



Workload for Consultant Anaesthetists in Ireland

Guidance on the 2008 (Connaughton) Contract
and Job Planning for Consultant Anaesthetists in Ireland

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The Association of Anaesthetists of Great Britain and Ireland
21 Portland Place, London, W1B 1PY
Telephone 020 7631 1650 Fax 020 7631 4352
info@aagbi.org
www.aagbi.org

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Membership of Working Party

Dr Michael Staunton	Chairperson, Member of Irish Standing Committee
Dr Kevin Bailey	Member, Irish Standing Committee
Dr Anne Bergin	Member, Irish Standing Committee
Dr David Honan	Member, Irish Standing Committee
Dr John Kennedy	Member, Irish Standing Committee
Dr Avine Lydon	Member, Irish Standing Committee
Dr Geraldine Maloney	Hon. Secretary, Irish Standing Committee
Dr John McAdoo	Member, Irish Standing Committee
Dr Carlos McDowell	Member, Irish Standing Committee
Dr Stephen Mannion	Member, Irish Standing Committee
Dr Ellen O’Sullivan	Member, Irish Standing Committee
Dr Rory Page	Convenor, Irish Standing Committee

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1. Key points

- The consultant contract is an agreement between an individual consultant anaesthetist and his or her employer.
- The 2008 (Connaughton) Consultant Contract contains many important differences from the 1997 (Buckley) Consultant Contract.
- The Irish Standing Committee of the AAGBI advises that all consultants are members of both a medical representative organisation and a medical defence organisation.
- Each consultant anaesthetist who has signed the 2008 contract must agree a consultant work schedule and a ratio of public to private practice with his or her employer.
- All consultant anaesthetists who have signed the 2008 contract should fully honour their 37-hour scheduled weekly commitment.
- The increase in weekly working hours under the 2008 contract should include an increase in both clinical and non-clinical activities.
- As previously recommended by the AAGBI, approximately 25% of total weekly working hours should be devoted to non-clinical activities.
- Failure to devote adequate time to non-clinical activities may adversely affect the maintenance of professional competence and the quality of patient care.
- Consultant anaesthetists within a department of anaesthesia may have different clinical and non-clinical activities.
- Consultant anaesthetists with additional non-clinical responsibilities, e.g. chairperson or secretary of department, clinical director, should have a reduction in working hours devoted to clinical activities.
- The consultant work schedule should be supported by a robust diary exercise.
- If workload changes, a change in the consultant work schedule may be required.
- The measurement of the ratio of public to private practice may not adequately capture many clinical activities which are regularly performed by consultant anaesthetists.
- Consultant anaesthetists should consider maintaining their own records of their public and private clinical activity.
- All changes in working patterns as a result of the European Working Time Directive (EWTd) should be carefully evaluated for their effects on the safety of patients and staff.

2. Introduction

The 2008 (Connaughton) Consultant Contract

The Irish Standing Committee of the Association of Anaesthetists of Great Britain and Ireland (AAGBI) produced a guideline in 1992 and a supplement in 1993 to advise members on the 1991 Irish Consultant Contract. The Irish Consultant Contract was subsequently revised in 1997 and in 2008. The 2008 (Connaughton) Consultant Contract contains many important differences from the 1997 (Buckley) Consultant Contract. Therefore, the Irish Standing Committee considered it appropriate to review and update its previous guidance.

This new guideline will give members a broad overview of the principles of the 2008 contract together with specific advice appropriate for consultant anaesthetists. The objective of this guideline is to enable consultant anaesthetists and, thus, their patients, to adapt to and benefit from the 2008 contract.

Professional advice on your contract

The Irish Standing Committee advises that you maintain membership of a medical representative organisation, e.g. the Irish Medical Organisation (IMO) or the Irish Hospital Consultants Association (IHCA). Both of these organisations recommend that new consultants have their contracts reviewed by them before signing. In addition, both organisations provide advice to consultants regarding the local interpretation of their contracts.

The Irish Standing Committee and the Health Service Executive (HSE) both advise that you take out supplementary membership of a defence organisation or insurer of your choice, so that you have adequate cover for matters not covered by the Clinical Indemnity Scheme, e.g. representation at disciplinary and fitness to practise hearings or Good Samaritan acts outside the jurisdiction of the Republic of Ireland (Section A, Part 27).

At the time of writing, at least 85% of consultants in the Republic of Ireland have signed the 2008 (Connaughton) Consultant Contract. However, it is important to note that many aspects of the contract are the subject of ongoing negotiations between the HSE and the medical representative organisations.

3. Overview of the consultant contract

Definition

A contract is a set of statements governing the agreement between you and your employer: what work you agree to perform; what facilities your employer agrees to make available for you to do this work; and what your employer agrees to reward you with for your work.

Components

The consultant contract is not a single document. It has several components, all of which should be given to each consultant:

- Terms and conditions
- Appendices
- Correspondence exchanged between the parties as set out at Appendix VII of the contract
- HSE Letter of Approval
- Job description

This section will outline the main features of the 2008 (Connaughton) Consultant Contract. Where appropriate, differences between this contract and the previous, 1997 (Buckley) Consultant Contract will be highlighted. Throughout this guideline, the 2008 (Connaughton) Consultant Contract will be referred to as 'the 2008 contract' or 'the contract'.

Most important differences

The most important differences between the 2008 contract and the previous contract are as follows:

- Reporting relationship
- Clinical directors and clinical directorates
- Consultant teams
- Increased total hours of work per week
- Longer normal working day
- Structured on-site attendance at weekends and on public holidays
- Re-introduction of a 'public-only' contract
- Regulation of private practice

Terms and conditions

Appointment and tenure

The qualifications required for the consultant post are set out in the HSE Letter of Approval which is attached at Appendix 1 of the contract. The HSE has published revised consultant qualifications with effect from 16 March 2009. These qualifications are given in Appendix 1 of this guideline. It should be noted that the only special interests that are specified are those in paediatric anaesthesia, intensive care medicine and pain medicine.

Reporting relationship

The contract states that the consultant's "reporting relationship" and "accountability for the discharge of his/her contract" is to "the Chief Executive Officer/General Manager/Master of the hospital (or other employing institution) through his/her Clinical Director (where such is in place)." The contract also states that the hospital network manager "may require the consultant to report to him/her from time to time."

The previous contract did not specifically refer to a 'reporting relationship' or 'accountability', but did state that the consultant was responsible for "producing a realistic agreed schedule," "agreeing with management the details of the service levels and mix to be provided" and "supplying to his employing authority such information...as is necessary and reasonable to establish that he is fulfilling his contractual commitment."

Hours of work

The most important differences between the 1997 and 2008 contracts are summarised below.

	1997 (Buckley) Contract	2008 (Connaughton) Contract
Total number of hours per week	33	37
Total number of sessions per week	11 (= 33 notional hours per week)	No reference to sessions
Types of sessions	"Mix of fixed and flexible sessions, the ratio of which will vary depending on specialty"	No reference to fixed or flexible sessions
Definition of normal working day	"During the hours normally worked within the Monday to Friday working week"	Between 8am and 8pm Monday to Friday
Total duration of shift	No reference to total duration of shift	"The Consultant will not be obliged to work more than 8 hours in any one day."
Splitting of shift	No reference to splitting of shift	"This will be structured as a single continuous episode."
Weekend sessions	No	Yes (see below)

In addition to the above 37-hour commitment per week:

- The consultant may be required to participate in an on-call roster.
- The consultant rostered on-call may be required to provide a "structured commitment on-site of up to 5 hours on a Saturday and/or 5 hours overtime on a Sunday and/or 5 hours on a public holiday."

The structured on-site attendance at weekends and on public holidays will be subject to premium payments of time-and-a-half on Saturdays and double-time on Sundays and public holidays. Consultants who have onerous on-call rosters (1:4 or more frequent) "shall not be expected to deliver the upper end of this requirement as determined by the Clinical Director."

If a consultant remains in the hospital longer than the structured 5-hour commitment or is required to re-attend the hospital later in the day, he/she may claim C Factor (Call-Out) Payments for this additional working time.

The contract states that, where there is local agreement to implement different work patterns (including any arrangements providing for up to 24/7 hour working), the involvement of any individual consultant in any such arrangement(s) “shall be subject to his/her agreement.” Appendix VII (‘Correspondence between the parties’) states that any issues regarding such local agreements will be referred to the Contract Implementation Group, a committee comprising representatives of the HSE and the medical organisations.

Consultant teams

The contract states that the consultant will “generally work as part of a Consultant team.” The purpose of such teams is “to ensure Consultant provided services to patients on a frequent and continuing basis.”

The previous contract briefly mentioned the concept of a clinical directorate being led by a member of its ‘consultant team’. The majority of consultant anaesthetists in the Republic of Ireland already work as part of a consultant team with regard to rostering arrangements and delivery of the clinical service.

On-call commitment of consultants who work on multiple hospital sites

The contract does not contain guidance regarding the on-call commitment of consultants who work on multiple hospital sites. Nonetheless, it seems reasonable that the on-call commitment should reflect the sessional commitment, e.g. if a consultant has 50% of his sessions in hospital A and 50% of his sessions in hospital B, and has an on-call commitment on both sites, 50% of his/her on-call commitment should be in each hospital; further, his/her on-call commitment in each hospital should be 50% that of consultants with all their sessions in that hospital. Such arrangements should be locally discussed and agreed by the departments of anaesthesia on these hospital sites.

4. Consultant contract types and regulation of private practice

Consultant contract types

A consultant holding contract type A (a 'public-only' contract) may not engage in privately remunerated professional medical practice.

Consultant contract types B, B* and C

Consultants holding contract types B, B* and C may engage in privately remunerated professional medical practice.

Several types of practice, e.g. preparation of reports relating to insurance claims or for the courts, are not regarded as private practice (see Section A, part 21).

The most important differences between these contract types are summarised on the next page.

	Type A	Type B	Type B*	Type C
Consultants eligible to hold contract	New consultants, category 1 consultants, category 2 consultants	New consultants, category 1 consultants, category 2 consultants	Category 2 consultants	New consultants
Location of private practice				
Public hospital(s)	No	Yes	Yes	Yes
Co-located private hospital(s)	No	Yes	Yes	Yes
Outside public hospital(s)	No	No	Yes	Yes
Regulation of private practice				
Volume of public practice	Must fully discharge standard 37-hour weekly commitment	Must fully discharge standard 37-hour weekly commitment	Must fully discharge standard 37-hour weekly commitment	Must fully discharge standard 37-hour weekly commitment
Volume of private practice in locations 1 and 2	None	Not > 20% (not > 30% for existing consultants if this is agreed, see below)	Not > 20% (not > 30% for existing consultants if this is agreed, see below)	Not > 20% (not > 30% for existing consultants if this is agreed, see below)

Change in contract type

Consultants may apply to change contract type to type A, B or C at five-yearly intervals. Consultants who previously held a category 1 or category 2 contract may, 2 years after accepting the 2008 contract, and thereafter at 5 yearly intervals, apply to transfer to contract type B*. Applicants must demonstrate “that the change in Contract Type is consistent with the public interest and that there is a demonstrable benefit to the public health system.”

Where a new or replacement post is designated as type C, the applicant organisation must satisfy a number of criteria, including the following:

- “A clear indication as to why the post requirements cannot be met through a Type A or B arrangement.”
- “A clear demonstration as to the added patient, service and public system benefits and values to be achieved through establishment of the post as a Type C rather than a Type A or B position.”

The total number of consultants holding category 2, type B* and type C contracts will be subject to an upper limit of such posts within the system. Appendix VII (‘Correspondence between the parties’) suggests that this upper limit will be in the order of approximately 700 posts.

Regulation of private practice

Regulation of private practice for consultants who have type B, B* or C contracts

For consultants who have type B, B* or C contracts, the contract states:

- The volume of private practice in the public hospital(s) and co-located private hospital(s) may not exceed 20% of the consultant’s clinical workload in any of his/her clinical activities, including inpatient, day-patient and outpatient. Appendix VII (‘Correspondence between the parties’) states that “Serving consultants whose public to private ratio in 2006 was greater than 20% will be permitted to retain this higher ratio, subject to an overriding maximum ratio of 70:30.” However, data regarding the public to private ratio of individual consultant anaesthetists were not collected in 2006 and, therefore, cannot be used to determine their permitted public to private ratio under the new contract.
- The volume of practice shall refer to patient throughput adjusted for complexity through the medium of the case mix system.
- The 80:20 ratio of public to private practice will be implemented through the clinical directorate structure. The employer has full authority to take all necessary steps to ensure that for each element of a consultant’s practice; he/she shall not exceed the agreed ratio.
- The consultant will be advised on a timely basis if his or her practice is in excess of the 80:20 ratio of public to private practice in any of his or her clinical activities. An initial period of six months will be allowed to bring practice back into line but if within a further period of 3 months the appropriate ratio is not established, he/she will be required to remit private practice fees in excess of this ratio to the research and study fund under the control of the clinical director.
- The clinical director may exercise some discretion in dealing with the implementation of the ratio either for an individual or a group of

consultants once the overall ratio in relation to the particular clinical activity is satisfied.

- The implementation of the 80:20 ratio of public to private practice shall be the subject of audit, including audit by the Department of Health and Children.

Measurement of the ratio of public to private practice

Each hospital inpatient is admitted under the care of a single primary consultant, e.g. a consultant physician, surgeon, paediatrician or obstetrician. This primary consultant bears overall responsibility for the patient's management throughout his or her hospital stay. A patient may require the services of other, secondary consultants, e.g. consultant radiologists, consultant pathologists or consultant anaesthetists. However, he or she will not be under the care of a single consultant radiologist, consultant pathologist or consultant anaesthetist. For example, a patient who has several surgical procedures and is admitted to an intensive care unit may be cared for by many consultant anaesthetists during his or her hospital stay.

The Casemix System/Hospital In-Patient Enquiry (HIPE) Scheme will be used to provide monthly reports of each consultant anaesthetist's ratio of public to private practice on a casemix adjusted basis. Data will be provided separately for inpatients and day cases. All consultant encounters in a case will be recorded and reported. However, the measurement of a consultant anaesthetist's ratio of public to private practice is predominantly based on his or her direct provision of anaesthesia in the operating theatre. This measurement may not adequately capture the many other clinical activities that are regularly performed by consultant anaesthetists and are given in Appendix 2 of this guideline.

Therefore, the measurement of a consultant anaesthetist's ratio of public to private practice may not accurately reflect either the number of patients for whom he or she has cared or the ratio of 'public patients' to 'private patients'. Consultant anaesthetists should consider maintaining their own records of their public and private clinical activity. These records should include the number of patients and the duration of patient care. If consultants detect any inaccuracies in the measurement of their ratio of public to private practice, these should be brought to the attention of hospital management.

Control by consultant anaesthetists over their ratio of public to private practice

Most consultant anaesthetists have no control over their ratio of public to private practice. With the exception of consultants with a special interest

in pain medicine, they are not primary consultants and are not involved in the scheduling of patients for elective surgery. They also have no control over the number of patients with private health insurance who require urgent admission to hospital and subsequently require the services of an anaesthetist, e.g. patients who require urgent surgery, patients who require obstetric care or patients who require admission to an intensive care unit. The Irish Standing Committee believes that it is not rational to attempt to control the ratio of public to private practice for patients who require urgent hospital admission.

Measurement of the ratio of public to private practice for consultants who work on multiple hospital sites

At present, a consultant anaesthetist who works on multiple hospital sites has his/her ratio of public to private practice measured and reported separately for each hospital site. The Irish Standing Committee believes that, as a consultant anaesthetist's post represents a single appointment, his/her ratio of public to private practice from multiple hospital sites should be aggregated and reported as a single ratio.

Regulation of private practice for consultants who remain on the 1997 (Buckley) Consultant Contract

According to the previous contract, a consultant holding a category 1 contract was permitted to engage in private practice only on the site of the public hospital(s) ('on-site' only). A consultant holding a category 2 contract was permitted to engage in private practice on the site of the public hospital(s) and outside the public hospital ('on-site' and 'off-site').

With regard to 'on-site' private practice, the previous contract stated "a consultant's overall proportion of private to public patients should reflect the ratio of public to private stay beds designated under the 1991 Health (Amendment) Act, which requires that all public hospital beds be classified as public, private or non-designated." This act does not stipulate any particular ratio of public to private beds. However, the Department of Health has determined that the ratio of public to private beds in public hospitals should be 80:20 (the so-called '80/20 split').

5. Consultant work schedule

Introduction

A 'consultant work schedule' or 'practice plan' is a detailed description of the duties and responsibilities of a consultant and of the facilities required to carry them out.

In the previous contract, the 33-hour working week was divided into 11 sessions. Each session had a duration of 3 hours. A session could be fixed or flexible. A fixed session involved work that had to be performed at a particular time and in a particular place, because it required the presence of other members of staff and/or other resources, e.g. outpatient clinics, theatre sessions, ward rounds, investigative and treatment sessions. A flexible session involved work that could be performed more flexibly as regards time and location, e.g. teaching, minor ward rounds, reporting, research, meetings, hospital management and medical audit. The contract stated that "A consultant's commitment shall comprise a mix of fixed and flexible sessions, the ratio of which will vary depending on specialty."

The 2008 contract does not refer to sessions and does not refer to fixed or flexible commitments. Therefore, it gives less guidance than the previous contract regarding the type of work that may be performed as part of the scheduled weekly commitment. Unlike the 2003 consultant contract in the United Kingdom, it gives no guidance regarding the proportion of total working hours that should be devoted to clinical activities (Direct Clinical Care) and non-clinical activities (Supporting Professional Activity). Appendix III of the contract contains a sample consultant work schedule, but the range of clinical and non-clinical activities is very limited and some of the clinical activities are undertaken by only a few consultant anaesthetists, e.g. OPD. This section will outline the features of the contract that are relevant to the consultant work schedule and give recommendations regarding the formulation of work schedules for individual consultant anaesthetists.

Working greater than or less than 37 hours per week

The contract states: "If the time worked consistently and significantly varies from the scheduled commitment, there will be a review of the commitment to ensure that the Consultant is not working regularly in excess of or less than the 37 hour weekly commitment. Where the commitment is being unavoidably exceeded for reasons of a temporary nature, local arrangements will be made to compensate the Consultant concerned."

Non-clinical duties

The contract explicitly mentions the following non-clinical duties of consultants:

- Medical education and training (Section A, part 1; Section A, part 14). This may, with the agreement of the employer, include a structured and scheduled commitment to a medical/dental school or a training body for postgraduate medical education and training (Section A, part 14)
- Research (Section A, part 1; Section A, part 14)
- Maintenance of professional competence (Section A, part 11)
- Clinical audit (Section A, part 12)
- Proactive risk management (Section A, part 12)
- Formal review of “the execution of the Clinical Directorate Service Plan with the Clinical Director/Employer.” This should occur “periodically, at the request of the Consultant or Clinical Director/Employer.” (Section A, part 12)
- Participation in the “development and operation of the Clinical Directorate structure and in such management or representative structures as are in place or being developed.” (Section A, part 12)
- Ensuring, “in consultation with the Clinical Director, that appropriate medical cover is available at all times.” (Section A, part 12). This would obviously include the appropriate rostering of consultant anaesthetists and anaesthetic trainees for daytime and on-call clinical duties
- Participation in “selection processes for non-Consultant Hospital Doctors and other staff as appropriate.” (Section A, part 12)

Maintenance of professional competence and clinical governance

The Medical Practitioners Act 2007 places a statutory obligation on all registered medical practitioners to maintain their professional competence and cooperate with any professional competence scheme developed, established or operated by the Medical Council. The Act also places an obligation on the HSE or other employer to facilitate these activities. Professional competence schemes will be delivered by the postgraduate training bodies.

The College of Anaesthetists of Ireland is accredited by the Medical Council to operate a continuing medical education (CME) credit system for anaesthetists. CME activity is classified into the following categories: (i)

internal activities, (ii) external activities, (iii) personal activities, (iv) research and (v) postgraduate examining, training and supervision (see Appendix 3). At least 50 CME credits must be obtained annually, of which at least 10 credits must be in the internal category and at least 20 credits must be in the external category. The College of Anaesthetists of Ireland also recommends that an individual specialist working in a typical hospital and participating in the emergency on-call rota should have up to date knowledge of and proficiency in the list of 'core topics' in anaesthesia agreed by the Union of European Medical Specialists (UEMS). Consultants should aim to cover all topics relevant to their practice once during a three year cycle.

It is likely that a professional competence scheme for anaesthetists will include activities other than CME, such as peer review, multi-source feedback and clinical audit. The report of the Commission on Patient Safety and Quality Assurance recommends that all healthcare professionals be involved in clinical governance activities, such as the establishment and implementation of evidence-based standards and guidelines, clinical audit, adverse event reporting and participation in CME and competency revalidation programmes. It is essential that all consultant anaesthetists are given adequate time and resources to maintain their professional competence and be actively involved in clinical governance activities.

Performance monitoring

The contract contains several references to monitoring of a consultant's performance:

- "Both the Consultant and the Employer shall co-operate in giving effect to such arrangements as are put into place to verify the delivery of the Consultant's contractual commitments." (Section A, part 4)
- "The scope of this post is as set out in the HSE letter of approval for this position at Appendix 1 and the Job Description as issued by the Employer. These describe the Consultant's service commitments, accountabilities and specific duties...The Consultant's annual Clinical Directorate Service Plan will detail how these are to be implemented and will be validated by a series of performance monitoring arrangements." (Section A, part 9)
- Standard duties and responsibilities include: "To participate in and facilitate production of all data/information required to validate delivery of duties and functions and inform planning and management of service delivery." (Section A, part 12)

As noted on page 16, the previous contract contained several similar references.

Resources

The contract states that it is the responsibility of the employer to provide adequate resources: “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.” (Section A, part 4)

The resources that may be required for consultant anaesthetists to perform their duties have been previously outlined by the AAGBI and are given in Appendix 4 of this guideline.

Advocacy

The core principles of the contract include “recognition of the Consultant’s role as an advocate.” However, the consultant also has a “responsibility, in the first instance, to express any concerns within the employment context.” (Section A, part 1)

Later, the contract states that “In the first instance...advocacy should take place within the employment context through the relevant Clinical Director or other line manager.” The contract also states that “Information given to the public should be expressed in clear and factual terms. It must never cause unnecessary public concern or personal distress, nor should it raise unrealistic expectations.” (Section A, part 16)

Recommendations

- The consultant contract is an agreement between an individual consultant anaesthetist and his or her employer.
- Each consultant anaesthetist who has signed the 2008 contract must agree a consultant work schedule and a ratio of public to private practice with his or her employer.
- The clinical activities of consultant anaesthetists are given in Appendix 2 of this guideline.
- The non-clinical activities of consultant anaesthetists are given in Appendix 3 of this guideline.
- All consultant anaesthetists who have signed the 2008 contract should fully honour their 37-hour scheduled weekly commitment.
- The increase in weekly working hours under the 2008 contract should include an increase in both clinical and non-clinical activities.
- As previously recommended by the AAGBI, approximately 25% of total weekly working hours should be devoted to non-clinical activities.
- Failure to devote adequate time to non-clinical activities may adversely affect the maintenance of professional competence and the quality of patient care.
- Consultant anaesthetists within a department of anaesthesia may have different clinical and non-clinical activities.
- Consultant anaesthetists with additional non-clinical responsibilities, e.g. chairperson or secretary of department, clinical director, should have a reduction in working hours devoted to clinical activities.
- The consultant work schedule should be supported by a robust diary exercise.
- A work diary does not have to be kept permanently. However, it is important that it is representative of the usual hours worked.
- If workload changes, a change in the consultant work schedule may be required.

6. Clinical directors and clinical directorates

Details of the appointment and profile of a clinical director are contained in Appendix IV of the contract.

Appointment of clinical directors

The post of clinical director is appointed by the employer. Applications are invited from all eligible consultants within the clinical directorate and all applicants are interviewed. Alternatively, the body of consultants within the directorate may nominate a candidate. Appointment is initially for two years.

Clinical director profile

A clinical director may cover one speciality area or a range of specialities. Each directorate is headed by a clinical director, generally supported by a nurse manager and a business manager. Each member of staff in the directorate has a reporting relationship, through his/her line manager, to the clinical director. Each consultant who has signed the 2008 contract reports to the clinical director. Clinical directors in a HSE hospital report to the hospital manager or the hospital network manager. Clinical directors in a voluntary hospital or agency report to the chief executive of the hospital or agency.

Clinical directorates

The contract does not give any guidance on the size of clinical directorates. Since the contract was agreed, the HSE has maintained that "Clinical Directorates must be large enough to justify support by business managers... In practice, this means that Clinical Directorates shall be based on a minimum of 30-60 whole time consultant posts." The clinical directors who have been appointed appear to have areas of responsibility similar to those of medical directors in the United Kingdom.

The role and responsibilities of clinical directors and the size and functioning of clinical directorates will undoubtedly undergo considerable evolution in the next few years.

A consultant anaesthetist applying for the post of clinical director should:

- Review and understand the principal duties and responsibilities of a clinical director.

- Consider his/her need for additional training and/or support, either before or after taking up the post of clinical director.
- Discuss the application with his/her lead clinician.
- Discuss the availability of supporting resources with the relevant hospital or network manager(s). These resources may include accommodation, staffing, administrative time and additional training and/or support.
- Discuss the functioning of the post and the important current issues with the existing clinical director (if present).

The discussions with the lead clinician, local manager(s) and the existing post-holder should include consideration of the necessity to reduce clinical commitments and the effect of this reduction on clinical skills, the clinical service and the requirement for locum cover. This is particularly important in a small department or subspecialty group.

Relationship between clinical directors and departments of anaesthesia

The relationship between clinical directors and individual clinical specialties is not specifically discussed in the contract. However, the Irish Standing Committee believes that departments of anaesthesia should ensure the following:

- Each department of anaesthesia has a nominated lead clinician.
- Each department of anaesthesia considers the nomination of consultants with responsibility for anaesthetic subspecialties.
- Arrangements for communication with the clinical director are locally discussed and agreed.
- The clinical service is compliant with the standards set by the relevant professional bodies.

Relationship between clinical directors and consultants who remain on the 1997 (Buckley) Consultant Contract

Consultants who remain on the 1997 (Buckley) Consultant Contract do not have a “reporting relationship” and “accountability for the discharge of his/her contract” to a clinical director. However, as discussed above, they are responsible for “producing a realistic agreed schedule,” “agreeing with management the details of the service levels and mix to be provided” and “supplying to his employing authority such information...as is necessary and reasonable to establish that he is fulfilling his contractual commitment.”

The 1997 (Buckley) Consultant Contract contains the following statements regarding involvement of consultants in management and the role of clinical directors and clinical directorates:

“Consultants need to be involved in the management process. This involvement commences with the consultant’s responsibility to manage his/her own practice and will involve co-operation with colleagues and other health professionals, at department, unit, hospital or hospital group level, extending to involvement in the management of the hospital/hospital grouping through direct membership or representation on the hospital Executive Management Board.” (Consultant contract Section 7.1 and memorandum of agreement Section 6.6.1)

“The recent experience of the pilot projects in a number of hospitals confirms that the concept of a distinct unit, grouping the clinical functions together under the leadership of a selected consultant (e.g. a Clinical Directorate model), represents an effective model to facilitate participation of Hospital Consultants in the management process.” (Consultant contract Section 7.2 and memorandum of agreement Section 6.6.2)

7. Academic consultants

All terms of the contract also apply to the holders of academic consultant posts that have been approved by the HSE/Higher Education Authority. These posts are joint appointments between universities or the Royal College of Surgeons in Ireland and the HSE. In general, the posts are structured to ensure a minimum 50% commitment to the academic institution, but this ratio may vary with the agreement of the employers and the academic consultant.

8. Locum and temporary consultants

Definitions

A locum consultant post is defined as a consultant post that is occupied in a non-permanent capacity by someone other than the legal post holder. The locum acts in place of this post holder during, for example, annual or sick leave.

A temporary consultant post is defined as a consultant post for the interval between a permanent post becoming vacant and it being filled on a permanent basis, or for the interval between a permanent post having been approved by the HSE and it being filled on a permanent basis.

Requirement for locum cover

The Irish Standing Committee recognises that consultant locum cover is necessary in many circumstances, e.g. to cover annual leave, study leave, sick leave or maternity leave. The requirement for locum cover may increase in the future because of the decreased working hours of anaesthetic trainees as a result of the EWTD. The Irish Standing Committee believes that the use of locum and temporary consultant anaesthetists should be minimised and, where possible, these posts should be filled by permanent consultant anaesthetists.

Recruitment and selection of locum and temporary consultants

The HSE has published a revised procedure for recruitment and selection of locum and temporary consultants, with effect from 07 May 2009. This document states that the same qualifications apply to all permanent, temporary and locum consultant appointments. An accompanying circular (HSE HR Circular 014/2009) draws particular attention to the provision that “an individual applicant who is not qualified for appointment as a Medical Consultant on a permanent basis may not be appointed to a temporary or locum position. New appointments to temporary or locum consultant posts require that the appointee be registered on the Specialist division of the register of Medical Practitioners maintained by the Medical Council.” This advice differs from that of the Medical Council which has suggested that entry in the specialist register may not be required for short-term locum appointments. The Medical Council newsletter in June 2009 contains the

following statements: (i) "Trainee specialist registration only permits the practice of medicine within the clinical site/health service setting stated on a doctor's Certificate of Registration or in the clinics/health service settings associated with the training post. Trainees should therefore not fill locum consultant appointments of more than three months' duration. A trainee specialist, in the final year of their training, can act up at consultant grade in that specialty for a period of up to three months." (ii) "The Council has expressed particular concern about any medical practitioner, who is not in the Specialist Division, taking up a locum Consultant appointment of more than three months' duration. Entry in the Specialist Division is the most reliable indication of a doctor's suitability to practise at a consultant grade."

Many existing locum and temporary consultant anaesthetists do not have their names entered in the Register of Medical Specialists in the division of anaesthesia. The Irish Standing Committee believes that all permanent, temporary and locum consultant anaesthetists should have the appropriate knowledge, skills and attitudes to enable them to safely fulfil their role. In addition, all temporary and locum consultants should have the appropriate qualifications for appointment on a permanent basis. However, these new rules will make it more difficult to appoint appropriate candidates to locum or temporary posts. This may affect the delivery of anaesthesia services, especially in smaller hospitals which are more dependent on locum and temporary consultant staff.

Protection of Employees (Fixed-Term Work) Act 2003

This Act implements Directive No.1999/70/EC of 28 June 1999 of the Council of the European Communities. The purpose of the Act is to improve the quality of fixed-term work by applying the principle of non-discrimination and provides a framework to prevent abuse through successive fixed-term contracts.

While the Act specifically excludes persons such as defence force personnel, trainee Gardaí and trainee nurses, there is no specific part of the Act relating to either fully qualified medical staff or doctors-in-training.

"A fixed term employee is a person with a contract of employment entered into directly with an employer where the end of the contract of employment concerned is determined by an objective condition such as arriving at a specific date, completing a specific task or the occurrence of a specific event."

A contract that contravenes Section 9(1) or 9(2) of the Act is deemed to be a contract of indefinite duration (Section 9(3)). The terms and conditions of this contract, except tenure, should be the same as the fixed-term contract at the time of the breach of the Act. Broadly speaking Sections 9(1) and 9(2) distinguish between those employed before and after 14 July 2003. The employer is in breach of Section 9(2) if the aggregate duration of contracts exceeds four years.

The legal situation is less clear for medical employees. In two recent cases brought to the Labour Court by NCHDs in Psychiatry (FTC/07/6 DETERMINATION NO. FTD081 and PTW/05/13 DETERMINATION NO. FTD064), the Court found in favour of the complainants and awarded them contracts of indefinite duration. However, a case taken by a temporary consultant orthopaedic surgeon was rejected (FTC 05/4 DETERMINATION NO. FTD081).

The Irish Standing Committee recommends that independent legal advice on employment law be sought should members have queries regarding this area.

9. The European Working Time Directive

The EWTD is health and safety legislation that is designed to protect you from being exploited by your employer. From August 2004, the Directive has applied to all hospital doctors (European Working Time Directive - IMO AGM 2005 Briefing). The EWTD was originally issued in 1993 (Directive 93/104/EC) and excluded the activities of doctors in training from its application in relation to key provisions regarding working hours. It was amended in 2000 (Directive 2000/34/EC) to reverse this exclusion and provide for a phased reduction of working hours (average 58 hours per week by August 2004, average 56 hours per week by August 2007 and average 48 hours per week by August 2009). A consolidating Directive was published in 2003 (Directive 2003/88/EC) which replaced the previous version of the EWTD and took effect on 02 August 2004. The EWTD has been transposed into Irish law by means of the Organisation of Working Time Act, 1997, and the European Communities (Organisation of Working Time) (Activities of Doctors in Training) Regulations 2004 (S.I. No. 494 of 2004).

Although the EWTD applies to consultants as well as doctors-in-training, the original Directive (Directive 93/104/EC) stated that member states may derogate from its requirements when, “on account of the specific characteristics of the activity concerned, the duration of the working time is not measured and/or predetermined or can be determined by the workers themselves...particularly in the case of...managing executives or other persons with autonomous decision-taking powers.” The Organisation of Working Time Act, 1997, states that the requirements of the Directive shall not apply to “a person the duration of whose working time (saving any minimum period of such time that is stipulated by the employer) is determined by himself or herself, whether or not provision for the making of such determination by that person is made by his or her contract of employment.” It can be argued that this derogation would apply to the working arrangements of hospital consultants.

The requirements of the EWTD are as follows:

Maximum weekly working time:	48 hours, averaged over a reference period
Minimum reference period:	None
Maximum reference period:	6 months
Reference period may include:	Study leave Course leave Exam leave Interview leave
Reference period may not include:	Annual leave Sick leave Maternity leave Adoptive leave
Daily breaks:	At least 15 minutes every 4 hours 30 minutes or At least 30 minutes every 6 hours
Daily rest:	At least 11 hours every 24 hours
Weekly/fortnightly rest:	At least 35 hours rest (11 hour rest period followed by 24 hours rest) once a week or twice a fortnight or At least 59 hours rest (11 hour rest period followed by 48 hours rest) once a fortnight

Compensatory rest must be given to a doctor who has not been granted his or her daily break, daily rest or weekly/fortnightly rest; it must be equivalent to the break or rest which the doctor has not had; and it must be taken before the doctor begins his or her next period of work.

The 2008 contract states that the consultant should “ensure in consultation with the Clinical Director that appropriate medical cover is available at all times having due regard to the implementation of the European Working Time Directive as it relates to doctors in training.” (Section A, Part 12) However, the joint Royal College of Anaesthetists and Royal College of Surgeons of England document, ‘WTD - Implications and Practical Suggestions to Achieve Compliance’ (2009) states: “A 1:8 rota is the minimum to be able to include prospective cover and adequate training. A 1:10 rota allows for more flexibility and training opportunities but it is acknowledged that many of the smaller specialties will be unable to achieve this.” The Royal College of Physicians document, ‘Designing safer rotas

for junior doctors in the 48-hour week' (2006) states: "A 'cell' of 10 junior doctors is necessary for any post that provides 24-hour cover, plus specialty work and training during weekdays." The final report of the Irish National Implementation Group (2008) states: "As NCHD (Non-Consultant Hospital Doctor) rosters are currently structured, any roster of 10 doctors or less is unlikely to comply with the EWTD either from the viewpoint of hours worked or availing of rest periods. In particular it will not be possible to achieve compliance in smaller acute units many of whom currently have duty roster cells consisting of 3-6 doctors."

Therefore, the EWTD can only be implemented when each on-call rota contains at least eight to ten anaesthetic trainees. Many smaller hospitals do not have an adequate number of trainees to achieve this. Attempts to implement the directive with a smaller number of trainees may cause unacceptable decreases in the level and safety of anaesthetic service delivery and the quality of anaesthetic training.

It has been suggested that the two key measures to support EWTD implementation are cross-cover and reductions in layered/tiered on-call. These measures are usually not appropriate for anaesthesia and intensive care services, for the following reasons: (i) trainees in other disciplines do not have the knowledge or skills to provide anaesthesia services; and (ii) reductions in the number of anaesthetic trainees on-call are often impractical because of the necessity to cover multiple clinical areas and the short response time required for many anaesthetic interventions.

Any decrease in the working hours and/or experience of anaesthetic trainees has the potential to increase the workload of consultant staff. If this occurs, changes in consultant work schedules or the appointment of additional consultant anaesthetists may be required.

All changes in working patterns as a result of the EWTD should be carefully evaluated for their effects on the safety of patients and staff.

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Appendix 1. Qualifications for the post of consultant anaesthetist

The HSE has specified that the following qualifications are required for appointment to the post of consultant anaesthetist:

Consultant anaesthetist

Registration as a specialist in the Specialist Division of the Register of Medical Practitioners maintained by the Medical Council in Ireland in the specialty of anaesthesia.

Consultant paediatric anaesthetist

Registration as a specialist in the Specialist Division of the Register of Medical Practitioners maintained by the Medical Council in Ireland in the specialty of anaesthesia

and

Two years' postgraduate training and experience in paediatric anaesthesia.

Consultant anaesthetist with a special interest in paediatric anaesthesia

Registration as a specialist in the Specialist Division of the Register of Medical Practitioners maintained by the Medical Council in Ireland in the specialty of anaesthesia

and

One year's postgraduate training and experience in paediatric anaesthesia.

Consultant anaesthetist with a special interest in pain medicine

Registration as a specialist in the Specialist Division of the Register of Medical Practitioners maintained by the Medical Council in Ireland in the specialty of anaesthesia

and

One year's postgraduate training and experience in pain medicine.

Consultant anaesthetist with a special interest in intensive care medicine

Registration as a specialist in the Specialist Division of the Register of Medical Practitioners maintained by the Medical Council in Ireland in the specialty of anaesthesia

and

One year postgraduate training and experience in intensive care medicine and possession of the Diploma in Intensive Care Medicine or its equivalent.

The qualifications required for a post are set out in the Health Service Executive's Letter of Approval which is attached at appendix 1 of the contract.

Appendix 2. Clinical activities of consultant anaesthetists

The clinical activities of consultant anaesthetists may include but are not limited to the following:

- Provision of anaesthesia in the operating theatre
- Provision of anaesthesia in locations other than the operating theatre, e.g. intensive care unit, coronary care unit, emergency department, radiology department
- Pre-operative assessment in hospital wards, day surgery units and pre-operative assessment clinics
- Post-operative care
- Acute pain management, including acute pain management ward rounds
- Chronic pain management, including chronic pain management ward rounds and outpatient clinics and chronic pain interventional procedures
- Obstetric anaesthesia, e.g. epidural analgesia for labour
- Intensive care medicine, including the assessment and management of patients who may need intensive care in locations other than the intensive care unit, e.g. hospital wards, coronary care unit, emergency department, radiology department
- Resuscitation
- Venous access
- Transfer of patients within the hospital and between hospitals.
- Supervision of the clinical work of anaesthetic trainees
- Handover, e.g. in the obstetric unit or in the intensive care unit
- Administration related to patient care, e.g. documentation, correspondence

Appendix 3. Non-clinical Activities of Consultant Anaesthetists

The non-clinical activities of consultant anaesthetists may include but are not limited to the following:

Administration

- Chairperson of committee or department
- Secretary of committee or department
- Lead clinician in anaesthetic sub-speciality
- Clinical Director
- College Tutor
- Medical Student Tutor
- Membership of committee
- Attendance at multidisciplinary meetings
- Attendance at morbidity and mortality meetings
- Organisation of theatre rota
- Organisation of on-call rota
- Organisation of meetings
- Organisation of courses
- Clinical governance activity
- Organisation of orientation sessions
- Writing of clinical protocols and guidelines
- Audit
- Research
- Managing equipment and drugs in the local theatre environment, e.g. maintenance, supply, reporting, compliance with standards
- Clinical management, e.g. examination of consultant anaesthetist workload and requirements, preparation of application forms and job specifications for new consultant anaesthetist posts
- Recruitment of hospital staff, including anaesthetic trainees, e.g. advertising, short listing, interviewing and selection
- External duties, e.g. Chairperson, Secretary or membership of national committee, Director of training programme, examining in Primary and Final FCARCSI exams, acting as an external member of an advisory appointments committee
- Job planning
- Appraisal

Teaching

- Medical students
- Trainees in Anaesthesia
- Other trainees
- Nursing staff
- Regional or national meetings
- Courses, e.g. ACLS, ATLS, APLS/PALS, exam preparation courses, workshops

Continuing professional development (College of Anaesthetists of Ireland classification)

Internal activities

- Audit meetings, hospital lectures, journal clubs, critical incident meetings, grand rounds, appraisal training, morbidity & mortality meetings
- Hospital lectures
- Attending another consultant's session within the base hospital
- Internet lectures - non-interactive, watched with colleagues

External activities

- Attendance at CARCSI meetings
- Attendance at accredited international meetings
- Attendance at accredited national meetings
- Attending another consultant's session outside the base hospital
- Training courses, e.g. ATLS, APLS, ACLS
- Video conference teaching with live interaction

Personal activities

- Independent study
- Distance learning
- Computer assisted learning
- Watching educational video without colleague interaction
- MCQs in medical journal

Research

- Research meetings
- Presentation of research findings
- Publication in recognised medical journal
- Publication of chapter or book

Postgraduate examining, training and supervision

- College or university examinations
- Trainer in ATLS, ACLS, APLS, etc.
- Preparation of a lecture
- Conducting tutorial

Appendix 4. Supporting resources

The resources which may be required for consultant anaesthetists to perform their duties have been previously outlined by the AAGBI and may include but are not limited to the following:

Staffing support

- Adequate staffing levels within department, to allow absence on Continuing Professional Development activities and other leave
- Resident trainee staff to cover on-call work
- Trained anaesthetic assistance, with adequate orientation for new or temporary staff
- Specialist nursing support, e.g. in pain management, pre-assessment
- Secretarial support
- Technical and information technology support
- Managerial support
- Audit support staff
-

Accommodation

- Office accommodation. The office should be located in a site which is accessible during the normal working day
- Office space for supporting staff, e.g. allied health professionals in pain service
- Secretarial office(s)
- Common room
- Teaching space
- Clinic space as required for pre-assessment, pain clinics or other outpatient work
- Availability of intensive care unit/high dependency unit
- Appropriate space within all theatre areas for changing, rest and refreshment
- 24 hour staffed recovery room

Equipment

- Up to date anaesthetic machines, monitors and other equipment, which comply with published standards and which are regularly serviced
- A dedicated computer for each consultant with access to an appropriate range of programmes and email/internet connection. Software should be up to date

- Access to confidential telephone and fax facilities
- Access to equipment allowing suitable delivery of teaching, e.g. projectors, flip charts
- Adequate secure storage space, both for paperwork and personal belongings
- Secure locker space in theatre
- A constant supply of all sizes of theatre clothing and footwear

Other

- Funding for study leave
- Timely access to a full range of supporting services, such as laboratory services, radiology
- Time allowed for administrative meetings within working hours.
- Access to up to date library services
- Car or bicycle parking, particularly out of hours, should provide for personal safety as well as protecting the vehicle



THE ASSOCIATION OF ANAESTHETISTS
of Great Britain & Ireland

21 Portland Place, London, W1B 1PY
Tel: 020 7631 1650
Fax: 020 7631 4352
Email: info@aagbi.org
www.aagbi.org