Chapter 39 Health Service Executive

Implementation of the Medical Consultants' Contract

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39.1 In July 2008, agreement was reached between the Health Service Executive (HSE) and the consultants' representative organisations on a new Consultant Contract (Consultant Contract 2008). The new contract positions consultants, for the first time, as employees – working under terms and conditions similar to those in place for workers across the health service. It brings about alterations in consultants' working hours, reporting relationships, the structure of their employment and the terms governing private practice. It also introduces disciplinary procedures for consultants similar to those applying to other employees.

Previous Review of Medical Consultants' Contract

39.2 In April 2007, a Special Report was published on an examination of the operation of the previous Medical Consultants' Contract. It reported on the extent to which the terms of that contract, agreed in 1997, were being implemented in the acute hospital sector. The report found that there was a persistent disagreement over a period of ten years in regard to the time commitment of consultants and there was little monitoring of the delivery of those commitments by hospital management.

39.3 In May 2008 the Public Accounts Committee of Dáil Éireann considered the findings of the examination. In its report[133] the Committee recommended that

- The new consultants' contract should provide absolute transparency on the time commitment to public hospital duty of consultant staff and that those commitments should be monitored and enforced in order to ensure that value is received for the salaries paid to consultants.
- The HSE should introduce a stringent monitoring regime of public and private caseloads in hospitals and data on the level of private practice in public hospitals should be published on a consultant by consultant basis.
- The terms of the 1997 contract should be strictly enforced in respect of those consultants who do not transfer to the new contract so that those consultants are seen to deliver services in accordance with their commitments.
- The contract implementation group, that will oversee the change process, should provide six-monthly progress reports to the Minister for Health and Children.

New Contractual Arrangements

39.4 Under the new arrangements there are four contract types as outlined in Figure 143.

[133] Dáil Éireann Committee of Public Accounts – Third Interim Report on the 2006 Report of the Comptroller and Auditor General – Expenditure on Health Services (November 2008).

Figure 143 Types of Consultant Contract under the New Contractual Arrangements

Type	
A	Consultants who work exclusively for the public hospital and are solely remunerated by way of salary.
B	Consultants who may engage in private practice including ▪ new entrants who may engage in limited private practice on-site in a ratio of 80% public to 20% private. ▪ existing consultants who may engage in private practice in a ratio of 70% public to 30% private practice and retain off-site out-patient private practice.
B*	Existing consultants who may engage in private practice in a ratio of 70% public to 30% private practice and retain off-site in-patient and out-patient private practice.
C	New consultants entitled to engage in off-site in-patient and out-patient private practice. (Only to be created in exceptional circumstances where there is a demonstrable benefit to the public health system).

39.5 The HSE was voted a Supplementary Estimate, amounting to €68 million in 2008. The bulk of this (about €65 million) was intended for payment of consultant's pay arrears arising from acceptance and implementation of the new contract terms. The payments did not take place in 2008 and under cash accounting rules governing voted expenditure, the funds were surrendered to the Exchequer. Payments on foot of the contracts began in May 2009. A provision of €91 million was allocated to meet them.

Key Provisions – Consultant Contract 2008

39.6 The principal features of Consultant Contract 2008 are as follows

- The 2008 contract defines the commitment of each consultant as a scheduled 37-hour week delivered over the period 8am – 8pm Monday to Friday, an increase of four hours on the previous scheduled working week. In addition, consultants can now be rostered to work on-site for up to five hours on Saturday, Sunday or public holidays.
- The contract provides for team working which comprises the provision of diagnoses, treatments and care to patients that are under the care of other consultants on the same team. This extends to discharge and further treatment arrangements in order to facilitate a more timely discharge of patients and speedier admission of patients to hospital.
- Each consultant is required to report to a Clinical Director who will, *inter alia*, prepare a Clinical Directorate Service Plan setting out how clinical services are to be delivered, how consultant resources are to be deployed and managed through rosters (with an emphasis in the short to medium term on the move to an 8am – 8pm day and obtaining value from the additional four hours of consultant time per week).
- Each consultant while remaining clinically independent in relation to decisions on the diagnosis, treatment and care of individual patients will now also be subject to the corporate policies and procedures of their employing hospital including, *inter alia*, clinical governance and patient safety initiatives, participation in competence assurance arrangements, operation of quality and risk frameworks, maintenance of risk registers, and provision of education and training to other clinicians.
- The Consultant Contract 2008 introduces a set of measures designed to improve equity for public patients, including a 20% limit on private practice for new consultants. Consultants who were previously employed under Consultant Contract 1997 may engage in up to 30% private practice. A common waiting list is to be introduced for out-patient diagnostics (including radiology and laboratory services). These services are subject to the permitted

public : private practice ratio and the employer must be satisfied that billing for these services reflects the permitted ratio.

Audit Focus

Critical to the successful management of change in this area are the following

- conclusion of contracts with a critical mass of consultants and verification that the centrally negotiated terms are applied
- confirmation that the time commitments are being reflected in on-the-ground rosters and that there are arrangements in place to confirm adherence to public : private ratios
- ensuring that clinical directorate models are in place and, where not, that interim arrangements sufficient to guarantee delivery of the new arrangements are in place
- enforcement of the delivery of commitments by those consultants who remain on the 1997 contract.

The audit sought to ascertain the progress made in regard to each of the above.

Audit Findings

39.7 In 2009, the consultant workforce was composed of a mix of permanent, temporary and locum appointees. The whole time equivalent workforce eligible for offer of Consultant Contract 2008 comprised 1,888 permanent employees and 312 locum or temporary employees – a total of 2,200.

39.8 By July 2009, 1,688 consultants out of the 1,888 permanent consultants had opted into the new contract arrangements. The breakdown in respect of these contracts was as outlined in Figure 144.

Figure 144 Filled Consultant Posts by Contract Type

Type	Number
A	629
B	703
B*	356
	1,688

This represents an acceptance rate of around 89%.

39.9 While a large majority of locum or temporary employees accepted the offer of Consultant Contract 2008, many of these have left health service employment, due to the expiry of their contracts by 1 June 2009.

39.10 The five Universities employing Academic Consultants have – from June 2009 – begun the offer of Consultant Contract 2008 to those consultants that are in their employment. At 7 July 2009, around 50% of Academic Consultants had accepted the terms of the new contracts.

39.11 Of 326 consultant posts created by the HSE between 1 March 2008 and 1 April 2009 (a 13 month period), 76 were Type A, 250 Type B and none Type C.

Verification of Adherence to Contract Terms

39.12 The HSE informed me that its Internal Audit Unit carried out a review to verify that the 1,667 contract documents as signed at March 2009 had not been altered from the agreed standard contract.

39.13 In regard to the scope of the work carried out, the review was at a high level but examined all contracts issued and accepted by consultants employed in the HSE and HSE funded agencies. Each contract was reviewed to identify any alterations to the standard terms and conditions contained in the *pro forma* contract agreed with the medical representative bodies in July 2008.

39.14 The review found

- The vast majority of contracts signed by consultants and authorised by the employer were in accordance with the standard terms and conditions.
- A relatively small percentage of contracts had been signed as approved by the employer prior to being issued to the employee (none of these contained any anomalies).
- A small percentage of contracts were not physically signed as authorised by the employer, but these were included in the employer's records as issued contracts.
- A very small number of contracts did contain manual amendments relating to the treatment of private out-patients, however, these were not found to materially affect the standard terms and conditions.

39.15 In regard to the extent of deviations found by Internal Audit, the Accounting Officer informed me that deviations were limited to a small number of contracts signed by the consultant but not signed or authorised by the Hospital Manager or CEO and two instances where consultants had signed a contract categorised as Type C – even though Type C was not on offer to those consultants.

Rostered Time Commitments and Private Work

39.16 HSE Human Resources (HR) Directorate conducted a verification of work schedules to ensure that they reflected a 37-hour commitment and an additional four scheduled hours dedicated to clinical work including

- the service gain resulting from the increase from 33 to 37 scheduled weekly working hours
- the extent of service delivery over an extended working day as required (8am to 8pm in contrast to 9am to 5pm)
- the introduction of scheduled overtime on Saturdays, Sundays or bank holidays in place of C Factor payments[134] for duties performed by consultants on-site while on-call outside their scheduled hours, the service gain arising and cost basis for same
- measurement arrangements regarding each of the consultant's clinical activities, including in-patient, daycase, out-patient and diagnostics
- the extent to which there is compliance with the specified ratio of public : private practice
- the extent to which a single waiting list for out-patient diagnostics has been introduced.

[134] These relate to payments, on a per call-out basis, for the provision of on-site services by a consultant while on-call outside their scheduled 37-hour week commitment.

39.17 The extent to which work schedules were compliant with the agreed changes was recorded as part of the verification process. Only complete schedules were verified while incomplete schedules were set aside for revision and further review. The further review has now been completed.

39.18 The Accounting Officer informed me that the verification by HR was undertaken immediately after the deadline for acceptance of Consultant Contract 2008 in order to ensure that key elements of the contract were in place prior to payments being made thereunder. The verification exercise entailed confirming the presence of each of the elements rather than recording the extent of same.

39.19 A small number of hospitals are still dealing with data collection difficulties, particularly with the reporting of on-site private out-patient department activity and diagnostics. Consultants in these hospitals have been asked to supply details of their private practice activity but this has not been provided to date. This is being followed up by the Hospital Managers in the particular hospitals concerned. Further discussions are continuing with the Dublin Maternity Hospitals on the particular requirements of the Maternity service for the measurement of private practice.

39.20 The HSE National Hospitals Office (NHO) is currently progressing the introduction of a common waiting list in out-patient diagnostics.

Monitoring Private Practice

39.21 Since September 2008, the HSE has introduced systems for reporting public and private in-patient and daycase activity on a consultant by consultant basis. Reports from these systems – which record individual consultant public and private practice in relation to in-patients, daycases, out-patients and diagnostics are being produced. Currently, these monthly reports are five months in arrears. The HSE informed me that it will be able to report the percentage of eligible consultants operating within the limits specified by Consultant Contract 2008 in addition to overall compliance at hospital level in the second half of 2009. At that point, the information will begin to be used to inform the decisions of clinical directorates.

39.22 The report will be circulated to the Clinical Director and the Hospital Manager and an overall status report will be prepared for internal HSE monitoring and management purposes and shared with the Department and the representative associations of consultants.

39.23 The Accounting Officer stated that a key requirement for the implementation of Consultant Contract 2008 was the monitoring of private practice activity by consultants individually. Prior to, during and since the verification exercise, new measurement systems had been developed in order to fulfil this requirement in the manner set out in the Contract negotiations, i.e. measuring clinical activity adjusted for case mix. The features of the measurement system included

- The development of the measurement system in conjunction with the Economic and Social Research Institute (ESRI). This has now been introduced in the 49 acute hospitals through the Hospital In-Patient Enquiry (HIPE) System[135]. The measurement system records in-patient and day case activity (as weighted for casemix[136]) by consultant and reports on the level of private practice on a monthly basis.

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135 The HIPE System collects demographic, clinical and administrative data on patients in acute general hospitals nationally.

136 Casemix provides a means for standardising data collected on activity and costs within acute hospitals, so that meaningful comparisons can be made between different areas of activity and different hospitals.

- Residual activity which is not yet captured by the HIPE system including details of on-site private out-patient activity and certain diagnostic activity is being collected manually by the hospitals as an interim measure pending the development of automated data collection systems.
- There is an inevitable time lag (minimum of 4 months) in providing reports, due to the time required for coding activity from the patient charts. The first measurement reports covering the January 2009 activity period were coming on stream in mid 2009 and have been issued to individual consultants.
- These reports are being prepared for the attention of Clinical Directors and Hospital Managers for compliance monitoring purposes.

39.24 Consultants have been receiving individualised reports each month since the beginning of 2009.

Implementation and Operation of Clinical Directorates

39.25 The revised arrangements make provision for a new service wide senior management position – that of Clinical Director. Clinical Directors are expected to

- ensure that service standards and governance requirements are met
- monitor and manage the public : private mix
- develop and manage consultants' rosters, deal with grievances and disputes
- manage the initial stages of the disciplinary process and
- help organise medical education and training.

39.26 In December 2008, the HSE commenced the appointment process for Clinical Directors. As of 1 July 2009, 46 Clinical Directors had been appointed across the hospital system from amongst those consultants who accepted the Consultant Contract 2008. The HSE expect further Clinical Director appointments to be made over the next two years as services evolve.

39.27 Clinical Directors appointed under Consultant Contract 2008 receive an allowance of €50,000 per annum.

39.28 Work has not commenced on the verification of the operation of Clinical Directorates. The terms of reference for an audit have yet to be agreed. It is intended that it will concentrate on evidence available to support increased working hours, improved flexibility in accessing theatres, improved discharge rates, compliance with agreed public : private ratios, reduced waiting times in Emergency Departments.

39.29 The Accounting Officer stated that changes are being implemented by local and regional hospital management with support and guidance from HR and the NHO. In relation to change management, the HSE is currently pursuing an integrated services programme which entails the appointment of Regional Operations Directors and Clinical Directors in key areas. The Clinical Directors – appointed under Consultant Contract 2008 are taking lead roles in aligning services to patient need, meeting care and quality standards and structuring consultant commitments accordingly. Clinical Directors function as senior managers in the larger hospitals reporting at hospital or regional level.

39.30 Prior to the introduction of Consultant Contract 2008, there were a range of Clinical Director, Medical Director and other clinical leadership posts in place, under historical local arrangements in various hospital and community settings. There was little consistency in the roles

assigned to those posts and in most instances, consultants holding them did not have a management role in relation to other consultants. Consultants who held remunerated leadership roles under Consultant Contract 1997 may retain those roles and receive payments under Consultant Contract 2008 pro-rata to their payments under Consultant Contract 1997. The number of consultants benefiting from these arrangements are not maintained centrally and were not available at the time of the review.

39.31 The Accounting Officer informed me that in many instances consultants holding Clinical Director or other leadership roles under the previous contract has either secured new appointments as Clinical Directors under Consultant Contract 2008 or has taken a different role in new management structures. Where that had not happened, management were seeking to build on the benefits associated with the consultant's existing role, align it to the new management structures and ensure maximum cost effectiveness.

Consultants who remain on Previous Contracts

39.32 Consultants who remain on Consultant Contract 1997, the Academic Consultant Contract 1998, the Consultant Contract 1991 or previous contractual arrangements will not be subject to the terms and conditions of Consultant Contract 2008. The HSE stated that they will, however, be required to work closely with Clinical Directors as senior managers in the health service. The HSE has informed me that it anticipated that approximately 200 consultants would remain on their previous contractual arrangements.

39.33 The HSE has stated that it will ensure consistency in application of the various contractual arrangements applying to consultants. In relation to Consultant Contract 1997 and the Academic Contract 1998, this will include full implementation of those provisions relating to the consultant's time commitment to the public hospital and to their entitlement to engage in private practice. The HSE has indicated that it will commence implementation of these provisions once initial payments under Consultant Contract 2008 are completed.

Conclusions

89% of permanent consultants have opted into the new contract arrangements. Work has been done to ensure that the contracts signed by hospitals accord with the standard terms and that schedules incorporate the extra time commitment negotiated.

Arrangements to monitor private practice, introduce changes associated with the Clinical Directorate model and monitor contractual compliance for consultants who remain on contractual arrangements that predate Consultant Contract 2008 have yet to be bedded in.

The HSE needs to push ahead with arrangements to verify that the envisaged gains resulting from increased resource availability and changed management processes are being realised in practice.