Plan to progress measures required to ensure EWTD compliance
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1. Background and Introduction

This document sets out key data relating to the current non-consultant hospital doctor (NCHD) workforce, working hours and related European Working Time Directive (EWTD) compliance; and describes the extent to which measures identified previously as improving EWTD compliance have been implemented in the period since January 2010 and measures in train and planned to achieve compliance. It builds on the Report submitted to the Commission in January 2010. Where certain paragraphs of the Report are reproduced, this is to aid understanding of the scale of the change required.

In the Report the HSE indicated that a series of studies had identified measures which, if implemented, would facilitate EWTD implementation. While there has been significant progress in some of these, such as the development of medical education and training, implementation of reductions in tiered on-call and introduction of cross-cover arrangements, it has not been possible to implement other measures or they have not yet resulted in significant changes in NCHD working-hours.

For example, while there has been large-scale change in the contractual arrangements applying to NCHDs, there has not been meaningful change in rostering arrangements due to ongoing negotiations with the doctors’ representative body, the Irish Medical Organisation (IMO). Similarly, while there have been increases in consultant numbers to address identified service deficits, for the most part these have not been in the areas or specialties that would promote NCHD hours reduction. Changes in consultant rostering have also not been put into effect on a service-wide basis.

The changes in the organisation of acute services which are required to achieve compliance in a number of hospital sites need to be progressed. While some reorganisation of services has been undertaken in specific smaller hospitals, this has not been on the scale required to satisfy legislative requirements regarding working-time.

The Government is committed to a programme of radical reform of the health system. In particular, there will be early changes to the governance of acute hospitals. These will provide for autonomy and accountability for hospital services in a way that will drive the optimum service reforms, including the implementation of measures set out in sections 7-11 relating to progressing EWTD compliance. They will involve the organisation of hospitals into logical networks or groups, each with a CEO and single management team. Each Group will have autonomy to organise services across the group, subject to compliance with agreed national policy.

This document sets out the measures necessary to implement the EWTD in the public health service within a three-year timeframe. The HSE has recently established a National Implementation Group on EWTD to drive this process and this has already begun its work. In addition the HSE's Draft Service Plan for 2012 includes, for the first time, key performance indicators relating to progress of EWTD.

A key contextual issue now and for the foreseeable future is the commitment by Ireland to a major fiscal consolidation, to reduce the national Budget deficit to a level of 8.5% of GDP in 2012 and to below 3% of GDP by 2015. Overall, by 2015 Public Service numbers are projected to fall by 37,500 since 2008 (a reduction of almost 12%). The Health Service must make a substantial contribution to this programme and overall staff numbers have already fallen from 111,000 in 2008 to approximately 104,000 by the end of 2011. A further reduction in health service employment, to approximately 102,000, is required in 2012 and significant further reductions are anticipated in following years. Health service funding has also been reduced substantially, from €14.9m in 2008 to €13.5m in 2012. Among the features of Government policy on the public service most relevant to the EWTD issue are the requirement to achieve substantial change in

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how services are organised and in work practices, and to effect redeployment as necessary of staff as between locations and services.

2. The current NCHD workforce

The current NCHD workforce comprises approximately 530 Interns, 1,597 Senior House Officers (SHOs), 1,254 Registrars and 1,279 Specialist / Senior Registrars – a total of 4,660 NCHDs.

Of the 4,660, 3,750 hold Initial Specialist Training (IST) or Higher Specialist Training (HST) posts; 910 NCHDs hold service posts. The numbers of doctors in training generally reflects the currently projected future consultant/GP staffing needs of the Irish health service.

3. EWTD requirements

From 1st August 2004 the European Working Time Directive (EWTD) has required that doctors in training receive:

- a 15-minute break every 4 hours 30 minutes or a 30 minute break every 6 hours, or equivalent compensatory rest;
- 11 hours' rest every 24 hours or equivalent compensatory rest;
- 35 hours’ rest once a week, twice a fortnight or 59 hours’ rest once a fortnight, or equivalent compensatory rest;
- and work for no more than an average of 58 (August 2004), 56 (August 2007) or 48 (August 2009) hours a week.

4. Change in NCHD working hours 2009 - 2011

Data collated up to 17th November 2009 on rosters encompassing a total of 4,006 NCHD posts indicated the following:

<table>
<thead>
<tr>
<th>Grade</th>
<th>Daily Breaks</th>
<th>Daily Rest</th>
<th>Weekly/ Fortnightly Rest</th>
<th>Average 48 hour week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intern</td>
<td>94%</td>
<td>75%</td>
<td>96%</td>
<td>54%</td>
</tr>
<tr>
<td>SHO</td>
<td>85%</td>
<td>48%</td>
<td>85%</td>
<td>40%</td>
</tr>
<tr>
<td>Registrar</td>
<td>66%</td>
<td>56%</td>
<td>85%</td>
<td>32%</td>
</tr>
<tr>
<td>Specialist Registrar</td>
<td>90%</td>
<td>56%</td>
<td>91%</td>
<td>40%</td>
</tr>
<tr>
<td>Total</td>
<td>87%</td>
<td>52%</td>
<td>88%</td>
<td>39%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EWTD compliance in 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade</td>
</tr>
<tr>
<td>Interns</td>
</tr>
<tr>
<td>SHOs</td>
</tr>
<tr>
<td>Registrars</td>
</tr>
<tr>
<td>Senior / Specialist Registrars</td>
</tr>
</tbody>
</table>

Revised - EWTD compliant - rosters were introduced incrementally from 1st July 2009, with some start-dates for this group up to 1st November 2009. It was anticipated at that time that additional compliance would be achieved in rosters that were to commence in a number of major teaching
hospitals on 1st January 2010, with further rosters scheduled to be introduced up to 1st April 2010.

Data collated up to 10th January 2012 in respect of 2011 shows a slight improvement in Daily Rest and Weekly/Fortnightly Rest as follows:

<table>
<thead>
<tr>
<th>Grade</th>
<th>Daily Breaks</th>
<th>Daily Rest</th>
<th>Weekly/ Fortnightly Rest</th>
<th>Average 48 hour week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intern</td>
<td>79%</td>
<td>77%</td>
<td>97%</td>
<td>43%</td>
</tr>
<tr>
<td>SHO</td>
<td>72%</td>
<td>69%</td>
<td>93%</td>
<td>30%</td>
</tr>
<tr>
<td>Registrar</td>
<td>73%</td>
<td>67%</td>
<td>92%</td>
<td>31%</td>
</tr>
<tr>
<td>Specialist Registrar</td>
<td>73%</td>
<td>65%</td>
<td>94%</td>
<td>37%</td>
</tr>
<tr>
<td>Total</td>
<td>73%</td>
<td>69%</td>
<td>93%</td>
<td>33%</td>
</tr>
</tbody>
</table>

5. Key measures required to achieve EWTD compliance

As noted previously, the changes required to achieve compliance with the EWTD have been the subject of a series of reports over the past nine years. The reports identify seven key measures required to support EWTD implementation:

a) New work patterns for NCHDs to include 5/7 working and shorter shift periods;

b) Reduction of tiered on-call – where interns, senior house officers, registrars and senior or specialist registrars and Consultants participate in a tiered on-call system;

c) Cross-cover arrangements at Senior House Officer and Registrar levels;

d) Changes to delivery of Medical Education and Training to ensure that Medical education and training receive due priority in rostering arrangements;

e) Introduction of a Consultant-provided service;

f) Transfer of elements of work currently undertaken by NCHDs to other grades

g) Reorganisation of acute hospital services;

Expert reports have consistently rejected an alternative means of achieving EWTD compliance - increasing the number of NCHDs employed so as to reduce average NCHD hours.

For example, the Report of the National Task Force on Medical Staffing concluded:

"the Task Force believes there should be a significant reduction in the number of NCHDs as the number of consultants increases. The objective must be, in line with the Tierney, Forum and Hanly reports, to
reverse the current ratio of more than two NCHDs for every one consultant.

There are some important reasons for this approach. Firstly, it will not be possible to recruit sufficient extra NCHDs to cover existing rostering arrangements under the EWTD, particularly in smaller hospitals where there are already serious problems in maintaining the current numbers of NCHDs. Secondly, there will be serious implications for the provision of quality patient care and clinical decision-making if doctors are recruited to posts which are not considered suitable for training by the relevant authorities.* (Section 3.2.8, p33 Report of National Task Force on Medical Staffing 2003).

In this context and in line the recommendations of the range of reports on the matter, Government policy has been to reduce the number of NCHDs and, instead of increasing numbers, to increase the proportion of training posts as compared to non-training posts within the NCHD workforce.

In fact, HSE and HSE-funded agencies are currently encountering significant difficulty in filling the full cohort of NCHD posts – particularly in smaller and medium-sized hospitals. This resulted in approximately 150 vacant NCHD posts in January 2010, with 190 identified as vacant in July 2011. However, this had reduced to about 60 vacancies as of January 2012. While this reduction is welcome, particular difficulties remain in filling posts in certain specialties, e.g emergency medicine, where service provision has to be maintained.

Notwithstanding the importance of the number of NCHD posts funded or approved, the extent to which such posts can be filled is the key determining factor in the number of NCHDs working in the public health system. The failure to fill vacant posts has a detrimental effect on EWTD compliance in some settings, as it reduces the number of NCHDs available to staff rosters.

The extent to which health service management have implemented measures a) to f) is set out below. Section 8 addresses the organisation of acute hospital services.

a) New work patterns - not yet implemented

NCHD Contract 2010 and the associated Labour Court Recommendations provide for 5/7 shift working, averaging of NCHD overtime (in excess of an average of 39 hours a week during a set period), rostering on-site of up to 24 hours in duration and a range of other measures designed to support flexible rostering in line with service needs.

Nevertheless, in most service settings NCHDs are rostered to work Monday to Friday and to cover hours outside the 8 a.m. to 8 p.m. period Monday to Friday and the full 24-hour period Saturday and Sunday via attending on-site on-call. Factors shaping current work patterns include traditional work patterns, consultant requirements and the incentivisation associated with maintaining overtime payments. Addressing this is a key priority for 2012, as set out in section 11 and Appendix I.

b) Reduction of tiered on-call - achieved

Previously, in many instances the various grades of NCHD - Interns, Senior House Officers, Registrars and Senior or Specialist Registrars - and Consultants participated in a tiered on-call system. If the appropriate clinical decision could not be made by the first doctor on-call, the patient was referred to the next most senior doctor and the process continued until the appropriate diagnostic and treatment decisions were made.

In the large majority of hospital sites, reductions in tiered on-call have been achieved in the period 2009 - 2011 to the maximum possible extent. This has included moving Registrars from on-site
on-call to off-site on-call, removing Interns from the on-call roster and ensuring that there is only one grade of NCHD on-site at any one time.

c) Use of Cross-cover - achieved

In 2003, the National Task Force on Medical Staffing concluded that there was scope within each specialty for the introduction of cross-cover arrangements at senior house officer and registrar levels.

While there was some concern regarding whether such arrangements were appropriate as regards NCHD training and medical registration, these concerns were resolved following agreement in January 2010 between the HSE, Medical Council and the Forum of Postgraduate Medical Training Bodies (representing the bodies responsible for medical training in Ireland) on the use of cross-cover in range of settings for appropriate grades of NCHD. Taking this into account, a substantial number of cross-cover arrangements have been introduced, particularly at SHO level and consequent duplicate rostering (General Surgery and Orthopaedic Surgery at SHO level, multiple sub-specialties of Medicine and Surgery) has been removed.

d) Prioritising Medical Education and Training in NCHD rostering - achieved

Subsequent to the publication of the Report of the National Task Force on Medical Staffing (2003), the Department of Health, health service employers, postgraduate training bodies and the Irish Medical Organisation agreed a set of “Training Principles to be incorporated into new working arrangements for doctors in training”. These principles have shaped EWTD-compliant rostering arrangements.

In 2004, the then Minister for Health and Children established a Postgraduate Medical Education and Training Group, the terms of reference for which included:

- "Having regard to section 3.4.3 of the Report of the National Task Force on Medical Staffing, to examine and report to the Minister for Health and Children on the measures required to:
  1. Accommodate NCHD training in all postgraduate training programmes within a 48-hour working week.
  2. Facilitate NCHDs in addressing any skills deficits which may hinder entry to the specialist register.
  3. Safeguard both training and service delivery during the transition to a 48-hour working week."

The Report of the Group, entitled ‘Preparing Ireland’s doctors to meet the needs of the 21st Century” has informed the current national reform programme in medical education and training.

A new Medical Practitioners Act was enacted in 2007. The Act has resulted in meaningful and very positive changes in the way doctors are registered and the regulation of medical education and training.

In 2007, a survey conducted by the Royal College of Physicians of Ireland found that less than 40% of NCHDs were in structured training. As of October 2011, following significant work by the HSE in partnership with the medical training bodies and the Medical Council, 81% of NCHDs were in structured training. As part of the doubling of numbers of NCHDs in structured training, the number of Specialist and Senior Registrar posts has increased by 85% - from 691 in July 2005 to 1,279 in July 2011.

Each year the HSE invests more than €25m in medical education and training. In the past, much of this money was distributed directly to each NCHD in the form of an annual grant, irrespective of whether the NCHD participated in training of any kind, and with little measurable return. From July 2010 the HSE has instead paid the fees of each doctor in training directly to the relevant
training bodies, under service level agreements. The HSE has also contracted with the postgraduate training bodies to deliver similar funded programmes to maintain the professional competence of the 18% of NCHDs not in structured training.

e) Consultant provided service – limited effect on EWTD compliance to date

A key element of the HSE approach to medical staffing is the development of a Consultant-provided service, wherein the Consultants have a substantial and direct involvement in the diagnosis, delivery of care and overall management of patients.

The clinical workload delivered by the public health service increases each year. In recent years, the HSE and HSE-funded agencies have delivered this increasing workload with reduced funding and a smaller workforce. In contrast to the overall trend, the number of Consultant posts has increased substantially since 2005 - from 1,947 in 2005 to 2,506 in September 2011 or an increase of 31%.

The main increase in consultant numbers has been in previously understaffed specialist areas. There has not been a commensurate increase in consultant numbers in specialties where NCHDs are working hours significantly in excess of the EWTD. In addition, measurable change in consultant work patterns would facilitate a reduction in NCHD hours. This partly reflects the need to ensure full implementation of the new consultant contract (see next paragraph), an issue which is under examination at present in the context of achieving greater productivity and flexibility in line with the Public Service Agreement.

A new Consultant Contract was agreed in July 2008 and was accepted by in excess of 80% of Consultants as of 31st December 2010. Key changes include a longer scheduled working week – 37 instead of 33 hours; an extended working-day – 8 a.m. to 8 p.m.; provision for up to 5 hours’ additional structured overtime on each of Saturday, Sunday or bank holidays; protected time for medical education and training and the introduction of Clinical Directors to develop, manage and lead hospital services.

f) Transfer of work undertaken by NCHDs to other grades – not implemented

Detailed analysis\(^2\) of the existing NCHD workload has indicated that elements of it could be more efficiently and appropriately delivered by other grades or disciplines within the health service. This may involve expansion of the staff nursing role/nursing practice to encompass such skills as venepuncture and intravenous cannulation, transfer of administrative work to clerical staff, increased automation and use of electronic systems. It would be desirable also to rebalance staffing arrangements so as to have more nurse practitioners and phlebotomists and to introduce more assistant grades – for example in operating theatres.

Previously, implementation of these measures would most likely have been dependent on the allocation of additional resources. Furthermore, measures involving change in work practices or increasing numbers in a particular discipline could have significant industrial relations implications.

In the context of the difficult financial position the State now finds itself in and the provisions around reform and reorganisation of work practices agreed in the Public Service Agreement there is now considerable scope for much more flexibility in achieving the necessary work practice reforms. Resources must be allocated so as to maximise the service benefit and this may also, as appropriate, involve a shift of services or activity from the acute to the non-acute setting.

Good progress is being made in nursing and midwifery following the development of the Strategic Framework for Role Expansion of Nurses and Midwives: Promoting Quality Patient Care. This strategic document sets policy direction for the enhancement of nursing and midwifery roles. A six step process provides a framework for nursing and midwifery role expansion in line with service need and national policy direction. Regional meetings to promote the framework model have been held in the last three months. The strategic framework is developed within the context of clinical and regulatory standards and supports the quality improvement initiatives under the national clinical programmes.

6. Administrative steps taken to promote compliance 2009 - 2010

Taking the above into account, the following summarises instructions and guidance issued to HSE and HSE-funded hospitals and agencies:

a) March 2009 - Instruction to prepare EWTD-compliant rosters

Following the issue of the report of the National Implementation Group in December 2008, the then National Director, National Hospitals Office issued instructions to Hospital Network Managers in March 2009 requiring them to ensure that EWTD-compliant rosters were prepared for each hospital and speciality within their remit. Managers were advised that rosters must be designed to ensure safe patient care and should be based on measures that: reduce the number of tiers of on-call, expand cross-cover, change skill mix and practice, and increase efficiency through use of bleep policies and maximise on-call off site.

b) June 2009 - Labour Court Recommendation 19559

In March 2009 the IMO initiated legal action seeking to prevent the HSE acting to implement the EWTD or apply cost-containment measures. The action was settled prior to trial on 28th April. The Settlement Agreement agreed by the HSE and IMO in April 2009 provided for a period of negotiation, with referral to the Labour Court. The Labour Court issued a recommendation on 16th June. It provided for:

- a 5/7 work pattern for NCHDs – replacing Monday-Friday with weekends as overtime;
- an extended working day of 8 a.m. – 9 p.m. Monday to Friday and 8 a.m. – 7 p.m. Saturday and Sunday – replacing 9 a.m. – 5 p.m. Monday to Friday;
- a minimum shift of 6 hours Monday to Friday and 5 hours Saturday and Sunday.

On 26th June 2009 the HSE issued comprehensive guidance to HSE and HSE-funded hospitals and agencies regarding implementation of LCR 19559 and the EWTD.

c) 1st July 2009 – Moves to ensure Interns were compliant with EWTD

As of 1st July 2009, arising from consideration of the recommendations of the Report of The National Committee on Medical Education & Training on the reform of the Intern year, the HSE Management Team decided to reinforce the need to introduce a 48-hour working week for new Interns from July 1st 2009 and to approve the allocation of a portion of the savings gained through this measure towards the reform and development of the intern system. The HSE adjusted hospitals’ base budgets arising from the move by those Interns commencing employment on 1st July 2009 to EWTD-compliant work patterns.

d) 16th July 2009 – Guidance re rostering and compensatory rest

3 Strategic Framework for Role Expansion of Nurses and Midwives: Promoting Quality Patient Care, May 2011

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On 15th July 2009 the HSE issued guidance to HSE and HSE-funded agencies regarding the rostering of doctors for periods of up to 24 hours and associated compensatory rest requirements. This guidance was designed to assist management in implementing EWTD compliant rosters and noted that in practical terms, were a doctor to be rostered for 24 hours, they should be rostered off for 22 hours prior to their next period of work to ensure that daily rest requirements are met.

e) 7th August 2009 – Guidance re legal basis for rostering in excess of 13 hours

On 7th August 2009, the HSE issued guidance setting out the legal basis – in European Court of Justice case law, in the EWTD and in domestic legislation – for the use of compensatory rest following rostering in excess of 13 hours.

f) Guidance re rostering and compensatory rest

On 9th September 2009, the HSE issued comprehensive guidance incorporating the documentation issued on 15th July and 7th August.

g) 29th January 2010 - guidance on new NCHD contract and EWTD compliance

Negotiations on all other aspects of the NCHD contract began on 28th September 2009. The Labour Court heard arguments from both parties on 16th December and issued a recommendation on 22nd December 2009 (LCR 19702).

In January 2010, following a further High Court action by the IMO regarding EWTD compliance, the HSE and IMO agreed another Settlement Agreement. This provided for a new NCHD Contract to take effect from 8th February 2010 and included a Collective Agreement which allowed for rostering of NCHDs in excess of 13 hours, extended the reference period for calculation of working time for some NCHDs and set out how rostered time spent training was to be calculated for EWTD purposes. The new NCHD Contract – NCHD Contract 2010 incorporated the terms of LCR 19559 and 19702.

On 29th January, the HSE issued comprehensive guidance to HSE and HSE-funded hospitals and agencies setting out the combined requirements of NCHD Contract 2010, the IMO and HSE Settlement Agreement of 22nd January 2010, the subsidiary Collective Agreement, Labour Court Recommendation (LCR) 19559, LCR 19702 and the European Working Time Directive (EWTD).

7. Scope for further improvements in EWTD compliance

Section 5 above summarises some of the key measures required to achieve EWTD compliance. The HSE proposes to take the following steps in relation to measures that are largely outstanding:

a) Implementation of new NCHD work patterns

The HSE has recently established an EWTD Implementation Group (as detailed in Appendix I) including representation from the Integrated Services, Human Resources, Clinical Strategy and Programmes and Quality and Patient Safety Directorates; Medical Manpower Managers and lead Clinicians. A key element of the work of that group will be to ensure the re-engineering of current NCHD rostering arrangements to achieve the following:

- Work patterns that ensure that the period outside 8 a.m – 6 p.m. and Saturdays and Sundays are covered by normal rostered working instead of overtime;
- Consequent introduction of Tuesday to Saturday / Sunday to Thursday work patterns in place of the Monday to Friday pattern as part of normal roster rotation;
• Reduction in average weekly working hours to EWTD-compliant levels for appropriately staffed rosters.

b) Consultant-provided service

Further increases in Consultant numbers have significant resource implications and, where these can be afforded, will need to be closely targeted at reducing NCHD hours. The provisions of the existing consultant contract and other measures are being examined with a view to achieving greater productivity under the Public Service Agreement. The HSE will:

• require reductions in NCHD hours in those specialties where NCHDs are working in excess of legal limits and additional Consultant posts have been created;

• identify those specialty / sub-specialty areas that require additional inputs where other means, including service reorganisation, will not achieve EWTD compliance and will prepare a report on the associated resource implications. This will inform consideration of any future consultant appointments, subject to availability of resources.

c) Transfer of work to other grades

The HSE intends to progress this objective as part of the implementation of the Public Service Agreement 2010-2014 and will make this a specific, priority target for implementation under the Agreement in a resource-neutral manner.

8. Service delivery changes required to achieve compliance

a) Full EWTD compliance depends on service reorganisation

While the approach described at Section 5 and 7 above will progress EWTD compliance, it will not achieve it in a large number of hospital and specialty settings. Each of the reports addressing how Ireland can achieve compliance concluded that implementation of the EWTD for a significant proportion of the NCHD workforce also depended on reorganisation of acute hospital services. They also emphasised that acute hospital reorganisation and consequent EWTD compliance are key factors in providing high quality, accessible and safe hospital services.


These conclusions have been endorsed in more recent Reports produced by the Health Information and Quality Authority on foot of investigations into certain smaller hospitals.

b) Current reorganisation measures

Hospital reorganisation measures which have already been implemented or commenced in a number of regions are contributing to improved levels of EWTD compliance. The regions

4 See Reply to Letter of Formal Notice, 25 January 2010 and Appendix 10 to that Reply.
concerned (as currently organised) are Dublin/North East, involving services in Drogheda, Dundalk, Navan, Cavan and Monaghan; HSE West involving the Mid-Western Regional Hospitals at Dooradoyle, Nenagh and Ennis, the Regional Maternity Hospital in Limerick, the Regional Orthopaedic Hospital at Croom and St John’s Hospital Limerick; and HSE South involving the Cork University Hospital Group, the Royal Victoria South Infirmary Hospital, Mercy University Hospital, Kerry General Hospital, Tralee and Bantry General Hospital.

There is a need to build on the progress made and to increase the pace of reorganisation elsewhere in the country so that compliance is achieved within the shortest possible timeframe in a manner that enhances patient safety. The plans already referred to, which will see all acute hospitals organised into networks under clear management and governance structures, will facilitate this process.

c) Development of hospital model to support EWTD compliance

In summary, the reports cited above note that the objective of reorganisation is to reshape services to ensure that they provide systematic, high-quality, patient-centred, integrated acute and community services to a defined catchment population. Such services should be delivered through formal clinical networks with patient management following agreed care pathways that reflect international best practice. A summary of the HSE’s Clinical Programmes is attached, see Appendix 2.

As set out in the HSE’s 2010 document, taken together, the reports propose a network of local and regional centres and the development of new models of care that provide alternative settings to the traditional acute hospital environment, including preventative programmes to improve well-being and self care; chronic disease management programmes that minimise the need for acute care in hospital; and supported care programmes that keep ‘at risk’ patients out of the institutional environment. This will ensure that more care is provided at home or as close to home as possible, and that when patients do need acute hospital services, they will receive high quality care that is integrated with local services. Such hospital services, the reports propose, are the best means of achieving EWTD compliance while maintaining high quality patient care.

9. High-level initiatives currently in train

The Irish Authorities wish to draw the Commission’s attention to developments being implemented since the change of Government in March 2011. These are wholly consistent with the preceding section and will intensify the progression of these measures.

a) Special Delivery Unit

The Minister for Health established the Special Delivery Unit (SDU) on 2nd June 2011. The Unit is located within the Department of Health and works closely with associated teams from the HSE. While a short-term priority is to reduce waiting lists, priorities include building capacity and capability to create and sustain improvements and developing the detailed solutions to the operational problems of the health service.

The SDU is establishing a performance management infrastructure based on real-time information collection and analysis, hospital by hospital. The clinical programmes provide the service strategy context within which performance can be benchmarked. This is the first step to sustainable improvement.

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5 Reply to Letter of Formal Notice, Appendix 10
The SDU and HSE are working to develop and implement a number of projects, such as the roll-out of the acute medicine and associated programmes, including an emergency medicine programme, to channel patients quickly to the service best suited to their needs and reduce ED use by those best treated elsewhere.

This approach matches the HSE’s intention to deliver reform of NCHD rosters and working times with rosters reflecting the levels of hospital activity throughout the week and the intensity of services required 24 hours a day, 7 days a week. It also reflects the current policy of smaller hospitals doing what they can do best.

b) Development of a Framework for Smaller Hospitals

The Government has decided to develop an overall Framework for the Development of Smaller Hospitals. This is aimed at

(i) mapping out the role of smaller hospitals in the years ahead, with a particular emphasis on the scope for transferring additional less complex, mostly day-based work to them and
(ii) making sure that any remaining safety issues in relation to the type of service being provided there are fully addressed.

It is intended that the Framework will detail how

- smaller hospitals can and should do more of the less complex work, transferring it from larger hospitals to free up their capacity;
- smaller hospitals will treat more patients overall, particularly in areas such as day surgery, ambulatory care, medical services and diagnostics and acknowledging that a significant proportion of these services should be provided in the primary care setting.

It will include well-developed plans which will have timelines for implementation built in and will be run via a well-structured project management framework. This will include monitoring of timelines and integration.

One of the key factors influencing the type of services that can safely be provided in individual hospitals is the availability of medical staff. Some services can only be provided when appropriately trained and experienced medical staff are present. This has important implications for the services that smaller hospitals can provide, especially at night time and weekends.

Given that the EWTD sets down strict limits on the average working hours permitted for NCHDs, it effectively limits the scope for more extensive rosters, especially in smaller hospitals.

With the parameters of the EWTD in mind, and the Government’s wish to reorientate smaller hospitals in the direction of day-based work, the Framework’s plans for each hospital will be of importance in reducing the need for substantial out-of-hours work by NCHDs. In turn this will operate to the advantage of the agenda to achieve a reduction in the average working hours of NCHDs.

c) New Specialist Grade

The Minister for Health has decided to develop a proposal for the creation of a new Specialist grade of doctor between the senior NCHD grade (Specialist Registrar) and Consultant levels. A project leader and an Advisory Group have been appointed to progress the development of a proposal and an Interim Report is to be provided to the Minister by 31 January 2012. It is envisaged that persons filling this new post will have completed specialist training. When
established, this grade should allow suitably qualified NCHDs to remain in the Irish health system as an alternative to travelling abroad to advance their careers.

10) Implementation by hospital type and timeframe (Appendix 3 refers)

Taking the factors outlined in the preceding sections into account, it can be seen that the implications of ensuring EWTD compliance in hospitals are significant and vary depending on size, workload, specialty configuration and medical staffing. The issues according to general hospital type are set out below.

a(i) Smaller Hospitals

Small hospitals of less than 200 acute beds are typically staffed by 3-4 Consultants and 7-10 NCHDs in each of Medicine, Surgery and Anaesthesia, with smaller numbers of both Consultants and NCHDs in Radiology and Pathology. A single Consultant post in Emergency Medicine may be present and Consultants in larger hospitals will often have minor weekly commitments to the hospital. Examples of such hospitals are Roscommon, Bantry, Mallow, Ennis and Nenagh.

In such settings the requirement to ensure EWTD compliance means that if 24/7 acute medical and surgical services are to be maintained, it is only possible to roster 1 NCHD in each of Medicine, Surgery and Anaesthesia on-site at any particular time. Annual leave and sick leave, coupled with recruitment problems facing such hospitals in recent years, mean that maintaining 1 NCHD on-site is itself difficult. Issues of competence and safe clinical practice have arisen as the number of NCHDs willing to work in such settings has fallen. In 2009, for example, NCHD vacancies were in excess of 150 – mostly in smaller to medium-sized hospitals. The volume of NCHDs applying for posts in Ireland has reduced considerably.

The low number of Consultants in such hospitals may be used to support the roster to maintain emergency services – albeit in such circumstances they themselves would be required to work hours significantly in excess of EWTD requirements. The structure of Consultant posts may itself militate against participation in rosters on this basis and Consultants will typically have minor commitments to larger hospitals to ensure they maintain competence. Additionally, taking leave and rest-day requirements into account, at least one Consultant in each specialty will be rostered off at all times, reducing the number of Consultants available to three and often two.

Assigning the limited number of NCHDs to support the provision of emergency services on a 24/7 basis has the effect of reducing NCHD availability to provide standard inpatient, outpatient and daycase services. The extent to which the hospital can provide elective services is significantly reduced, if not compromised. In Surgery and Anaesthesia, should the NCHD on duty be required to attend theatre there is no NCHD cover for inpatient or Emergency Department services. At this point, safe services are no longer sustainable.

a(ii) Medium-sized Hospitals

These hospitals differ from smaller hospitals in respect of the range and configuration of specialist services. In addition to 5-7 Consultants in each of Medicine, Surgery and Anaesthesia such hospitals will 3 or more Consultants in Obstetrics & Gynaecology and Paediatrics. Numbers of NCHDs will range from 10-15 in each of Medicine, Surgery and Anaesthesia with smaller numbers in Obstetrics & Gynaecology, Paediatrics and Emergency Medicine. Examples of such hospitals are Portlaoise, Wexford, Clonmel and Portiuncula.

While such hospitals can readily achieve EWTD compliance in Medicine, this is invariably at the expense of elective services. In most cases, the volume of outpatient, daycase or elective
inpatient work must be reduced, with consequent increases in the number of patients on waiting lists and on waiting times.

However, EWTD compliance in Surgery is more difficult and is almost impossible in Anaesthesia, as Consultants and NCHDs are required to support a 24/7 Emergency Department – often with no dedicated NCHDs in Emergency Medicine – theatre services for emergency surgery and obstetrics and Intensive Care or High Dependency Units.

EWTD compliance in obstetrics and paediatrics is extremely difficult and would normally require cessation of most elective work. In such circumstances, EWTD compliance can only be achieved through centralisation of urgent and emergency Obstetric and Paediatric services at a regional level. This would have the effect of promoting EWTD compliance in Anaesthesia, albeit such hospitals may not achieve EWTD compliance in Surgery without cessation of out-of-hours emergency surgery and centralisation of same.

a(iii) Large Hospitals

Large hospitals typically provide a wide spectrum of acute services to the extent that they operate on-call services in four or more subspecialties in each of Medicine and Surgery; operate Emergency Departments with four or more Consultants and large numbers of NCHDs in Emergency Medicine; and provide a wide range of diagnostic and laboratory services with multiple Consultants in each of the sub-specialties of Radiology and Pathology. Obstetric services may be provided on-site or in a separate location under the same governance; paediatric services are generally provided on-site (hospitals in Dublin are the exception in each case) and the hospital may be designated as one the eight Cancer Centres. Examples of such hospitals include Cork University Hospital, Galway University Hospitals, St James’s, Beaumont and St Vincent’s University Hospital.

In such hospitals, EWTD compliance is readily achieved in respect of Emergency Medicine, Anaesthesia, Pathology, Radiology, General Medicine and General surgery, albeit increased cross-cover at Senior House Officer level may be required. EWTD compliance in sub-specialties of Surgery and Medicine requires an element of cross-cover and almost certain merging of rotas.

At sub-specialty level, compliance may also require a reduction in elective workload and/or significant change in Consultant work patterns. In settings where four of five NCHDs are employed in a particular sub-specialty, current volumes of elective workload are unsustainable. In some settings – Neurosurgery, Liver Surgery and tertiary medical sub-specialties – EWTD compliance with current staffing levels would mean cessation of 24/7 emergency services and significant reductions in elective workload with consequent increases in the number of patients on waiting lists and on waiting time.

In such settings, compliance will be achieved only through the introduction of additional Consultants or other health and social care professionals who can address deficits in workload and maintain services; reorganisation of tertiary sub-specialty services; or a combination of both.

iv) Specialty Hospitals

Single or multiple-specialty hospitals may provide elective, urgent or emergency services on a single or more rarely a dual-specialty basis. Examples of such hospitals include Cappagh, Kilcreene and Croom – which provide orthopaedic services; the Royal Victoria Eye and Ear Hospital; the Children’s University Hospital (Temple Street) and Our Lady’s Children’s Hospital, Crumlin – which provide wide-ranging paediatric services; maternity hospitals such as the National Maternity Hospital Holles Street, the Coombe Women’s’ Hospital and the Mid-Western Regional Maternity Hospital in Limerick.

EWTD compliance in those hospitals providing elective or largely elective services should be
readily achievable – subject to NCHD numbers in Anaesthesia. EWTD compliance in paediatric hospitals faces similar challenges to those being experienced in medium and large hospitals. Compliance in Maternity Hospitals is extremely difficult given current increased volumes of workload and may be possible only in certain sub-specialty settings.

b) Achievement of compliance in each hospital and related timeframes

The following measures set out the level of change required to achieve EWTD compliance in each public hospital. As noted above and in the 2010 Reply, the implications of ensuring EWTD compliance in hospitals vary depending on size, workload, specialty configuration and medical staffing. The HSE has identified minimum timelines for attainment of compliance, depending on the type of hospital involved and the extent of change necessary.

It is intended that compliance will be largely achieved in a number of specialised hospitals and some small hospitals within 12 months. These hospitals include the Orthopaedic Hospitals (Cappagh, Kilcreene, Croom) and the Royal Victoria Eye and Ear Hospital.

It is envisaged that compliance will be achieved in the next layer of hospitals within 24 months. Typically the developments required encompass changes in work patterns, transfer of services between hospitals with changes in the organisation of service delivery and, if possible, limited, increases in certain types of staff. Where budgetary constraints preclude increased staffing, some of these hospitals would require 36 months, as service reorganisation would become more complex.

Finally, compliance in a number of hospitals in certain regions will require measures that will take 36 months to implement. This timescale is dictated by the extent of service reorganisation involved.

Appendix 3 summarises the measures on a site-by-site basis according to HSE Region. In each instance, EWTD compliance is dependent on restructuring and re-engineering of current NCHD rosters.

The Irish Authorities are committed to supporting the implementation of the measures set out in this and the following section, and also those addressed in sections 7, 8 and 9 above. They note that in relation to a limited number of sub-specialties, compliance will require an increase in consultant numbers. This is likely to be most challenging, given the overall economic situation and the absolute need to continue reduce expenditure and employee numbers in the health service over the period to 2015. The incremental steps outlined in the following section are intended to progress compliance over the envisaged timeframe.

11. Next steps

a) Measures necessary to achieve EWTD compliance

Achieving EWTD compliance within 36 months as noted above will require a multi-faceted approach. This must include the following, listed in order of priority and the extent to which the action will contribute to reduction in NCHD hours:

i) Change in NCHD rosters and work patterns;
ii) Significant reorganisation of acute services and in particular of surgical, obstetric and paediatric units in certain areas
iii) Targeted increase in medical staffing in certain specialties – outside the current clinical programmes and explicitly focused on reducing NCHD hours in those specialties;
iv) Expansion of the nursing role, transfer of work to clerical grades and the introduction of electronic systems that introduce efficiencies into clinical work practices.

The immediate focus will be on change in NCHD rosters and work patterns. Other than such changes, each of the above has resource implications, to a greater or lesser degree. In the current fiscal environment, the challenge will be to leverage sufficient efficiency savings in the service generally to enable these developments and changes to proceed.

In conjunction with the above, overall national policy, including the work of the Special Delivery Unit, the development and implementation of the Framework for Smaller Hospitals and reform of acute hospital governance and management will be progressed.

b) EWTD Implementation Group

This Group's remit is to:

i) Implement new rostering arrangements

New NCHD rostering arrangements need to achieve the following:

- Work patterns that ensure that the period outside 8 a.m. – 6 p.m. and Saturdays and Sundays are covered by normal rostered working instead of overtime
- Consequent introduction of Tuesday to Saturday / Sunday to Thursday work patterns in place of the Monday-to-Friday pattern as part of normal roster rotation.
- Reduction in average weekly working hours to EWTD-compliant levels for appropriately staffed rosters.

ii) Draft a detailed framework for minimum necessary service reorganisation

Parallel to action on rosters, it is important to evaluate the extent to which the changes required in acute hospital services can be achieved and the associated timescales. A framework is required, outlining the minimum necessary service changes

iii) Identify need for increased medical posts to facilitate compliance

The resource implications of strengthening medical manpower in specialty / sub-specialty areas that require additional inputs where other means, including service reorganisation, will not achieve EWTD compliance will be examined. This will inform consideration of any future consultant appointments, subject to availability of resources. Any increases in capacity will need to be closely targeted at reducing NCHD hours.

iv) Support renegotiation of role expansion / change in staff roles under the PSA

This will be progressed as part of the implementation of the Public Service Agreement and form a specific, priority target for implementation under the Agreement. The EWTD Implementation Group will support and contribute to this process.

The document at Appendix I was prepared by the HSE prior to the establishment of the Implementation Group in December 2011.

* * *
Appendix I – EWTD Implementation Group

National Working Group - EWTD

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive
1. Background

All doctors in training (Non-Consultant Hospital Doctors - NCHDs) employed in the public health service have been subject to the requirements of the European Working Time Directive (EWTD) since 1st August 2004.

From 1st August 2004 the European Working Time Directive (EWTD) has required that NCHDs receive:

- a 15 minute break every 4 hours 30 minutes or a 30 minute break every 6 hours or equivalent compensatory rest;
- 11 hours rest every 24 hours or equivalent compensatory rest;
- 35 hours rest once a week, twice a fortnight or 59 hours rest once a fortnight or equivalent compensatory rest;
- and work for no more than an average of 58 (August 2004), 56 (August 2007) or 48 (August 2009) hours a week.

The HSE has indicated previously that a series of reports had identified six measures which, if implemented, would increase compliance with EWTD.


2. EWTD National Working Group on EWTD

The HSE will establish under ISD, a National Working Group on EWTD compliance that will build upon previous work undertaken in this area since 2009. Although, established under ISD, the National Working Group will be a collaborative effort of the National Directorates of Clinical Programmes, Quality and Patient Safety and Human Resources. These Directorates will form a part of the overall group and will assist in leading on different parts of the work streams of the group. This will be particularly important as clinical leadership in modernising the current way our NCHD resource base is utilised and deployed is critical.

3. Composition of the Working Group

The National Working Group will be chaired by Mr. Barry O’Brien, AND HR South and will report to the National Director ISD. The National Director ISD will report progress to the SMT each quarter.

Membership will be finalised by Mr. O’Brien but will include officials with significant experience in EWTD compliance planning and implementation and contain the following representatives:

- Regional AND’s HR
- Medical Manpower Manager Rep
- National Corporate HR rep
- Clinical leads rep (AMP, EMP and Surgery)
- Quality and Patient Safety Rep
- MET Unit Rep
• Training Colleges Rep
• ISD Acutes Rep
• ISD Mental Health Rep
• 4 X Work stream Leads (where not a rep already)

The Department of Health will be offered representation on the group also. The Chair of the Group will also be responsible for communicating with relevant unions (particularly the NCHD groups within the IMO) on the work and progress of the group in line with the PSA.

The Chair of the Group will be responsible for ensuring awareness of the working group’s progress to the SDU each quarter.

4. Workstreams

There will be four distinct workstreams with defined deliverables for each workstream. Although each workstream will work on its own deliverables, it will be the role of the National Working Group to ensure the synergies between workstream outputs are coordinated and cross pollinate the thinking within each workstream.

Workstream 1: Re-engineering current NCHD rosters to increase EWTD compliance and maximise new opportunities

Workstream lead: TBC Consultant Clinician (to be identified by Barry White and Philip Crowley)

Deliverables:
• Toolkit and standardised rosters for implementation across hospitals which are EWTD compliant and based on best practice and are patient safety appropriate. These standardised rosters will focus on a number of key specialties.
• Information and communication phase with consultant community on opportunities to re-engineer rosters to increase EWTD compliance. Services achieving changes through reorganisation of clinical rosters should feature.
• Identify how each of hospital and each specialty within each hospital are re-engineering rosters to promote EWTD compliance. Each hospital (or specialty within those hospitals) should present its plan to implement new rosters within a specific time to the workstream group.
• Monitoring of the implementation of the new rosters in each hospital / specialty hospitals over 2012.
• Progress report on implementation to the National Chair of the Working Group.

Notes: It remains the responsibility of Hospital managers / CEOs with the support of Medical Manpower Managers and regional HR to present revised rosters to the workstream group, to control implementation and to report on progress for their own hospital set. It is the responsibility of the workstream to provide toolkits, advice, support and assistance to local implementation teams. This workstream may also be in a position to provide a national resource (e.g. standardised rosters, access to specialised experts on roster scheduling, etc) to facilitate local improvements. All hospitals will be required to submit revised rosters to the workstream.

Inter-linkages:
• Workstream 2 where planned changes to smaller hospitals and new rotational arrangements may impact.
• HSE and postgraduate training bodies to ensure alignment of posts with training systems and NCHD database (postgraduate bodies determine the location of training posts, HSE the number of training posts).
Workstream 2: Realigning the Medical workforce to meet service need in re-organised hospital networks

Workstream lead: TBC

Deliverables:
- In hospitals, currently undergoing re-organisation and development as part of a network, realignment of the current consultant and NCHD resource base to maximise opportunities for the network as a whole and EWTD compliant rosters. A medical workforce profile for the network, the proposed rotational systems to be implemented with proposed systems of supervision which take advantage of a network configuration will be a key output of this group.
- Commencement of implementation and realignment of the new consultant and NCHD resource base for the new network entity. Commencement to happen by Q1 2012.
- Progress report on implementation to the National Chair of the Working Group.

Notes: It remains the responsibility of hospital managers / CEOs with the support of Medical Manpower Managers and regional HR to present the updated and proposed re-aligned medical workforce system. It is the responsibility of the workstream to ensure that each region takes a (mostly) uniform approach to the re-organisation of the medical workforce within the network.

Inter-linkages: Small hospitals framework and communication process.

Workstream 3: An assessment of the changes in the medical workforce required to achieve EWTD compliance

Workstream lead: TBC

Deliverables:
- A profile of the current medical workforce (NCHDs and Consultants) positions by speciality and a profile of the current vacancies, locum and agency filled positions within the system.
- A profile of the potential changes that are required in order to achieve full EWTD compliance within 36 months.

Notes: A profile of current NCHD and Consultant posts, vacancies and agency / locums is currently available and requires validation.

Inter-linkages: Linkages with the DoH will be required for this workstream to ensure appropriate planning and provision is made to enable changes in the number of NCHDs vs the number of Consultants. The outcome of workstream 1 will form an important input into the assessment of future requirements.

Workstream 4: Identification of potential work role changes and task shifting opportunities available to assist in achieving EWTD

Workstream lead: TBC

Deliverables:
- A specification of the potential work tasks shifting to other staff that could be undertaken within each hospital to assist in achieving EWTD by NCHDs.
- A roll out plan for each region to achieve this task shifting for a selected list of opportunities

Inter-linkages: PSA implementation group and agreement by unions to engage in task shifting duties.
5. Reporting on Progress

The Chair of the Group will be responsible for reporting progress to the National ISD and SMT. The Chair of the Group may also be required to periodically report progress in a specified format for a number of external agencies including the Department of Health and the European Commission.

In its normal reporting cycle, the EWTD working group will produce each quarter:

- A short report on actions undertaken and achieved for each workstream and at each hospital site to increase compliance rates. A KRA will be inserted in the service plan to facilitate reporting on this issue to the Department.
- A suite of overall Key Performance Indicators will be reported on twice yearly to monitor compliance levels. The main performance indicator will be overall compliance by hospital which will be a composite of a number of other indicators. These composite key performance indicators will be available for each hospital and speciality. The composite KPIs will be compliance levels with:
  - 48 hour average working week
  - 30 minute rest break every 6 hours during period on-site on-call;
  - 11 hours rest every 24 hours OR equivalent compensatory rest before return to work
  - 35 hours continuous rest per week OR twice a fortnight OR 59 hours continuous rest per fortnight
Appendix 2 – HSE Clinical Programmes

The Health Service Executive’s Directorate of Clinical Strategy and Programmes was established to improve and standardise patient care throughout the HSE by bringing together clinical disciplines and enabling them to share innovative solutions to deliver greater benefits to every user of HSE services.

The national clinical programmes have three main objectives:

- To improve the quality of care delivered to all users of HSE services
- To improve access to all services
- To improve cost effectiveness

Each of the programmes is led by a team of national experts, selected by their peers through the academic colleges and professional bodies. The teams include consultant, GP, nursing and allied health professional, management and regional representatives, who are bringing together experience and expertise from services around the country to help plan the work of the programmes. The clinical programmes are a multidisciplinary initiative between the HSE, the Royal College of Physicians of Ireland (RCPI), the Irish Association of Directors of Nursing and Midwifery (IADNAM), the Therapy Professions Committee (TPC) and the Irish College of General Practitioners (ICGP).

Currently there are 31 clinical programmes in different stages of development, across a number of different areas including:

- **Chronic disease management programmes** for the management of Stroke, Heart Failure, Acute Coronary Syndrome, Chronic Obstructive Pulmonary Disease (COPD), Asthma, Diabetes, Mental health and Epilepsy.
- **Emergency functions** including Emergency Medicine Teams, Acute Medicine, Critical Care and Surgery
- **Outpatient Care** specifically in the areas of Dermatology, Rheumatology, Neurology, Kidney Medicine, along with the development of community interventions and Out-Patient Antibiotic Therapy (OPAT)/Home Intravenous (IV)
- **Other programmes** including Clinical Governance, Orthopaedics, Primary Care, Medication management, Radiology, Care of the Elderly, Rehabilitation, Palliative care, Audiology, Paediatrics Obstetrics and Gynaecology, Pathology and Healthcare associated infections (HCAI)

Opportunities associated with the clinical programmes

The clinical programmes are a sea-change in the way we provide healthcare in Ireland. The programme approach use the key proven drivers of success in improving disease management and have the opportunity to improve patient care through the following:

- **Patient at the centre of care.** Patients have been key players in the development of the clinical programmes. There is a strong commitment in the programmes to providing care for the patient from prevention through early identification, treatment and disease management. Involvement of primary care and public health is essential in ensuring that the correct reorientation of disease management towards primary care and prevention occurs.
• **Clinical leadership and buy-in.** The engagement of clinicians in leading change across all the programmes has led to huge commitment and is driving changes that will lead to real health improvements.

• **Structured approach focusing on simple interventions.** The programmes focus on using the right intervention, at the right time, in the right setting.

• **Meaningful measurement.** The programmes will identify metrics in terms of real outcomes that matter to patients, that are meaningful and that can be used to inform decisions, without being excessive or creating an unnecessary burden on the system.

• **Clinical accountability as a key focus of the programmes ensures a system through which each member of the health service is accountable for continuously improving the quality of the service and safeguarding high standards of care.**
## Appendix 3 – Implementation Timeframe, Summary Table by Hospital

### Timetable for EWTD Compliance

<table>
<thead>
<tr>
<th>Structured changes required to achieve compliance</th>
<th>Hospitals</th>
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</thead>
<tbody>
<tr>
<td><strong>12 Months</strong></td>
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</tbody>
</table>
| It is intended that compliance will be largely achieved (or maintained) in a number of specialised hospitals and some small hospitals within 12 months – Typically reorganisation of services in the regions and the transfer of NCHD workload to other grades of staff is required. | - Navan Hospital  
- Monaghan Hospital  
- Louth County Hospital  
- Cappagh Orthopaedic Hospital  
- Royal Victoria Eye and Ear Hospital  
- Mid-Western Regional Hospital, Croom  
- Mid-Western Regional Hospital Ennis  
- Mid-Western Regional Hospital, Nenagh  
- Roscommon General Hospital  
- Kilcreene Orthopaedic Hospital  
- Bantry General Hospital  
- St John’s Hospital Limerick  
- Children’s University Hospital, Temple Street Hospital |
| **24 Months**                                   |           |
| It is envisaged that compliance will be achieved in the next layer of hospitals within 24 months. Typically the developments required are significant. They encompass changes in work patterns, transfer of services between hospitals in each of the HSE areas, changes in the organisation of service delivery, centralisation of a range of acute services provided, reorganisation of services in the regions across a number of sites, the transfer of NCHD workload to other grades of staff, increases in certain types of staff, the introduction of additional consultants or other health and social care professionals who can address deficits in workload. | - Beaumont Hospital  
- Mater Hospital  
- St James’s Hospital  
- Connolly Hospital  
- Coombe Maternity Hospital  
- Rotunda Maternity Hospital  
- National Maternity Hospital  
- St Vincent’s University Hospital  
- St Columcille’s Hospital  
- Our Lady’s Hospital for Sick Children, Tallaght Hospital  
- Naas Hospital  
- Cork University Hospital  
- Mallow General Hospital  
- South Infirmary Victoria Hospital  
- Mercy Hospital  
- Kerry General Hospital  
- Mid-Western Regional Hospital, Limerick  
- Mid-Western Regional Maternity Hospital  
- Mayo General Hospital  
- Sligo General Hospital  
- Letterkenny General Hospital |
| **36 Months**                                   |           |
| A number of hospitals in certain regions require a 36 month timeframe for the implementation of measures that will deliver | - Our Lady of Lourdes Hospital, Drogheda  
- Cavan General Hospital  
- Midland Regional Hospital, Portlaoise  
- Midland Regional Hospital, Mullingar |
compliance. Typically these hospitals will require implementation of all the measures set out above. The hospitals require the extended timeframe given the complexities arising from the extent of reorganisation and centralisation of services involved.

- Midland Regional Hospital, Tullamore
- Waterford Regional Hospital
- Wexford General Hospital
- South Tipperary General Hospital
- St Luke's Hospital, Kilkenny
- Galway University Hospital
- Portiuncula General Hospital