# Consultants – Implementing the Public Service Agreement

***17th September 2012***

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## Context for health service management proposals

The Government has indicated the unprecedented nature and scale of the financial pressures facing the state. The complexity of the task of putting the public finances on a sustainable footing is evident to all parties. The public health service must deal with an effective reduction in resources in 2013 of some €750m and a reduction in staff numbers of some 6,500 WTE staff over the next two years.

As we move into the next phase of implementation of the Public Service Agreement 2010-2014 (PSA) it is vital that health service makes best use of the flexibility and efficiencies contained within the Agreement.

A key challenge is to give effect to the spirit of the Agreement by ensuring that the maximum possible is achieved. A key priority for the Government is sustaining the largest possible quantum of existing service while maintaining essential supports to those dependent on the public health system.

The Health Sectoral Agreement constitutes a key element of the PSA. It emphasises that the required reorganisation of health services and the health service workforce will focus on providing, across all settings, planned services over an extended (8 a.m. to 8 p.m.) day on a Monday to Friday basis and/or five over seven day basis, while also providing emergency services on a 24-hour 7-day basis.

This requires achieving a more productive match between staffing and service activity levels while safeguarding quality and clinical performance. It will entail demonstrable changes in Consultants' attendance patterns, clinical and non-clinical work practices and reporting relationships. Health service management is therefore proposing the immediate implementation of the measures described at Section 5 below.

## 1. Putting the Public Service Agreement into effect in the health sector

The Health Sectoral Agreement constitutes a key element of the Public Service Agreement 2010-2014 (PSA).

It notes that over the coming years, the population will continue to grow and age, and the factors impacting on demand for services (such as the incidence of cancer and chronic diseases) will increase. At the same time, the numbers working in the health services will reduce. Against this background of reduced budgets and workforces, the challenge therefore is not only to maintain the level, quality and safety of services but to expand the range of services that can be easily accessed by patients and clients in their own communities so as to avoid them having to attend hospital.

It emphasises that the required reorganisation of health services and the health service workforce will focus on:

- providing, across all settings, planned services over an extended (8 a.m. to 8 p.m.) day on a Monday to Friday basis and/or five over seven day basis, while also providing emergency services on a 24-hour 7-day basis, thereby reducing the staffing and other resources required at nights and weekends;
- achieving a more productive match between staffing and service activity levels across the working day/week/year while safeguarding quality and clinical performance;

The 2012 Health Service Action Plan – agreed as part of PSA implementation – is designed to facilitate the fast-tracking of measures required to deliver essential health and personal social services across the country within the context of further reductions in funding and staff numbers.

The Plan acknowledges there will be an unavoidable impact on frontline service delivery in 2012 because of the scale of the reductions in funding and employee numbers but commits to an acceleration of changes in service delivery/care models and work practices to mitigate the impact on services to the greatest extent possible. In this regard, the Plan identifies a number of priority actions in respect of Consultants.

## 2. The consultation and implementation process

This document sets out how those priority actions are to be implemented. It identifies key objectives for the public health service and the changes to Consultants' work patterns and practices required to achieve those objectives.

Implementation will be challenging for Consultants, managers and other health service employees. Taking that into account, each of the elements of the management team – Department of Health, the Health Service Executive and the Department of Public Expenditure and Reform wish to ensure that implementation is informed by a detailed consultation process and full engagement with the Irish Hospital Consultants Association and Irish Medical Organisation.

The PSA sets out a process and time frames for consultation and implementation and the management team intends to follow this process and timeframe. Any disagreement which arises in relation to this process and the subsequent implementation process will be referred to the LRC and the Labour Court for resolution within the terms of the Public Service Agreement[1].

[1] Paragraph 1.24 of the Public Service Agreement 2010 – 2014 provides that "Where the parties involved cannot reach agreement in discussions on any matter under the terms of this agreement within 6 weeks, or another timeframe set by the Implementation Body to reflect the circumstances or nature of the particular matter, the matter will be referred by either side to the LRC and if necessary to the Labour Court…. The outcome from the industrial relations or arbitration process will be final. Such determination(s) will be made within 4 weeks, or another timeframe set by the Implementation Body to reflect the circumstances or nature of the particular matter."

## 3. Best use of resources

One of the earliest decisions taken by the Government was to reduce the pay of the Taoiseach, Ministers and senior public servants. Subsequently, in June 2011, the Government introduced a public service pay cap of €200,000 per annum. The Government agreed at that time to defer consideration of the remuneration of hospital Consultants, at the request of the Minister for Health. This was intended to allow the Minister time to establish whether it would be possible instead to agree changes in the working hours and work practices of Consultants which would, in particular, support the work of the Special Delivery Unit and the HSE's Clinical Programmes in increasing efficiency and delivering faster access by patients to services and consequential reductions in expenditure based on these productivity changes.

Currently the State is borrowing over €1.25 billion every month to pay our ongoing expenses. This excludes any banking related expenditure. We are borrowing from the European Union (EU)/ International Monetary Fund (IMF) to continue funding our public services, our pay costs, pensions and social welfare benefits.

In 2012 spending on Health will amount to almost 30% of overall current expenditure. In this context the need to reduce costs and maximise the return for patient services and patient care from expenditure incurred has never been so great. The Public Service Agreement is a key enabler of this process.

Based on data available to the HSE the total spend on pay within Consultant grades in 2011 was approximately €475m. Of this figure approximately €434m was spent on basic pay and a further €39m on variable pay, comprising on-call, standby, sessional payments and allowances.

Taking this into account, a key measure of whether the Public Service Agreement has been implemented in relation to Consultants will be the delivery of greater productivity and measurable co-operation with major reform and efficiency measures. While these are being implemented, it is recognised that the determination of the range, volume and type of services to be provided and responsibility for the provision of same within available resources rests with the Employer. Services not provided as a consequence of a resource limit are the responsibility of the Employer and not the Consultant.

## 4. Shared objectives

Health service management and Consultants share common objectives. We recognise that underlying the provision of a high quality and safe health service is the requirement that patient care is delivered by the appropriate staff, twenty-four hours a day, seven days a week. A key challenge for the health service is to ensure that the way in which services are delivered directly relates to the needs of patients and service users.

Patients must – if they are to avoid long waiting times and adverse impacts on the quality and outcome of care - receive the right care, at the right time – over the full 24/7 period - from staff appropriate to and trained for the best possible management of each patient's condition. It follows that we must organise our services on a 24/7 basis and ensure that staffing is appropriate to patient needs over the full 24/7 period. This will entail demonstrable changes in Consultants' attendance patterns, clinical and non-clinical work practices and reporting relationships.

We must also ensure that care is delivered in the right place – in a setting with the capacity and capability to meet the needs of the patient. Should the patient require it, they must be transferred directly to the location most capable of providing them with appropriate care. Such locations require on-site availability of senior clinical decision-makers, including Consultants, over an extended working day for many and on a 24/7 basis for some. This means that Consultants must be available to respond directly to emergency activity and attendances, that patients do not experience unnecessary delays and that all those using our services have simple and direct access to the person best placed to decide how their care is to be delivered.

## 5. Changes required from Consultants

Taking this into account, management are seeking the agreement of Consultants – with particular reference to the need to provide high quality, safe care described above - to the immediate implementation of the following as part of the implementation of the PSA and specifically the Health Service Action Plan 2012:

### i) Measures to improve patient care

a. Implementation of the work programme of the Special Delivery Unit (SDU) and the National Clinical Programmes including the use of an outcome-based approach focusing on patient access times, quality measures and efficient and cost-effective use of resources. This includes the use of new information and data management systems as part of the process of patient care.

b. Participate in delivery of reductions in patient waiting time in Emergency Departments in line with targets set by the SDU on behalf of the Minister with particular reference to the implementation of the Emergency Medicine Programme.

c. A series of measures designed to improve patient flow through the hospital system (Appendix I refers) with the potential to deliver a saving of 220,000 bed days per annum, including:
   i. when the appropriate admitting Consultant is rostered on-site, the decision to admit the acute patient shall be made by the Consultant or Senior Clinical Decision maker. In the absence of a Consultant, the decision to admit is to be made by a Specialist / Senior Registrar / Registrar;
   ii. as part of implementation of the National Clinical Programmes, the Consultant Physician / Surgeon on-call available day of on-call to the Emergency Department / AMAU / MAU with no conflicting commitments and available for consultation and instruction the following day;
   iii. Consultants to undertake daily or more frequent early-morning ward / board rounds as required - to ensure implementation of the 'home by 11am' objective;
   iv. Consultant Physicians to implement a 24-hour turnaround time for consultations
   v. implementation of team-based working as provided for in Consultant Contract 2008 (irrespective of the Consultant's individual contract);
   vi. documented introduction of discharge arrangements that facilitate discharge by other Consultant 'firms';
   vii. implementation of standardised 7-day and weekend discharge arrangements with planning starting on admission;
   viii. daily diagnostic reporting for patients requiring acute care.
   ix. provision of 2-4 rapid access Out-patient Department slots to the Acute Medical Unit and Emergency Department;
   x. implementation as required of a full capacity response – as described in the Full Capacity Protocol developed as part of the Emergency Medicine Programme - including a rapid review of all potential discharges in response to surge in bed occupancy.

### ii) Changes in Consultant work patterns to ensure Consultant presence at busy times

a. a review of existing Consultant rosters / work schedules to ensure:
   i. a greater scheduled Consultant presence from Consultants in General Medicine, General Surgery, Paediatrics and others in Emergency Departments;
   ii. best use of Consultant hours where access to operating or other facilities is restricted;

b. changes in work location as determined by the Clinical Director / Employer with reference to the appropriate structuring of Consultant posts and the relevant Consultant Contract to support implementation of the Smaller Hospitals Framework., which will set out what services can and should be delivered safely by these hospitals in the interests of better outcomes for patients.

c. Full implementation of the flexibilities arising from the 8am-8pm working day and 5/7 working already agreed as part of the PSA, meaning that where necessary, Consultant rosters can be realigned to ensure a rostered Consultant presence as part of the multidisciplinary team on-site on Saturdays and Sundays in line with the volume, frequency or acuity of workload in acute services. Each hospital / agency will determine at local level the appropriate means of implementing rosters within the parameters described below:

i. Monday – Friday working

For a cohort of Consultants this will continue to involve delivery of services Monday to Friday as part of the 37/33 hour week with provision of on-call outside such hours and potential for structured overtime on Saturdays, Sundays and bank holidays. This will involve:

- delivery of the 37/33 hour commitment across a span of 12 hours between the hours of 8am-8pm Monday to Friday;
- the Consultant will not be obliged to work more than 8 hours in any one day, structured as a single continuous episode;
- scheduling arrangements may be changed from time to within the 8am to 8pm period in line with clinical and/or service need as determined by the Clinical Director on behalf of the Employer in consultation with the Consultant;
- in addition, the Consultant may be required to participate in the on-call roster or structured overtime as determined by the Clinical Director on behalf of the Employer and such participation will continue to attract the payment arrangements provided for under the Consultant's contract;
- participation in the on-call roster will include attendance on-site as required to review patients recently admitted, those who have deteriorated or who are ready for discharge. In this context, board rounds and pre-defined discharge arrangements may apply;
- where the Consultant is required to provide structured overtime of up to 5 hours on Saturdays, Sundays and bank holidays, this will be as decided by the Clinical Director;
- the Clinical Director will have regard to each Consultant's seniority, particular specialist skills and other relevant factors when determining roster requirements;
- the Consultant will be liable to participate 5/7 or 24/7 rostering and where such changes is required, the provisions at b) or c) below will apply.

ii. 5/7 working

A further cohort of Consultants will regularly be required to deliver part of their standard 37/33 hour commitment on Saturday and Sunday. Such rostering will be based on international (UK / Australasia) norms for specialist staffing, availability of appropriate NCHD staffing, availability of multi-disciplinary supports and the frequency, volume and acuity of workload. This will involve:

- delivery of the 37/33 hour commitment across a span of 12 hours between the hours of 8am-8pm Monday to Sunday;
- the Consultant will not be obliged to work more than 8 hours in any one day, structured as a single continuous episode;
- the two days on which the Consultant is rostered off will be continuous;
- scheduling arrangements may be changed from time to within the 8am to 8pm period in line with clinical and/or service need as determined by the Clinical Director on behalf of the Employer in consultation with the Consultant;
- in addition, the Consultant may be required to participate in the on-call roster or structured overtime as determined by the Clinical Director on behalf of the Employer and such participation will continue to attract the payment arrangements provided for under the Consultant's contract;
- where the Consultant is required to provide structured overtime of up to 5 hours on Saturdays, Sundays and bank holidays, this will be as decided by the Clinical Director;

- the Consultant required to provide part of their 37/33 hour commitment on Saturday or Sunday will not be expected to do so or to provide on-call on more than a 1 in 5 basis;
- the Clinical Director will have regard to each Consultant's seniority, particular specialist skills and other relevant factors when determining roster requirements;
- where the Consultant works hours as part of the 37/33 hour commitment and 5/7 roster, the Consultant will be eligible for premium rates in accordance with public health sector norms.

iii. 24/7 rostering

In some settings (e.g. Emergency Medicine, ICU, Neonatology, Obstetrics) and locations Consultants will be required to participate in 24/7 rostering. Such rostering will be based on international (UK / Australasia) norms for specialist staffing, availability of appropriate NCHD staffing, availability of multi-disciplinary supports and the frequency, volume and acuity of workload. This will involve:

- delivery of the 37/33 hour commitment during the span of the 24 hour day, Monday to Sunday to ensure a rostered on-site consultant presence over the 24/7 period;
- 65-75% of the Consultant's time will involve clinical activity with the remainder allocated to other on-site activities;
- the Consultant will not be obliged to work more than 8 hours in any one day, structured as a single continuous episode;
- the two days on which the Consultant is rostered off will be continuous;
- scheduling arrangements may be changed from time to within the 8am to 8pm period in line with clinical and/or service need as determined by the Clinical Director on behalf of the Employer in consultation with the Consultant;
- participation in 24/7 rostering is recognised as being more onerous than the standard model of service delivery;
- Consultants participating in 24/7 rostering will not be required to participate in on-call or structured overtime;
- the Clinical Director will have regard to each Consultant's seniority, particular specialist skills and other relevant factors when determining roster requirements;
- where the Consultant works hours as part of the 37/33 hour commitment and 24/7 roster the Consultant will be eligible for premium rates in accordance with public health sector norms.

iv. Implementation of such changed work patterns will as necessary entail designation of Saturday, Sunday and bank holidays as part of the 5/7 week. The 'structured hours' payment will not apply on a day on which the Consultant is rostered to work as part of the 5/7 week;

v. Participation in cost-effective provision of on-call and call-out services, including implementation of a time-limit on claims for payment of C-factor which requires that claims must be made – where the Consultant is rostered on-duty and available to make the claim and other than in exceptional circumstances - no later than three months from the earliest date of the on-call liability to which they relate or they are forfeited.

**iii) Measures to promote equity of access for public patients**

Implementation of measures that ensure public patients waiting for elective care of any type are seen within clinically appropriate timeframes and the entirety of the Consultant's clinical activity, including in-patient, day-patient and out-patient activity, is within contractual limits. In such circumstances, the Consultant will continue to complete all aspects of the claim form in a timely manner as set out at Section 5 vii) b below. Additionally, all parties will agree that the current methodology and process for private practice measurement will be accepted as a minimum base for the purpose of determining compliance with contractual commitments on private practice and the parties are committed to developing the system to include the appropriate range of clinical activity.

**iv) A consistent reporting relationship and accountability to Clinical Directors**

Consultant Contract 2008 introduced the role and post of Clinical Director in order to ensure implementation of key aspects of the contract, drive clinical performance and the delivery of high quality, safe patient care and align the organisation of clinical care with the delivery of services internationally. Since 2008, over 50 Clinical Director posts have been created and Clinical Directors now hold a key place in revised organisational structures.

In order to give best effect to these developments, it is required that each Consultant report to their relevant Clinical Director, including reporting in relation to:

- work schedules, performance, annual leave, cross-cover arrangements;
- compliance with contractual limitations on private practice (including consultants employed under Consultant Contract 1991, Consultant Contract 1997, Academic Contract 1998 and Consultant Contract 2008) and associated measures designed to ensure appropriate access to public health services by public patients;

The Commission notes that Management may delegate the reporting relationship of Consultants employed under Consultant Contract 1997 and other contracts from the CEO to the Clinical Director where a Clinical Director has been appointed.

**v) A strengthened management role for Clinical Directors**

a. The role of the Clinical Director will be strengthened to reflect the senior management role held by such individuals. This will include:
   i. responsibility for driving improved clinical performance;
   ii. responsibility for leading on clinical issues on behalf of the employer as appropriate;
   iii. authority to determine the composition of Consultant teams and associated responsibilities;
   iv. authority to specify work schedules and how each Consultants' commitments will be discharged to ensure the most appropriate and cost-effective delivery of services;
   v. authority to deploy Consultants to other hospitals and change the location at which Consultants deliver scheduled inpatient, outpatient, daycase or diagnostic services to support changes in the roles of hospitals;
   vi. authority to deploy - in partnership with other senior managers - resources including nursing and diagnostic staff - to respond to organisational priorities;
   vii. responsibility for implementation of standardised leave scheduling, cross cover and other policies to ensure Consultant cover is maintained at all times;
   viii. responsibility for demonstrating that public patient access to the full range of public hospital services is determined solely by clinical need / priority and not insurance status; and for ensuring compliance with contractual limits on private practice.
   ix. responsibility for driving compliance with the European Working Time Directive and implementation of associated measures designed to reduce NCHD working hours.
   x. In order for a Consultant to be appointed to a Clinical Director post, (s)he must have accepted the reporting relationship to the Clinical Director outlined above.

**vi) Changes to support improved Community and Mental Health services**

a. For those Consultants working in the Community sector, cooperation with revised accountability arrangements to support efficient provision of services relating to the management of elderly patients and others requiring community supports, including home help, respite, step-down and long-term care.

b. For those Consultants working in or in conjunction with the Mental Health Services, implementation of A Vision for Change (Appendix II refers), with particular emphasis on:
   i. Facilitating the creation and enhancement of General Adult Community Mental Health Teams (CMHTs) and Child and Adolescent Community Mental Health Teams to include amalgamation/reconfiguration to serve populations of 50,000 in line with Vision recommendations, merging of existing teams/WTEs across all disciplines to

enhance availability of Allied Health Professionals; and ensuring that all Health Professionals are managed and deployed as part of the Community Mental Health Team, managed by the Area Mental Health Management Team.

ii. Realignment of mental health catchment areas to reflect HSE Areas;
iii. Facilitating the second filling of the posts of Executive Clinical Director (ECD);
iv. cooperating with measures to ensure that where a Clinical Director post falls vacant due to retirement or resignation or is vacant on the ECD taking post, the functions of Clinical Director under the Mental Health Act, 2001 form part of the responsibility of the Executive Clinical Director. It is noted that transitional arrangements may be required to ensure compliance with the requirements of the Mental Health Act 2001;
v. working to ensure the inclusion of Allied Health Professionals as active members of the multidisciplinary HSE Area Mental Health Management Teams in managing the mental health services and the inclusion of the Service User Representative on the multidisciplinary HSE Area Mental Health Management Teams according to the recommendations of A Vision for Change.
vi. Facilitating the flexible deployment of all staff across mental health services and settings.
vii. Agree and facilitate the implementation of protocols to ensure:
    - the provision of Child and Adolescent Mental Health Services across the full age range under 18 in each HSE Area;
    - unambiguous access to Mental Health Services across the full spectrum of care for service users, including but not limited to older people, individuals with special needs and people who are homeless with a mental health issue;
    - unambiguous access to Mental Health Services across the full spectrum of care for service users, irrespective of domicile or geographic presentation;
    - Implementation of multidisciplinary care planning for each service user across all mental health services to incorporate all multidisciplinary input into a single care plan.

**vii) Timely and efficient management of private patients**

Consultant facilitation and implementation of measures to support collection of income arising from the treatment of private patients in public hospitals, including:

a. A commitment from all Consultants to fully complete and sign private insurance forms within 14 days of receipt of all the relevant documentation. The purpose of this provision is to effect a significant reduction in outstanding income due to the public health system. Persistent failure to comply will be addressed by the employer and it is noted that the employer has full authority to take the steps necessary to resolve the matter.

b. Co-operation with the Secondary Consultant scheme whereby a secondary Consultant involved in a case can sign the claim form if the primary consultant has not signed within a reasonable timeframe. The current timeframe in operation with the VHI is claims older than three months. Health service management wish to reduce this and the timeframes operated by other health insurers to one month and commit to supporting Consultants to achieve their responsibilities in this regard.

c. Co-operation with the implementation of electronic claim preparation and submission in the manner required by the insurer (the HSE has recently awarded a tender for the introduction of an electronic claims management system in eleven of its key hospitals).

d. Co-operate with the implementation of reasonable changes that may be introduced to generate and collect additional income.

**viii) Leadership and support for reducing NCHD hours in line with the EWTD**

Support for the implementation – as part of the Consultant's role regarding responsibility for the diagnosis, treatment and care provided by NCHDs - of required revisions to NCHD work patterns and reductions in NCHD working hours to comply with provisions of the European

Working Time Directive (EWTD), including ward-based rostering, use of cross cover at SHO level, replacement of NCHD hours by Advanced Nurse / Midwifery Practitioner hours where appropriate, transfer of certain duties to other staff and other measures as set out in Ireland's 2012 plan to drive EWTD compliance.

**ix) Delivering high quality and effective medical education and training**

Consultants make an important and significant commitment to medical education and training. This commitment is a valuable part of the work of the Consultant and contributes significantly to staff development and patient care. In this context, management wish to introduce a mechanism to record such activities and - in line with the HSE's statutory and contractual responsibilities regarding medical education and training and professional competence - to direct them. The following is therefore required:

a. Where the Consultant contributes in a structured manner to or receives any remuneration associated with the education, training and supervision of students, non-Consultant Hospital Doctors and trainee professionals including members of the multi-disciplinary team totalling more than two hours per week this commitment must be specified in terms of purpose, affiliated Medical School or Training body and role.

b. Such commitments must be agreed with the Clinical Director and notified to the HSE Medical Education and Training Unit.

c. Each Medical School and postgraduate training body will be requested to report annually to HSE MET on the arrangements it has in place with Consultants as above. In relation to these arrangements, the report will address scale and scope, utility and effectiveness and recommendations for development. These reports will be reviewed by HSE MET in conjunction with the relevant Clinical Directors with a view to ensuring the effectiveness of these arrangements, while ensuring minimal impact on service delivery.

d. While medical students and doctors in specialist training will be the principal responsibility of Consultants in terms of the issues identified above, other health professionals in training may from time to time fall within its scope.

e. Currently, each Consultant receives an individualised Continuing Medical Education grant of €3,000 per annum. This grant is vouched and expenditure is not subject to any contractual limits nor guidelines relating to expenditure.

   The Medical Practitioners Act 2007 and Consultant Contract 2008 oblige health service employers to facilitate the professional competence of Consultants in their employ. The Management position is that public funding targeted at Continuing Medical Education for Consultants must be utilised and managed in a manner that is aligned with legislative requirements, is transparent, measurable, ensures value for money and is provided through appropriate structures.

   To ensure that the substantial investment in continuing medical education for consultants by the HSE meets those criteria, management is proposing that this funding be managed directly by the HSE instead of being used to support a range of personalised grants. This will mean that Consultants will no longer receive the annual grant of €3,000 per annum.

   The changed arrangement will entail the HSE funding – via the Postgraduate Medical Training bodies - arrangements for the provision of appropriate professional competence supports for Consultants working within the public health service. This will include supports that enable Consultants to access CME internationally including attendance at international meetings and other activities as appropriate. Funding would be allocated via contractual frameworks agreed between the HSE and postgraduate training bodies at national level and would deliver savings through economies of scale and the focusing of expenditure on targeted professional competence supports.

Current arrangements will remain in place pending introduction of the revised arrangements and the consultation and implementation process will include further engagement with the Consultant representative organisations.

**x) Remuneration**

In line with the Government Decision to implement a public service annual pay cap of €200,000, paragraph 1.15 of the PSA states that "there will be no further reductions in the pay rates of serving public servants for the lifetime of this agreement". The parties recognise and accept that the protections arising from the PSA pertain to the pay rates of medical Consultants as of 1st January 2010.

Revised remuneration rates for application to new appointees to Consultant grades which currently attract remuneration rates in excess of the public service pay cap will be published as part of public service pay scales.

**xi) Ongoing flexibility and reform**

The measures specified in this document or any related agreement are not exhaustive and all parties will commit to continuing engagement with the evolving process of health service reform, at both service and structural level, during the lifetime of the Public Service Agreement 2010 – 2014.

## 6. Conclusion

Amending our rostering, staffing and support structures to provide the appropriate level of care over the full 24/7 period will prove difficult and must be implemented with regard to the existing volume and complexity of clinical activity, the priority accorded to emergency vs elective workload and the availability of appropriate support services and staff - including diagnostic and theatre services.

Nevertheless, the PSA and the related Health Sector Action Plan provides us with an agreed basis to work on. The measures outlined above will allow us to expand the level of patient access to Consultant-provided services. This will significantly improve how we respond to patient need in both hospital and community settings. Both parties are committed to using this agreement reached by the parties proactively and in a positive way at local and national levels to deliver better services for patients.

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## Appendix I – Measures to improve Patient Flow

### 1. Objectives

Set out below are specific requirements with respect to patient flow including weekend discharging. These measures are intended to deliver

- Prompt patient review and plan of clinical care (eliminates the “lost hours prior to senior review”)
- Proper immediate streaming of patients into Short stay or specialty, etc- allows for Consultant to Consultant discussion.
- Prompt essential diagnostic ordering.
- Prompt identification of complex vs non complex discharge issues and subsequent referral to MDT/ other colleagues.
- Prompt discharge plan in place (where possible) and an estimated discharge date (EDD) documented in the health care record and discussed with the patient and family.
- Prompt decision and documenting of the identifiable criteria that the patient must meet for discharge.

### 2. Approach to Weekend Discharge

- Patients for discharge at the weekend should be identified at the Consultant ward round on each Thurs /Friday am.
- The patients discharge plan should be documented by the Consultant / Registrar in the Patients health care record.
- All relevant discharge documentation including prescription, GP letter medical certificate and any referrals for ongoing services should be completed by the primary team at this time.
- The list of proposed discharges for each Consultant must be submitted by the SHO / Intern to the Bed Management Office /General Managers Office /CEO’s office by 14:00 hours each Friday.
- When the proposed list of weekend discharges is complete this will in turn be circulated to
    - the Bed Management Office and Assistant Director of Nursing in charge for the weekend
    - all Wards to ensure proactive weekend discharge planning – The Nurse in Charge of each ward will contact Bed Management with the confirmed and potential discharges on the day
    - the duty office for the weekend for collection by the On-call Weekend Consultant / Registrar.
- All Patients for weekend discharge should also be identified on the visual white board in each ward.
- On each Saturday / Sunday the on-call Medical Registrar who is reporting for duty will review and discharge relevant patients in accordance with the weekend discharge plan.
- Any Deviations from the discharge plan should be discussed with the on-call Consultant of the day.

It is noted that discharge planning is the responsibility of all Health Care professionals involved on the delivery of care

## Appendix II – Actions for Mental Health under the PSA Health Sector Action Plan

**"4.6 Mental Health Services**

**4.6.1 - Implementation of A Vision for Change:-**

- Facilitate the creation and enhancement of General Adult Community Mental Health Teams (CMHTs) and Child and Adolescent Community Mental Health Teams to include:-
  - Amalgamation/reconfiguration to serve populations of 50,000 in line with Vision recommendations
  - Facilitate the merging of existing teams/WTEs across all disciplines to enhance availability of Allied Health Professionals
  - Ensure that all Health Professionals are managed and deployed as part of the Community Mental Health Team, managed by the Area Mental Health Management Team
  - Provide all necessary data in relation to the management and functioning of Community Mental Health Teams to include Key Performance Indicators and other data as required in a timely fashion.
  - Implement the Clinical Care Programmes for Mental Health when agreed.

- Realignment of mental health catchment areas to reflect HSE Areas

- Establishment of the HSE Area Mental Health Management Team:-
  - Facilitate the second filling of the posts of Executive Clinical Director (ECD)
  - Where a Clinical Director post falls vacant due to retirement or resignation or is vacant on the ECD taking post, to accept that the functions of Clinical Director under the Mental Health Act, 2001 form part of the responsibility of the Executive Clinical Director
  - Inclusion of Allied Health Professionals as active members of the multidisciplinary HSE Area Mental Health Management Teams in managing the mental health services.
  - Inclusion of the Service User Representative on the multidisciplinary HSE Area Mental Health Management Teams according to the recommendations of A Vision for Change.

- Facilitate the flexible deployment of all staff across mental health services and settings:-
  - Facilitate deployment within the HSE Area to support service objectives
  - Facilitate deployment to critical service areas
  - Co-operation in moving across service settings or into new infrastructure
  - Support the review and amendment of rostering arrangements to maximise service efficiencies, to provide appropriate and safe staffing levels, to provide continuity of care to the service user and to reduce reliance on overtime and agency arrangements within the mental health services.

- Statutory Obligations under the Mental Health Act, 2001
  - Mental Health Tribunals – support the cost efficient delivery of Mental Health Tribunals

- Support and identify opportunities to explore skill mix arrangements to release skilled professional staff for deployment to best meet service user need.

- Support streamlined pathways of care for service users:
  - Agree and facilitate the implementation of protocols to ensure the provision of Child and Adolescent Mental Health Services across the full age range under 18 in each HSE Area.
  - Agree and facilitate the implementation of protocols to ensure the provision of Child and Adolescent Mental Health Services across the full age range under 18 in each HSE Area irrespective of the domicile arrangements or area of clinical presentation.

- Agree and facilitate the implementation of protocols to ensure unambiguous access to Mental Health Services across the full spectrum of care for service users, including but not limited to older people, individuals with special needs, people who are homeless with a mental health issue
- Agree and facilitate the implementation of protocols to ensure unambiguous access to Mental Health Services across the full spectrum of care for service users, irrespective of domicile or geographic presentation.

- Implementation of multidisciplinary care planning for each service user across all mental health services to incorporate all multidisciplinary input into a single care plan."