



Comptroller and Auditor General

Special Report

Health Service Executive

# **Medical Consultants' Contract**

March 2007

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This report was prepared on the basis of information, documentation and explanations obtained from the public bodies referred to in the report. The draft report was sent to the Health Service Executive and the Department of Health and Children. Where appropriate, the comments received from the Executive and the Department were incorporated in the final version of the report.

# **Report of the Comptroller and Auditor General**

## **Medical Consultants' Contract**

I have, in accordance with the provisions of Section 9 of the Comptroller and Auditor General (Amendment) Act, 1993, carried out an examination of the operation of the Medical Consultants' Contract.

I hereby submit my report on the above examination for presentation to Dáil Éireann pursuant to Section 11 of the said Act.

A handwritten signature in black ink, appearing to read 'John Purcell', with a large circular flourish in the middle.

**John Purcell**  
**Comptroller and Auditor General**

30 March 2007



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# Summary of Findings

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## Summary of Findings

Over 2,000 medical consultants work in public and voluntary hospitals in Ireland. Their terms of employment are governed by a common contract agreed in 1997 and revision of this contract is currently the subject of negotiations between the Department of Health and Children, the Health Service Executive (HSE) and the medical consultants' representative organisations.

This examination set out to review the extent to which the terms of the existing common contract were implemented in the acute hospital sector and in particular

- the arrangements put in place to ensure that consultants' contractual commitments to the public health service are monitored by employing authorities
- the current status of clinical audit and related activities
- the progress achieved in involving consultants in management.

## Monitoring Consultants' Commitments

The examination found that key elements of the contract were undefined or lacked sufficient clarity to allow for smooth implementation.

There is a fundamental difference of interpretation between the HSE and the consultants about the number of hours to be worked under the contract. The HSE claims that 39 hours per week, inclusive of six hours of unschedulable activities, is provided for, while the consultants contend that a 33 hour week is what was contracted for. It is disappointing that this matter has not been resolved in the ten years since the contract was signed in 1997.

The 33 scheduled weekly hours are divided into 11 three hour sessions, comprising 7-8 clinical sessions and 3-4 flexible sessions covering training, research and management activities. There are also provisions for on-call availability. The contract envisaged the production of schedules which would be agreed with hospital managements in order to show how the service commitment would be delivered by each consultant.

The examination found that, while most hospitals had received work schedules from consultants after their initial appointment to the post, these were not generally subject to systematic review, and in many cases, remained unaltered for many years even where consultants' delivery of sessions had changed. Most hospitals did not request updated schedules from consultants.

There was a general lack of information available in hospitals to enable managers to satisfy themselves that consultants' contractual commitments were being discharged. There was a particular difficulty in establishing exactly how flexible sessions are delivered and what gets done during those sessions.

Although there was a belief among hospital managers that many consultants exceed their contractual commitment, this cannot be substantiated in the absence of reliable records.

The contract allows consultants to treat private patients while discharging their obligation to the public hospital. Accordingly, in addition to their salary, consultants receive fees for the treatment of private patients. While there is universal entitlement to treatment in the public hospital system, there is also a policy to limit private treatment in these hospitals to a designated level set by the Minister by reference to bed numbers.

The contract provides that a consultant's overall proportion of private to public patients should reflect the ratio of public to private beds as designated by the Minister at individual hospital level. Overall, 20% of all beds in public hospitals are designated as private beds. In practice, private patient treatment in public



hospitals exceeds 20% in all three categories of clinical activity – elective, emergency inpatient and day case. To the extent that private patients are accommodated and treated in excess of the designated level, there are implications for equity of access. It also means that less resources than intended are being applied for the treatment of public patients.

There is considerable tension between the sessional nature of consultants' work and the freedom to engage in private practice which could give rise to conflicting professional responsibilities. There has been no meaningful attempt to monitor the level of consultants' private practice for its impact on the fulfilment of the contractual commitment within public hospitals.

Firm information on consultants' existing work patterns is essential to cost effective delivery of consultant services. Ultimately, the attainment of value for money from any new contract will largely depend on how well organisational and system change complements and supports the revised arrangements. Otherwise, there is a risk that the State will end up paying more for, what might turn out to be, the same quantum and quality of service.

## **Clinical Audit and Risk Management**

Clinical audit is a vital element in ensuring that hospital services are provided to the highest quality. One of the obligations of consultants under the 1997 contract was to participate in clinical audit. A corresponding obligation of management was to resource the structures within which this clinical audit could be planned, carried out and reported. There was limited follow through on the obligations set out in the agreement.

No central guidance has been provided to hospitals or regions on the development of a clinical audit programme. Consequently, any arrangements that exist are implemented at local level and to a variety of standards.

The examination found that, while about 80% of hospitals claimed to have some arrangements for clinical audit, the nature of these varied from hospital to hospital. Although several examples of good practice were noted in the course of the examination, clinical audits carried out were not generally part of planned prioritised programmes nor were the results reported to hospital managements or shared with other hospitals. Without appropriate arrangements for reporting of results, it is unlikely that hospitals will be in a position to optimise the benefits from audits. None of the hospitals visited could demonstrate that time was allocated for consultant review and assessment of audit outcomes.

Clinical risk management is currently underdeveloped in public and voluntary hospitals. There are as yet no national risk management guidelines and the HSE has not promulgated standard procedures or best practice for the operation of risk management for the acute hospital sector.

The advent of the State Claims Agency has led to a greater awareness of the importance of risk management and proactive measures have been taken by some hospitals. However, the HSE is of the view that, even in hospitals where risk management appears to be well developed, it is still proving difficult to operate effectively.

While both clinical audit and risk management involve all medical staff, consultants have a pivotal role to play in this area. Consequently, future contractual arrangements should address the obligations of the respective parties and the mechanisms through which clinical audit and risk management will be implemented. Full implementation of a comprehensive national plan is likely to take three to five years.

## Consultants and Management

The 1997 contract envisaged an increase in the involvement of consultants in the management of hospital services. Principally, it provided for the creation of management boards with consultant representation to run each hospital and the establishment of unit groupings.

The examination found that nearly all the acute hospitals had full executive management boards or similar structures in place with varying degrees of consultant involvement. However, at the unit grouping level, more refinement is needed in most cases before the arrangements could be regarded as effective clinical directorates.

A Clinicians in Management Initiative launched in 1998 and which was allocated €10 million in the period to 2004 had limited success. A report on the initiative in 2005 recorded that full clinician involvement in decision making and in the management of resources was not yet the norm. While considerable management change has taken place since 1997, the pace of change has not been as fast as might reasonably be expected in a ten year timeframe.

## General Finding

The failure to evolve and implement a model that integrates responsibility for resources, activities and outcomes was a factor that contributed to the failure to activate the key terms of the 1997 contract in regard to monitoring commitments and clinical audit.

Overall, any new contractual arrangements need to specify the administrative and governance changes that are required to achieve effective implementation and be underpinned by a change management drive. Moreover, it would be desirable that the arrangements provide for a verification process to ensure that the agreed change envisaged is delivered in accordance with action plans tailored to the circumstances of individual hospitals.

## Medical Consultants' Contract

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# 1 Introduction

**1.1** It is estimated by the Department of Health and Children (the Department), that approximately €350 million was paid by way of salary in respect of consultants' services in 2006. This remuneration is paid under the terms of a common contract of employment.

**1.2** A common contract of employment for consultants working in public and voluntary hospitals was first recommended in the Fitzgerald report, in 1968. However, the first agreed common contract did not come into operation until 1981<sup>1</sup>. Prior to 1981 consultants in health board hospitals were usually salaried, pensionable State employees with very limited rights to private practice, whereas consultants in the voluntary hospitals earned most of their income from treating private patients, who paid them directly.

**1.3** In place of the arrangements, the new common contract provided for the payment of a salary to consultants in both health board and voluntary hospitals for a basic working week. In addition, consultants could engage in private practice to the extent permitted in their contractual arrangements. This change meant that consultants in public hospitals could now pursue private practice like their voluntary hospital colleagues, while consultants in the voluntary hospitals gained the security of pensionable employment without ceding their private practice rights.

**1.4** These arrangements were subsequently renegotiated resulting in two further contracts in 1991 and 1997. The basic terms of each contract, however, remained fundamentally unchanged during this period<sup>2</sup>.

**1.5** Under the terms of the latest contract - concluded in 1997 - an appointment as a consultant involves a continuing responsibility for investigation of illness and the treatment of patients without supervision in professional matters by any other person. The consultant may discharge this responsibility directly in a personal relationship with the patient, or in the exercise of clinical judgment, may delegate aspects of the patient's care to other appropriate staff. The responsibility may be exercised concurrently with another doctor or doctors. Notwithstanding this however, the unique position of the consultant in the hospital requires that he or she carries the continuing responsibility for patients so long as they remain in his or her care.

**1.6** A consultant has obligations to the employing authority arising out of the contract and an ethical and legal contract with the patient. The guide to Ethical Conduct and Behaviour of the Medical Council specifies that

*'doctors who accept contractual commitments or commitments with public bodies, the boards of voluntary hospitals or other medical or teaching institutions have a duty to fulfil these. If they find that they cannot do so, they should ask to be relieved of them.'*

**1.7** The role of the consultant is defined under the Consultant Contract (1997) as follows

*'A consultant is a registered medical practitioner in hospital practice who, by reason of his training, skill and experience in a designated specialty, is consulted by other registered medical practitioners and undertakes full clinical responsibility for patients in his care, or that aspect of care on which he has been consulted, without supervision in professional matters by another person. He will be a person of considerable professional capacity and personal integrity.'*

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<sup>1</sup> Common Contract for Consultant Medical Staff, 1981.

<sup>2</sup> A small number of staff are governed by prior contractual arrangements. Their pay entitlements are adjusted in accordance with national agreements and reviews.

**1.8** The terms of the contract are set out in two documents – a contract template and a memorandum of agreement (the contract documents). The contract documents are set out at Annex A.

## Numbers and Types of Consultants

**1.9** There are different forms of consultant contracts. Annex B outlines the arrangements for engaging consultants. Consultants can be classified into two main categories

- 60% of consultants have contracts which oblige them to devote substantially all their time (including time spent on private practice) to servicing a designated public hospital or hospitals (Category I).
- 32% have contracts which allow them to engage in both on-site and off-site private practice (Category II).

The remainder mainly fall into the academic category.

The salaries of consultants are within the range set out in Figure 1.1.

**Figure 1.1 Consultants' Salaries as at December 2006**

Category	Salary Range €
Category I	160,962 - 178,429
Category II	143,738 - 159,269
Geographical Wholetime Consultants without fees <sup>a</sup>	186,922
Academic – Category I	191,115 - 229,637
Academic – Category II	166,161 - 220,408

Source: Department of Health and Children

Note:

a This category of consultant is similar to Category I consultants but their right to engage in private practice is confined to the public hospital(s) in which they are employed.

The remuneration levels of medical consultants are set out in more detail in Annex C.

**1.10** At 6 November 2006 there were 2,069 approved permanent consultant posts but only 1,789 of these posts were filled at that date (see Figure 1.2). In addition, a further 316 non-permanent posts are available and used mostly to cover situations where permanent posts are vacant or to provide locum posts in respect of permanent consultants who are on leave.

**1.11** Historically, there have been delays between the issuing of the offer of a consultant post and the taking up of that position in Health Service Executive (HSE) hospitals. Since the beginning of 2004 the average time from approval being granted for the filling of a post to the taking up of the position was 379 days.

**Figure 1.2 Permanent Consultant Posts – 6 November 2006**

Speciality Group	Filled	Vacant Approved	Total
Anaesthesia	265	32	297
Emergency Medicine	46	5	51
Intensive Care	1	0	1
Medicine	363	51	414
Obstetrics/ Gynaecology	96	17	113
Paediatrics	107	10	117
Pathology	159	33	192
Psychiatry	255	67	322
Radiology	167	23	190
Surgery	330	42	372
<b>Total</b>	<b>1,789</b>	<b>280</b>	<b>2,069</b>

Source: HSE – Consultant Appointments Unit

A further 35 permanent posts were being considered for approval at 6 November 2006.

**1.12** Since 1993 several reviews of the hospital medical workforce<sup>3</sup> have made recommendations for a substantial increase in the number of consultants appointed and a corresponding decrease in the numbers of Non-Consultant Hospital Doctors (NCHDs). Talks are taking place between the Department, the HSE and the medical representative organisations regarding a renegotiation of the consultants' contract. The talks are taking place in the context of a report of the National Task Force on Medical Staffing, 2003 – adopted as government policy in September 2003 – which recommended an additional 1,800 consultants subject to agreement on changed work practice and a new consultants' contract. The report suggested a policy change – a move from consultant-led services to consultant-delivered services.

**1.13** Talks with the medical representative organisations on revised contractual arrangements which had been adjourned were resumed on 20 February 2007. The Department has informed me that the State's negotiation stance is informed by a number of recent reports

- the Audit of Structures and Functions in the Health Service
- the Report of the National Task Force on Medical Staffing
- the Report of the Commission on Financial Management and Control Systems in the Health Service.

Annex D outlines the key elements of these reports which relate to consultants' contracts.

<sup>3</sup> Report on Medical Manpower in Acute Hospitals (1993), Report of the Forum on Medical Manpower (2001), Report of the National Task Force on Medical Staffing (2003).

## Objectives and Scope of the Examination

**1.14** The contract, inter alia, represented an agreement between the parties under which

- the consultants would deliver a defined level of input
- the quality of service would be underpinned by clinical audit
- consultants would have a greater involvement in management.

**1.15** The objectives of the examination were to review

- the arrangements put in place during the term of the latest agreement to ensure that consultants' contractual commitments to the public health service are monitored by employing authorities
- the current status of clinical audit and related activities
- the progress achieved in involving consultants in management.

**1.16** The examination focused mainly on the status of implementation of contract provisions in 2006 and, in particular, on the acute hospital sector.

## Methodology

**1.17** The examination was conducted by staff of the Office of the Comptroller and Auditor General. Assistance was provided by an independent management consultant, also qualified and practising as a medical consultant in the UK<sup>4</sup>. In the absence of any existing data on the implementation of the consultants' common contract 52 voluntary and public hospitals in the State where the vast majority of consultants are employed, were surveyed. A questionnaire sought information in regard to the following issues

- Consultants' scheduled commitments
- Delivery of services in a mixed public and private health system
- Progress in implementing clinical audit
- Progress in involvement of consultants in hospital management.

Responses were received on behalf of all hospitals.

**1.18** The examination also included visits to seven hospitals in order to evaluate the arrangements in place with regard to the management of consultants' contracts. These visits included interviews with key personnel including Chief Executive Officers, Medical Administrators, Planning Officers and consultants. The hospitals visited were

- Beaumont Hospital
- Mater Misericordiae University Hospital
- Cork University Hospital
- Roscommon County Hospital
- Mayo General Hospital

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<sup>4</sup> Dr. Bairbre Golden.



- St. James's Hospital
- St. Luke's General Hospital, Kilkenny.

**1.19** The examination team met with officials from the Department, the HSE, and the HSE's National Hospitals Office. It consulted with the Irish Medical Council and the Royal Colleges<sup>5</sup> as well as with representatives of the Irish Medical Organisation (IMO) and the Irish Hospital Consultants' Association (IHCA) to discuss issues relating to the contract arrangements. It also sought the views of the State Claims Agency on the operation of the Clinical Indemnity Scheme and the views of international experts on clinical safety<sup>6</sup>.

**1.20** The report considers the issues outlined above in the following chapters. Chapter 2 reviews the extent to which consultants' contractual obligations are monitored. Chapter 3 reviews current practices for monitoring standards of clinical care and Chapter 4 examines the progress achieved in involving consultants in the management of hospital resources.

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<sup>5</sup> Royal College of Physicians of Ireland and Royal College of Surgeons in Ireland

<sup>6</sup> Professor Charles Vincent – Director of Clinical Research Unit in the Department of Bio-surgery and Surgical Technology, Imperial College, London and Professor Dame Carol Black DBE, President, Royal College of Physicians, UK.

## 2 Monitoring Consultants' Commitments

**2.1** This chapter examines the arrangements put in place by the Department, the HSE<sup>7</sup> and by hospital managements in the 52 public and voluntary hospitals under the aegis of the HSE's National Hospitals Office to monitor the commitments of consultants in accordance with the terms of the 1997 contract.

### Consultants' Time Commitment

**2.2** The consultants' input to the service is structured as follows

- Each consultant's input is made up of scheduled and unscheduled three-hour sessions. Each full-time appointment consists of 11 sessions (33 hours) of scheduled activities and two sessions (six hours) per week devoted to non-schedulable activities. Consultants are paid for the full 39 hours.
- Scheduled sessions are further broken down into 'fixed' and 'flexible' sessions. Fixed sessions are agreed between management and the consultant and normally comprise 7-8 clinical sessions a week (21-24 hours). Flexible sessions are composed of regular activities performed at the consultant's discretion and comprise 3-4 sessions a week (9-12 hours) of training, research and management activities.
- Non-schedulable activities are those that are episodic such as involvement in planning, interviews and infrequent meetings.

**2.3** In order to ensure that a cost-effective, quality service is provided to all patients in the public system, hospital services and staff resources need to be linked to consultants' working patterns. The principal mechanism for achieving this linkage was the agreement of scheduled commitments<sup>8</sup>.

**2.4** Accordingly, under the contract the consultant's responsibilities include the production of a realistic agreed schedule specifying how it is intended to discharge in person the full contractual commitment. The consultant is also required to supply the employing authority with whatever information on the discharge of the scheduled fixed and flexible sessions as is necessary and reasonable to establish that the contractual commitment is being fulfilled. In addition, consultants are required to provide adequate notice of planned absences, ensure that fixed sessions start as scheduled and provide management with on-call rosters. The requirement to discharge the commitment personally does not preclude the consultant from delegating aspects of scheduled work.

**2.5** Consultants dispute that the contract provides for non-schedulable activities to be delivered in two further three-hour sessions. Their view is that the 1997 contract specifies a commitment to 11 sessions of three hours each as well as specifying on-call obligations. They maintain that it is disingenuous to suggest that there is a further unscheduled commitment of six hours. Their view is that episodic and unplanned activities such as attending interviews, teaching, administration, research and attending management meetings are to be undertaken during flexible sessions. This is a fundamental difference of interpretation that has never been reconciled in the course of the contract implementation<sup>9</sup>.

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<sup>7</sup> Including its predecessor health boards.

<sup>8</sup> Section 2.11.7 of the Memorandum of Agreement.

<sup>9</sup> Section 2.11.5 and 2.11.6 of the Memorandum of Agreement refer to this matter.

## Patient Treatment

**2.6** Consultants, depending on their categorisation, are permitted to treat private patients in the public hospital

- A Category I consultant is required to devote substantially all the contracted commitment to servicing a designated hospital and under the terms of the contract is only allowed to engage in private practice off-site on an out-patient basis<sup>10</sup>.
- A Category II consultant is permitted to engage in private practice both on-site and off-site (including in a private hospital or clinic).

**2.7** The contract provides that a consultant's overall proportion of private to public patients should reflect the ratio of public to private stay beds designated under the Health (Amendment) Act 1991. Designations have been made by the Minister over the years at individual hospital level resulting in a situation where, overall, 20% of all beds are designated as private beds. The Health Services (In-Patient), Regulations, 1991 prohibit the accommodation of private patients in public beds except in circumstances of emergency admissions where no private bed is available.

**2.8** Since 1991 all citizens, irrespective of their insurance status, are entitled to public hospital services<sup>11</sup>. Over the years, with the growing number of people covered by private health insurance the number of persons who designate themselves as private patients has tended to exceed the overall 20% level of private bed capacity envisaged. In practice, private patients whether through insurance or otherwise, meet an element of the maintenance cost of accommodation in designated private beds while they pay fees to consultants for their treatment even where they occupy a public bed<sup>12</sup>.

## Hospitals' Implementation of Contract Provisions

**2.9** A Category I consultant may treat private patients in consulting rooms off-site, but not in a private hospital or clinic, other than 'occasionally' at the request of another consultant. Nevertheless, the extent to which the employing authorities could take action to address a breach of contract is limited by the contract provision that

*'The principal criterion to be employed in assessing whether any particular activity falls within the permitted limits is the effect which it has on a consultant's ready availability to the public hospital.'* (Section 2.9.7, Memorandum of Agreement, Consultant Contract 1997)

**2.10** There is considerable ambiguity in the contractual terms which can be read as suggesting that notwithstanding the provision that Category I consultants cannot treat patients in a private hospital or clinic, it is only if this activity has an effect on the consultant's ready availability to the public hospital that a breach of the provisions would occur. In practice, there has been little attempt to monitor or enforce these provisions.

<sup>10</sup> Section 2.9.7 of the Memorandum of Agreement

<sup>11</sup> Under the Hospital (In-patient) Regulations, 1991

<sup>12</sup> It is Government policy since 1999 that the full economic cost of private beds in public hospitals should be paid by insurance companies. The Department have indicated that the charges for private beds in public hospitals are between 50 and 60 per cent of what can be calculated as the full economic cost. The charges are being increased in 2007.

**2.11** Other than, at a general level, using information from the Hospital In-Patient Enquiry System (HIPE)<sup>13</sup>, the HSE and its predecessors were not in a position to transparently account for how the individual contribution of a consultant remunerated by way of State salary is delivered or to what extent a consultant sees private patients or whether consultants are meeting the terms of their contracts regarding the extent of private practice. The stipulation that off-site private practice is subject to the consultant satisfying the employing authority that he or she is fulfilling the contractual commitment within public hospitals is not monitored.

**2.12** To the extent to which private patients are accommodated and treated in excess of the level envisaged there are implications for equity of access. A further effect is that the outlay by the State may not be fully applied for the purposes for which it is intended i.e. to treat private patients in line with the proportion of designated private beds in each hospital (20% of beds nationally) and, thereafter, to apply the balance to the treatment of public patients.

**2.13** There has been considerable change in the structure of hospital throughput over the years. In 2005, in-patient elective work accounted for 17% of all throughput with day cases constituting 39% and emergency cases accounting for 44%<sup>14</sup>. Within this throughput, private patients accounted for 34% of all elective in-patient discharges in 2005<sup>15</sup>, 24% of day cases and 24% of emergency cases. The level varied across the country being much higher in areas where no private facilities are available. The highest proportion of private elective in-patients was 58% in St. John's Hospital, Limerick where 46% of all beds had been designated as private by the Minister. Annex E sets out a comparison between private patient discharge levels and associated bed designations for acute hospitals for 2005.

### ***Submission of Consultants' Scheduled Commitments***

**2.14** The 1997 Contract provides for work plans to be provided by consultants to hospital managements specifying how they intend to discharge their full weekly contractual commitment. My examination suggests that there is no consistent approach across hospitals in relation to the production, by consultants, of a schedule setting out how the commitment is to be delivered. The survey of hospitals showed that of the 52 hospitals

- 33 hospitals indicated that schedules were provided when the consultant was appointed
- consultants in 10 hospitals provided written schedules during the period since the contract came into effect
- in three hospitals some of the consultants provided schedules
- in four hospitals consultants did not provide written schedules
- up to date schedules were not held on file in two hospitals.

**2.15** Of the 33 hospitals where schedules were provided on appointment

- 18 stated that schedules were revised, on an ad hoc basis, when significant changes occurred in service needs
- nine indicated that schedules were subject to revision as a result of periodic service planning processes

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<sup>13</sup> The Hospital In-Patient Enquiry System collects demographic, clinical and administrative data on discharges and deaths from acute general hospitals nationally.

<sup>14</sup> Based on discharges of patients as recorded on the HIPE system.

<sup>15</sup> The rate has increased from a level of 31% in 2002.

- six hospitals indicated that it was not common practice to have formal schedules submitted after appointment.

### **Review of Schedules**

**2.16** Hospital managements and consultant representatives informed the examination team that while documented schedules may not be changed for some time the annual service planning process frequently gives rise to changes in consultants' delivery schedules to reflect the exigencies of the service and the most effective utilisation of resources and changed health needs assessments of the populations being served. The implication of this is that once-off schedules may no longer reflect work patterns and that the provision is not properly enforced.

**2.17** Only eight hospitals stated that they had a periodic review of consultants' schedules on a planned basis while 29 hospitals had no review process in place. The remaining 15 hospitals indicated that schedules were subject to review only on an ad hoc basis and generally as a result of changes in service developments or staffing and skill mix levels within individual specialties.

**2.18** If schedules were to be kept up to date it would be necessary for management to request them and for consultants to comply with that request. 33 hospitals stated that they do not request these schedules from consultants on an ongoing basis and a further 18 hospitals said that they do not request them at all. It was explained that this situation arose, in part, from an instruction to its members by the IHCA in February 1998. The IHCA instructed its members not to comply with requests from hospital managements "to supply schedules of commitment and other requirements provided for in the revised contract until contracts have been signed by both parties (i.e. employing authorities and individual consultants) and the revised salaries and retrospection paid". It appears that after this instruction was sent many hospitals did not generally follow up on the submission of schedules.

**2.19** The IHCA has pointed out that the circular went on to advise consultants to cooperate with employing authorities in the implementation of the contract when the retrospection and revised salaries had been paid on foot of the contract being signed. It viewed it as inexcusable for management in any hospital or region to advance the letter of February 1998 as an excuse for their own inaction.

**2.20** In general, consultants' contractual commitments are only reviewed if and when an individual consultant might wish to change their working practices, e.g. move sessions, take on a more academic role or change their research commitments elsewhere. Analysis of questionnaire results indicates that this process does not generally occur at the instance of hospital management. This leaves management particularly exposed where an issue arises about an individual consultant's service delivery. In these cases, the only recourse is to use other data to infer what activity was performed.

**2.21** The IMO has commented that one reason schedules are not altered derives from the fact that the lack of resources (physical, staffing and otherwise), out-patient and secretarial rooms can make it impossible to revise schedules when very often this would be the preference of consultants and managers. The IMO would welcome the implementation of practice plans on the basis that they would make explicit the responsibility of the employer in terms of resources for consultants and recognise the need to reward consultants regularly working in excess of their contracted commitment as well as detailing the commitments to be delivered upon by consultants.

**2.22** Only about 60% of hospitals stated that consultants were requested to agree and provide details of the service levels and mix of services to be delivered within their scheduled commitment as provided for in the contract. Most of these hospitals responded that consultants did provide such details on an agreed periodic basis. The remaining hospitals (40%) indicated that these details were not generally provided or were only provided for some departments.

***Discharge of Scheduled Commitment*****2.23** Of the 51 hospitals who submitted valid responses

- 13 hospitals said that consultants provided information to management on the discharge of their scheduled fixed and flexible sessions sufficient to establish that they were fulfilling their contractual commitments.
- Four hospitals maintained that the matter was monitored on the basis of absence notifications by consultants.
- In three hospitals monthly statistics were used to monitor the delivery of commitments.
- 12 hospitals responded that consultants did not provide this information.

**2.24** Of the remaining 19 around half had no formal monitoring mechanism although the majority had received schedules from consultants. The balance relied on working contacts or monitored the commitment of some consultants only.

**2.25** The IHCA has stated that it is imperative that any claim by hospital management that they do not monitor consultants' contractual input should not be interpreted as implying that the appropriate input is not given or that it is not possible to monitor consultants' work volumes and time commitment.

***Provision of On-Call Rosters***

**2.26** 51 of the 52 hospitals surveyed said that consultants provided management with on-call rosters. The remaining hospital (Cappagh National Orthopaedic) stated that it shares consultant appointments with other acute hospitals and therefore, rosters are fixed.

**2.27** In general, schedules for out-of-hours work are organised, monitored and maintained by consultants themselves. All hospitals visited had records of these rotas.

***Patient Information***

**2.28** All hospitals indicated that consultants had provided information on patients either systematically or when requested to do so by management.

***Accounting for Consultants' Flexible Sessions***

**2.29** Responses to the survey indicated that in the case of those who supplied a valid response 73% claimed that they could account for some or all of their consultants' flexible sessions. However, visits to hospitals, during this examination, found that in many cases managers could not provide evidence to support the flexible sessions being expended by their consultant employees. Hospital managements stressed that while formal systems may not be in place to measure activities undertaken within consultants' contracted flexible sessions, it would become evident in the functioning of the hospital if consultants did not undertake that work.

**2.30** While it is recognised that this element of the contractual commitment may not be measurable in the same way as fixed sessions there is little clarity in relation to how flexible sessions are delivered and what gets done during those sessions. Concerns regarding the ability of hospital managements to account for consultants' use of paid flexible sessions surfaced at meetings with hospital managements. The examination team were informed that, in many instances, hospital management were not aware what these sessions were being applied towards as consultants engaged in this element in isolation from them.

**2.31** Interviews with consultants, in the hospitals visited, indicated that in many cases their flexible

sessions have been replaced by additional fixed sessions in order to meet increased service needs. However, this in general, is an on the ground adjustment not formally reflected in the consultants' scheduled commitments.

## Difficulties in Monitoring

**2.32** Hospitals have argued that since they cannot compel their consultants to complete a schedule of commitments a variable response to this request can be expected. For example, Mayo General Hospital has only managed to get a schedule of commitments for 11 of their 32 consultants.

**2.33** Beaumont Hospital has experienced considerable difficulty in the establishment of consultants' scheduled commitments. A survey by hospital management indicated that session organisation varied considerably among different specialties. Beaumont management felt that they had no control over session allocation and would welcome a mechanism whereby they could define sessions and identify accountability for service delivery.

## Management Information

**2.34** Overall, there appears to be a need for a structure within which consultants' inputs can be specified, delivered and recorded so that there is more clarity about the quantum of work delivered and the form it takes.

**2.35** In order for the HSE and employing authorities to be in a position to monitor contract performance relevant management information is necessary. However, no arrangements have been made for the collection of overall data on delivery and implementation of the 1997 Consultants' Contract. The HSE acknowledges that there would be benefits in measuring consultants' scheduled sessions.

**2.36** In the absence of a formal mechanism to record consultants' input, hospital managers can only base their assessment of the discharge of the commitment on general observation. The absence of any systematic collection of service inputs denies employing authorities key management data especially relating to current workload.

**2.37** Collection of data on the input of individual consultants is complicated by the nature of their relationships with the teams who assist and support them – much of the service is delivered under their supervision and control rather than directly. Consequently, current national databases like HIPE record activity undertaken by a range of staff under the direction of a consultant as having been undertaken by the consultant<sup>16</sup>. It is not possible to link specific clinical activities to individual consultants themselves because the system does not differentiate among team members and identify work actually performed by the consultant as opposed to the Specialist Registrar, Registrar, Senior House Officer or Intern. In any event, the examination team were informed that consultant participation in the HIPE system was based on an agreement that it would not be used for this purpose.

**2.38** The IMO has cautioned that if an overly prescriptive approach is taken by hospital managers to the measurement of hours of practice, it could have the unintended consequence that consultants would merely fulfil their contracted hours while their preference, and patient care, would require working in excess of contracted commitments within public hospital settings.

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<sup>16</sup> The activity while related to a consultant who has clinical responsibility for the patient may be delivered by non-consultant hospital doctors or other staff.

## Local Good Practice

**2.39** Some hospitals had developed systems and practices that provide reasonable assurance on the schedules of consultants and how they were delivered.

### ***Former Midland Health Board***

In the former Midland Health Board an initiative was taken by management in collaboration with local consultants. Hospital managers agreed a work schedule with each consultant, ensuring it fitted in with the workload of other consultants. On their schedule, consultants identified their out-patient clinics, ward round days and theatre sessions and outlined their fixed sessions, on-call commitment and location for on-call. The result was that the former health board had schedules for nearly all consultants. In general, its records indicated that most consultants worked more than the required scheduled commitment within their contract.

The former health board also distributed monthly anonymous activity reports among the consultant staff to enable them to benchmark workloads. While each consultant could only identify himself or herself it allowed for a general comparison of output with that of colleagues. These reports also helped hospital management to work with their consultants to control the hospital budget.

### ***St. Luke's Hospital, Kilkenny***

In St. Luke's Hospital a job plan is furnished to the Clinical Director. This plan records both fixed and flexible sessions and allows the burden of administration, management, education and audit within the directorate to be shared among the consultants in the directorate.

### ***The Mater Misericordiae University Hospital***

The Mater Misericordiae University Hospital had obtained a schedule of commitments for all consultants working in the hospital in 1997. A second review was conducted in 2005. This information, in conjunction with their clinical governance model, has been used to agree changes and flexibility within agreed scheduled commitments. For example, their theatre user group noted that the theatre working day in some areas did not break down into distinct morning and afternoon slots but rather ran all day in what could be better classified into three sessions. This resulted in changes being made to the scheduled commitments of the consultants involved with their agreement working through the established governance infrastructure.

### ***St. James's Hospital***

St. James's Hospital collects activity data on a named consultant basis. This is distributed to the Executive Management Group and is cascaded down to Clinical Directors, individual specialties and consultants.

## UK Experience

**2.40** The UK has moved to recorded scheduled time-commitments. This system has the merit of transparently recording consultant time inputs. However, the lesson from the UK experience is that such a move

- needs to be made in the context of systems reform in order to ensure that the consultants' input is effectively used by aligning hospital processes and mechanisms with attendance patterns



- can give rise to extra costs in the case of consultants who previously had worked hours in excess of their time commitment.

**2.41** At this stage, some of the benefits expected from these changes are still potential benefits. Nonetheless, it is anticipated that increasing accountability should open the way for result and outcome comparison, performance measurement and enhanced clinical audit.

## Value for Money Considerations

**2.42** As the service attempts to forge a new contractual relationship with consultants, international experience cautions that there is a value/cost trade-off to be faced. Without information on existing work patterns the State's negotiating strategy can only be based on anecdotal information. The risk of increased costs is highlighted in the UK experience.

- In March 2006, Audit Scotland noted that the initial costing model used to estimate the financial impact of contract changes was inaccurate due to a lack of information on consultant working patterns. This model underestimated the overall financial impact by about £171 million for the first three years.
- The 2006 King's Fund paper, *Assessing the New NHS Consultant Contract*, stated that it was difficult to identify the actual cost of implementing the new contract. The UK's Department of Health originally estimated that the cumulative total additional cost would be £250 million between 2003 and 2006. This was revised upwards to £340 million following an acknowledgement by the Department of Health that its own forecasts were an underestimate by about £90 million. This King's Fund paper indicated that the funding formula used to cost the new contract relied on a number of financial and workload assumptions that have proven unreliable.
- The King's Fund paper suggested that ultimately, the actual costs of the contract depended on how hospital trusts approached job planning. A recurring message from their research was that consultant workload had been underestimated in the funding formula.

**2.43** There is, therefore, a risk that unless the organisational changes associated with revised work patterns are clearly specified and new processes and practices agreed, the State could well end up paying more for the same service.

## Conclusions

**2.44** The consultants' contract is designed as a contract of employment. However, it has additional features more akin to a contract for services which confer entitlements including that of limited private practice.

**2.45** The examination found that key elements of the contract were undefined or lacked sufficient clarity to allow for smooth implementation. There is considerable tension between the sessional nature of consultants' work and the freedom to engage in private practice which could give rise to conflicting professional responsibilities.

**2.46** According to the HSE, the contract provides for a commitment of 39 hours which is divided into an unscheduled six-hour element and a scheduled commitment divided into fixed and flexible sessions. Discussions with management suggest that there is no clarity on the purpose and application of the unscheduled six-hour commitment agreed in the contract. The IMO maintains that this additional six-hour commitment does not, in fact, exist.

While acknowledging the fact that consultants are required to be available to manage emergencies as required, there is a need to clarify the number of sessions which are being purchased by the State salary.

**2.47** While it is widely acknowledged by hospital management that many consultants exceed their commitment, in the absence of management information, this cannot be demonstrated and management has inadequate planning data. It was found that most hospitals had received schedules on initial appointment. Few hospitals operated planned systematic reviews of consultants' schedules. As a consequence, there is inadequate information on the scheduled input of consultants and the discharge of their commitment under contracts with employing authorities.

Future arrangements need to put information capture mechanisms in place to ensure that consultants' inputs are recorded.

**2.48** Over one quarter of the hospitals surveyed said they had no means of accounting for how consultants' flexible sessions were utilised. At the overall level there was no monitoring to ensure that the commitments agreed were delivered.

The mechanism for monitoring the delivery of consultants' agreed commitment cannot be divorced from the management system within which they operate. If the present consultant-led model is retained there would appear to be a need to fundamentally alter the management system so that rostering and scheduling take place within a team structure. Agreement of work schedules at department or unit level would have the merit of allowing for alignment between the different specialties and support services.

The best prospect of achieving this appears to be in circumstances where a clinical director is accountable to the employing authority for the use of resources within an organised system that manages inputs, activities and outputs so that the service can be in a position to demonstrate the economy and efficiency with which resources are applied.

**2.49** The IMO has suggested that the clinical director model deserves debate and it has advocated the development of such a model on a properly resourced basis. However, it highlighted the concerns consultants have identified around the break in continuity of care and lack of accountability which follows any break in the personal doctor/patient relationship and the tendency to 'pass the buck' to the incoming shift, as has been apparent in some systems where such changes have been introduced. It ought to be possible to develop team-working in a way which deals with these concerns and the IMO indicated

that it is prepared to discuss such developments recognising their greater appropriateness to some specialties and settings rather than others and the fact that team-working is already a feature of a number of settings and specialties in Irish hospitals and mental health services.

**2.50** In regard to the management of private practice entitlements under the contract, there is a risk that the funds provided to pay consultants' salaries are not being applied to the purpose intended i.e. to treat private patients in line with the proportion of designated private beds in each hospital (20% of beds nationally) and, thereafter, to apply all remaining resources to the treatment of public patients. Over recent years in-patient elective activity has reduced and now constitutes 17% of all throughput. The proportion of work in this category devoted to private patients is out of line with in-patient bed designation. Overall, private patients constitute an average of 34% of elective in-patient cases compared with the average private bed designation level of 20%. Both private patient bed designation and private patient throughput vary widely by hospital, speciality, sub-speciality and consultant.

In future arrangements, in order to facilitate clarity and implementability, there will be a need to resolve tensions that exist between universal entitlement to a public bed and the level of private bed designations. Internal provisions of the contract which limit the entitlement to private practice but use a 'test of ready availability for public practice' also need to be reconciled in order to provide clarity on whether a particular private practice activity falls within permitted limits.

**2.51** A fundamental shift in the role of consultants has been proposed in numerous reports over the past seven years. These envisage a shift from consultant-led to consultant-delivered services. The key recommendations of these reports are set out at Annex D. Managing this change is likely to be a major challenge for health service managements.

In order to demonstrate the achievement of value for money from any such changes it would seem appropriate to set up a verification group akin to that which operates under national wage agreements to monitor the implementation of non-pay provisions and associated change management plans.

### 3 Clinical Audit and Clinical Risk Management

**3.1** The maintenance of service quality and improvement of health outcomes can be underpinned by feedback from clinical audits and through the proactive management of clinical risks. This chapter reviews the extent to which clinical audit and clinical risk management have been implemented at national, regional and hospital level.

#### Consultants' Contract and Clinical Audit

**3.2** The contract documents provide that the employing authority, in meeting its primary obligation to provide hospital services which best meet the needs of the population served, has a right, duty and responsibility to determine the range, type and volume of services to be provided and to strive for the highest quality in these services.

**3.3** The contract documents provide for the participation of each consultant in creating and operating a clinical audit system<sup>17</sup>. The employing authority has the responsibility to provide the necessary support and organisational systems, including where appropriate a regional audit system.

**3.4** While the contract documents did not make any detailed provision for how clinical audit should be implemented, it provides that one of the Executive Management Board's functions envisaged under the contract is to provide support for clinical audit.

#### Clinical Audit Arrangements

**3.5** The Health Strategy<sup>18</sup> defined clinical audit as

*'the systematic, critical analysis of the quality of care, including the procedures used for diagnosis and treatment, the use of resources and the resulting outcome and quality of life for the patient.'*

**3.6** Taken from a service user's perspective it can apply to audits of activities undertaken by clinicians as well as audits of the clinical environment. No central guidance has been provided to hospitals or regions on the development of a clinical audit programme. Consequently, any arrangements that exist are implemented at local level and to a variety of standards.

**3.7** Nationally sponsored involvement has been limited to one single audit - the Hygiene Audit which focused on the wider clinical environment. The HSE is currently auditing cardiovascular and stroke services. Audits have been planned in the areas of the handling of donor management, chest pains and wounds. At regional level, the Dublin Maternity Hospitals have over the years conducted a substantial body of clinical audit work which has resulted in changed practices in obstetrics.

**3.8** One of the key reform proposals in the Health Strategy was the formation of the Health Information and Quality Authority (HIQA). The Authority was set up on an interim basis in March 2005. Legislation designed to establish it on a statutory basis has been passed by Dáil Éireann<sup>19</sup>. This body will be independent of both the Department and the HSE and its responsibilities will include promoting and implementing quality assurance programmes nationally.

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<sup>17</sup> Section 6.2 (viii) of contract and Section 6.7 of Memorandum of Agreement.

<sup>18</sup> Quality and Fairness – A Health System For You (Department of Health and Children, 2001)

<sup>19</sup> Health Bill, 2006.

**3.9** The functions of the Authority will be to

- set standards on safety and quality in relation to services provided in accordance with relevant health legislation
- monitor the level of compliance with those standards
- investigate and make recommendations in respect of the safety, quality and standards of services and ensure the best outcomes for the resources applied
- operate accreditation programmes and grant accreditation to any services meeting standards set or recognised by the Authority
- operate schemes aimed at ensuring safety and quality in the provision of services.

**3.10** It is intended that HIQA will identify good practice among clinical teams. To do this, there will be a requirement for performance and service data to be available, including data on the results of clinical audits, for benchmarking against national and international norms.

**3.11** Because clinical audit extends to all clinical disciplines and processes, there appears to be a role for a body such as HIQA in consultation with other relevant bodies including the Irish Medical Council to establish or recognise standards for audits that govern their planning, execution and reporting and distinguishing between local, regional and national audits.

**3.12** The IMO suggests that there is a need to differentiate between clinical quality improvement (i.e. audit) and process audit. In their view clinical audit should be under the control and management of medical doctors whereas process audit may be appropriate to general management as the situation demands. However, such a clear cut distinction may not be possible since process audit can address issues that impact on patient safety and quality of care.

***Clinical Audit at Hospital Level***

**3.13** Responses to the survey of hospitals indicated that about 80% of the hospitals surveyed claimed to have some arrangements for clinical audit. However, the processes covered by these arrangements varied from hospital to hospital. Few claimed that a hospital-wide process existed, while a number stated that only certain specialties, divisions or departments carried out clinical audits. In nine of the 52 hospitals there were no central arrangements for, or information about, clinical audit processes at those hospitals<sup>20</sup>.

**3.14** In the case of most of the hospitals that claimed to have audit systems in place, audits were not generally performed as part of a regular planned cycle of work. They were not, in general, authorised on foot of a prioritised programme. Typically, initiatives were taken by individual consultants and their teams and resources dedicated to this function were diverted by hospital management from other areas.

**3.15** The IHCA noted that clinical audit tends to take place as an additional responsibility but it disputed that it did not take place on a structured basis.

**3.16** Overall, the quality of audits carried out within acute hospitals cannot be assessed, as they generally have not been evaluated by peers or against international standards.

**3.17** In two particular areas, well-developed systems were noted

- St. James's Hospital has a sophisticated system of clinical audit in place supported by appropriate information technology. This has advanced in some clinical areas to the level of outcome

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<sup>20</sup> Some were, however, aware that clinical audit was occurring in certain units of the hospital.

measurement. The hospital has also developed a Performance Indicator Programme tracking its service delivery for 120 key performance indicators, both clinical and corporate.

- The area previously known as the South Eastern Health Board had developed a clinical audit office with secretarial support and an IT system to record and analyse information. All data on agreed surgical procedures and outcomes were recorded. Surgeons from the regional hospitals met on a quarterly basis to discuss findings and debate changes to practice if required.

**3.18** A further example of a well-developed clinical audit process is provided by Sligo General Hospital. This is outlined in Annex F.

## **Arrangements for Audit and its Reporting**

**3.19** In cases where clinical audit was performed it was found that responsibility for its performance was devolved to local consultant level. In general, audit teams were not multi-disciplinary and clinicians within a single specialty area conducted this work. Audits frequently did not culminate in reports to hospital management nor were they shared with other hospital divisions. There was little evidence of hospital management and consultants collaborating on clinical audit nor was there evidence of mechanisms for hospitals to establish priorities to be addressed by clinical audit.

**3.20** In regard to review and reporting, no hospital could demonstrate that time was allocated monthly for review and assessment of audit outcomes. Audit results, generally, appear to be presented, if at all, to rushed meetings during lunch-breaks or early morning sessions. There is no evidence in any hospital of dedicated time where audit outcomes are presented, debated and decisions made on how to move forward from present practices on the basis of audit findings. This is in contrast with practice in the UK National Health Service (NHS) where such a feedback process is acknowledged as being of particular benefit to practitioners and patients under their care.

**3.21** Many consultants have informed the examination team that their audits have resulted in change. However, due to the general absence of formal coordinated clinical audit systems, there is no data on change effected based on audit outcome.

## **Accreditation of Services**

**3.22** Apart from its contribution to addressing the delivery of quality services, clinical audit conducted to specified standards and reporting norms can support applications for the accreditation of services – which, in turn, can give greater public assurance on the quality of health service delivery.

**3.23** Accreditation is an effective, internationally recognised evaluation process used by many countries world-wide to assess and promote quality in healthcare. The Irish Health Services Accreditation Board (IHSAB) was formally established by Statutory Instrument in May 2002. It is proposed that IHSAB will be subsumed into HIQA upon that body's statutory establishment.

**3.24** Many health service organisations across Ireland have opted to seek accreditation of their services and commenced preparations in anticipation of an in-depth evaluation of the care and quality of services they provide to their patients or clients by reference to a set of standards validated internationally by the International Society for Quality in Healthcare.

**3.25** The objectives of the Acute Care Accreditation Scheme which the IHSAB uses to evaluate acute hospitals, include

- consistency and equity of quality across the healthcare system for patients/clients

- provision of assurance with regard to the quality status of healthcare entities
- provision of a basis for assuring International Peer Status of healthcare entities.

**3.26** As all these objectives demand robust clinical audit and risk management to ensure successful delivery, any new consultants' contract will need to provide for liaison with HIQA in this area.

## Reportable Clinical Events

**3.27** The potential role of clinical audit in highlighting reportable clinical events was also demonstrated by the Lourdes Hospital Inquiry.

### *The Lourdes Hospital Inquiry*

This Inquiry highlighted the urgent need for high quality clinical audit and risk management systems in the acute hospital sector. Judge Maureen Harding Clark in her report on the excessive number of caesarean hysterectomies carried out in the Lourdes Hospital made the following recommendations for Obstetricians to minimise the risk of such an event recurring

- The lead clinician should be responsible for organising regular clinical audit meetings, clinical pathological conferences, clinical governance and continuing education.
- The duty to ensure that regular and effective audit takes place should be delegated to a specific consultant in charge of audit and that audit consultant should have a deputy.
- The lead clinician should be responsible for educating all medical staff on the value and importance of clinical incident reporting and should work with the Institute of Obstetricians and Gynaecologists, the Royal Colleges and the Medical Council to establish an agreed trigger list of reportable clinical events.
- Back up and support by way of a separate office, full time secretarial and IT services and a meeting room for discussion and presentations should be available to the lead clinician.
- The consultants delegated to work on audit should have dedicated secretarial assistance with training and experience of audit procedures and specific IT programming.

**3.28** There would be merit in considering how such a regime might be established in practice and extended to other specialties.

## Clinical Audit Guidance

**3.29** Guidance is available from a number of sources in regard to planning, conduct and reporting of clinical audit. In particular, work has been funded by the UK National Institute for Clinical Excellence which is designed to assist staff leading clinical audit projects in the NHS<sup>21</sup>.

**3.30** Key points made in the guidance in regard to the preparation for audit and the selection of criteria against which performance might be judged are set out at Annex G.

<sup>21</sup> Principles for Best Practice in Clinical Audit, Radcliffe Medical Press (2002)

## Clinical Risk Management

**3.31** Quality of service needs to be approached not just by adjusting to audit feedback but by proactive risk management. There is a dynamic relationship between risk audit and risk assessment. To be cost-effective risk audit needs to be targeted at areas of perceived exposure while risk mitigation activities need to follow after the assessment of risk whether through audit or otherwise. Risk management applies to all clinical staff but consultants have a key place in any such system since they drive the material risks associated with hospital care. The Health Strategy defined risk management as the prevention and containment of liability by careful and objective investigation and documentation of critical or unusual patient care incidents.

**3.32** Risk management involves consideration of

- risks to patients
- risks to practitioners
- risks to the organisation.

**3.33** Clinical risk management is based on three principles - risk identification, risk analysis and risk control. International research and experience suggest that this approach will be successful only in the context of a “blame-free” model. This would require review of the entire process leading to the occurrence of an adverse event, rather than focusing on the individual healthcare worker involved in the actual event.

## Clinical Indemnity Scheme

**3.34** A Clinical Indemnity Scheme (CIS) was established in July 2002, within the State Claims Agency (SCA), with a brief to

- provide clinical indemnity on the basis of “enterprise liability” (i.e. the organisation assumes liability for all its employees’ alleged clinical negligence arising from the delivery of professional medical services)
- manage claims in a timely and cost-effective manner
- reduce the numbers of clinical claims
- drive and support safe patient care
- lead and support clinical risk management.

**3.35** A mapping exercise of all the organisations covered by the scheme was carried out by the SCA in late 2004 to establish the clinical risk management framework in place and also to identify any patient safety initiatives underway. This survey confirmed wide variation in risk management practice throughout the country. It found that no two former health board regions or large acute hospitals had a similar governance structure. Some operated a highly integrated system, whereby health and safety, complaints handling, clinical risk management and non-clinical risk management activities were delivered by a team in a co-ordinated fashion. In others, these personnel operated with little or no communication between them. Many enterprises employed a Risk Manager who might not have a clinical background. However, the majority of Clinical Risk Managers were nurses.

**3.36** Each organisation is required to develop and promote a culture that supports clinical risk management. All organisations covered by the CIS have a statutory duty to

- report all adverse incidents to the SCA which may give rise to a claim



- furnish relevant information and facilitate SCA investigation when requested to do so
- preserve relevant evidence.

**3.37** The aims of the CIS are to minimise claims and improve patient safety in hospitals. A number of hospitals explained to the examination team that their lack of a formal risk management programme was a consequence of an expectation that the CIS would issue guidance and standards for best practice in the set-up and delivery of hospital risk management schemes. This view is not shared by the SCA/CIS which points out that the Department had provided appropriate and designated levels of funding to hospitals to support formal clinical risk management structures. However, a team of Clinical Risk Advisors at CIS is available to provide guidance and support to hospitals who require it when developing a risk management framework.

**3.38** Incident reporting has increased significantly since the introduction of the CIS. The majority of incidents reported are non-clinical in nature and, overall, approximately 85,000 cases had been recorded up to December 2006. Annex H outlines the arrangements for reporting.

**3.39** While the major portion of reported incidents are non-clinical in nature the vast bulk of the cost of maturing claims is associated with clinical claims. Figure 3.1 sets out the total contingent liability of live claims at 31 December 2006 categorised by clinical activity.

**Figure 3.1 Potential Liability at 31 December 2006**

Clinical Activity	Number of Claims	Total Provision €
Peri-operative/ peri-procedure incident	458	36,834,345
Diagnosis Incident	345	26,489,443
Other	282	13,998,889
Treatment Incident	248	13,332,851
Peri-natal	217	103,518,723
Slips/ Trips/ Falls	94	3,381,629
Consent/ Confidentiality incidents	88	2,959,412
Infection Control	60	2,574,444
<b>Total</b>	<b>1,792</b>	<b>203,089,736</b>

Source: State Claims Agency

**3.40** In the period 2002 – 2006, 95 cases have been settled at a total cost of €16.6 million.

**3.41** While the SCA seek to encourage the drive for risk management development in Ireland, its view is that it is up to the HSE to implement it. A National Risk Management Plan agreed between the SCA and HSE would be an important first step in this process. The SCA has informed me that it has, in partnership with HIQA and the HSE, commenced work on the development of a national risk management strategy.

**3.42** In January 2007, the Minister established a Commission on Patient Safety. The Commission will examine arrangements for risk management and review the roles of the HSE, HIQA and the SCA in these processes. The Commission will develop proposals for

- greater accountability within the health system for performance in relation to patient safety
- more effective reporting of adverse clinical events and complaints
- a clearer role for patients and carers in providing feedback on care received

- ways to ensure healthcare practice is consistently based on what has been shown to work in other centres
- a statutory system of licensing of public and private providers of healthcare
- better integration of the work of the different regulatory bodies in the health system in order to achieve a joined-up approach and a sharing of best practice.

### ***Good Practice Opportunities***

Because of their central position in the delivery system consultants can encourage appropriate clinical risk management in the following respects

- take a lead on the development and delivery of a clinical risk management programme in their hospital
- sit on the risk management committee and participate in weekly/monthly reviews of critical incident or near-miss reports
- on a personal level, complete incident reports when a critical incident or near-miss occurs
- undertake root cause analysis training and participate in such exercises when required
- review the monthly risk reports as issued by the hospital risk management committee and analyse the impact to personal and department practice
- work with risk management teams to identify potential risks in their department
- identify a person with responsibility and accountability for reducing these potential risks
- identify mechanisms to reduce risk and oversee the change management programme required to introduce these different work practices
- encourage and demand that NCHDs become involved in risk management as part of their training.

### ***Arrangements at Hospital Level***

**3.43** There are as yet no national risk management guidelines. The HSE's National Hospitals' Office is charged with developing a risk management strategy for the acute hospital sector. As yet, the HSE has issued no standard procedure or best practice for the operation of risk management within hospitals. There are no defined procedures for dealing with adverse event, near-miss or sudden untoward incident escalation within acute hospitals.

**3.44** Most hospitals have a clinical incident reporting mechanism in place. Some have also developed hospital risk management strategies. For example, Mayo General Hospital has set up a Clinical Risk Management Committee that reviews incident reports on a monthly basis.

**3.45** Certain hospitals have Health Risk Advisors, who investigate Sudden Untoward Incidents and carry out Root Cause Analysis<sup>22</sup>. Hospitals with Risk Managers record these events locally. Some may be reported to the CIS and become part of the national records. However, proactive practices such as the establishment of a clinical risk register are rarely taken. The Mater Misericordiae University Hospital was one of the few organisations that had a risk register in place.

<sup>22</sup> A Sudden Untoward Incident is any unexpected event that has an actual or potential detrimental effect on a patient/client, employee, member of the public or the assets of an organisation (Mayatt, V.L 2002). Root Cause Analysis is a retrospective review of an incident undertaken in order to identify what, how and why it happened (adapted from the UK National Safety Agency).

**3.46** For hospitals with risk management systems in place, it is difficult to assess their effectiveness. Some described quite well-developed and organised systems but on closer examination it appeared that risk management operated in isolation from consultants rather than with them.

**3.47** The HSE have informed the examination team that it is of the view that even in hospitals where risk management appears to be well-developed, it is still proving difficult to operate effectively. The explanation put forward for this is difficulties in engaging clinicians in the process. On the other hand, during the conduct of this examination, the examination team met with some consultants who expressed their frustration at being excluded from the development of clinical risk management within their hospital.

**3.48** Although the CIS provides indemnity on an enterprise basis it is important that clinical risk management systems in acute hospitals get consultant sponsorship and buy-in because they are the key decision makers and shoulder considerable accountability and responsibility for patient care. Though consultants and NCHDs are the principal clinical decision makers, there is a low level of incident reporting by medical staff to the SCA (approximately 3.5% of all reports). This would suggest that, while consultants may not necessarily control and lead risk management programmes they need to be actively involved in the management of risk.

**3.49** A key objective of the reporting of incidents and risk management is to provide feedback that will lead to better practice and the reduction of claims. In circumstances where the discipline of premium adjustments which would pertain in an insurance approach are not available to drive risk mitigation activities it is imperative that information on risk at hospital level be complete, accurate and used to effect change where appropriate. The SCA maintains that its role is to advise and assist hospitals to identify sources of risk that may occasion clinical claims. It is not involved in the direct mitigation of risks.

**3.50** Although the system does not operate on an insurance basis i.e. by incentivising good risk management through levying of premia, there is still scope for using the databank of claims and incidents to establish risk profiles and point the way towards improved clinical risk management.

## Professional Formation

**3.51** The body with statutory responsibility for the protection of patients in their relationship with the medical profession is the Irish Medical Council. The Council discharges this responsibility by

- setting standards for undergraduate, postgraduate and continuing medical education and training
- monitoring the delivery of education and training
- accrediting bodies delivering training and education to those standards.

**3.52** It has accredited 13 bodies who deliver training and education to standards set by it. The 13 training bodies are set out at Annex I. Most are affiliated to Royal Colleges<sup>23</sup>. I sought the views of the colleges on clinical audit and clinical risk management.

**3.53** The Royal Colleges are supportive of the introduction, development and expansion of clinical audit throughout the acute hospital system. All colleges are in agreement that clinical audit takes time and resources. They, therefore, call for protected time<sup>24</sup> and dedicated funding to develop systems further. The HSE expressed a wish to work more closely with the Royal Colleges in the area of clinical audit.

<sup>23</sup> Royal College of Physicians of Ireland (RCPI) and Royal College of Surgeons in Ireland (RCSI).

<sup>24</sup> This has been recognised by the Department arising out of the work of the Medical Manpower Forum. (Report of the Forum on Medical Manpower, 2001)

This same collaboration was suggested by the Royal Colleges during our consultation process. These arrangements should be progressed as a matter of urgency and priority.

**3.54** In 1998 the RCSI proposed the setting up of the National Comparative Audit Service to Surgeons, within and supported by RCSI. The objective was to provide a confidential service to the Fellows of RCSI and to surgery in general. It was proposed that it should be set up with an audit officer identified in each hospital to support their audit practices. This proposal foundered due to lack of funding. The RCSI, however, set up a confidential audit system along the lines suggested (i.e. to allow comparisons of outcomes against national and international norms). The system was used extensively by surgeons, in its initial stages. The percentage of surgeons using this system is now about 34%. A new Medical Practitioners Act will, inter alia, include an obligation on the HSE to facilitate the maintenance of professional standards and the competence of medical practitioners by means of clinical audit, continuing medical education and peer review of clinical performance. The RCSI is now of the view that the role of a national audit office should be located in HIQA.

**3.55** The Royal Colleges have stated that they would welcome a systematic development of risk management systems within the acute hospital sector. Clinical audit and risk management are seen as inter-related processes which they very much favour. In the view of the Royal Colleges, good clinical audit and risk management would allow for comparisons against national and international benchmarks. The colleges view this positively as it would allow clinical care to be pushed to deliver according to international norms and best practice.

## UK Experience

**3.56** In the UK doctors in hospitals have for many years been involved in clinical audit at local level. Hospital Episode Statistics<sup>25</sup> are collected on every patient in the NHS. The data is collected by hospital administrators and is based on coding of information in patients' notes. This data collection allows individual consultant outcomes to be compared with those of their colleagues both locally and nationally.

**3.57** At national level, the UK Royal Colleges lead and run comparative audits. An example is the Myocardial Infarction<sup>26</sup> Audit, which has led to decreased mortality, decreased door to needle time and more consistent prescribing of drugs in acute situations. Consultants give these audits better support and buy-in because they are professionally led.

**3.58** In addition, as all consultants are involved nationally, there is significant peer-pressure to ensure individual practices are not 'at the bottom of the list'. Consultants can access their individual and unit results but the rest of the data remains anonymous.

**3.59** Currently, the UK Royal College of Physicians is in discussion with the National Healthcare Commission to develop a national strategy to prioritise national audit needs. Recent examples include audit of Cardiovascular Accidents, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, Incontinence, Falls, Multiple Sclerosis and Psoriasis. In the area of information on adverse incidents, the UK operates a system of anonymous reporting to the National Patient Safety Agency.

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<sup>25</sup> Hospital Episode Statistics (HES) is the national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere.

<sup>26</sup> Myocardial Infarction or Acute Myocardial Infarction, commonly known as a heart attack, occurs when the blood supply to a part of the heart is interrupted.

## Implications for Change

**3.60** It has been estimated by an international expert<sup>27</sup> that to develop, introduce and implement a comprehensive National Clinical Risk Management and Audit System in Ireland would require a three to five year plan.

**3.61** The implementation of this change would necessitate an initial assessment of current practice and the development of a final vision of how the system should work in practice including elucidating the inter-relationships between various professional bodies and data holders. A national implementation plan and roll-out programme including milestones for delivery would also be required. In addition, local, regional and national mechanisms would need to be agreed to facilitate review of the data collected and development of meaningful reports to be used to effect change.

**3.62** The passing of new legislation and enhanced regulatory requirements will not be sufficient to guarantee the successful introduction of a clinical risk management and audit nationally. For such a programme to be successfully implemented a major organisational and culture change will need to be achieved to get all healthcare staff to participate fully in the process. Critical issues to be addressed include

- Planning for the delivery of clinical audit programmes at all levels and resource allocations to reach identified goals over time will need to be specified.
- The roles and relationships of organisations (e.g. HSE, HIQA, Medical Council, Royal Colleges and hospitals) to be involved in implementing and monitoring performance of audits will need to be clarified, and guidance promulgated on the types of hospital structures (e.g. clinical directorates) which may be appropriate in a clinical audit context.
- Procedures, processes and routines to carry out effective clinical audits in hospitals to meet required performance standards will need to be established.
- The staff that need to be involved and the structures within which clinical audits will be conducted will need to be established.

**3.63** Although the available evidence suggests otherwise, a particular issue to be addressed is the fact that many individuals and organisations have fears that openness about errors and adverse events may lead to an increase in litigation. The issue is ultimately a moral and ethical one. Policies on open disclosure have been developed and implemented in other countries including the US, Australia and the UK and have been welcomed by patients, their families and by clinicians.

## Concerns Regarding Freedom of Information

**3.64** The examination team's meetings with consultants at hospitals found a reluctance by those carrying out clinical audits to formally record the results of their investigations. This reluctance emanates from concerns regarding the possibility that negligence claims might emerge if a request was made for records by patients or relatives of patients under the Freedom of Information Acts. Some ambiguity exists as to whether records of patients' treatments, and peer assessments of them through clinical audit, are covered under the Acts.

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<sup>27</sup> Professor Charles Vincent – Director of Clinical Research Unit in the Department of Bio-Surgery and Surgical Technology, Imperial College, London.

**3.65** Consultants in other jurisdictions have similarly had concerns regarding the making available of clinical audit information. In a modern health system it is imperative that medics be accountable for their actions and the outcomes arising from their care. Experience in other countries has shown that the benefits from good clinical audit practice facilitates improvements in the effectiveness of care provided by practitioners and this, generally, supercedes concerns regarding potential litigation.

## Conclusions

**3.66** Clinical audit is a vital element in ensuring that hospital services are provided to the highest quality. One of the obligations of consultants under the 1997 contract was to participate in clinical audit. A corresponding obligation of management was to resource the structures within which this clinical audit could be planned, carried out and reported. There was limited follow through on the obligations set out in the agreement.

It is vital that hospital services be in a position to demonstrate the quality of outputs and outcomes. Without a well-developed system of clinical audit, where the results are widely shared, effectiveness cannot be evidenced and continuous improvement is unlikely.

**3.67** Ideally, in order to facilitate feedback and benchmarking there should be audit at local, regional and national levels. The only national audit carried out was that on hygiene in 2005 with a follow up review in 2006. No regional structures have been provided though a good practice model had evolved in the former South Eastern Health Board area. Audits are undertaken in many hospitals but overall coordination of this activity is poor. The hallmark of good clinical audit should be the extent to which the results are shared and disseminated in order to promote hospital-wide change.

There is a need to conduct an in-depth assessment of the scope of clinical audit activity to establish its current state of development and put local, regional and national structures in place to facilitate audit.

**3.68** At local level audits did not appear to be carried out as part of planned prioritised programmes. However, at this level, St. James's Hospital had a sophisticated system of clinical audit in place supported by appropriate information technology and Sligo General Hospital had a well-developed model.

**3.69** Without adequate arrangements for reporting of results, practitioners are unlikely to derive benefit from audits. Most reporting does not take place in a planned and organised way.

There is a need to address

- The mechanism through which audits might be prioritised at hospital, regional and national levels
- The standards to which audits are planned, carried out and reported
- The arrangements to support audit activity
- The quality assurance of audits through peer review or other mechanisms.

There is a role for HIQA in sponsoring the standards for clinical audit in consultation with other authorities including the HSE and the Irish Medical Council.

**3.70** In addition to adjusting to feedback from clinical audit there is a need for proactive clinical risk management – the planned containment of liability should have the concomitant effect of improving quality. Consequently, both clinical audit and clinical risk management should be seen as vital elements in addressing the quality of hospital services.

While both clinical audit and clinical risk management involve all clinicians, consultants have a pivotal role to play in this area. Consequently, future contractual arrangements should address the obligations of the respective parties and the mechanisms through which clinical audit and clinical risk management will be implemented.

## **4 Consultants and Management**

**4.1** The 1997 contract envisaged an increase in the extent to which consultants participate in the management of hospital services. To a large degree, these desired changes were aspirational and the contract called for collaboration of consultants and employing authorities (with the support of the Department) to identify the most suitable management models for implementation in individual hospitals and hospital groupings. While the specific commitments and obligations undertaken by consultants and referred to in Chapters 2 and 3 can be viewed as self-standing elements of the contract there is no doubt that they would best be administered within a framework where consultants are involved in the management process.

**4.2** In the area of hospital management, the contract envisaged two key initiatives

- the creation of boards with consultant representation to run the hospital (Executive Management Boards)
- the establishment of unit groupings (the clinical directorate model).

**4.3** This chapter looks at progress achieved in engaging consultants in hospitals' governance structures and the management of hospital resources and in particular

- to what extent Executive Management Boards (EMBs) or equivalent structures exist and
- whether Clinical Directorates or equivalent structures have been established.

### **Establishment of Executive Management Boards**

**4.4** The 1997 Consultants' Contract suggested that EMBs should be established with defined terms of reference and should be involved in planning, strategy and policy making for the overall development of a hospital or hospital grouping and the provision of support for clinical audit.

**4.5** The survey of hospitals found that 46 of the 52 hospitals had EMBs or a similar structure in place (e.g. Hospital Management Committees/Teams and Executive Consultative Boards). Membership of these boards generally included

- Chief Executive Officer or General Manager or Master of Maternity Hospital, as appropriate
- Director of Medical Boards or Medical Executive Boards
- Director of Nursing
- Financial Controller
- Human Resources Directors/Managers.

Many of these structures predated the 1997 agreement.

**4.6** The Contract specifically states that the EMB must formulate and implement the annual service plan. However, it did not define who should sit on an EMB. In fact, it did not even state that a consultant should have representation on it. Nonetheless, the examination found that consultant membership of EMBs varied from hospitals where one or two consultants were on the EMB (e.g. Portlaoise and Mullingar) to some where all consultants were members as in Roscommon County Hospital.



**4.7** The Contract recognised the need for training and support to be provided to enable the smooth operation of EMBs. 29 hospitals stated, in their responses to the survey that some training had been provided, two hospitals were developing training while 16 stated that none had yet been provided. Five hospitals did not reply to the question.

## Clinical Directorates

**4.8** A clinical directorate is a group comprising clinical specialties and multiple disciplines and grades of staff that has been brought together to work as a unit within an individual hospital structure. The contract outlined proposals for units to be led by a member of the consultant team in each unit – the leader being appointed by management on the recommendation of the consultants in the unit. A number of designated sessions would be allocated to enable the person appointed to fulfil this role.

**4.9** Whatever the structure of these units the overall aim is to have mechanisms in place, which ensure that consultants and hospital managers work together within agreed structures and deal with shared agendas such as hospital quality assurance, clinical audit, performance outcome, strategy development and service planning.

**4.10** The examination found that these sub-board structures exist, at least to some extent, in 39 hospitals. There are a wide variety of mechanisms which currently involve consultants in management, including hospital directorates, hospital divisions, clinical directors, medical directors, medical boards, executive hospital boards, chief medical officers and hospital masters.

**4.11** Further refinement would be necessary before these models could be said to equate to the clinical directorate model envisaged. Some hospitals are taking steps to move in that direction - for instance, Beaumont and Tallaght<sup>28</sup> indicated that they intended to move towards a clinical directorate model from other centralised and hybrid structures. Eight other hospitals indicated that only some sub-structures were in place or in development. 12 indicated that no sub-board structures were set up to facilitate participation of consultants in the management process.

**4.12** The IMO has drawn attention to the fact that it considers that many successful models currently operate in the mental health services, in many of the larger teaching hospitals but most particularly the systems led by the Masters within the three Dublin-based Maternity Hospitals.

**4.13** The view of the Irish Hospital Consultants Association (IHCA) is that the authority vested in Chief Executive Officers (CEOs) under the Health Act 1970, constituted an obstacle to the involvement of consultants in management as distinct from involvement in administration. It stated that Health Board CEOs were reluctant to cede real decision-making authority to Medical or Clinical Directors or EMBs. Now that the legal framework has changed, hospital consultants and the IHCA are willing to promote the policy of the involvement of consultants in management.

## Clinicians in Management Initiative

**4.14** In November 1998, arising from the 1997 contract and the wider agenda to improve management throughout the health service, the Minister launched a Clinicians in Management Initiative (CIM). It was intended that the initiative would be implemented over a three-year period. Following work undertaken

<sup>28</sup> The Adelaide and Meath Hospital, Dublin Incorporating the National Children's Hospital.

in four pilot sites<sup>29</sup>, the CIM initiative was rolled out to a further 17 hospitals. The Office for Health Management (OHM)<sup>30</sup> was requested by the Department to take responsibility for the commissioning of management development initiatives to increase the involvement of consultants in management and to provide support to the participating hospitals.

**4.15** In the period 1997-2004 the Department allocated funding totalling €10.2 million to individual health boards or hospitals for the development of the CIM initiative. The bulk of this allocation was made available to former health boards (€6.9 million) with the OHM receiving €1.1 million and the balance being distributed among 15 hospitals.

**4.16** The OHM did not meet with success in encouraging these developments. As well as progress being slow the experience on the ground has been variable. As the OHM noted in 2005

*'although notable progress under the initiative has been made in a number of hospitals the CIM experience has been variable. Full clinician involvement in decision-making and in the management of resources is not yet the norm'.*

**4.17** Ultimately, to facilitate movement on the initiative, the OHM sought to create a charter to help define the rights and responsibilities of Consultants, Senior Hospital Managers and Clinical Directors within the acute hospital setting.<sup>31</sup> This charter was published in 2005 and was the result of the discussions of a working group, comprising senior clinicians and hospital managers. It was OHM's intention that the findings could be used to help build and develop better working relations and collaboration between consultants and senior management.

**4.18** The Charter was also intended to provide a framework that could be used to facilitate discussion in hospitals attempting to involve consultants in their management structure or to improve on present performance. Publication of the framework, in October 2005 almost seven years after the initiative was first introduced is in itself an indication of the slow pace of progress. The content of the charter is set out in Annex J.

**4.19** At this point, individual hospitals have different models to facilitate participation of consultants in hospital management. However, the examination found that their involvement is generally in the areas of clinical standards and clinical audit and not in the areas of budget control, resource planning, strategy development or operations management. To the extent that involvement has been achieved in some cases, it takes place within a voluntary system with no specific incentive or compulsion to participate.

**4.20** In order to guide change at local level, national standards and norms are essential. Without standards and a mandate from the HSE to implement appropriate structures, hospitals continue to operate in accordance with local arrangements. Standards promulgated at national level can assist management in achieving change. Without such leverage it may be difficult to achieve progress. For instance, in one hospital visited, it was noted that it still has department leaders who are nominated by virtue of their seniority and that they then hold the position for life. While hospital management attempted, some years ago, to implement a structure in accordance with the clinical directorate model, this attempt failed and the previous practice still prevails.

**4.21** The involvement of consultants in management as envisaged in the 1997 Contract cannot exist effectively without participative leadership and governance. However, in practice, responsibility is

<sup>29</sup> St. James's Hospital, Cork University Hospital, Wexford General Hospital and the Hospitals Programme in the North Western Health Board.

<sup>30</sup> This office was subsumed into the HSE with effect from 1 January 2005.

<sup>31</sup> A Charter of Rights and Responsibilities of Hospital Consultants, Senior Hospital Managers and Clinical Directors (Office for Health Management, 2005)

divided without a clear means of integrating the roles of managers and consultants. The resultant ambiguity militates against coherent service delivery so that to varying degrees consultants and management see themselves as responsible for different aspects of service delivery.

**4.22** Short of formal arrangements, good examples of consultants and management working together to manage their hospital and services were found to exist. For example, Roscommon County Hospital informed the examination team that they had no “clinicians in management” model in operation within the hospital. Yet, all ten of their consultants were part of the hospital management team. When the hospital recently underwent a capital refurbishment programme, all consultants worked with hospital management to change their sessions to meet and support the hospital service needs. This is an example of cooperation between consultants and management to the benefit of patient care.

**4.23** It is acknowledged, however, that the scale of the hospital operations needs to be taken into account in devising models for governance. This is something that might best be examined under the sponsorship of the HSE.

## **Consultant Involvement in Management**

**4.24** The examination found that consultants were involved in decision making processes in all hospitals, to a greater or lesser extent. The extent of involvement of consultants in the strategic direction of hospitals, the management of change and the allocation of resources varies from hospital to hospital. Formalisation of their roles varied considerably from paid posts with protected sessions for management activities to situations where their involvement in management processes were performed entirely on a voluntary basis.

**4.25** The IHCA has stated that while accepting that the pace of change has not been as rapid as one would have wished, the involvement of consultants in a more active way in the management of hospitals, is much more significant now than in 1997.

**4.26** It also noted that the nature of the doctor-patient relationship is one in which the patient trusts the consultant. This relationship of trust creates a degree of friction between the consultant and hospital management because the resources and facilities which the consultant may require to provide optimum care for his patient may not always be available.

## ***Service Planning***

**4.27** The examination noted that in practice consultants and managers in some hospitals collaborate on service planning. While the HSE has no national requirement for service plans to be signed off by consultants it informed us that its explicit expectation is that service plans should represent an output of all clinical staff involved in service delivery, including consultants. It regards this process as a catalyst to open up consultant/management dialogue. A difference in perception was evident in the course of the examination – management’s experience was that it was hard to get consultants to focus on future developments. This view, however, conflicts with that of individual consultants met during the preparation of this report. Their common complaint was a lack of opportunity to be involved in this process in a meaningful way.

## ***Strategy and Change Management***

**4.28** The health reform programme might best be driven by hospital level strategies and change agreed on a partnership basis between consultants, other clinicians and management. While good examples of effective strategy formulation and the implementation of associated change are difficult to find, the examination found a number of examples of good practice in the areas of corporate planning, strategy

development and change management.

- Development of the Mater Misericordiae University Hospital five-year Corporate Plan involved the Medical Executive, Allied Health Professionals, Nurses and Hospital Management. Together, they decided on areas of priority which were targeted in their development plans. They focussed on linking their priorities with the Health Strategy as this facilitated funding from the HSE.
- Beaumont Hospital also described how their latest hospital strategy development, covering 2006 – 2010 was drawn up in collaboration with the Planning and Development Manager and Consultants. Each specialist unit or division made contributions that were evaluated and compiled into what became the final document. They use a similar process for the development of the annual service plan.
- The benefit of collaboration between consultants and management can be seen in cases where the Accident and Emergency (A&E) issue has been jointly tackled. The Medical Assessment Unit in St. Luke's Hospital, Kilkenny is a good model of hospital management working with their consultants to address the urgent problem of prolonged 'trolley waits' in their Emergency Department. Their programme has been copied in some other hospitals.

### ***Management of Hospital Budgets***

**4.29** There is limited alignment between budget decisions and responsibility for service delivery. In practice, consultants deliver services within budgetary constraints. Key decisions in regard to allocation and resource rationing are made by management.

**4.30** Some instances were noted of the involvement of consultants in resource rationing

- When the Mater Misericordiae University Hospital had to address a budget deficit in 2003, the solution was developed from collaboration between clinicians and the senior management team. Together they decided which services needed to get priority (A&E in their case) and which would have to be reduced or suspended in the short-term. Collective responsibility and accountability was taken for the decisions and their impact on clinical services until the deficit was eliminated. This teamwork and partnership demonstrates clearly the benefits to be gained from the involvement of clinicians in decision making.
- St. James's Hospital also made good use of their clinical directorate model to target savings when faced with a budget deficit. This approach has the ultimate advantage of ensuring that the cutbacks are agreed by clinicians who have an intimate understanding of the impact of these decisions on their patient population.

However, in most cases the management of deficits is ultimately a financial control function. Consultant involvement in these circumstances is limited.

**4.31** A wider involvement of consultants in budgetary decisions is desirable since these decisions impact on the way they can deliver services. However, it has to be recognised that a considerable element of the cost base of hospitals is fixed in nature and that the scope for reallocation is limited in practical terms to a residual discretionary element of the budget. This is not to say that individual elements of the service would not benefit from periodic bottom-up reviews involving consultants in examining and reviewing the resource base and costs.

**4.32** The IMO has pointed out that consultants had been reluctant to get involved in decision making structures within hospitals because of a top-down approach which persists and which has been exacerbated by increasingly centralised management systems developed by the HSE. In its view, what all hospital executive medical boards require is the presence of a senior manager who can ensure resources are delivered for the development of services on the basis of a devolution of power from the HSE to individual hospitals.

### ***Potential Scope for Consultant Involvement***

**4.33** The views of the management consultant who advised me in the course of the examination are set out in the box beneath.

There has been much talk around the Clinicians in Management initiative. I saw many different mechanisms in place during the examination, ranging from the very simple to extremely complex arrangements. It is worthwhile to address the whole point of having governance models to incorporate consultants into hospital management and ask whether they are, in fact, worth the effort of implementation.

The organisations involved are large and often very intricate. They are responsible for complex service delivery and decision-making in an uncertain and unpredictable environment. This all takes place against a background of resource constraint despite a Government spend of over €12.5 billion on health in 2006.

I did not set out to evaluate the effectiveness of the type of model in place but just whether the Consultants in Management model appeared to be functioning appropriately at all. All seven hospitals visited said that they had a successful Consultants in Management programme in place but I was of the view that this was not the case in three organisations.

A key indicator of effectiveness of consultant involvement in the management process of an acute hospital is the presence of a joint decision-making process between consultants and hospital management. In my view, this is fundamental to establishing a credible infrastructure that is accepted and used appropriately by both consultants and management to the betterment of their hospital governance and patient services.

A joint decision-making process is one in which management decisions are informed and made by both consultant and management leaders together. These are decisions that are recorded in executive team meetings and can be tracked to assess follow-through and recognise mutual responsibility both in a proactive and retrospective fashion. The presence of mutual decision-making in hospital management could be seen clearly in the Clinical Divisions Model of the Mater Misericordiae University Hospital and the Clinical Directorates Model at St. James's Hospital.

These hospitals had a mechanism for executive team meetings involving consultant leaders who were nominated by their peers and the hospital senior management team. These meetings could be held daily, weekly or monthly but they served to sort issues, set agendas and review progress. They all set the tone for the functional operation of their individual hospital. The decision-making process was clear to all stakeholders including clinicians and management but could also be easily explained to others such as patients and their families.

### **General Views of the IHCA**

**4.34** While progress on implementing specific initiatives designed to involve consultants in management may not have been as fast as had been hoped, the IHCA has pointed out that considerable

management change has still taken place and change has been a continuous feature of the service. The development of new technology and medicines, changes in surgical procedures, the development of new medicines and alterations in the general management of patients are the greatest drivers of change within the hospital services. In particular,

- The development of keyhole surgery is an example of patients now being treated on a day-case basis rather than being retained as inpatients for between three and five days.
- The management of cancer patients has changed dramatically in less than a decade. Patients, who in the relatively recent past would have had lengthy inpatient stays, are now mostly treated on a day-case basis.
- The number of inpatients in psychiatric hospitals continues to fall as a result of the drive to manage patients within the community, in day hospitals and in clinics.
- Changes in the management of patients has led to the development of multi-disciplinary teams consisting of consultants, nurses, therapists, social workers and other healthcare professionals.
- The number of day-case beds has risen from 540 in 1995 to 1,250 in 2005 and, in addition, the majority of hospitals now have five-day wards reflecting the shorter length of stay of inpatients with the ensuing cost savings both in terms of accommodation and personnel by having patients discharged before the weekend.

## **The Royal Colleges' Perspective**

**4.35** The Royal Colleges are anxious to see further development of consultants in management. The RCPI has suggested that, to facilitate this, protected time should be allocated within an individual consultant's contract for involvement in non-clinical activities such as clinical audit and hospital governance.

**4.36** They would welcome changes whereby consultants would have their voice heard in decision-making and could participate to effect change. However, they recognise that hospital reconfiguration and structured departments are required to support this programme. The RCSI would welcome consultants working as teams as opposed to independent practitioners.

## **UK Experience of Implementing Clinicians in Management Systems**

**4.37** Clinicians in Management has recently become more prevalent in the UK, in parallel with the reform of the health service although consultants have been involved in hospital management in the UK since 1983.

**4.38** The NHS's experience of the introduction of the role of Medical Director has been a testing one, requiring patience and persistence over time. One of the early tasks facing the new Medical Directors was to lead the on-the-ground introduction of job planning. This came into play amid a change designed to achieve greater accountability and responsibility for service delivery from all consultants. Recently appointed consultants embraced this process of change more readily than their more established colleagues for whom it was a major shift in practice. However, the new system was successfully implemented over time.

## Conclusions

**4.39** Consultants are involved to a greater or lesser extent in management. However, there is little consistency from hospital to hospital in the scope of their involvement.

**4.40** Heretofore, there has been a divide between accountability for allocation and application of resources on the one hand and responsibility for service outcomes on the other. Budgetary decisions were reserved to management while service outcomes were primarily the responsibility of consultants.

There appears to be a need to clearly define the objectives and structures of a clinical directorate model. At a minimum it might include day-to-day responsibility for services, resource utilisation and a framework for monitoring the quality of outputs subject to overall accountability to hospital management.

**4.41** At overall hospital management level, a 1998 Clinicians in Management Initiative was designed to involve clinicians in the planning and management of services. While work was done at four pilot sites the attempt to extend the initiative met with variable degrees of success. In October 2005 a charter was published by the OHM to help facilitate the local discussions on how to manage change in order to involve consultants.

There appears to be a need to establish better arrangements for the representation of consultants in decision making structures of the hospitals and for a partnership mechanism in the formulation of strategy, the planning of services and the management of change.

**4.42** The failure to evolve a model that integrates responsibility for resources, activities and outcomes was a factor that contributed to the failure to implement the key terms of the contract referred to in Chapter 2 and 3.

Overall, any new contractual arrangements need to specify the administrative and governance changes that are necessary for its effective implementation and be underpinned by a change management drive. There is a continuing need to integrate responsibility for resources and outcomes in a way that gives due regard to the accountabilities of individual consultants and the teams involved in providing hospital care.

**4.43** In regard to increased involvement of consultants in resource allocation and resource rationing it is acknowledged that this gives rise to a need to reconcile their obligations to patients with the reality that resources are finite. However, the moral imperative to do the best for patients while arguing for better resource allocation and application can also be seen as an argument for greater involvement.





## **Annexes**

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## **Annex A     Contract Documents**

### **CONTRACT** **SCHEDULE OF SECTIONS**

<b>Section 1</b>	Name of appointee.
<b>Section 2</b>	Offer of appointment.
<b>Section 3</b>	Regulation of appointment, qualifications and experience.
<b>Section 4</b>	Tenure of appointment.
<b>Section 5</b>	The Nature of Consultant Appointments.
<b>Section 6</b>	The Nature of Consultant's Role and Responsibilities.
<b>Section 7</b>	The Nature of the Employing Authorities Role and Responsibilities.
<b>Section 8</b>	Terms and Conditions - Non-Salary Conditions of Service.
<b>Section 9</b>	Terms and Conditions - Remuneration and Expenses.
<b>Appendix I</b>	Comhairle na nOspidéal letter of approval.
<b>Appendix II</b>	Job Description (new appointees).
<b>Appendix III</b>	Grievance and Disputes Procedure.
<b>Appendix IV</b>	Disciplinary Procedure.

Note: Appendices I and II are not included in this Annex.

**CONTRACT FOR APPOINTMENT OF CONSULTANT (SPECIALTY)**  
**WITH (THE EMPLOYING AUTHORITY)**

**(Note: Throughout these documents the use of the masculine pronoun connotes the feminine gender also unless the contrary intention appears).**

1. (Name and address of the person to whom the appointment is being offered).
2. You are hereby offered an appointment of Consultant (Specialty) on a Category 1 / Category 2 / Geographical Wholetime without fees\* basis under (the employing authority) from (date) subject to the terms and conditions specified in this contract, its appendices and in the Memorandum of Agreement appended hereto; these jointly being the contract documents. This appointment has a weekly commitment of ( ) sessions as defined in Section 2.4 of the Memorandum of Agreement.

**3. Regulation of Appointment, Qualifications and Experience**

- 3.1 This appointment has been regulated by Comhairle na nOspidéal in accordance with section 41(1)(b)(i) of the Health Act, 1970.
- 3.2 The qualifications required for this appointment are those specified by Comhairle na nOspidéal subject to any general requirements determined by the Minister for Health in accordance with section 41 (1)(b)(ii) of the Health Act, 1970. The type of appointment and the qualifications so specified are as determined for this appointment by the Comhairle and are given in the Comhairle's letter attached at Appendix I.

**\* Delete as appropriate**

**4. Tenure of Appointment**

- 4.1 Subject to clause 4.3 of this contract in relation to probation, your appointment will be permanent and pensionable.
- 4.2 On appointment, you will hold office under (the employing authority). Where the appointment is under a Health Board, Part II of the Health Act, 1970 will apply to the appointment. In this connection see Appendix F to the Memorandum of Agreement.
- 4.3 A probationary period shall apply in the case of each consultant appointment except where a consultant currently holds the Common Contract or where he already holds a permanent appointment of consultant of a type regulated by Comhairle na nOspidéal under section 41(1)(b)(i) of the Health Act, 1970. In the case of your appointment, a probationary period shall / shall not apply\*.
- 4.4 Where a period of probation applies your appointment shall be subject to the condition that you shall hold your appointment for a probationary period of 12 months which (the employing authority) may at its discretion extend, in which case the specific reasons for the extension shall be made known in writing to you. At the end of the probationary period, (the employing authority) shall either:
  - (a) certify, with stated specific reasons, that your service has not been satisfactory in which case you will cease to hold the appointment, or
  - (b) certify that your service has been satisfactory and confirm your appointment on a permanent basis.
 If (the employing authority) should fail to certify in accordance with (a) or (b) above, your appointment shall be deemed to take effect on a permanent basis.

**\* Delete as appropriate**

- 4.5 In the case of joint appointments, including the probationary period under each employing authority, the holding of any one part of the post is contingent on continuing to hold the other part or parts of the post.

**5. The Nature of Consultant Appointments**

- 5.1 For the purpose of this contract, a consultant is defined in the following general terms:  
 A consultant is a registered medical practitioner in hospital practice who, by reason of his training, skill and experience in a designated specialty, is consulted by other registered medical practitioners and undertakes full clinical responsibility for patients in his care, or that aspect of care on which he has been consulted, without supervision in professional matters by any other person. He will be a person of considerable professional capacity and personal integrity.
- 5.2 Being a consultant involves continuing responsibility for investigation and for the treatment of patients without supervision in professional matters by any other person. This continuing responsibility for investigation and for treatment of patients is a personal matter between each consultant and each patient in his care and it extends for as long

as the patient remains in the consultant's care. The consultant may discharge this responsibility directly in a personal relationship with his patient, or, in the exercise of his clinical judgement, he may delegate aspects of the patient's care to other appropriate staff, or he may exercise responsibility concurrently with another doctor or doctors. Notwithstanding this however, the unique position of the consultant in the hospital requires that he carries the continuing responsibility for his patients so long as they remain in his care.

5.3 The employing authority and the consultant acknowledge that the provision of services to patients is a joint task which sets obligations on both parties.

## **6. The Nature of a Consultant's Role and Responsibilities**

6.1 (The employing authority) recognises your right to the exercise of your independent judgement in clinical and ethical matters (subject to the provisions of clause 8.11 of this Contract where applicable).

6.2 As a consultant, your responsibilities will include, inter alia, responsibility for:

- (i) producing a realistic agreed schedule which specifies how you intend to discharge in person your full contractual commitment, over the period from Monday to Friday, taking into account the exigencies of the service and the most effective utilisation of resources,
- (ii) supplying adequate advance notice in writing to hospital management advising them of all planned absences, together with their duration,
- (iii) ensuring that fixed sessions, in particular Out Patient and Theatre sessions etc., should start as scheduled in order to minimise delays for patients and possible disruption of services,
- (iv) providing management with rosters indicating clearly who will be on call and available to the hospital at any given time where approved on-call/emergency services are to be provided,
- (v) agreeing with management the details of the service levels and mix to be provided within the scheduled commitment,
- (vi) supplying to (the employing authority) such information on the discharge of your scheduled fixed and flexible sessions as is necessary and reasonable to establish that you are fulfilling your contractual commitment. The obligation to provide a schedule and information on the discharge of the scheduled commitment exists independently of the other provisions of this contract and accompanying Memorandum of Agreement,
- (vii) participating, as of right in the selection process for Non-Consultant Hospital Doctors, and in the selection process for such other staff as the employing authorities agree are appropriate, in in-service teaching and training of medical and other staff, in research within the hospital and in administration outside the management of your own particular department or unit of the hospital,
- (viii) participating in a process of clinical audit, which will preserve the confidentiality of the doctor/patient relationship,
- (ix) providing information to (the employing authority) including data for hospital information systems and service planning and for such other purposes as (the employing authority) and you agree are appropriate.

6.3 A job description in respect of your appointment is attached at Appendix II (new appointments only).

## **7. The Nature of the Employing Authority's Role and Responsibilities**

7.1 For hospitals to operate in an efficient and effective manner it is necessary that decisions affecting patient care are taken as near as possible to the point of service delivery. Consultants need to be involved in the management process. This involvement commences with the consultant's responsibility to manage his own practice and will involve co-operation with colleagues and other health professionals, at department, unit, hospital or hospital group level, extending to involvement in the management of the hospital/hospital grouping through direct membership of, or representation on, the hospital Executive Management Board.

7.2 Each hospital or hospital grouping will have an Executive Management Board, the precise constitution and role of which will depend on the structure and size of the hospital or hospital grouping. It is equally necessary that sub-Board structures are put in place to assist in the management process. The recent experience of the pilot projects in a number of hospitals confirms that the concept of a distinct unit grouping the clinical functions together under the leadership of a selected consultant (e.g. the Clinical Directorate model), represents an effective model to facilitate participation of hospital Consultants in the management process.

7.3 It is agreed that (the employing authority) and the consultants will work together, and will have the support of the Department of Health and Children, in identifying the most suitable management models for implementation in individual hospitals/hospital groupings. The concept of establishing distinct units (as set out in 7.2 above) is agreed, such units to be led by a member of the consultant team in each unit.

7.4 It is acknowledged that the effectiveness of the leader of the unit is dependent not alone upon the calibre of the person appointed but upon the support, co-operation, and commitment of the members of the unit and of the consultants in general. The leader of the unit should be appointed by management on the recommendation of the consultants in the unit and should be for a fixed term, (e.g. 3 to 5 years) and involve the allocation of a number of designated sessions to enable him fulfil his role.

7.5 The Executive Management Board will have a constitution and its functions will include:

- the formation and implementation of annual service plans for the hospital/hospital grouping which will cover inter alia;
  - activity levels
  - personnel
  - budget
- the development of strategies and policies for the overall development of the hospital/hospital grouping.
- the provision of support for clinical audit.

Appropriate training and support will be provided for the operation of the Executive Management Board and the devolution of executive responsibility for each of the elements of the service plan will be agreed between the Executive Management Board and the employing authority.

7.6 Under the traditional representative model, consultants organise themselves in groupings which reflect the characteristics of individual hospitals/hospital groupings in order to deal with collegiate/non executive matters. This representative system provides a mechanism to complement and inform the work of the Executive Management Board. Where these representative structures for consultants do not exist, employing authorities will encourage and support their establishment. Employing authorities will, with the agreement of consultants, encourage the development of collaborative working arrangements through their representative structures and by so doing, encourage the fullest participation by all consultants in the arrangements. The appropriate representative head (Chairman or Honorary Secretary) of such a structure, e.g. Medical Board, Medical Advisory Board, Medical Committee or Medical Council, will be accorded a consultative status within the hospital, commensurate with his important representative function, on matters of significance impinging on the medical aspects of the hospital's services.

## **8. Terms and Conditions - Non Salary Conditions of Service**

### **8.1 Work Location**

You will be based at (location indicated in the Comhairle letter of approval). You will be required to conduct clinics and out-patient work as appropriate to your specialty both at your base and at (designate specific locations of the clinics and out-patient work); these locations may be changed by (the employing authority) but they will not be outside the area served by (the hospital or hospital group) for your specialty without your consent, nor will the overall duration or frequency be changed without your consent. The location, frequency and duration will not be changed by you except with the approval of (the employing authority). You will not be transferred from (the hospital or hospital group) without your consent unless major changes take place in the character of the work being carried out there, in which case arrangements will be made to offer you an appropriate alternative appointment, including an option to change category of appointment without competition, in another hospital. In such a case, removal expenses calculated in accordance with the Removal Expenses Scheme for health boards and local authorities will be paid, if claimed.

### **8.2 Residence**

You will be required to reside convenient to the hospital in which you hold your appointment or at such other place as may be approved by (the employing authority). In the case of a dispute arising under this paragraph, the parties will have recourse to the Grievance and Disputes Procedure outlined in paragraph 8.9.

### **8.3 Private Practice**

You may engage in private practice in accordance with the terms of the Memorandum of Agreement.

### **8.4 Leave**

Annual, sick, special, maternity and sabbatical leave and leave for continuing education shall be as set out in Section 5 of the Memorandum of Agreement.

### **8.5 Public Holidays**

Leave in respect of public holidays shall be granted in accordance with the Holidays (Employees) Act, 1973.

### **8.6 Rest Days**

As per 5.6 of Section 5 of the Memorandum of Agreement.

### **8.7 Provision of Locums**

Arrangements for locum cover will be as set out in Section 5.8 of the Memorandum of Agreement.

### **8.8 Disciplinary Procedure**

The disciplinary procedures, as set out in Appendix IV will apply to you.

**8.9 Grievance and Disputes Procedure**

It is intended that, to the greatest extent possible, problems associated with your contract should be addressed and resolved within the normal structures of the (employing authority). In exceptional cases, problems will be referred to a third party - see Appendix III of this contract and Section 7 of the Memorandum of Agreement.

**8.10 Age Limit**

You shall cease to hold this permanent appointment on reaching the age of 65 years.

**8.11 Ethical Principles**

Existing contractual provisions in, and ethical principles and regulations specific to, individual non-Health Board hospitals will be inserted here.

**9. Terms and Conditions - Remuneration and Expenses**

9.1 The various elements of the remuneration and expenses package are outlined in Section 4 of the Memorandum of Agreement.

In the case of your appointment, remuneration shall be as follows:

- (i) \_\_\_\_\_ (Salary)
- (ii) \_\_\_\_\_ (Extended duty liability)
- (iii) \_\_\_\_\_ (Emergency services)

**9.2 Superannuation**

The provisions of

- The Local Government (Superannuation) Act, 1980\*
- The Voluntary Hospitals Superannuation Scheme\*
- The Nominated Health Agencies Superannuation Scheme\*

will apply to you. \* delete as appropriate.

Contributions at the appropriate rate in accordance with the provision of the relevant scheme and its allied spouses and children's pension scheme will be deducted from pensionable remuneration.

An explanatory note outlining the main features of the scheme will be given to you on request.

**9.3 Travelling and subsistence expenses**

Travelling and subsistence expenses necessarily incurred in the course of your duties shall be met on the basis applicable to persons of appropriate senior status in the public sector. Consultants holding joint appointments or appointments involving a commitment at more than one location will be re-imbursed expenses in respect of travel between locations specified in the schedule which are agreed with the employing authority or authorities.

**9.4 Medical Indemnity**

You shall, as long as required by (the employing authority) and while you continue to hold your appointment, keep yourself indemnified against claims arising from malpractice and negligence in relation to your appointment. The (employing authority) shall reimburse you promptly to the extent of ( %) in respect of the cost of such indemnity.

These provisions may be rescinded by the employing authority and replaced by others in the event of alternative arrangements for the provision of cover against claims for negligence being introduced following agreement between the Department of Health and Children and the Irish Medical Organisation and the Irish Hospital Consultants Association.

You will agree to participate in agreed clinical risk management programmes at hospital and unit level.

**9.5 Telephone and Communications**

You shall be reimbursed either the cost of telephone rental for your home or the cost of a mobile phone rental.

**Signed on behalf of the Employing Authority** \_\_\_\_\_

**Date** \_\_\_\_\_

**Signed** \_\_\_\_\_

**Acceptance (do not detach)**

**I hereby accept the appointment offered above by (the person authorised on behalf of the employing authority) on the terms and subject to the conditions of appointment referred to and I undertake to commence my duties with the Employing Authority on the**

**Date:** \_\_\_\_\_

**Signed:** \_\_\_\_\_

**Grievance and Disputes Procedure**

This procedure is to deal with problems arising during the initial development period of the revised contract. To the greatest extent possible, such problems should be addressed and resolved within the normal structures of the employing authority. Issues such as the resourcing of services, roles of hospitals and general service issues will be excluded from this process.

Where a dispute during the initial development period of the revised contract arises between the employer and a consultant(s), the following steps are to be taken:

- 1 Local level discussions must be undertaken and completed within three months from the date on which either party to a dispute indicates that it wishes to avail of this procedure.
- 2 In exceptional cases where resolution at local level proves impossible, the matter will be referred by way of written submission to the mediator by individual consultants and / or the employer, accompanied by a memorandum outlining the local discussions that have taken place.
- 3 The mediator will decide whether all avenues at local level had been explored and exhausted and whether it is now an appropriate matter for his consideration.
- 4 The mediator will be assisted by representatives of the HSEA / IBEC (as appropriate), the IMO and the IHCA (as appropriate). As a rule two representatives from the HSEA / IBEC and one representative from each of the medical organisations will assist the mediator but where a consultant(s) wishes to be represented exclusively by one or other of the medical organisations, two representatives from that organisation will be permitted.

Disputes which fail to be resolved at local level, as indicated at 1 above, should be referred with the necessary documentation directly to the mediator. The costs attendant on utilising the mediator's services will be borne by the employing authority concerned.

The following list of people have agreed to act as mediator:

**Name**

**Address**

In order to ascertain which of the above names should be approached to act as mediator in particular cases the Employer side should contact the HSEA / IBEC and the Employee side should contact the IMO and IHCA, whichever is appropriate.



**Appendix IV****Disciplinary Procedure****Preamble**

The purpose of the disciplinary procedure is to ensure that complaints concerning the competence, capability or conduct of consultants will be dealt with in a matter which has due regard to the rights and obligations of the parties. Where a complaint concerning a consultant is considered under this procedure it shall be dealt with expeditiously while affording the consultant adequate opportunity to reply to any complaint or allegation made against him. The consultant shall be entitled to be represented at all stages of the procedure should he so desire.

**1 Where:**

(a) The Chief Executive Officer of a Health Board

or

(b) The Chief Executive Officer, Secretary/Manager of a hospital or some other person authorised by him of a hospital not being a Health Board hospital

- hereinafter called "the appropriate person",

is concerned that a consultant may have failed to comply with any of the terms of his appointment or may have otherwise misconducted himself in relation to his appointment, he shall notify the consultant in writing of the reasons for such concerns and inform him that any representations in regard to the matter may be received by the Chief Executive Officer or the appropriate person, as the case may be, from the consultant within two weeks of the issue of the notification and will be considered.

**2 A complaint relating to an individual living patient shall not be considered except where:-**

(a) It is made by the patient, by a member of his family or by the employer, colleagues, statutory authorities or, by another person with the written consent of, the patient or where the patient is a child, of his parent or guardian and it is in writing and signed by the person making it, and

(b) It is made within six weeks of the alleged event in relation to which the complaint is made or within such longer period as appears reasonable to the Chief Executive Officer or the appropriate person.

**3 Where it appears to the Chief Executive Officer of a Health Board, the Chief Executive Officer, Secretary/Manager of a hospital or other health agency or his authorised representative, that by reason of the conduct of a consultant there may be an immediate and serious risk to the safety, health or welfare of patients or staff the consultant may apply for or may be required and shall, if so required, take immediate administrative leave with pay for such time as may reasonably be necessary for the completion of any investigation into the conduct of the consultant in accordance with the provisions hereof. This investigation should take place with all practicable speed. In taking such action the Chief Executive Officer of a Health Board, the Chief Executive Officer, Secretary/Manager of a hospital or other health agency or his authorised representative shall consult with the Chairman or Secretary of the Medical Board or equivalent structure.****4 The Chief Executive Officer of a Health Board, Chief Executive Officer, Secretary / Manager of a hospital or other health agency or the appropriate person, after consideration of any representations which the consultant may make in regard to the matter, and after carrying out such further examination into the matter as he considers necessary may:-**

(a) if he is satisfied that the matter was trivial or without foundation, so inform the consultant in writing,

or

(b) if he is satisfied that the consultant had not complied with the terms of his appointment or had otherwise misconducted himself in relation to his appointment, and if he thinks fit, issue a warning or other like communication to the consultant,

or

(c) where he is the Chief Executive Officer of a Health Board, decide to act in accordance with the provisions of sections 22, 23 and 24 of the Health Act, 1970 and the regulations made thereunder,

or

(d) where he is not the Chief Executive Officer of a Health Board, decide to act by way of the following analogous provisions.

**5 (1) Where the appropriate person decides to proceed under the provisions of paragraph 4(d), he may request the Minister to appoint a committee under this paragraph to inquire into the matter and the Minister shall thereupon appoint such a committee.**

(2) A panel shall be established for the purpose of providing members for the aforesaid committee.

(3) Membership of a committee referred to in sub-paragraph (1) shall consist of:-

(a) one person (to be a Chairman of the Committee) to be selected by the Minister in agreement with the Irish Medical Organisation and the Irish Hospital Consultants Association and the appropriate person,

- (b) two persons selected by the Minister from lists of names of persons supplied by the Irish Medical Organisation and the Irish Hospital Consultants Association, and
- (c) two persons selected by the Minister following consultation with the employing body concerned.
- (4) The quorum for a committee under this paragraph shall be three, at least one member of the quorum being a person referred to in sub-paragraph (3)(b) and at least one being a person referred to in sub-paragraph (3)(c).
- (5) Any question arising before the committee under this paragraph shall be decided by the majority of the members of the committee who are present and vote and in the case of the equality of votes on any question the chairman shall have a second or casting vote.
- (6) A committee under this paragraph may act notwithstanding any vacancy among its members.
- (7) The chairman of a committee shall convene the first meeting of the committee not less than ten days after the committee is established.
- (8) During the conduct of the committee's proceedings, which shall be held in private, the chairman shall have discretion as to the conduct of the proceedings, and, in particular, shall:
  - (a) decide the order of appearance of persons appearing before the committee,
  - (b) permit the consultant and the appropriate person to appear in person or to be represented or assisted by another person or persons or to make written submissions to the committee, and
  - (c) hear, if he thinks fit, any person who is not a party to the proceedings.
- (9) Where, before a committee has made a recommendation, a member of the committee for any reason becomes unable to continue to act as such, the Minister may, at the request of the consultant concerned, or if the Minister considers it desirable so to do, appoint another committee.
- (10) The committee shall complete its examination of a complaint with all practicable speed and shall make its recommendations in writing to the appropriate person and shall also send a copy of the recommendations to the consultant concerned.
- (11) A committee having inquired into the matter may recommend:
  - (a) the termination of the consultant's appointment, or
  - (b) a period of unpaid suspension, or
  - (c) deduction of a specified sum of money from the consultant's remuneration, or
  - (d) that the consultant concerned should be admonished.
- (12) Where a committee recommends the termination of a consultant's appointment, the appointment may be terminated after the expiration of a period of 21 days from the communication to the consultant concerned of such recommendation, unless a request has been made to the Minister under sub-paragraph (13).
- (13) A consultant in relation to whom a recommendation for termination of his appointment or for unpaid suspension or for the deduction of a specified sum of money has been made under sub-paragraph (11) may request the Minister to issue a direction to the appropriate person in relation to that recommendation.
- (14) A request under sub-paragraph (13) shall be submitted in writing to the Minister either by the consultant concerned or on his behalf and shall specify the grounds on which the consultant requests the Minister to issue a direction to the appropriate person and the Minister shall notify the appropriate person of the receipt of such request.
- (15) Where a request is made to the Minister under sub-paragraph (13), the Minister may give to the appropriate person a direction (being a direction to comply with the recommendation of the Committee or such other direction as the Minister considers appropriate) and the appropriate person shall comply with such direction.

## MEMORANDUM OF AGREEMENT

### SCHEDULE OF SECTIONS

<b>Section 1</b>	Introduction.
<b>Section 2</b>	The Nature of Consultant Appointments.
<b>Section 3</b>	The Structuring of Consultant Appointments.
<b>Section 4</b>	Remuneration and Expenses.
<b>Section 5</b>	Non-Salary Conditions of Employment.
<b>Section 6</b>	The Nature and Conduct of the Employment Relationship.
<b>Section 7</b>	Grievance and Disputes Procedure.
 <b>Appendix A</b>	 Comhairle na nOspidéal Guidelines for Joint Appointments.
<b>Appendix B</b>	Rates of Remuneration. <sup>a</sup>
<b>Appendix C</b>	Rates for mileage. <sup>b</sup>
<b>Appendix D</b>	Sick Leave provisions.
<b>Appendix E</b>	Special Leave provisions.
<b>Appendix F</b>	Chief Executive Officers' Statement.

Notes:

a Not included (See Annex C for current rates of remuneration).

b Not included – the original rates have been adjusted in line with public service mileage rates.

## **MEMORANDUM OF AGREEMENT**

### **1. INTRODUCTION**

- 1.1 This Memorandum of Agreement has been formulated having regard to the terms of the existing contract, the recommendations of the Review Body on Higher Remuneration in the Public Sector (Report No. 36) and the negotiations with the representative bodies of the medical profession.
- 1.2 This Memorandum covers the following issues:
- The nature of Consultant appointments;
  - The structuring of Consultant appointments;
  - Remuneration and expenses;
  - Conditions of employment and Superannuation;
  - Provision of Locums;
  - The nature and conduct of the employment relationship;
  - Grievance and Disputes Procedure.

### **2. THE NATURE OF CONSULTANT APPOINTMENTS**

- 2.1 For the purpose of this Memorandum, a consultant is defined in the following general terms:-  
A consultant is a registered medical practitioner in hospital practice who, by reason of his training, skill and experience in a designated specialty, is consulted by other registered medical practitioners and undertakes full clinical responsibility for patients in his care, or that aspect of care on which he has been consulted, without supervision in professional matters by any other person. He will be a person of considerable professional capacity and personal integrity.
- 2.2 Being a consultant involves continuing responsibility for investigation and for treatment of patients without supervision in professional matters by any other person. This continuing responsibility for investigation and for treatment of patients is a personal matter between each consultant and each patient in his care and it extends for as long as the patient remains in the consultant's care. The consultant may discharge this responsibility directly in a personal relationship with his patient, or, in the exercise of his clinical judgement, he may delegate aspects of the patient's care to other appropriate staff, or he may exercise the responsibility concurrently with another doctor or doctors. Notwithstanding this, however, the unique position of the consultant in the hospital requires that he carries continuing responsibility for his patients so long as they remain in his care.
- 2.3 The agreed objective of the parties to this Memorandum is the maintenance of the highest standards in the public hospital system. To this end, the remuneration, general conditions of employment and facilities are intended to attract and retain the major part of the practices of consultants of the highest calibre on the sites of public hospitals.
- 2.4 Qualifications for holding appointment as a Consultant
- 2.4.1 It is a function of Comhairle na nOspidéal under section 41(1)(b)(ii) of the Health Act, 1970 to specify qualifications for Consultants whether in Health Boards or Voluntary Hospitals. The Minister for Health also has power to determine qualifications of a general nature under that section and under section 15 of the Health Act, 1970. The following is an outline of the qualifications which are ordinarily specified:
- (i) each person must be a medical practitioner who is registered otherwise than provisionally or temporarily, in the Register of Medical Practitioners for Ireland;
  - (ii) each person must possess the professional qualifications specified by Comhairle na nOspidéal in relation to the particular appointment.
- 2.5 Health  
A candidate for and any person holding the office must be free from any defect or disease which would render him unsuitable to hold the office and be in a state of health such as would indicate a reasonable prospect of ability to render regular and efficient service
- 2.6 Character  
A candidate for and any person holding the office must be of good character.
- 2.7 Duties
- 2.7.1 In the case of Health Board appointments the Chief Executive Officer has power under section 14(3) of the Health Act, 1970 to determine the duties of all officers. The agreed statement of the Chief Executive Officer of each Health Board is attached at Appendix F indicating that the exercise of his powers under section 14 (3) of the Health Act, 1970 will be in accordance with the terms of this Contract.
- 2.7.2 The duties of consultants in non-Health Board hospitals will be specified at the time of appointment.

- 2.7.3 A mechanism to determine disputes about duties will be put in place at local level by the employing authority in agreement with the representative grouping(s) for consultants. Where it is not possible to settle a dispute locally, in the case of consultants employed in Health Board hospitals, the matter should be referred to the Minister under section 14(6) of the Health Act, 1970.

In the case of consultants employed by non-Health Board hospitals, the matter should be dealt with under the Grievance and Disputes Procedure outlined in paragraph 7.1.

## 2.8 Occupational Hazards

- 2.8.1 The employing authority recognises the particular risks to the health and safety of all professional and occupational groups, (including Consultants) employed in the health services. Services and facilities to deal with these risks are set out in existing schemes including the Safety, Health and Welfare at Work Act, 1989. The operation of these schemes will be reviewed, at regular intervals, in consultation with the organisations representing the medical profession.

## 2.9 Private Practice

- 2.9.1 The Government has consistently affirmed its commitment to the availability of a mix of public and private care within the Irish health system. Most recently, this has been restated in the Health Strategy, Shaping a Healthier Future (1994). The Health Strategy also states that "it is important to ensure that the co-existence of public and private practice does not undermine the principle of equitable access".
- 2.9.2 The agreement in relation to scheduling and organisation of work set out at Section 6 of the Contract is designed to demonstrate clearly that any entitlement to off-site private practice does not result in a reduction of contracted service to public sector patients whether public or private.
- 2.9.3 With regard to on-site private practice, a consultant's overall proportion of private to public patients should reflect the ratio of public to private stay beds designated under the 1991 Health (Amendment) Act which requires that all public hospital beds be classified as public, private or non-designated. Variations in the nature or extent of a consultant's work as between his public and private practices will be subject to review under the terms of Section 6 of the Memorandum of Agreement.
- 2.9.4 Each consultant will be entitled to engage in private practice within the hospital or hospitals in which he is employed. The extent to which a consultant is entitled to engage in private practice outside the hospital or hospitals in which he is employed is determined by the category of post which he holds (see section 3 of the Memorandum of Agreement) and subject to him satisfying the employing authority that he is fulfilling his contractual commitment to the public hospital(s).
- 2.9.5 Where a consultant is engaged in private practice within institution(s) financed from public funds, and with which he has a contract, then that private practice will be considered as on-site.
- 2.9.6 Conversely, where a consultant is engaged in private practice within institution(s) where the managing authority is separate from the public hospital and/or the hospital is financed from private funds, then that private practice will be considered as off-site.
- 2.9.7 Notwithstanding the provisions of paragraphs 2.9.4 and 2.9.5 above, a Category 1 Consultant who, by definition, devotes substantially the whole of his professional time to a public hospital cannot treat patients in a private hospital or clinic. He may, however, see private patients in consulting rooms which are not on the site of the public hospital. The nature and extent of the activities pursued in consulting rooms should not extend beyond consultation, examination of patients and the performance of minor treatments i.e. activities normally carried out in out-patient clinics. It does not encompass day-ward procedures involving anaesthesia. The principal criterion to be employed in assessing whether any particular activity falls within the permitted limits is the effect which it has on a consultant's ready availability to the public hospital. The long-term objective is to provide consulting rooms in the public hospital(s) which may be availed of by Category 1 Consultants to see fee paying patients. Occasional consultations at the request of another consultant are not precluded by the above provisions

## 2.10 Medical Indemnity

- 2.10.1 Each consultant shall, as long as required by (the employing authority) and while he continues to hold his appointment, keep himself indemnified against claims arising from malpractice and negligence in relation to his appointment. The (employing authority) shall reimburse him promptly to the appropriate extent in respect of the cost of such indemnity, as set out in 2.10.2.

These provisions may be rescinded by the employing authority and replaced by others in the event of alternative arrangements for the provision of cover against claims for negligence being introduced following agreement between the Department of Health and Children and the Irish Medical Organisation and the Irish Hospital Consultants Association.

Consultants will agree to participate in agreed clinical risk management programmes at hospital and unit level.

- 2.10.2 Category 1 Consultants and Geographical Wholetime Without Fees Consultants should have 90% of their subscription refunded. Category 2 Consultants should have 80% of the cost refunded (part-time consultants will be proportionate of 80%). Where a holder of the common contract (1981) was entitled to retain the right to a more

favourable level of recoupment on taking the common contract (1991) he shall be allowed to retain his present level of recoupment on a personal basis.

#### 2.11 Scheduled Commitment

- 2.11.1 The time commitment contracted by a consultant will be expressed in terms of notional three hour sessions.
- 2.11.2 A consultant's time commitment, which will be personally discharged, will be scheduled in sessions during the hours normally worked within the Monday to Friday working week. The requirement to personally discharge all of the commitment does not preclude the consultant from delegating aspects of his scheduled work while the time commitment to (the employing authority) is being personally discharged elsewhere.
- 2.11.3 Each session may be scheduled as either fixed or flexible.
- (i) A fixed session is a time commitment which must be fulfilled, except by agreement between the consultant and the employing authority or in emergency, because of the significant impact which such activities have on the utilisation of other resources and the deployment of other staff e.g. out-patient clinics, theatre sessions, ward rounds, investigative and treatment sessions.
  - (ii) A flexible session which is not fixed (as defined above) is a regular and predictable time commitment, the extent of which can be anticipated, which may be discharged in a flexible manner within a specific time frame e.g. 1 week or 1 month. Flexible sessions will cover medical activities such as - depending on specialty - teaching, minor ward rounds, reporting, research, meetings, hospital management and medical audit.
- 2.11.4 The aggregation of fixed and flexible sessions in a given time period shall be on a cumulative basis of notional hours e.g. 11 sessions per week = 33 notional hours per week. This does not imply that Consultants' work is necessarily organised in equal periods of time. If the time actually worked on a scheduled session consistently and significantly varies from the notional three hour commitment, there will be a review of the scheduled commitment to ensure that the consultant is not working regularly in excess of or less than his weekly scheduled commitment. Where the commitment is being unavoidably exceeded for reasons of a temporary nature, local arrangements shall be made to compensate the consultant concerned. A consultant's commitment shall comprise a mix of fixed and flexible sessions, the ratio of which will vary depending on specialty.
- 2.11.5 It is acknowledged that some professional activities are infrequent and irregular and cannot be scheduled in advance within the definition of fixed/flexible sessions. The professional time devoted to such activities is being described as non-schedulable.
- 2.11.6 The equivalent of two sessions of professional time per week will be available for episodic activities such as involvement in planning, interviews and periodic meetings which if they become regular will be deemed flexible.
- 2.11.7 It is both recognised and accepted that consultant medical staff hold key senior positions in the health service. In the case of senior postholders a large degree of reciprocal trust and confidence is required. Hospital services and staff resources need to be critically linked to consultants' working patterns to ensure that a cost effective, quality service is provided to all patients in the public hospital system..
- 2.11.8 To enable the hospital/service to function in the most effective manner possible each consultant will produce a realistic agreed schedule which specifies how he intends to discharge in person his full contractual commitment, over the period from Monday/Friday, taking into account the exigencies of the service and the most effective utilisation of resources. In delivering service within this schedule it is expected in particular that:
- (i) Consultant medical staff should give adequate advance notice in writing to hospital management advising them of all planned absences, together with their duration,
  - (ii) Fixed sessions, in particular Out-Patient and Theatre sessions, should start on time in order to minimise delays for patients and possible disruption of services,
  - (iii) All specialties providing approved on call/emergency services should provide hospital management with rosters indicating clearly who will be on call and available to the hospital at any given time.
- 2.11.9 Details of the service levels and mix to be provided within the scheduled commitment for each consultant are a matter to be agreed with management.
- 2.11.10 A consultant will supply to his employing authority such information on the discharge of his scheduled, fixed and flexible sessions as is necessary and reasonable to establish that he is fulfilling his contractual commitment. The employing authority is entitled to satisfy itself that the agreements referred to in paragraph 2.11.8 above are being fulfilled.
- 2.11.11 A consultant will co-operate with the employing authority in the collection of maintenance fees.

### 3. THE STRUCTURING OF CONSULTANT APPOINTMENTS

- 3.1 The determination of the number and type of consultant appointments is the statutory responsibility of Comhairle na nOspidéal. This statutory function is discharged within the context of Government policy on hospital services. The parties to this agreement fully support the considerations laid down by Comhairle na nOspidéal in Section 3 of its

Seventh Report for the sanctioning of consultant appointments, the aim of which in the approval of appointments has been to ensure a viable job and to achieve as near a maximum commitment as possible to a single hospital or group of hospitals.

3.2 It is agreed that consultant appointments will fall into the two categories set out at paragraphs 3.3 and 3.4 below.

### 3.3 Category 1 Consultants

3.3.1 A Category 1 Consultant will have a scheduled commitment of 11 fixed and flexible sessions (an aggregate of 33 notional hours). He will also be liable for extended duty and emergency services. He will devote substantially the whole of his professional time, including time spent on private practice, to the public hospital(s).

### 3.4 Category 2 Consultants

3.4.1 A Category 2 Consultant will have a scheduled maximum commitment of 11 fixed and flexible sessions (an aggregate of 33 notional hours). He will also be liable for extended duty and emergency services. In addition he may engage in private practice on-site and off-site.

### 3.5 Geographical Wholetime without fees category

A Geographical Wholetime without fees consultant will have a scheduled commitment of 11 fixed and flexible sessions (an aggregate of 33 notional hours). He will also be liable for extended duty and emergency services. He will devote substantially the whole of his professional time to the public hospital(s).

### 3.6 Part-time Consultants

The commitment of Part-time Consultants should range from 7 up to 9 schedulable sessions but should not be less than 3 sessions.

### 3.7 Joint Appointments

A joint appointment is one which involves a commitment by a consultant to two or more employing authorities. The need for a single contract or interdependent contracts (with reciprocal clauses) for joint appointments is accepted. The total commitment should not exceed that which will be expected from other Consultants in the same specialty who have a wholetime commitment in any one of the employing hospitals. Guidelines relating to Joint Consultant Appointments by Two or More Authorities published by Comhairle na nOspidéal are attached at Appendix A.

### 3.8 Academic Appointments

The future arrangements to apply to the remuneration and conditions of employment of consultants holding joint academic/clinical appointments are being currently addressed by management, the profession and the appropriate academic bodies. These arrangements will apply from the same effective date as applicable to other consultants.

### 3.9 Options for existing Consultants

3.9.1 Consultants who had an entitlement to exercise an option under paragraph 3.8.1 of the Memorandum of Agreement in the 1991 Common Contract will be offered an opportunity to opt initially for one of the categories described in paragraphs 3.3 and 3.4 above.

3.9.2 Existing "wholetime" consultants who wish to opt for a part-time commitment may do so subject to agreement with the employing authority or authorities concerned on the implications of the part-time arrangements for the services of the hospital or hospitals and the approval of Comhairle na nOspidéal. Normally any sessions "lost" through having the commitment of a post reduced shall be retained in the hospital concerned. In some circumstances, they may, by agreement, be transferred to another hospital.

3.9.3 Consultants who hold existing part-time posts under the common contract will be offered posts with a similar sessional commitment under this contract.

3.9.4 Consultants who held posts in the Geographical Whole-time without fees category at 20/9/97 or who had given written notice to their employing authority(s) by that date of their intention to exercise an option under paragraph 3.3.3 of the Memorandum of Agreement attached to the 1991 Common Contract, to change to that category will be allowed, on a personal basis, to exercise an option to remain as a Geographical Whole-time without fees Consultant.

3.9.5 Conditions relating to arrangements for fees earned in the treatment of private patients by such consultants as set out in paragraphs 3.3.3, 3.3.4 and 3.3.5 of the 1991 Common Contract shall continue as heretofore.

### 3.10 Movement between categories

3.10.1 Both sides accept the recommendations contained in paragraph 3.24 of Review Body Report No. 36 that suitable arrangements, which take account of all the factors contained in paragraph 3.24, be introduced to allow more flexibility for consultants to move at reasonable intervals from one category of post to another.

3.10.2 Nothing in the following paragraphs shall impede consultants from moving from one category of post to another where the employer has no objection to any such request.

3.10.3 The category of post shall be determined by Comhairle na nOspidéal at the time of approval. The employer shall obtain the views of the Hospital Medical Board prior to submitting an application to Comhairle.

3.10.4 Consultants may apply to have the category of post changed at 5 year intervals. In the event that the employer does not accede to the request the matter will be referred to an agreed third party for a recommendation.

3.10.5 Where significant changes occur in a particular area in the delivery of acute hospital care, (e.g. - hospital closures) consultants shall be entitled to have their category of post reviewed within the 5 year period.

#### **4. REMUNERATION AND EXPENSES**

##### **4.1 Remuneration**

4.1.1 Remuneration of each consultant shall consist of payment in respect of the following three groups of services, namely:

- (i) the scheduled commitment, including his continuing responsibility for his patients, his extended duty liability for emergency cover (except as described below) and emergency services (except as described below)
- (ii) extended duty liability as described in paragraphs 4.3;
- (iii) emergency services as described in paragraphs 4.4 - 4.8.

4.1.2 Remuneration does not cover expenses incurred which shall be provided for separately.

4.2 The main part of a consultant's remuneration is in respect of sub-paragraph (i) of paragraph 4.1.1

##### **4.3 Extended Duty Liability**

4.3.1 The (employing authority) has a responsibility to provide clinical cover for emergencies arising within the hospital and for patients brought to the hospital for emergency treatment. The employing authority is responsible for arranging appropriate rosters for the provision of such cover.

4.3.2 Payment for extended duties shall be as follows:

- (i) to each consultant with an on call liability an amount of £\_\_\_\_\_ per annum
- (ii) in addition consultants on a 1:1, 1:2 and 1:3 roster will be paid £\_\_\_\_\_, £\_\_\_\_\_ and £\_\_\_\_\_ respectively.

4.3.3 Payment of these additional allowances will be implemented following the completion of a review of rosters recommended in paragraph 4.7 of the Review Body Report No. 36. These rosters will be reviewed at least once a year to ensure that they are being operated in the most cost effective and efficient manner possible.

##### **4.4 Emergency Services**

4.4.1 The third element of a consultant's remuneration, namely that referred to at sub-paragraph (iii) of paragraph 4.1 shall reflect the specific instances where he attends at the hospital for emergency duties arising from unscheduled work (other than that involving continuing responsibility, see paragraph 2.2) for eligible patients.

4.4.2 The consultant will be eligible for payment under this provision when he attends at the hospital after the end of his scheduled commitment in circumstances set out in paragraph 4.4.3

4.4.3 A consultant will be eligible for payment on a per call-out basis under this provision in respect of the specific instances when he attends at the hospital where the consultant is:

- (a) rostered for on-call duty and is contacted by another medical practitioner in the hospital, by a senior nurse or other member of the hospital staff specifically designated for that purpose and attends at the hospital to undertake emergency duties
- or
- (b) rostered for on-call duty and in the exercise of his professional judgement, the consultant attends at the hospital and performs clinical work of an urgent nature or carries out urgent diagnostic or therapeutic procedures.

4.4.4 If an employing authority considers that a consultant is making excessive claims for emergency services it may ask to have the matter considered under a complaints procedure. Likewise, if a consultant considers that an employing authority is acting unreasonably in relation to any claim made by him for emergency services he may ask to have the matter considered under a complaints procedure. It is expected that disputes arising would be settled at hospital level.

4.4.5 Where a consultant makes a domiciliary call or a call to another hospital for an eligible patient on the request of another doctor, payment shall be made except where the call is made during the period of the doctor's scheduled commitment, (but that period may be adjusted by the consultant to permit a visit to be made). This payment shall be on the basis of the equivalent payment per call-out.

4.4.6 The current rates applicable to the constituents of the remuneration package are set out in Appendix B.

##### **4.5 Additional Responsibilities**

4.5.1 It is recognised that additional responsibilities may arise for some consultants in relation to the management of a hospital, a service within or outside the hospital or a department or unit in a hospital. In such situations, the employing authority, in agreement with the consultant concerned, will arrange either to reduce the time-related commitment to clinical work in the case of a particular appointment, or alternatively, to compensate the consultant undertaking the additional work by paying him an appropriate allowance.

##### **4.6 Travelling and subsistence expenses**

Travelling and subsistence expenses necessarily incurred in the course of a consultant's duties shall be met on the basis applicable to persons of appropriate senior status in the public sector. The rates are detailed in Appendix C attached. Consultants holding joint appointments or appointments involving a commitment at more than one location will be re-



imbursed expenses in respect of travel between locations specified in the schedule which are agreed with the employing authority or authorities.

#### 4.7 Continuing Medical Education

It is the duty of each consultant to take the initiative in relation to a programme of continuing medical education relevant to his responsibilities both as a practising consultant and as a manager of resources. The extensive benefits that accrue from continuing medical education include the maintenance of the highest standards of service for patients, efficient network arrangements for patient care, rapid assessment of medical advances, and excellent training for non-consultant medical support staff. Employing authorities in recognition of the importance of continuing medical education for consultants, will provide, following consultation with individual consultants, an appropriate level of resources to facilitate the pursuance of continuing medical education on a systematic basis. The method of allowing for the expenses involved will be such as to facilitate and support the efforts of the consultant involved. In addition to the provision specified in Paragraph 4.15 of the Memorandum of Agreement attached to the 1991 Common Contract an additional £500 per head will be made available under the terms of this agreement.

### 5. NON-SALARY CONDITIONS OF EMPLOYMENT

#### 5.1 Disciplinary procedures

The disciplinary procedures are as set out in Appendix IV of the Contract.

#### 5.2 Age Limit

Each consultant holding a permanent appointment shall cease to hold such appointment on reaching the age of 65 years.

#### 5.3 Annual Leave

The annual leave entitlement for consultants is 31 working days per annum. The employing authority should ensure that a consultant is able to take his leave entitlement at reasonable times and in a reasonable manner.

#### 5.4 Sick Leave and Special Leave

5.4.1 Provisions which apply to permanent officers of Health Boards and Voluntary Hospitals and which are included at Appendix D in the case of sick leave, and Appendix E in the case of special leave, shall apply.

5.4.2 Special leave to provide services in countries whose health services are underdeveloped shall be available to consultants in accordance with the relevant Ministerial circular and with the agreement of the employing authority.

5.4.3 Sabbatical leave or Career Breaks shall be available to consultants in accordance with the terms of the relevant Ministerial circulars and with the agreement of the employing authority.

5.4.4 Maternity leave shall be available to consultants in accordance with the terms of the relevant Ministerial circular.

5.4.5 The procedures for the granting of leave for continuing education shall be such as to facilitate consultants in the planning of their continuing medical education. In most cases it should be possible to decide on study leave well in advance of the leave date.

#### 5.5 Public Holidays

Leave in respect of public holidays shall be granted in accordance with the Holidays (Employees) Act, 1973.

#### 5.6 Rest Days

Consultants with an on-call liability shall have an entitlement to avail of rest days on the following basis:

<b>Roster</b>	<b>Rest Day Entitlement*</b>
1 : 1	5
1 : 2	3
1 : 3	2
1 : 4	1

\* Days in lieu per four week period.

The rosters to be used for the calculation of rest day entitlements are those approved by hospital management to enable the hospital to provide emergency services. Where a dispute arises as to the need for sub-specialty rosters for emergency services, management will seek the advice of the medical board of the hospital on the need for such rosters.

Having regard to the agreed purpose of rest days, every effort should be made to take them as soon as possible following the on-call liability to which they relate. Where service demands do not permit them to be taken immediately, rest days may be accumulated for a maximum of six months from the earliest date of the on-call liability to which they relate. At that point they must be availed of or forfeited.

Alternatively, rest days may be accumulated for a maximum of three months from the earliest date of the on-call liability to which they relate. If it is not possible to avail of them at the end of the three month period the consultant may seek to be compensated for them at a rate equivalent to the daily rate for the category of post which he occupies.

### 5.7 Historic Rest Days

- 5.7.1 As an exceptional measure to dispose of the problem of accumulated rest day liabilities the following arrangements will be put in place.

A consultant holding this contract who wishes to establish an entitlement to be compensated in respect of rest days not taken up to 31 December 1997 must make an application to his employing authority by 30 June 1998. If he is able to satisfy the employing authority that

- (i) Rest days were not incorporated in his roster and
  - (ii) The number of rest days not taken are verified by the employing authority
- he shall be entitled to avail of time off in lieu on the following basis.

- 5.7.2 Subject to an agreed entitlement to a minimum of 63 accumulated rest days and a maximum of 250 accumulated rest days, a consultant will be entitled to a minimum of three months and a maximum of 12 months time off. An agreed entitlement to accumulated rest days between 63 and 250 days will entitle a consultant to a pro-rata benefit, e.g. 125 rest days is equivalent to six months time off. This leave is to be taken immediately prior to the consultant's retirement date.

A consultant signing this contract agrees to accept these provisions as a full and final settlement of any claim for compensation in respect of accumulated rest days.

### 5.8 Provision of Locums

- 5.8.1 The circumstances that require locum replacement vary for hospital, specialty, nature of practice and for other reasons from time to time. Where locum or alternative arrangements that are agreed to be satisfactory exist, they should continue. Consultants and hospital management will work together in the planning of leave arrangements to ensure that consultants who continually undertake onerous emergency duties in hospitals are in a position to obtain leave with locum cover. Consultants and hospital management will act in a responsible way in agreeing the circumstances in which locums will be provided and the extent to which cross cover (as defined at 5.7.3 below) and planned service reductions will obviate the need for such locums.

- 5.8.2 In the absence of a consultant who is availing of leave entitlements, his work will be undertaken by another consultant supplying either:

- (a) cross-cover; or
- (b) locum duties.

- 5.8.3 Where the leave is taken at such a time in hours, or at such a day, when the routine hospital consultant work is not performed or is not expected to be performed, then the consultant - substitute's work is in the nature of "cover"; the incumbent-consultant's patients are receiving consultant coverage for both therapeutic and medico-legal purposes, but no routine work is expected. This cross-cover may be undertaken by another consultant in the same hospital as the incumbent consultant taking that leave, providing the substitute-consultant is in a position to provide that cover without interference with his own work commitment. For example, a consultant on emergency surgical duty could not, from the very nature of his theatre commitment, be able to undertake ward emergency visiting or immediate post-operative care for another consultant on leave.

- 5.8.4 When the leave taken is on such a day or such a time when routine hospital consultant service work must be undertaken, the substitute consultant will be in the nature of a locum tenens to undertake such services and such work as would be undertaken were the incumbent consultant available. Should the leave-day be one of commitment to out-patients, casualty, acute or planned admissions, ward-rounds, operation sessions or lists - then, where available and when practical, a substitute-consultant should be employed to undertake these duties in order to maintain the service-commitment of the absent consultant and the productivity of the hospital. If, for valid and true reasons, a locum cannot be obtained and a consultant colleague has to undertake all or part of the absent consultant's work, other than that of cross-cover as defined, then that part of that consultant's work shall be regarded as that of a locum and remunerated accordingly.

- 5.8.5 A locum undertaking the full, routine, hospital duties of a consultant on leave need not have the same experience or qualifications as the absent consultant. For a doctor to be appointed consultant-locum in these circumstances, the consultant going on leave will be required to certify to the employing authority the suitability of the locum-consultant applicant. While a senior qualification in the specialty of the incumbent-consultant would be a desirable requirement for any locum tenens, in certain and unusual circumstances, in order to facilitate the leave of the incumbent-consultant, a locum-consultant without senior qualifications might have to be appointed for a short period, and the hospital work scheduling may then require restructuring.

- 5.8.6 The Department of Health & Children will circulate guidelines in relation to the remuneration and conditions for employment of locums which will cover matters such as:

- calculation of daily rates
- travelling expenses

- medical indemnity reimbursement
- registration fee reimbursement
- accommodation

These guidelines will facilitate the application of the appropriate terms and conditions by all employing authorities.

- 5.8.7 A special fund of £500,000 will be made available to employing authorities to address problems in providing locum cover.
- 5.8.8 Where there are persistent problems in giving effect to these provisions and these have not been resolved within the normal structures of the employing authority, recourse may be had to the Grievance and Disputes procedures outlined in Section 7 of the Memorandum of Agreement.

## **6 THE NATURE AND CONDUCT OF THE EMPLOYMENT RELATIONSHIP**

6.1 The roles and responsibilities of both parties to the contract as well as the various elements of the employment relationship need to be defined and agreed before they are expressed in the terms of the individual contract.

6.2 The contract, therefore, contains provisions which encompass agreed statements on the following:

- (i) the unique nature of consultant work;
- (ii) the nature of the consultant's role and responsibilities;
- (iii) the nature of the employing authority's role and responsibilities.

### **6.3 The Nature of Consultant Work**

- 6.3.1 The contents of this section must be read in conjunction with the definition of a consultant contained in paragraph 2.1.
- 6.3.2 Being a consultant involves taking responsibility in his own name for the diagnosis and treatment of his patients, or that aspect of care appropriate to him when consulted, without supervision of his clinical judgement. This is the essence of clinical independence.
- 6.3.3 Clinical independence derives from the concept of the specific relationship between the patient and the doctor in which the patient authorises and trusts the doctor(s) personally involved in his care to make clinical decisions in the patient's best interest and to take continuing responsibility for their consequences.
- 6.3.4 Clinical independence, like any freedom, exists only insofar as the limits within which it is exercised are known. These limits include e.g. patient consent, the law and standards of professional conduct and ethics.
- 6.3.5 The contract must, therefore, recognise and expressly protect the right of the patient to the independent judgement of his personal consultant except where appropriately transferred by that consultant.

### **6.4 The Nature of the Consultant's Role and Responsibility**

- 6.4.1 The core of the consultant's work is diagnosing, investigating, treating or prescribing treatment for his patients. This may be done on a direct personal basis or by prescribing treatment or other professional services e.g. physiotherapy, occupational therapy. This does not preclude the consultant assigning any aspect of the medical care of the patient to a doctor working under his supervision.
- 6.4.2 Insofar as the work of the consultant is created by the demand placed on the hospital for the provision of specialist hospital services the consultant can be seen as providing a service to patients on behalf of the hospital. The work arising for him from the hospital's accident and emergency service is an example of the service provided by a consultant to patients on behalf of the hospitals. The work arising for him from General Practitioner referrals or from secondary or tertiary referrals to the hospital, where the hospital has a defined responsibility of providing such a service, are other examples of services the consultant is asked to provide. It should be noted that regardless of the mode of referral, once a patient and doctor come into contact, then the relationship is a personal one between the patient and the doctor.
- 6.4.3 It can be seen from the description of the unique characteristics of consultant work that not alone does he provide some overall service to patients on behalf of the hospital to a population, he may also diagnose and treat patients directly referred to him personally. He may also wish, or be required, to undertake research and developmental work; to participate, as of right, in the selection process for Non-Consultant Hospital Doctors; engage in teaching and education; conduct private practice and engage in systematic evaluation or audit of medical work with colleagues.
- 6.4.4 To plan and schedule his work a consultant must in the first instance decide what the balance in his practice will be as between emergency and elective clinical work and his teaching research and other work. This is the basis for exercising his right to seek an appropriate level of resources and facilities to conduct his practice.
- 6.4.5 The exercise of these rights by a consultant carries a corresponding responsibility on the consultant, recognising the finite nature of resources, to operate and manage his practice in a manner which makes best use of available resources by scheduling his work and co-ordinating it with that of his colleagues. In the case of joint appointees, there is a need to co-ordinate his schedule with the needs of the other hospitals with which he is contracted.
- 6.4.6 By recognising the finite nature of the resources available to his practice, a consultant does not relinquish his role as advocate on behalf of his patients or patients waiting for consultation or treatment. In this contract, the process of

negotiation and re-negotiation of resource and activity levels between the consultant and the employing authority will provide a forum, in the first instance, for the consultant's advocacy role. Neither does it preclude the profession as a body advocating more or better services for patients.

- 6.4.7 The right and responsibility of the employing authority to know and understand the resource implications of diagnosing and treating existing patients or planning for the care of future patients will enable it to negotiate realistically with its consultants on how to make optimum use of existing resources, how best to re-deploy resources, plan most effectively for new services and finally to prepare estimates for additional resources if required.

#### 6.5 The Nature of the Employing Authority's Role and Responsibilities

- 6.5.1 The primary obligation on the employing authority in relation to its hospital services is to provide the range of services which best meets the needs of the population served by each of the hospitals' specialist services within the resources available to it. Existing contractual provisions in, and ethical principles and regulations specific to, individual non-Health Board hospitals will continue to apply.
- 6.5.2 In discharging this obligation the employing authority must, in consultation with the appropriate representative grouping(s) for its consultant staff, continue to assess and review these needs and adjust its policies and service plans accordingly.
- 6.5.3 This obligation confers on the employing authority a right, duty and responsibility to determine the range, type and volume of services to be provided by a hospital and to strive for the highest quality in its services. This includes a responsibility on the employing authority to agree with the appropriate representative grouping(s) for its consultant staff their arrangements for reviewing the quality of clinical work.
- 6.5.4 As the range, type and volume of the medical service provided by a hospital is the sum of the services provided by each individual consultant, it is clear that the employing authority has a responsibility to ensure that its overall hospital service plan, based on available resources, is reconciled with each individual consultant's service, teaching, research and other work. Services not provided as a consequence of a resource limit are the responsibility of the employing authority and not the consultant.

#### 6.6 Consultants in Management

- 6.6.1 For hospitals to operate in an efficient and effective manner it is necessary that decisions affecting patient care are taken as near as possible to the point of service delivery. Consultants need to be involved in the management process. This involvement commences with the consultant's responsibility to manage his own practice and will involve co-operation with colleagues and other health professionals, at department, unit, hospital or hospital group level, extending to involvement in the management of the hospital/hospital grouping through direct membership or representation on the hospital Executive Management Board.
- 6.6.2 Each hospital or hospital grouping will have an Executive Management Board, the precise constitution and role of which will depend on the structure and size of the hospital or hospital grouping. It is equally necessary that sub-Board structures are put in place to assist in the management process. The recent experience of the pilot projects in a number of hospitals confirms that the concept of a distinct unit, grouping the clinical functions together under the leadership of a selected consultant (e.g. a Clinical Directorate model), represents an effective model to facilitate the participation of Hospital Consultants in the management process.
- 6.6.3 It is agreed that (the employing authority) and the Consultants will work together, and will have the support of the Department of Health and Children, in identifying the most suitable management models for implementation in individual hospitals/hospital groupings.
- 6.6.4 It is acknowledged that the effectiveness of the leader of the unit is dependent not alone upon the calibre of the person appointed but upon the support, co-operation, and commitment of the members of the unit and of the Consultants in general. The leader of the unit will be appointed by management on the recommendation of the Consultants in the unit and should be for a fixed term, (e.g. 3 to 5 years) and involve the allocation of a number of designated sessions to fulfil his role.

#### 6.7 Clinical Audit

At the individual level the consultant's management responsibility will involve him in the process of clinical audit. While service plans and scheduling will identify service objectives and improve the use of resources to achieve them they do not address the issue of the qualitative assessment of the work undertaken. Having regard to the nature of clinical independence this assessment must be undertaken through a peer review system in which the confidentiality of the patient and the doctor is preserved. Each consultant will participate in creating and operating a clinical audit system. The employing authority will provide the necessary support and organisational systems, including where appropriate a regional audit system. The employing authority will have the right, subject to the above, and the normal protocols in relation to unpublished research work, to be involved at certain stages and to receive information relevant to the overall efficiency and effectiveness of the hospital.

**7. GRIEVANCE AND DISPUTES PROCEDURE**

7.1 Problems arising during the initial development period of the contract need to be dealt with. It is intended that, to the greatest extent possible, such problems should be addressed and resolved within the normal structures of the employing authority. In those exceptional cases in which resolution at local level provides impossible, a mechanism to discuss and resolve the problems is required. Such problems will be referred to a third party appointed by agreement between the parties to the negotiations as outlined in Appendix III of the Contract.

**8. REVIEW**

8.1 The parties to this agreement accept that consultants' remuneration and terms and conditions of employment should be reviewed on a regular basis. Accordingly, the Review Body on Higher Remuneration in the Public Sector should undertake such reviews as part of the general reviews undertaken by the Review Body from time to time.

## Comhairle na nOspidéal

## Guidelines relating to Joint Consultant Appointments by Two or More Authorities

January, 1985

In relation to the making of a joint appointment of a consultant by two or more authorities, the following stipulations should be strictly adhered to by each management authority involved and the holder of the appointment.

- 1 In the first instance, application for the appointment will have been made to the Comhairle by the authorities concerned on a joint written basis.
- 2 The appointment will have been structured by the Comhairle, as a joint appointment, the component commitments of which together (and not separately) constitute a viable appointment.
- 3 The appointment should be publicly advertised on a joint basis and a qualified candidate selected for appointment following interview by an interview board on which each of the participating authorities is represented as agreed by the authorities themselves. (This stipulation is subject to whatever regulations may be enacted by Dáil Éireann in relation to a common selection procedure for consultant appointments).
- 4 With regard to the making of a contract of employment (i.e. the common contract) between the successful candidate and the participating authorities, there are two options:-
  - (a) The authority with the major commitment may enter into a single contract with the successful candidate for the total commitment of the post in which event the contract must specify the commitments to the other participating authorities in accordance with the approval given by the Comhairle as provided for in paragraph 7.1 of the draft form of contract issued by the Department of Health. The wording of the contract should be approved by all participating authorities before it is entered into by the contracting authority.
  - (b) Each participating authority may, simultaneously, enter into separate contracts with the successful candidate for the relevant portion of the appointee's commitment, as approved by the Comhairle, in which event, cross reference must be made in each contract to the commitments to the other participating authorities as provided for in paragraph 7.1 of the draft form of contract issued by the Department of Health.

The choice of option as between (a) and (b) is a matter for agreement amongst the participating authorities.
- 5 Where a probationary period is involved, confirmation of appointment on its expiration must be subject to the agreement of all participating authorities. Failure to reach agreement by the participating authorities must result in the appointment not being confirmed and, depending on the wishes of the authorities involved, application being made to the Comhairle for a replacement appointment. It should be made clear to all candidates in the documentation relating to the appointment that they will be required to complete a probationary period to the satisfaction of each participating authority. In the latter respect, paragraph 11.1 of the draft form of contract issued by the Department should be expressed in the plural rather than the singular irrespective of where option 4(a) or 4(b) is adopted. Consultation should take place between the authorities concerned at regular intervals during the course of the probationary period. The decision as to whether or not the appointment is to be confirmed at the expiration of the probationary period should be made by each authority only after consultation with the management authorities of the other hospitals involved. As indicated above, a similar decision (i.e. to confirm, not to confirm, or to extend the probationary period) should be conveyed to the appointee by each management authority.
- 6 In respect of all joint consultant appointments irrespective of whether option (a) or (b) at 4 above is applied, each authority should exercise due regard to the joint nature of the appointment in all matters related to the discharge of his commitments to it by the holder of the joint appointment.
- 7 With regard to resignation or retirement, the holder of a joint appointment must act similarly in relation to each of his component commitments (e.g. he cannot retire or resign from one participating authority and not from the others).
- 8 Any proposal for a restructuring of a joint appointment must be subject to the agreement of the holder of the joint appointment and each of the participating authorities. Such a proposal is also subject to the approval of the Comhairle but it will not be considered by the Comhairle unless it is agreed by all concerned.

*Appendix D***Granting of Sick Leave**

- 1 A Chief Executive Officer may grant sick leave to an officer who is incapable of performing his duties owing to illness or physical injury if, and only if, the Chief Executive Officer is satisfied that there is a reasonable expectation that such officer will be able to resume the performance of his duties and, in the case of a temporary officer will be able to resume during his period of office.
- 2 The Chief Executive Officer may require an officer to submit himself to independent medical examination before he is granted sick leave and at any time during the continuance of sick leave granted to him.
- 3 The Chief Executive Officer may pay salary during sick leave to permanent officers in accordance with the following provisions.
  - (a) Except in the case mentioned in sub-paragraph (d) no salary shall be paid to an officer when the sick leave granted to such an officer during any continuous period of four years exceeds in the aggregate 365 days.
  - (b) Subject to limitation mentioned in sub-paragraph (a), salary may be paid to an officer at the full rate in respect of any days sick leave unless, by reason of such payment the period of sick leave during which such officer has been paid full salary would exceed 183 days during the twelve months ending on such day.
  - (c) Subject to the limitation mentioned in sub-paragraph (a) salary may be paid at half the full rate after salary has ceased by reason of the provision in sub-paragraph (b) to be paid at the full rate.
  - (d) If before the payment of salary ceases by reason of the provision in sub-paragraph (a) the Minister so consents, salary may be paid to a pensionable officer with not less than 10 years service notwithstanding the said sub-paragraph (a) at either half the full rate or at a rate estimated to be the rate of pension to which such officer would be entitled on retirement, whichever of such rates shall be the lesser.
  - (e) For the purposes of these provisions every day occurring within a continuous period of sick leave shall be reckoned as part of such period.
- 4 From the salary paid during sick leave to an officer who is an insured person within the meaning of the Social Welfare Acts, 1952 to 1968, there shall be deducted the amount of any payments to which such officer has become entitled under those Acts during the period of such sick leave.
- 5 The Chief Executive Officer may make appropriate salary payments during sick leave to a temporary officer if he considers that having regard to all the circumstances of the case, such payment is reasonable.
- 6 Where a permanent officer is suffering from tuberculosis and is undergoing treatment, the Chief Executive Officer may extend the foregoing provisions to allow the payment of salary at three quarters the full rate to the officer for the second six months of his illness and at half the full rate during the third six months of his illness.

*Appendix E***Special Leave**

CIRCUMSTANCES	CONDITIONS
1 When appointed by a Minister of State to be a member of any Commission, Committee of Statutory Board or a Director of a Company.	Special leave with pay to enable him to attend meetings of the body in question
2 When invited by the Local Appointments Commission, Civil Service Commission, a Government Department, a Health Board or a local or other public authority, to act on a selection board.	Special leave with pay to enable him to serve on the Board.
3 For annual training with the Defence Forces / Reserves.	One week with pay; excess over one week, without pay
4 Serious illness or death of a near relative.	Up to three days with pay.
5 When a candidate for a post, advertised by the Local Appointments Commission, Civil Service Commission, a Government Department, a Health Board or a local or other public authority.	A maximum of six days with pay in any one year, to enable him to appear before such selection board.
6 For attendance at courses, conferences, etc. approved by the Minister for Health and Children and which the employing authority is satisfied are relevant to the work on which the consultant is engaged.	Leave with pay.
7 For World Health Organisation or Council of Europe Fellowships.	Leave with pay.
8 To attend clinical meetings of societies appropriate to their specialties.	Not more than seven days with pay, in any one year (exclusive of travel time).

*Appendix F***Agreed Statement of the Chief Executive Officer of each Health Board**

"The exercise of my powers, as Chief Executive Officer, under section 14(3) of the Health Act, 1970, in respect of your contract of appointment as consultant under this health board, will be in accordance with the terms of this contract".



## **Annex B    Engagement of Consultants**

Prior to 1 January 2005, Comhairle na nOspidéal, which was established by Ministerial Regulations made under the Health Act 1970, was responsible for regulating the number and type of hospital consultants. Its responsibilities included, inter alia, responding to a hospital's request for a consultant post by assessing service needs and verifying that the request was valid. The Department played a role in this process by ensuring that qualifications were correct and providing sanction and funding for posts.

In line with the provisions of the Health Act 2004, Comhairle na nOspidéal was dissolved on 1 January 2005, and the HSE assumed responsibility on that date for the assessment, approval and funding of consultant posts. Recruitment to consultant posts in voluntary hospitals is handled directly by individual hospitals. The recruitment process in HSE hospitals is conducted through the Public Appointments Service, which was established under the Public Service (Management and Appointments) Act 2004, which allows the HSE to apply for a licence to recruit consultants directly.

Responsibility for the regulation of the number and type of consultant appointments in the publicly funded health services and for the specification of qualifications for consultant medical staff has been delegated to the National Director of the Office of the Chief Executive Officer of the HSE.

Consultant appointments can arise in a number of ways, including the need to replace an existing post-holder who has retired or resigned, or in response to service developments identified in the HSE's national service plan which outlines how the HSE plans to achieve its priority objectives in a given year and its plans for development of various services. Associated with these services is a range of new staff which often includes additional consultant posts. Each application is initially drawn up by the applicant hospital or agency and must include an outline of how the post fits in with relevant national, regional and local policy.

The HSE's approach seeks to ensure, as far as possible, that each appointment is structured in such a manner as to constitute a viable job which is likely to adequately serve the needs of patients and the hospitals concerned and to satisfy the appointee from a professional viewpoint. In addition to the direct patient care duties, teaching, research and administrative commitments are also taken into consideration. Decisions are made with the objective of providing high quality, safe health services in the context of Government policy, HSE service requirements and available funding.

Once a consultant post is approved, the average time taken to fill it is one year, though the period can vary and be as long as 18 months. It is often the case that the selected candidate is practising abroad which delays him or her taking up a consultant post in Ireland for a number of months following selection.

### **Types of Consultant Contracts**

Five different types of consultant are recognised in the contract documents. The vast majority fall into Categories I and II. The most significant distinction between the different contract types is in terms of the consultants capacity to engage in private practice whereby consultants can charge fees to their private patients in addition to receiving the agreed remuneration package. Consultants employed under Category I contracts are restricted in the extent of the treatments they can offer and are obliged to fulfil their contracted sessions within public hospitals. Category II consultants may engage in private practice both within public hospitals and also in their own consulting rooms. The types of contract are outlined in Figure B.1.

**Figure B.1**      **Types of Consultant Contract**

<b>Types of Contract</b>	<b>Weekly Commitment</b>	<b>Responsibilities</b>	<b>Proportion holding such Contracts</b>
Category I	11 fixed and flexible sessions (each session represents a notional 3 hours duration)	Obligated to devote whole of their time including time spent on private practices in Public Hospital(s). Also liable for extended duty and emergency services	60.0%
Category II	11 fixed and flexible sessions (each session represents a notional 3 hours duration)	May engage in private practice on and off-site. Also liable for extended duty and emergency services	32.1%
Geographical Wholetime without fees Category	Similar to Category I	Similar to Category I but right to engage in private practice is confined to the public hospital(s) in which they are employed	1.9%
Full-time Academic Consultant <sup>32</sup>	In accordance with the terms and conditions of the contract for academic consultant medical staff	Combined service and academic responsibilities are involved	5.6%
Part-time Consultants (Category II)	7 to 9 schedulable sessions and not less than 3	Similar to Category II	0%
Others <sup>33</sup>	Weekly commitments unknown	Responsibilities unknown	0.4%

Source: HSE Consultant Appointment Unit. (Percentages refer to contracts filled i.e. 1,789 in November 2006).

Consultants may be employed on a “joint-appointment” basis. This involves a commitment by a consultant to two or more employing authorities.

<sup>32</sup> This group of academic posts features a wide range of different contractual arrangements between the health service and educational partners.

<sup>33</sup> This category of consultant post refers to a small number of consultants, including Top Grade Biologists, who do not hold the Consultants' Contract 1997.

## Annex C Current Remuneration Arrangements

**Figure C.1 Remuneration for Consultants with effect from 1 December 2006**

Consultant Category	Description	Salary Amounts €
I	Psychiatrists in all HSE areas, Geriatricians in all HSE areas, Consultants in Palliative Care in all HSE areas, Consultants in HSE Midland Area, HSE North Western Area and HSE Western Area	178,429
	Consultants in the HSE Southern Area/Mid-Western Area/North Eastern Area/South Eastern Area (excluding Psychiatrists, Geriatricians and Consultants in Palliative Care)	169,452
	Consultants in the HSE Eastern Regional Area (excluding Psychiatrists, Geriatricians and Consultants in Palliative Care)	160,962
II	Psychiatrists in all HSE areas, Geriatricians in all HSE areas, Consultants in Palliative Care in all HSE areas, Consultants in HSE Midland Area, HSE North Western Area and HSE Western Area	159,269
	Consultants in the HSE Southern Area/Mid-Western Area/North Eastern Area/South Eastern Area (excluding Psychiatrists, Geriatricians and Consultants in Palliative Care)	151,251
	Consultants in the HSE Eastern Regional Area (excluding Psychiatrists, Geriatricians and Consultants in Palliative Care)	143,738
Geographical Wholetime Consultants without fees <sup>34</sup>		186,922

**Figure C.2 Remuneration for Masters with effect from 1 December 2006**

Salary of a Category I Consultant	Master's Allowance	Total
€	€	€
178,429	51,206	229,636

<sup>34</sup> This category of consultant is similar to Category I consultants but their right to engage in private practice is confined to the public hospital(s) in which they are employed.

**Figure C.3 Pay for Academic Consultants from 1 December 2006**

Consultant Category	Description	Salary Amounts
		€
I	Professor	229,637
	Associate Professor	212,653
	Lecturer	195,662
	College Lecturer	191,115
II	Professor UCD, TCD, RCSI	205,020
	Associate Professor UCD, TCD, RCSI	188,817
	Lecturer UCD, TCD, RCSI	170,714
	College Lecturer UCD, TCD, RCSI	166,161
	Professor UCC	212,716
	Associate Professor UCC	196,266
	Lecturer UCC	178,511
	College Lecturer UCC	173,960
	Professor UCG	220,408
	Associate Professor UCG	203,715
	Lecturer UCG	186,307
	College Lecturer UCG	181,753

**Figure C.4 Remuneration for Consultant Orthodontist from 1 December 2006**

	Salary Amount
	€
Consultant Orthodontists	169,452

**Figure C.5 Emergency Call-Out Payments from 1 December 2006**

<b>Per call-out</b>	<b>€</b>
First 30 call-outs	79.71
31-120 call-outs	119.90
121 call-outs or more	158.38
<b>If the call-out occurs after midnight</b>	
First 30 call-outs	106.26
31-120 call-outs	160.66
121 call-outs or more	212.65
<b>For each hour or part hour in excess of the first hour</b>	
First 30 call-outs	53.05
31-120 call-outs	79.17
121 call-outs or more	106.34
<b>Annual Limit</b>	<b>22,622</b>

**Figure C.6 On-Call payments from 1 December 2006**

<b>Rota</b>	<b>€</b>
Flat Annual Payment	3,912
In addition to the Flat Annual Payment further payments will be made to Consultants on more onerous rotas as follow	
<b>1 in 3</b>	2,266
<b>1 in 2</b>	1-80 call-outs 5,656
	81-120 call-outs 6,537
	121+ call-outs 7,159
<b>1 in 1</b>	1-80 call-outs 6,789
	81-120 call-outs 8,591
	121+ call-outs 10,609

## **Annex D    Key Recommendations of Recent Reports**

The Government's health service reform programme is informed by the recommendations of three reports completed in 2003. These are

- the Report of the Commission on Financial Management and Control Systems in the Health Service
- the Report on the Audit of Structures and Functions in the Health System
- the Report of the National Task Force on Medical Staffing.

All three reports identified alteration of the consultants' contract as being fundamental to the success of a health service reform programme and made recommendations for addressing contract weaknesses. Their main findings are outlined below.

## Report of the Commission on Financial Management and Control Systems in the Health Service

This report drew extensively from the Report of the Review Body on Higher Remuneration in the Public Sector - Report No. 36 - Hospital Consultants (1996) and restated many of its recommendations. It focused almost exclusively on the relationship between the consultant contract and the extent to which individual consultants can be held accountable for resource management and the performance of their duties. It linked contractual change to how the system itself is funded and suggested that the conflicts of interest inherent in a mixed public/private system can only be resolved by appointing consultants on the basis of a commitment to work exclusively in the public sector. It stated

*'just improving the systems of financial management and control will do little to improve the efficiency and effectiveness of health expenditure unless there is fundamental reform in how the system is organised and managed.'*

### Management of Resources

The report considered clinical consultants to be the key decision makers affecting expenditure in hospitals. While resource management was already provided for in the consultants' common contract, the report noted that

*'resource management responsibilities are not being systematically and uniformly discharged because of the absence of appropriate mechanisms for planning outputs and budgets and monitoring expenditure.'*

*'We find the wording in the contract relating to Consultants' responsibilities for resource management to be somewhat vague and lacking in explicit detail.'*

The report concluded that the consultants' common contract as it currently stands contains inherent weaknesses that impede the full application of general principles of financial accountability by clinicians. These include

- *'Consultants are not required to account for the cost of resources consumed as a direct consequence of their clinical decisions.'*
- *Existing arrangements allow Consultants to pursue both public and private practices (including during the 33-hour scheduled commitment under the consultants' public contract).*
- *The mixing of public and private treatments also restricts the time available to clinicians to pursue resource management issues.'*

### Clinical Independence and Accountability

The report notes that attempts to introduce cost reductions or to increase efficiency may be met with resistance because they are perceived to interfere with the clinical autonomy of consultants. It argues that clinical independence or autonomy is *'the distinctive feature of general hospital services which has defeated the application of conventional financial and management accounting systems to hospital expenditure in the past.'*

However, it is not clinical autonomy of itself that the report defined as being the problem, instead *'the major obstacle. . . appears to have been the interpretation put on clinical independence of Consultants.'*

### **Consultants as Managers**

Addressing the issue of how consultants could participate in management the report noted that

*'While examples of good practice exist, there are currently no system-wide mechanisms in general hospitals to engage clinical Consultants in the service planning process, in the preparation of associated budgets or in the evaluation of results against budget.'*

*'Experience has shown that where clinicians have been successfully engaged in management and planning within the hospital, benefits flow to all concerned. St. James' Hospital in Dublin is one location where a Clinical Directorate system has been successfully instituted. We note that the Review Body on Higher Remuneration suggested that lessons could be learned from locations where the Clinicians in Management initiative has been implemented.'*

It proposed the establishment in hospitals of an 'Executive Management Committee' which

*'involves representation of clinical Consultants in the management of the hospital. The Executive Management Committee will provide a forum for clinicians to have an input into, and be accountable for, managing the hospital resources and to discuss clinical and management concerns.'*

### **Budget-Holding by Consultants**

The report noted that those with authority to commit resources and incur expenditure, including consultants and General Practitioners, are not accountable for that expenditure and the outputs to be delivered. They

*'are not designated as budget holders or expenditure controllers. This absence of a system of structured accountability has far reaching consequences for the way the entire health care system is organised, financed, managed and controlled.'*

*'With an absence of full accountability throughout the system, there is no built-in mechanism that links clinical decision-making and its financial consequences to those who actually make the clinical decisions. As a result, the service is not providing, as a matter of routine, high-quality information on factors impacting on efficiency and effectiveness including clinical outputs and the costs involved.'*

It recommended that

*'The role of clinical Consultants and their staff must be widened to include financial accountability as well as clinical accountability so as to develop a more accountable, cost effective health service.'*

*'Systems of clinical budgeting at the level of individual clinical practices should be developed. Budgets should focus on producing targeted outputs for patients in the most cost effective way. These systems should identify the true economic cost of treating private patients.'*

### **Individual Consultant Accountability**

The report recommended that

*'clinical Consultants and their practices in individual clinical specialties be designated as the primary unit of accountability in the general hospital programme.'*

The rationale for this was



*'In addition to the direct costs of their practice, the indirect costs (of management/administration, overheads etc.) should also be apportioned on an agreed basis to the individual practices. The rationale for this approach is that hospitals exist to provide services to patients - all costs of running the hospital should therefore be attributable to the patients through the clinical Consultants who decide on their admission, treatment and discharge.'*

It recognised the need for unit planning to be integrated with hospital plans and the wider planning process.

### **The Existing Common Contract**

The report expressed concern at the lack of explicit detail in the consultants' contract concerning their time commitment to public patients.

*'For example, the contract does not require an individual Consultant to discharge his responsibilities to public patients personally.'*

*'The consultant may discharge this responsibility directly in a personal relationship with his patient, or, in the exercise of his clinical judgement, he may delegate aspects of the patient's care to other appropriate staff.'*

*'A consultant's time commitment, which will be personally discharged, will be scheduled in sessions during the hours normally worked within the Monday to Friday working week. The requirement to personally discharge all of the commitment does not preclude the consultant from delegating aspects of his scheduled work while the time commitment to (the employing authority) is being personally discharged elsewhere.'*

The report acknowledged that individual Consultants personally carry

*'the continuing responsibility for his patients so long as they remain in his care.'*

### **Enforcing the Existing Consultant Contract**

The report recommended that the provisions of the consultants' existing common contract should be enforced to ensure that the following is undertaken:

- *'The setting of core times when a Consultant must be available to patients in the public hospital; and*
- *Formal active monitoring of work commitment in respect of public patients.'*

Furthermore, each health board/hospital CEO should put mechanisms in place to ensure;

- *'Consultants' sessional contractual commitments to the public hospital are met; and*
- *The cap on private activity in public hospitals is observed both with respect to inpatients and day-cases (i.e. agree with Consultants on the number of private patients to be treated in public hospitals).'*

### **Public/Private Mix and the Consultant Contract**

The report commented on public/private mix as follows

*'The existing arrangements for mixing public and private treatments are inherently unsatisfactory from a management and control perspective. They result in a conflict of interest for Consultants between meeting clinical obligations to public patients on the one hand and, on the other, the prioritisation, treatment and the use of publicly provided infrastructure and resources in public hospitals for private*

*patients. They also raise issues of fair competition with private hospitals in that the resources used are not charged for fully. They severely limit the time the majority of clinicians have to pursue resource management. Ultimately, these issues can only be resolved fully by completely separating public and private practices.'*

It stated:

*'we recommend that all new public consultant appointments be on the basis of a commitment to work exclusively in the public sector.'*

It argued that this might not be too difficult to do, because

*'The progressive implementation of the EU Working Time Directive over the coming years is likely to give rise to recruitment of a large number of additional Consultants.'*

It noted that this presented a unique opportunity to

*'recruit a substantial proportion of Consultants on a "public-only" contract. This would go a substantial way towards addressing the conflict of interest issue identified above and make sufficient time available to Consultants to fully engage in financial management and practice budgeting.'*

It asserted that such a move would

*'be consistent with Government policy, as reflected in the health strategy, to target public resources towards public patients. In particular in the health strategy, the Government has decided that there will be a progressive reduction in the proportion of private to public beds in the public hospital setting.'*

### **Regulation of Consultant Posts**

The report recommended that a Health Services Executive be established and that this body subsume the functions and authority of Comhairle na nOspidéal in regard to the regulation of consultant posts

*'as, specifically, it will require authority to perform the following functions:*

- *To plan and manage the organisation of Consultant-led specialist services/hospitals throughout the State.*
- *To decide on the number and type of Consultant posts in each specialist service/hospital.'*

## Report on the Audit of Structures and Functions in the Health System

This report set out to make recommendations which ensure clear lines of accountability between each part of the health system, remove overlaps or duplication between organisations and align health service structures as a whole with the vision outlined in the Health Strategy.<sup>35</sup>

It made two key recommendations regarding consultants, as follows

- the consultants contract should be revised
- consultants' posts should be regulated by a single agency.

### **Revision of Consultant Contract**

Firstly, it recommended that the Government

*'Revise the Consultant Common Contract to ensure effective accountability for resources used.'*

In this regard it stated that

*'The areas that need to be strengthened in a revised Common Contract for Consultants will include the following:*

- *effective accountability for resources used;*
- *participation in managed clinical networks;*
- *flexible provision of clinical services;*
- *co-operation with clinical audit.*

### **Regulation of Consultant Posts by a Single Agency**

Secondly, it advocated continuing regulation of consultant posts on a national basis, noting

*'There is a clear rationale for relocating the functions of Comhairle na nOspidéal in the National Hospitals Agency'*

including

*'Regulating the number and type of appointments of consultant medical staff.'*

### **Clinicians in Management**

The report noted that the Clinicians in Management Programme *'appears to fall within the remit of the Office for Health Management, under the direction of the Personnel Management and Development Unit of the DoHC.'*

It recommended that the *'programme now needs to be extended, resourced and aligned with the Action Plan for People Management. Responsibility for the Programme should transfer to the HSE on establishment.'*

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<sup>35</sup> Quality and Fairness – A Health System For You (Department of Health and Children, 2001)

## Report of the National Task Force on Medical Staffing

The National Task Force on Medical Staffing was established to

- devise an implementation plan for reducing Non Consultant Hospital Doctors (NCHD) working hours in line with the European Working Time Directive (EWTD)
- plan for the implementation of a consultant-provided service
- address the medical education and training needs associated with the EWTD.

The National Task Force on Medical Staffing expanded the recommendations of the Forum on Medical Manpower (2001) (Forum Report) and highlighted the need for contractual change for consultants as a precursor to implementation of the EWTD and the appointment of large numbers of additional consultants. It also linked further investment in consultant posts and change in the acute hospital system to contractual reform.

The Task Force report recommended, inter alia, changes in the consultant contract, increased numbers of consultants and centralised regulation of consultant posts by a single agency.

### **A 'Consultant-Provided' Service**

The report concluded that

*'a team-based consultant-provided service is the only way to ensure high quality safe patient care and achieve compliance with the EWTD.'*

Before making recommendations regarding the kind of contractual change needed to support a consultant-provided service, the report defined such a service as *'a service delivered by teams of consultants, where the consultants have a substantial and direct involvement in the diagnosis, delivery of care and overall management of patients.'*

This contrasted with a *consultant-led* service, defined in the Health Strategy (2001) *'as a service supervised by consultants who lead and advise teams of doctors in training and other staff in the delivery of care to their patients.'*

### **Key Elements to a Consultant-Provided Service**

The report stated that in a consultant-provided service, the following key elements would apply

- *Teamwork*

*'consultants act as an integral part of a multi-disciplinary team, sharing responsibility for patients with consultant colleagues and working alongside other health professionals including NCHDs, nurses and health and social care professionals. A critical concern in teamworking is that a consultant would take important decisions regarding patient care, including treatment and discharge, during the absence of a consultant colleague. Further details of how consultant teamworking would operate in practice have been dealt with in previous reports'<sup>36</sup>,*

It also stated that

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<sup>36</sup> See the Forum report; the RCSI's document Consultant Surgeons: Team Working in Surgical Practice; and in the RCPCH's document The Next 10 Years, Educating Paediatricians for New Roles in the 21<sup>st</sup> Century.

*‘any implications that may arise for such areas as clinical autonomy in the context of teamworking will also require careful examination.’*

- *Appointment to a network rather than an individual hospital*

*‘consultants are appointed to a network of hospitals based in a region, as discussed in section 3.5<sup>37</sup>, with defined and agreed commitments to emergency, elective and OPD/day work’*

- *Rosters, nightwork and extended cover*

*‘in line with the Forum’s previous recommendations, consultants would participate in rostered work, night work and extended cover as required. In some instances, where clinical needs and caseload require it, this may involve an on-site consultant presence on a 24-hour basis. This would be tested in the pilot regions’*

- *Three types of on-site consultant staffing*

*‘consultant staffing would be organised by reference to the requirements of each specialty. As proposed in section 4.1<sup>37</sup>, this involves providing hospital care in line with three levels of staffing need, depending on the volume and nature of caseload. These comprise 24-hour on-site availability, frequent on-call and infrequent on-call’ (Section 3.3.3)<sup>37</sup>*

- *Older consultants have different work patterns*

*‘the working patterns and roles of individual consultants could be structured to take account of seniority and clinical experience. It might be expected, for example, that consultants would have fewer night time duties (work or on-call) as they become more senior, and that they could focus increasingly on such areas as management, training, continuing medical education and continuing professional development’ (Section 3.3.3)<sup>37</sup>*

- *Safeguarded time for management, training and CPD*

*‘as described below, there would be appropriate provision for specific aspects of consultants’ work including safeguarded training time, continuing professional development and management responsibilities.’*

In a later section, it noted that

*‘it is essential to safeguard training time for trainers and doctors in training in order to ensure that doctors receive top-quality training and that consultant trainers have adequate time to provide that training. This will be of particular importance in the context of a 48-hour week and should be factored into the new rostering arrangements . . .’*

### **A New Role/Contract for Consultants**

The report then implicitly referred to how a future consultant contract might set out the role of a consultant

*‘It is important to define the future role of consultants in a manner which*

- *is based on the concept of consultants working in teams;*
- *emphasises the need for consultants to have a substantial and direct involvement in all aspects of patient care;*

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<sup>37</sup> Refers to Report of the National Task Force on Medical Staffing (2003).

- *outlines the proportion of a consultant's time that would be spent delivering a clinical commitment, which can include in-patient workload, out-patient workload and inter-specialty consultations;*
- *offers scope for more flexible work practices, including rostering and cover arrangements;*
- *ensures participation in processes such as competence assurance, audit and revalidation;*
- *promotes an increasing level of clinical involvement in management programmes;*
- *provides safeguarded time for education and training of other staff, both medical and non medical;*
- *provides for participation in continuing medical education and research;*
- *further develops and clarifies the accountability and responsibility of consultants for the different facets of their work to patients, their peers and management;*
- *ensures that consultants are properly supported in their work with sufficient facilities (e.g. secretarial support and office space) and time for each aspect of their agreed workload.'*

### **Centralised Regulation of the Hospital Medical Workforce**

The report noted that while the numbers and grades of hospital doctors are among the most important determinants of the range of services a hospital can deliver

*'the current system of hospital medical workforce planning and regulation is not well integrated.'*

It also noted that it is necessary to ensure that

- *'there are close links between the numbers of medical posts needed and the numbers of doctors in training;*
- *there is an appropriate relationship between the numbers of each grade of medical staff; and*
- *the number (and qualifications) of all grades of medical staff are centrally regulated at a national level.'*

The report recommended that

- *'The medical workforce requirements of hospitals should be identified in detail by the proposed national hospitals authority.*
- *A unit should be established within the national hospitals authority to regulate the total hospital medical workforce and engage in detailed hospital medical workforce planning.'*

## Annex E Private Caseload 2005

Hospital	Percentage of Inpatient Beds Designated as Private/Semi-Private	Private as Percentage of Total Elective Inpatients	Private as Percentage of Total Emergency Inpatients	Private as Percentage of Total Elective Day Cases
Beaumont Hospital, Dublin	17	36	27	20
Coombe Women's Hospital, Dublin	31	46	31	56
Connolly Memorial Hospital, Blanchardstown	9	20	14	16
Mater Misericordiae University Hospital	10	28	23	11
Naas General Hospital	8	19	7	24
National Maternity Hospital, Holles Street	34	50	37	23
Our Lady's Hospital for Sick Children, Crumlin	22	37	31	39
Rotunda Hospital, Dublin	29	39	29	31
Royal Victoria Eye and Ear Hospital, Dublin	29	40	45	43
St Columcille's Hospital, Loughlinstown	17	19	10	46
St James's Hospital, Dublin	15	26	21	0
St Luke's Hospital, Rathgar	19	26	27	35
St Mary's Orthopaedic Hospital, Cappagh	9	19	12	0
St Michael's Hospital, Dun Laoghaire	26	30	15	29
St Vincent's Hospital, Elm Park	10	11	22	1
Adelaide and Meath Hospital, Dublin Incorporating the National Children's Hospital, Tallaght	26	45	34	38
The Children's University Hospital, Temple Street	19	36	32	38
Midland Regional Hospital, Mullingar	17	26	14	31
Midland Regional Hospital, Portlaoise	15	31	21	40
Midland Regional Hospital, Tullamore	15	30	18	30
Mid Western Regional Orthopaedic Hospital, Croom	25	51	33	68
Mid Western Regional Hospital, Ennis	19	26	19	15
Mid Western Regional Hospital, Dooradoyle	32	50	41	42
Mid Western Regional Hospital, Nenagh	21	30	17	47
Mid Western Regional Maternity Hospital, Limerick	24	29	31	0

Hospital	Percentage of Inpatient Beds Designated as Private/Semi-Private	Private as Percentage of Total Elective Inpatients	Private as Percentage of Total Emergency Inpatients	Private as Percentage of Total Elective Day Cases
St John's Hospital, Limerick	46	58	40	39
Louth County Hospital, Dundalk	21	34	27	38
Monaghan General Hospital	13	21	16	31
Cavan General Hospital	17	20	17	20
Our Lady of Lourdes Hospital, Drogheda	32	27	28	22
Our Lady's Hospital, Navan	12	36	23	43
Letterkenny General Hospital	19	17	8	11
Sligo General Hospital	23	30	20	30
Lourdes Orthopaedic Hospital, Kilcreene	11	29	0	40
Our Lady's Hospital, Cashel	24	33	25	32
St Josephs Hospital, Clonmel	22	26	22	33
St Luke's General Hospital, Kilkenny	17	28	25	19
Waterford Regional Hospital	22	36	25	38
Wexford General Hospital	18	27	21	15
Cork University Hospital	21	40	28	36
Erinville Hospital, Cork	43	30	14	33
Mallow General Hospital, Cork	19	43	26	45
Mercy University Hospital, Cork	31	48	30	41
South Infirmary-Victoria University Hospital, Cork	31	46	27	20
St Mary's Orthopaedic Hospital, Cork	24	35	50	57
Kerry General Hospital, Tralee	9	24	19	5
Mayo General Hospital	17	26	20	20
Merlin Park Regional Hospital, Galway	12	30	19	16
Portiuncula Hospital, Ballinasloe	28	39	29	37
Roscommon County Hospital	16	22	22	24
University College Hospital, Galway	21	31	23	14
<b>Totals</b>	<b>20</b>	<b>34</b>	<b>24</b>	<b>24</b>

Source: Department of Health and Children. Figures are based on HIPE data received to end of October 2006.

Note: Bantry General Hospital does not participate in the HIPE system.

The figures upon which this table is based are numbers of discharges. In HIPE Public /private status refers to the patient status on discharge and not to the type of bed occupied. Emergency is any patient needing immediate care and treatment as a result of severe, life threatening or potentially disabling condition. Generally the patient is admitted through A&E. Elective is the patient's condition permits adequate time to schedule the availability of suitable accommodation. An elective admission can be delayed without substantial risk to the health of individual. This data does not include any private hospitals.



## **Annex F    The Clinical Audit Model at Sligo General Hospital**

A clinical audit model has been piloted in Sligo General Hospital (SGH) since 1999. The responsibility for clinical audit rests with the specialties, while practical support, advice and training is provided by a centrally resourced multi-disciplinary Clinical Audit Support Team (CAST) which devotes the following resources to the processes

- A Clinical Audit Coordinator devotes two-thirds of his time
- 3.5 wholetime equivalent staff is devoted to clinical audit facilitation and 0.5 to assistance.

The team encourages and facilitates the development of clinical audit by

- providing education and practical support on best audit practice methodology
- helping to select topics for audit
- helping to identify and agree the criteria and standards to be used in each audit
- assisting with the collection and analysis of data
- assisting with drafting the audit report.

### **Reporting Arrangements**

A Hospital Clinical Audit Committee (HCAC) was established to develop and steer the clinical audit project. The multi-disciplinary HCAC is open to all clinicians, has an overseeing role and provides for accountability to the Hospital Management Committee (HMC).

The approach is “bottom-up” with the ownership of each audit and the ensuing “quality improvement cycle/change process” remaining with the specialty. The HCAC meets quarterly to receive a report from the CAST and also provides a forum for the presentation of completed audits. The HCAC advises the HMC of clinical audits undertaken.

### **Audit Methodology**

For each audit the specialty nominates a lead clinician and a small audit subgroup. These then agree with the Clinical Audit Team the level of support required by the specialty which can vary from topic selection to audit tool design to support for each audit stage if required. The processes include

- Audits are conducted with reference to an explicit, objective standard
- A search for information on best practice from national and international literature is an integral part of each audit
- Most audits identify some potential for change
- Practical mechanisms for change are identified
- An explicit action plan to obtain improvement is produced within six weeks of audit completion
- The implementation of recommendations is reviewable after six months
- Subsequent re-evaluation is an agreed part of the process.

### **Report of the Medical Council Working Group**

In 2002, SGH was selected as a pilot site to the Medical Council Working Group in Competence Assurance with a view to using the SGH clinical audit model to support hospital doctors in satisfying Competence Assurance requirements elsewhere. This group reported, in March 2004, that the multi-

disciplinary, multi-skilled nature of the CAST enabled clinicians to engage in systematic clinical audit at a level which was not possible prior to its establishment. It further commented that the level of clinical audit activity since 1999 has been a factor in developing a culture of quality improvement throughout the hospital and that it facilitates accountability and responsibility for quality in clinical care by providing a measure of this against objective standards.

## Annex G Good Practice Principles in Clinical Audit

The UK National Institute for Clinical Excellence has issued guidance<sup>38</sup> in regard to the preparation for clinical audit and the selection of criteria as follows

### Preparation

- Clinical audit is used to improve aspects of care in a wide variety of topics. It is also used in association with changes in systems of care, or to confirm that current practice meets the expected level of performance.
- Clinical audit projects are best conducted within a structured programme, with effective leadership, participation by all staff, and an emphasis on team working and support.
- Organisations must recognise that clinical audit requires appropriate funding.
- Organisations need to recognise that improvements in care resulting from clinical audit can increase costs.
- The participation of staff in selecting topics enables concerns about care to be reported and addressed. Participation in choice of topic is not always necessary, but may have a role in reducing resistance to change.
- The priorities of those receiving care can differ quite markedly from those of clinicians. Service users should therefore be involved in the clinical audit process.
- There are practical approaches for user involvement in all stages of audit, including the design, the collection of data about performance, and in implementing change.
- Organisations should ensure that their healthcare staff learn the skills of clinical audit.
- The most frequently cited barrier to successful clinical audit is the failure of organisations to provide sufficient protected time for healthcare teams.
- Those involved in organising audit programmes must consider various methods of engaging the full participation of all health service staff.

### Selecting Criteria

- Clinical audit can include assessment of the process and/or outcome of care. The choice depends on the topic and objectives of the audit.
- Explicit rather than implicit criteria should be preferred.
- Systematic methods should be used to derive criteria from evidence. These include methods for deriving criteria from good-quality guidelines or from reviews of the evidence.
- Criteria should relate to important aspects of care and be measurable.
- Provided that research evidence confirms that clinical care processes have an influence on outcome, measurement of the process of care is generally more sensitive and provides a direct measure of the quality of care.
- Measurement of outcome can be used to identify problems in care, provided outcomes are clear, influenced by process, and occur within a short period.
- Adjustment for case mix is generally required for comparing the outcomes of different providers.
- If the criteria incorporate, or are based on, the views of professionals or other groups, formal consensus methods are preferable.
- There is insufficient evidence to determine whether it is necessary to set target levels in performance in audit. However, reference to levels achieved in audits undertaken by other professionals is useful.
- In some audits, benchmarking techniques could help participants in audit to avoid setting unnecessarily low or unrealistically high target levels of performance.

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<sup>38</sup> Principles for Best Practice in Clinical Audit, Radcliffe Medical Press (2002)

## **Annex H     Arrangements for Clinical Incident Reporting**

A key feature of the Clinical Indemnity Scheme (CIS) is electronic incident reporting to a national database. The CIS has established and maintains a national database for “adverse clinical incidents” and “near-misses”<sup>39</sup>. A confidential web-based IT system (known as STARSweb) links hospitals and other healthcare enterprises to the CIS core database.

National rollout of the STARSweb system commenced in November 2003, and the majority of all acute sector enterprises and former health boards are now live on the system. Although the system has a primary claims management functionality, the clinical incident reporting feature is designed to support sharing of learning from both “near misses” and in the aftermath of serious “adverse clinical events”, at local and national levels. About 85,000 clinical incidents had been logged on the system up to December 2006.

### **Benefits Expected from Use of Reported Incidents Data**

Each enterprise has access to its own data only while the CIS has access to all incidents notified. Each case recorded can be reviewed individually. Based on this data, it is intended that the CIS, in conjunction with the enterprises, will be in a position to identify and analyse developing trends and patterns. Data can be manipulated to provide a wide range of report options. Any enterprise may use the system to benchmark itself against the national picture or as an aid for quality improvement initiatives within the enterprise. It is also intended to refine the data to allow benchmarking between hospital groups.

The CIS team review “red alert”<sup>40</sup> cases weekly and liaise with the State Claims Agency (SCA) risk advisors as required. Risk advisors follow up with the appropriate hospital when necessary, perhaps looking for the outcome of their risk review.

The CIS team plans to periodically circulate a newsletter, which will provide feedback on trend analysis and lessons learnt from case studies. A first edition was issued in November 2006. It also plans to publish anonymised data of trends and the top clinical risks for the HSE on their web site. Thus, STARSweb has the potential to be a significant learning tool but at the time of my examination many of these benefits had not yet been realised.

### **Quality Assurance of Data**

In order to assure the quality and integrity of data inputted on the system, the CIS, in partnership with HIQA and the HSE, is developing a quality assurance tool.

### **Training in the Use of STARSweb**

Once the infrastructure to support the system has been installed, each enterprise is invited to identify the staff who will be inputting data on to the system. SCA personnel deliver training at local venues. As at November 2006 training had been provided to almost 600 staff. To ensure sustainability, a “Train the Trainers” approach is being developed in conjunction with the HSE.

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<sup>39</sup> The STARSweb manual defines an “adverse incident” as an event arising as a consequence of provision of, or failure to provide clinical care that results in injury, disease, disability, death or prolonged hospital stay for the patient and a “near miss” as an incident that could have but did not result in an injury, disease, disability, death of a patient.

<sup>40</sup> “Red alert” cases are incidents which, in the opinion of the SCA risk advisor or the hospital may give rise to a claim due to the seriousness of the adverse outcome.

## **Annex I      Recognised Specialist Training Bodies**

In relation to each specialty, the Medical Council recognises the following thirteen bodies in Ireland for the purpose of granting evidence of satisfactory completion of specialist training

<b>Specialty</b>	<b>Recognised Specialist Training Body</b>
Anaesthesia	The College of Anaesthetists
Paediatrics	The Faculty of Paediatrics, Royal College of Physicians of Ireland
Emergency Medicine	The Irish Surgical Postgraduate Training Committee, Royal College of Surgeons in Ireland
Pathology	The Faculty of Pathology, Royal College of Physicians of Ireland
General Practice	The Irish College of General Practitioners
Psychiatry	The Irish Psychiatric Training Committee
Medicine	The Irish Committee on Higher Medical Training, Royal College of Physicians of Ireland
Public Health Medicine	The Faculty of Public Health Medicine, Royal College of Physicians of Ireland
Obstetrics and Gynaecology	The Institute of Obstetricians and Gynaecologists, Royal College of Physicians of Ireland
Radiology	The Faculty of Radiologists, Royal College of Surgeons in Ireland
Occupational Medicine	The Faculty of Occupational Medicine, Royal College of Physicians of Ireland
Surgery	Royal College of Surgeons in Ireland
Ophthalmology	The Irish College of Ophthalmologists

## Annex J Rights and Responsibilities Charter

Rights of Hospital Consultants	Responsibilities of Hospital Consultants
<p><b>The right to:</b></p> <ul style="list-style-type: none"> <li>• Independent practice within the ethical guidelines laid down by the Medical Council</li> <li>• Advocate for patients under my care</li> <li>• Ongoing Continuing Professional Development to ensure my clinical practice continues to be safe and effective</li> <li>• Meet with other consultants/clinicians as part of my contracted working week</li> <li>• Make a case, publicly if needs be, for my perceived view of the resources needed to safely and effectively treat patients under my care</li> <li>• Management information on the allocation and utilisation of resources to allow me to make my case</li> <li>• Access the Hospital Management and the Board of the hospital – via an agreed process</li> <li>• Make my views known to the medical representative on the Management Team and/or the Board of Management</li> <li>• Treat private patients within agreed hospital/national norms and guidelines</li> <li>• Be supported in my management of Human Resources and Financial Resources</li> <li>• Influence national policy in an appropriate manner</li> <li>• Be involved in government, statutory or regulatory bodies when the opportunity arises.</li> <li>• Receive resources and support for the Clinical Audit and Quality Improvement process.</li> </ul>	<p><b>The responsibility to:</b></p> <ul style="list-style-type: none"> <li>• Ensure my clinical practice is safe and effective</li> <li>• Take account of the impact of my clinical decisions on others, both other clinicians and their patients</li> <li>• Ensure that all team members and I communicate with patients and families respectfully and appropriately at all times</li> <li>• Actively participate in the Clinical Audit process</li> <li>• Contribute to the development of safe hospital systems</li> <li>• Work with the hospital management team in service planning and decision making</li> <li>• Organise my clinical practice to enable me to participate in hospital decision making without unduly impacting on hospital finances, level of service or patient care</li> <li>• In making public statements, consider the impact of my actions on the standing of my hospital in the system</li> <li>• Practice safely and ethically as a clinician, and participate in the Medical Council Competence Assurance Scheme</li> <li>• Act within agreed Service Plan provisions</li> <li>• Take account of the multi-disciplinary nature of care and respect the contributions of other disciplines to patient care</li> <li>• Take responsibility for the supervision and education of the NCHDs under my supervision; promote safe clinical practice and be cognisant of the budgetary implications of their practice</li> <li>• Contribute to the hospital's Clinical Governance system and processes</li> <li>• Maintain effective two-way communication systems with GPs</li> <li>• Communicate as appropriate with Public Health services, Mental Health services and Community Care services including the Primary Care Team.</li> </ul>

Rights of Hospital Managers	Responsibilities of Hospital Managers
<p><b>The right to:</b></p> <ul style="list-style-type: none"> <li>• Manage the hospital, in co-operation with consultants and all other disciplines</li> <li>• Make decisions regarding requests for additional resources in the context of overall resource availability and having consulted appropriately</li> <li>• Take the corporate view in making decisions (also a responsibility)</li> <li>• Manage implementation of the Consultant Contract</li> <li>• Information on patterns and outcomes of clinical practice by consultants</li> <li>• Be informed by consultants about any public statements they intend to make about the hospital</li> <li>• Develop Hospital Strategic and Service Plans</li> <li>• Seek to influence national policy</li> <li>• A respectful relationship with consultants and the consultants' representative bodies</li> <li>• Expect an efficient use of hospital beds and other resources</li> <li>• Ask consultants to participate in hospital planning and decision making</li> <li>• Ask consultants to organise themselves to achieve a) medical representation and b) medical coordination of services</li> <li>• Advocate on behalf of my hospital</li> <li>• Support Clinical Audit and Quality Review programmes within my hospital.</li> </ul>	<p><b>The responsibility to:</b></p> <ul style="list-style-type: none"> <li>• Meet with consultants, both individually and collectively, on an agreed periodic basis</li> <li>• Take account of the views of consultants in making decisions on resource allocation</li> <li>• Ensure the hospital consultants operate safe systems and monitor their practice on a regular basis via Clinical Audit and Quality Review</li> <li>• Manage the whole hospital as an integrated unit serving a population</li> <li>• Measure operational and organisation performance of the whole hospital to ensure it meets defined patient needs</li> <li>• Allocate resources efficiently and according to an agreed set of criteria</li> <li>• Facilitate consultant participation in hospital planning and decision making</li> <li>• Represent the interests of the hospital to the funding system in order to access the resources necessary to deliver services</li> <li>• Ensure data is available for hospital consultants to fully inform their decision-making</li> <li>• Ensure that all staff have the skills necessary to fulfil their roles within the hospital, in conjunction with appropriate professional heads of discipline</li> <li>• Ensure hospital HR policies and procedures are developed and implemented within good practice standards</li> <li>• Develop safe systems and ensure consultants contribute to and observe the safety of the systems within their own practice</li> <li>• Participate in Continuing Professional Development</li> <li>• Participate in clinical, operational and organisation audit of hospital management in relation to efficiency, effectiveness and patient safety</li> <li>• Support Consultants in their organisation of medical representation and coordination of services.</li> </ul>

Rights of Clinical Directors <sup>41</sup>	Responsibilities of Clinical Directors
<p><b>The right to:</b></p> <ul style="list-style-type: none"> <li>• Manage the Directorate (in co-operation with the rest of the hospital and in conjunction with the consultants and clinicians in my directorate)</li> <li>• Participate in the hospital Corporate Management structure</li> <li>• Contribute to hospital/organisation Strategic Plan and Service Plan</li> <li>• Be given the authority and appropriate resources to meet the goals of the Service Plan</li> <li>• Have the freedom to make decisions within the parameters of the organisation goals</li> <li>• Lead and manage the Directorate within the parameters of the hospital guidelines</li> <li>• Appropriate corporate support to enable me to fulfil my management role</li> <li>• Full and timely management information on the allocation and utilisation of resources within my Directorate and within the hospital</li> <li>• Information regarding clinical and planning operations of other Directorates</li> <li>• Access to the Hospital Manager and Board of the hospital</li> <li>• Access to ongoing management training and continuing professional development as a Clinical/Medical Director</li> <li>• Tap into a support network of other clinical directors nationally</li> <li>• Meet with colleagues and other Clinical/Medical Directors as part of my contracted working week</li> <li>• Recognition of the time required to fulfil the Clinical/Medical Director role</li> <li>• Receive additional secretarial support during my tenure as Clinical Director.</li> </ul>	<p><b>The responsibility to:</b></p> <ul style="list-style-type: none"> <li>• Contribute to the implementation of the Strategic Plan for the hospital/organisation</li> <li>• Consult with the multi-disciplinary team within my Directorate on the short-term goals and long term strategic direction of the Directorate</li> <li>• Produce an annual Service Plan for the Directorate, in conjunction with my Business Manager, within allocated budget</li> <li>• Engage the multi-disciplinary team within my Directorate in discussions on the service plan of the Directorate</li> <li>• Monitor, review and report on the implementation of the annual service plan for the Directorate</li> <li>• Manage within agreed resources for the Directorate and take such action as may be necessary to meet Service Plan targets</li> <li>• Ensure work of the Directorate is in line with best practice standards of care</li> <li>• Develop a multi-disciplinary team approach to the management of all clinical issues arising in the Directorate</li> <li>• Collaborate with the Business Manager and others to ensure continuous quality improvement in patient services</li> <li>• Audit clinical services to ensure the Directorate standards and performance are comparable with national/international benchmarks</li> <li>• Review case mix to identify decision drivers, implications, costs and impact on other Directorates</li> <li>• Provide clinical leadership across disciplines within the Directorate and across the hospital with other consultants</li> <li>• Support and assist a Hospital Consultant who needs to provide clinical care and treat a priority patient who falls outside the service plan.</li> </ul>

<sup>41</sup> The Clinical/Medical Director is a consultant involved in a wider managerial capacity within the hospital. It is assumed that the Clinical/Medical Director reports in a representative capacity to the hospital Chief Executive.