that some practical nurses in N continue working beyond 65.

Presentation UK (Kate Ling / NHS Employers; Helga Pile, UNISON / Gill Coverdale, RCN)

Context

- A recent evaluation report states that the major challenge is to implement the government commitment to invest in CPD.
- The NHS constitution states that all staff should get CPD and LLL.
- Health Education England pays the training, including both pre- and post-qualification training.
- Education of support staff/health care assistants is traditionally underfinanced. In response to this, the Care Certificate has been introduced, which means that a person cannot practice as a health care assistant unless they have it.
- Career pathway: What is more needed is work-based training for HCA opening the door for upwards professional mobility and to become a nurse or a midwife

Examples

1. The Shape of Caring Review
   - The Shape of Caring review is the Health Education England reviewing the sector and bringing forth recommendations.

2. Training for Patient Safety
   - Training in whistleblowing when safety standards are drastically low, both for workers and management.

3. The Talent for Care
   - The strategy is initiated by Health Education England (HEE), social partners and other stakeholders. It concerns all staff. Healthcare support staff constitutes a great part of the health sector, but the training of care professionals is minimal; the idea is to shift this. There are three streams:
     - 'Get in' – attracting a wider and more diverse workforce, by giving them sense of progression routes in the field; career opportunities.
     - 'Get on' – making sure that all staff have development reviews and have a structure of qualifications within their role.
     - 'Get further' – to make it easier for people like HCAs to progress into nursing, midwifery, or pharmacy qualification without pushing them to give up their job.
   - This is delivered through social partnership at the local level, but a national social partnership structure is set up to oversee the delivery. The commitment to the Talent for Care is manifested in the employer signing the Partnership Pledge, which involves soft requirements. Funding is a bit piecemeal, therefore the social partners are looking into making a case for more funding, despite budget freezes.

4. The Clinical Leadership Programme (CLP)
   CLP is created to develop nurses leadership skills through coaching and leading on a service improvement project. CLP is targeted at nurses who aspire to, or are employed in, a team leadership role, e.g. a ward manager. Leadership in nursing is recognised as fundamental to ensure safe and effective care. Leadership influences organisational culture. CLP is delivered locally via RCN approved facilitators, and the nurses are supported by their employer to undertake the programme.

5. The Advanced Nursing Practice (ANP)
   ANP is a level of practice rather than a role or job title. The RCN has actively promoted ANP through the development of Master level education, competences and accreditation. The university works with the commissioning employing organisations to ensure the programmes meet practice requirements. The programmes are supported from the employing organisations from design to delivery, including financial support.

The following points were raised during the discussion focusing on the presentations (for the thematic exchange on other aspects, see the list of bullet points):

- It was added that RCM also provides leadership programme for midwives across the UK. There are various programmes and conferences for both midwives and support workers (HCA).
- Important success elements mentioned in the good practices are a sustainable funding structure, time availability to participate in further training (this also relates to replacement of employees).