CONAL DEVINE & ASSOCIATES
management consultants

13 February 2020

RECEIVED
14 FEB 2020

Mr. Val Moran
Director of Industrial Relations
General Practice, Public & Community Health
Irish Medical Organisation
10 Fitzwilliam Pl.
Dublin 2

Re: Review of Terms and Conditions of Employment, Community Ophthalmic Physicians

Dear Mr. Moran,

I enclose the final report of the above review in accordance with the terms of reference for the above review process.

If you have any queries in respect of the enclosed, please do not hesitate to contact me.

Yours sincerely,

Conal Devine
BCL Dip. Arb.

Encl.

Conal Devine & Associates Limited
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Company Reg No.: 298824 *VAT No.:* IE 8298824k *Witholding Tax No.:* 702188
Directors, Conal Devine BCL Dip Arb (Managing Director), Owen O'Mahony BCL Solicitor
Company Secretary Patricia Keohane BA, Mediator and Counsellor

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Independent Review of Community Ophthalmic Physician Salary, Terms and Conditions

February 2020

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1. Terms of Reference and Methodology

1.1. Terms of Independent Review of COP Salary, December 2018

This referral arises from the agreement between the Health Service Executive ("HSE") and the Irish Medical organisation (the "IMO"), give effect to Section 6.8 of the Primary Care Eye Service Review Group Report 2017

1. *The Primary Care Eye Service Review Group Report 2017 (PCESRGR) placed special emphasis on the role of the Community Ophthalmic Physicians (COPs) and ow their role would change through the implementation of the Report's conclusions. The scale of this change incorporates several elements, most notably:*

- *A shift of work from the hospitals to primary care setting.*
- *The establishment of Primary Care Eye Teams (PCET) requiring COPs to work in teams with members including optometrists and technicians.*
- *The design and development of care pathways.*
- *The introduction of new team-work arrangements and ways of working.*
- *The creation of new clinical and business governance arrangements*
- *The provision of a quality assurance and performance management system.*

2. *The Report provides for an examination of grades and roles, specifically Clause 6.8, Note 5, "the grading of posts may be modified as implementation progresses and the detail of staff roles are further agreed" and noting that the implementation of the report has commenced and the new role for COPs has been defined, it is agreed that a review of the grade of COPs is required.*

3. *The methodology to be used is as follows:*

   An examination of the additional roles and responsibilities involved in the transition to the new ways of working as set out in the Primary Care Eye Services Review Group Report.

   An examination of comparable grades within the HSE against which the role may be benchmarked.

Any agreed new salary will be subject to adjustments in accordance with relevant national public sector pay agreements
The review will accept written submissions from both the HSE and IMO with regard to their views on the new role and responsibilities.

4. *The person to conduct this review is Mr Conal Devine, of Conal Devine & Associates.*

5. *The report from the review will be presented to the HSE and the IMO*

6. *The target is to complete the report within 8 weeks of the commencement date.*

7. *Following completion of the review representatives from the HSE and IMO will meet to discuss the outcome of the review and agreed on next steps.*

8. *The HSE will endeavour to ensure that there is no unnecessary delay in seeking permission from the Department of Health/Department of Public Expenditure but it is recognised that implementation of findings/recommendations from this review will be dependent on such approval.*

9. *It is agreed between the Parties that the recommendations from the report are non-binding. In the event that the recommendations are provisionally agreed by the HSE and IMO, the IMO will revert to their members before entering into any binding agreement. For its part the HSE is required to obtain the approval to implement the report's findings from the Department of Health/Department of Expenditure and Public Reform.*

2. Introduction and Background

2.1. Introduction

2.1.1. This Review has been commissioned as a direct consequence of recommendations made in the Primary Care Eye Services Review Group Report (HSE April 2017). That report concluded that increasing patient numbers and a growing of chronic eye diseases were "*placing an enormous strain on the current model of eye care*". The model of eye care in the Irish Health Services has been based around effective Consultant led Ophthalmology units across 11 acute hospitals and community based medical ophthalmic services, with distinct geographical variations in respect of the staffing, structure and delivery of these community based services. The Eye Services Review Group Report describes the primary care eye services as "fragmented" with varied clinical governance systems and concluded that:

"*This presents risks as a result of isolated work, absence of standardised teamwork, peer review and often under-resourced services. In addition, regular engagement between the specialist eye service and the screening and surveillance services may be absent, resulting in poor communications and sometimes suboptimal referral practices*" [para 4.7].

2.1.2. The Primary Care Eye Services Review Report pointed to deliveries in the existing national structure for primary care services which did not facilitate shared learning , standards of work practices and efficiency measures, quality and service initiatives. The Report also commented on disparate reporting relationships, and an absence of formal contract/service level agreements supporting formal clinical governance arrangements which the Report found presented "*...a significant risk in assuring the quality, safety, and effectiveness of the services provided*".

2.1.3. The Primary Care Eye Services Review sets out (in chapter 6 of the Report) a "*Blueprint for the future provision of Primary Eye Care Services through:*

- *The establishment of Primary Care Multi Disciplinary Teams in each Community Health Organising (CHO) Area*
- *The introduction of defined clinical and administrative governance in respect of each Primary Care Eye Team (PCET)*
- *Clear stress links being established with acute hospital based Ophthalmic services*
- *That in addition to Ophthalmic Physicians in the PCETs providing leadership in governance, the team would also include other Medical Ophthalmic Physicians, Optometrists, Orthoptists, Nurses*

with special training in Ophthalmic care, technicians and administrative staff."

2.1.4. The Report has also detailed the staffing required to support proposed care pathways across population and eye disease categories which would allow for a significant shift of 60% of existing OPD eye services workloads from acute hospital units to a primary care setting. The Report concludes that this would assist in managing waiting lists more effectively and in delivering services in the setting most appropriate for the population and eye disease category.

2.1.5. The Report, following a substantial workforce planning exercise, detailed the national total of staffing requirements to service the major paediatric and adult eye conditions that would present to the newly established PCET's through defined care pathways. The principal staffing structure envisages an increase in Community Ophthalmic Physicians, including lead Medical Ophthalmologist, from 33 whole time equivalents to 59 whole time equivalents (wte's), substantial increases in Orthoptist posts and the engagement of up to 63 Optometrist posts as part of the PCET's. The Report envisaged that the proposed clinical lead posts in each PCET would be subject to the "usual processes to agree remuneration and working terms and conditions relevant to the responsibilities of the post". However, the Report (at Note 5 of Section 6.8, page 90) also envisaged that "*..the grading of posts may be modified as implementation progresses and the details of staff roles are further agreed*". In order to give effect to the above provisions, agreement was reached between the HSE and the Irish Medical Organisation which led to the commissioning of this Review under the Terms of Reference outlined in section 1 above. It should be noted that following the commencement of this review, the HSE announced revised integrated service area structures which will replace existing LHO and Hospital Group structures. Regard has been had to that proposed structure in formulating recommendations set out in section 5 below.

2.2. Historical background

2.2.1. The provision of public Medical Ophthalmology services has historically been delivered on a sessional basis, with a figure of 12 patients per three hour sessions being first formally recognised in the mid 1960's. 24 County Occultists (remunerated at equivalent levels to acute hospital based Consultant Ophthalmic Surgeons), were attached to Health Board clinics with approximately 80 Ophthalmic medical practitioners providing community based services on sessional rates with a higher rate payable for clinics outside of a twenty five mile radius. Limited medical 0phthalmology

services were also provided by District Medical Officers, particularly around eyesight testing and prescription of spectacles.

2.2.2. The phasing out of the District Medical Officer structure and the introduction of the General Medical Services scheme, reduced the availability of community Ophthalmic services, coupled which the ongoing development of hospital based Ophthalmic services (70% of all health funding in the 1960's was allocated to Hospital care [*Daly, UCD, 2012*]), accordingly, a pattern of patients attending hospital out patient eye clinics rather than the limited community based Ophthalmic services, continued apace.

2.2.3. Attempts to regularise contractual arrangements for Community Ophthalmologists continued through the 1970's and 1980's with a Revised Sight Testing Scheme agreed in 1979 and a determination made that "County Ophthalmologists" would deliver the service on the basis of a minimum commitment of 4 three hour sessions and a whole time equivalent of 9 three hour clinical sessions, and 2 two and a half administrative sessions. Such commitments were to include acute hospital/regional eye unit sessions. The Joint Working Group, which recommended the above arrangements in October 1979, also recommended that the sessional calculation would be based on the top point of the Senior Area medical Officer scale.

2.2.4. With the phasing out and non-replacement of County Occultist posts, a further Joint Working Group was established in 1980 to determine the number of what it termed "Community Ophthalmic Physicians" required. Comhairle na nOspidéal subsequently produced a paper emphasising the need to develop both community based Ophthalmic Medical services in the community and hospital based acute eye services.

2.2.5. Attempts were again made to regularise the above anomalies in the early 1990's which resulted in a Department of Health Circular (S200/49) being issued, defining the role of the Community Ophthalmic Physician based on seeing 12 patients per 3 hour session with CME funding, separate additional per patient fees when called to see patients attending Accident and Emergency Departments as well as administrative and Orthoptic support. Further reviews of the post were conducted in 1996-1998 where it was noted that Community Ophthalmologists would be entitled, on the basis of training/experience, to a certificate of completion of specialist training and to apply for specialist registration on the Medical Council Specialist Registrar. It was argued at the time that the historical links to the top of the Senior Area medical Officer scale was anomalous. An independently chaired Working Group, including Medical Ophthalmologists. The IMO, and Department of

Health, concluded that there was a case to be made for the establishment of a Medical Ophthalmology Consultant grade.

2.2.6. Throughout the 1990's disparate service and contractual arrangements became established in different geographical areas. Some Health Boards were proactive in establishing clear operational structures with managerial governance. These disparate arrangements included combinations of both the sessional rate based on the relevant incremental point of the Senior Area Medical Officer (SAMO) scale, (and not reportedly the top point as had been reportedly approved), and the historical "Consultant" sessional rate. The latter arrangement resulted in some Community Ophthalmic Physicians being paid at a lower rate than the SAMO based sessional rate, and this anomaly was compounded by the lower rate paid for a second session, if the first session was claimed as arising outside of a twenty five mile radius.

2.2.7. While there was a common training requirement for Non Consultant Hospital Doctors, leading to either/ or both Specialist Registration as an Ophthalmic Surgeon and/or Medical Ophthalmologist, with the Medical Council, a newly configured National Medical Ophthalmology programme was initiated in July 2018, comprising of 3 core years, MRCS qualification followed by 2 years of subspecialty training (Paediatrics, Glaucoma and Medical Retina). Accordingly, potential trainees are now faced with an earlier decision than heretofore, on embarking on either a Surgical or Medical Ophthalmology career. The absence of a clear parallel career path in Medical Ophthalmology compared to Ophthalmic Surgery, is noted. While the recommendations of the Primary Care Eye Services Review Group envisaged a Community Ophthalmic Physician lead for each Community Health Organisation, steps were taken in the course of this review process to proceed to draft a revised job description and to seek approval for new Consultant Medical Ophthalmologist posts. In the absence of an agreed revised job description, it was not possible to advance this Review. Ultimately, a job description for a Medical Opthalmologist was agreed between the parties on 16 October 2019 and furnished to the Reviewer on 17 October.

2.2.8. It is noted that the HSE has announced on 17 July 2019 that there was a planned restructuring of the Health Services into 6 Integrated Service Areas from the existing 9 CHO's and 7 Hospital Groups. It is noted that the recommendations made in the Primary Care Eye Services Review Group Report, were based on 9 Community Health Organisations within which multi-disciplinary primary eye care teams would be established under Medical

Ophthalmic clinical leads, and interim recommendations will be made, in this Review, on the basis of the existing Community Health Organisation structures. It is also noted that in July 2019 the National Treatment Purchase Fund (NTPF) announced a hospital out-patient waiting list in Ophthalmology of 44,000 patients, and it is estimated that a further 30,000 out patients await assessment and treatment in the community. It follows that while there are challenges on rolling out the recommendations of the Primary Care Eye Services Review Group, there are quantifiable service delivery improvements in implementing these recommendations, central to which is the structuring and regularisation of both existing Community Ophthalmic posts within multi-disciplinary primary eye care teams and the introduction of clinical posts in Medical Ophthalmology at Consultant level.

2.2.9. It is noted that three wholetime Consultant Medical Opthalmologist Posts were structured and advertised in Autumn 2019. The service commitments are predominantly weighted to the respective Community Healthcare Organisation with three sessions assigned to the relevant acute hospital regional eye unit

- Post 1: Community Healthcare Organisation Area 6 30hrs/ Royal Victoria Eye and Ear Hospital 9hrs
- Post 2: Community Healthcare Organisation Area 7, 30hrs/Royal Victoria Eye and Ear Hospital 9hrs
- Post 3: Community Healthcare Organisation Area 9, 30hrs/Mater Misercordiae University Hospital 9hrs

It is further noted that these appointments are to the Community Healthcare Organisation Area 6/7/9 on a Type B basis under the Consultants' Contract 2008 by the Health Service Executive.

3. Review Methodology and Process

3.1. Review Process

3.1.1. The Review Process formally commenced in March 2019 following an initial meeting and exchanges of correspondence with the HSE and the Irish Medical Organisation. A draft revised job description was provided for a "Consultant Ophthalmic Physician / Medical Ophthalmologist" post, which had been the subject of discussions between the stakeholders, but remains in draft form. The draft job description relating to Consultant Medical Ophthalmologist posts was superseded by the structuring of such posts in accordance with the Consultant Contract (2008) Type B. A job description for a Medical Ophthalmologist grade, working with and reporting to the Consultant Medical Ophthalmologist was agreed between the parties on 16 October 2019

3.1.2. The Irish Medical Organisation submitted a written submission, on behalf of its members, which is attached as appendix... to this Report. Both the IMO and the HSE suggested that key individuals would be interviewed in connection with the review process and those individuals were written to in mid- March 2019. Throughout late March, April and May 2019 discussions took place with a range of stakeholders as follows:

- 6 existing Community Ophthalmic Physicians
- 2 Consultant Ophthalmic Surgeons
- The Irish Medical Organisation
- The College of Ophthalmology
- HSE Community Health Organisation
- Acute Hospital Regional Eye Unit
- Two Primary Care Eye Units, one largely rural, one urban.

3.1.3. The College of Ophthalmology provided valuable assistance by way of a published survey of both Medical and Surgical Ophthalmologists engaged in higher specialist training " Training & Retaining the Ophthalmology Workforce –NTPD-HSE Development Funding 2016-2017 Evaluation" (May 2018).

3.1.4. Individual Community Ophthalmic Physicians submitted written supporting submissions outlining the service and industrial relation context regarding the post as well as detail on existing structural and operational issues relating to the medical ophthalmology service in their area.

3.1.5. Following the initial contacts the Reviewer sought clarification from both the HSE and the IMO on the status of the parallel developments regarding Consultant Ophthalmic Physician posts. Clarification was also sought on the job description that would apply to existing Community Ophthalmologists who were either not currently eligible for Consultant appointment or unsuccessful in any competitions for appointment to Consultant posts, should they become available throughout the existing Community Health Organisation structure. The job description for such posts was agreed in October 2019 and is attached as appendix .... To this report.

3.1.6. In order to assist the parties in clarifying the issues set out in paragraph 3.1.5 above, a report with preliminary recommendations was issued to the parties. A final report with findings and recommendations was concluded following receipt of comments from the parties/relevant stakeholders.

3.2. Review Methodology

3.2.1. The methodology attached to the Terms of Reference for this process envisages that the additional roles and responsibilities involved in the transition to the " *new ways of working*" as set out in the Primary Care Eye Services Review Group Report, would be reviewed against comparable grades within the HSE. It is recognised that there are some geographical areas that have progressed to a community service based multi- disciplinary team approach to eye care, and who work closely with the Regional Acute Hospital Eye Units. However there are other areas that, notwithstanding the dedication and commitment of Community Ophthalmic Physicians have relatively underdeveloped services. Some of those services do not have the type of established links with Regional Acute Hospital Eye Units, or a multi-disciplinary and sub specialty delivery profile, as envisaged in the recommended model of care. While it is envisaged in the PCES Review Group report that all CHO's would move toward the recommended model of integrated eye care, the reality is that some areas are further along that journey than others. Accordingly, this Review has to have regard for not only the existing structures but also to take a prospective view of the implementation of new structures in a manner that recognises existing roles, and anticipates future developments as outlined in the revised model of care.

3.2.2. The Review has also had regard to the Report of the Dáil Committee on the Future of Health Care -The *Slaintecare* Report, May 2017, and noted the recommendations in that Report which complemented the findings of the Primary Care Eye Services Review Group Report, relevant to this review, including;

- The movement toward a model of integrated care across acute and primary care settings
- The provision of care at the lowest level of complexity
- Seamless care between hospital and community based services in the best interests of the service user
- Building capacity in primary care to address high levels of unmet need
- Achieving greater clarity around clinical governance, leadership and accountability.

3.2.3. The methodology for this Review also envisages that there would be an examination of comparable grades within the HSE against which the role Medical Opthalmologist may be benchmarked. In the absence of implemented job descriptions, this presents self-evident challenges. In addition, while it is the case that there are no agreed job evaluation schemes in the Health Services for grades above Grade 6, including clinical grades, agreed schemes have existed in the Irish Health Services since 1971 for grades at or below Grade 6. The principal scheme applied to Clerical and Administrative posts [Grades 2-6] and the principal factors associated with that scheme as well as variations thereof, have been applied on a once off ad-hoc basis to evaluations of other grades. The Clerical/Administrative Job Evaluation Scheme was modernised following discussions involving Management and Unions, and agreement concluded in 2008. However, in early 2009, the Chief Executive of the HSE – Employers Agency advised that in the context of cost containment measures, which ultimately formed the basis of the Haddington Road Agreement, the revised Evaluation Scheme was suspended. The revised scheme, limited to Grades 2-6, has been introduced from late 2016. The factors identified in that scheme fall to be considered under the following headings:

1. Professional and Technical Competence
2. Problem Solving
3. Decision Making
4. Responsibility and Accountability
5. Communications

3.2.4. The report of the Public Service Benchmarking Body [June 2002] detailed generic descriptions relating to various grades within the Health Services. The second report from that Body [2007] confirmed the continued application of the Job Evaluation Scheme originally applied in the 2002 report. The Public Service Benchmarking Body prepared a bespoke job evaluation scheme, adopting an analytical approach based on points assessed per grade utilising the following factors:

(i) Knowledge and skills
- Education
- Experience
- Breadth and Depth of Knowledge

(ii) Judgement
- Precedent and Practice
- Variety of Problems
- Creativity and Complexity

(iii) Leadership and Teamwork

(iv) Accountability and Responsibility
- Making Decisions
- Responsibility for Resources
- Job Impact

(v) Interpersonal/Communications Skills

(vi) Physical Demands and Coordination
- Strength and Stamina
- Coordination and Dexterity

(vii) Conditions and Emotional Demands
- Working Environment
- Emotional Demands

Both Benchmarking reports were governed by terms of reference which stipulated that cross sectoral relationships were incompatible with the benchmarking process.

3.2.5. The Office for Health Management developed a competency framework for Clerical/Administrative to Senior Management roles within the Health Services over a three year period in the early 2000's, completed in 2004. The competency framework provides guidance on the application of 14 competencies across grades from grade IV to General Manager and membership of the Senior Management Team. The framework also allows for comparison between competencies expected from each range of grades.

3.2.6. Equal Opportunities/Diversity policies within the HSE stipulate that promotion and regrading will be decided on objective criteria relevant to the objectives of the job. Accordingly, the adoption of analytical approaches to job evaluations have been designed to

exclude the possibility of gender or other discriminatory bias through the adoption of objective criteria.

3.3. *Methodology Adopted for this Review*

3.3.1. In the absence of an agreed evaluation scheme for Health Service Grades above Grade 6, the methodology adopted exclusively for this salary review has had regard to the background and principles associated with the implementation of job evaluation processes within the Irish Health Services as set out in section 3.1 above. The factors identified as being appropriate for adoption in respect of this exercise is based on an analytical approach assessing the grade against the following factors:

1) Professional and Clinical/Technical Competence and Experience
2) Problem Solving
3) Judgement and Decision Making
   - Type of decisions
   - Impact on Decision Makers
4) Responsibility and Accountability
   - Leadership and Teamwork
   - Resources Management
5) Communications
   - Level of Contacts
   - Interpersonal Skills

The above factors can be defined as including the following:

3.3.2. Professional and Clinical/Technical Competence and experience

- The knowledge and competence typically required to perform the duties associated with the post. This includes all technical, clinical, specialist, procedural and organisational knowledge required to perform the job to a competent standard.
- The length of time reasonably required in education, training, direct or indirect work experience to reach a competent standard in the role.

3.3.3. Problem Solving

- The intellectual and clinical/technical challenge associated with the problems the grade holder is required to solve
- The intellectual analysis, including research, required to resolve a problem
- The independent initiative and innovation reasonably expected of a grade holder in resolving a problem.
- The evaluation of information to inform strategic planning of effective service delivery

3.3.4. Judgement and Decision Making

- The nature of the personal accountability for decision making for which the post holder is personally responsible
- The level of influence the grade holder has on decision makers
- The extent to which the grade holder is consulted by decision makers prior to decisions being made
- The nature/complexity/level of decisions that the grade holder is consulted on/has influence on

3.3.5. Responsibility and Accountability

- The level of responsibility for supervision direction and coordination of other staff
- The leadership of, and involvement in, multi- disciplinary team working
- Responsibility for financial resources
- Responsibility for physical resources and assets
- Responsibility to facilitate change and improve service delivery
- The responsibility of the post holder for the processing and maintenance of physical, intellectual primary and electronic/information assets across the organisation

3.3.6. Communications

- The levels at which there are ongoing contacts with people/other post holders within the organisation and external to the organisation

3.4. Internal Relationships

3.4.1. Internal relationships within medical grades providing eye care services within the public health services (HSE/Section 38 Agencies) were considered, including:

- Consultant Ophthalmic Surgeon (Contract B)
- Job Description Consultant Medical Ophthalmologist (Contract B)
- Specialist Registrar

3.4.2. Regard was had to the historic pay relationship with the Senior Area Medical Officer Grade

3.4.3. Regard was had to other HSE clinical grades to assess whether appropriate comparisons could be made, utilising the analytical factors, including:

- Principal Dental Surgeon (Regional Duties Allowance)
- Specialist in Orthodontics
- Specialist Public Health Medicine

3.5. Job Descriptions

3.5.1. Job descriptions of grades identified in section 3.4 above were examined by way of a desk top exercise.

3.6. Compliance with Health Sector Pay Policy

3.6.1. The Review has had regard to the provisions of public pay policy for the Health Sector and, in particular, the provisions of HSE Circular 30 September 2013 which specifies adherence to the Department of Health Consolidated Salary Scales.

4. Findings

4.1. Introduction

4.1.1. This Review takes place against a background of parallel initiatives regarding the approval and advertising of Consultant Medical Ophthalmologist posts, following initiatives taken by a number of Community Health Organisations. It is understood that, at this point, the roll out of any such posts nationally and the number of such posts to be established, has not been finalised. It is also understood that those posts may discharge the "Community Ophthalmic Physician Lead" for each of the existing 9 Community Health Organisation as recommended on page 90 of the Primary Care Eye Services Review Group Report. The Report also envisages that a further 50 whole time equivalent Medical Ophthalmologist posts would be required to discharge existing clinical services and to make significant inroads into acute hospital OPD lists through a transfer of up to 60% of those lists to the newly established Primary Eye Care Teams. This will require, in some areas, a fundamental re-structuring of services to ensure that a comprehensive specialty and sub specialty service covering the major groups of Eye Disorders in Children and Adults can be introduced. In other areas where services are more developed, and where existing Community Ophthalmologists provide an integrated range of eye care services, the new structures will present real opportunities for the delivery of enhanced and better integrated and responsive eye care services to patients in the most appropriate setting, with clinical governance and leadership provided by Medical Opthalmologists within defined criteria and otherwise through the relevant Consultant Medical Opthalmologist(s). It could also involve enhanced roles and opportunities to Medical Ophthalmologists, particularly around the delegation of Regional/CHO responsibilities

to them for the main categories of Eye Disorders in Children and Adults, as well as providing day to day clinical leadership at Primary Eye Care Team level. There may also be other existing Community Ophthalmologists who wish to broadly continue to focus on service delivery only. In order to assist with the transitional arrangements that will be required to introduce the recommended model of eye care, while maintaining the safety and integrity of the existing community based eye service delivery system, those transitional arrangements must also have regard to the regularisation of terms and conditions of employment applicable to existing community based Medical Ophthalmologists . Regard must also be had to ensuring that there is a clear career path for those currently undertaking higher specialist training in Medical Ophthalmology and those existing medical ophthalmologists who aspire to Consultant Medical Opthalmologist posts

4.1.2. It is acknowledged that the findings of this review, if implemented, will represent a substantially changed role and significant additional responsibilities for the enhanced Medical Ophthalmologist Grade. From a service delivery perspective, it is clear that the regularisation and enhancement of the role will, equip both primary eye care and acute hospital eye care services to jointly address hospital ophthalmology waiting lists on a qualitative, quantitative and measureable basis. It is also noted that the findings are consistent with the main recommendations of the Slainte Healthcare Report as summarised in section 3.2.2 above, and are consistent with the stated HSE priorities around the provision of high quality, accessible and safe, community based care.

4.1.3. Having regard to the considerations set out in Section 4.1.1 and 4.1.2 above, findings and recommendations are set out below.

4.2. Competencies attaching to (enhanced) Medical Ophthalmologist Grade

4.2.1. Professional and Clinical Technical Competence and experience;

(The professional/technical competence required to perform the role to a competent standard)

- Post holders and aspirant post holders require Specialist Registration in the division of Ophthalmology with the Irish Medical Council

- Post holders and aspirant post holders must demonstrate extensive experience in the provision of Opthalmology services in a community setting
- Post holders and aspirant post holders must have experience of working with a multidisciplinary team and show an ability to lead a team in service delivery

4.2.2. Problem Solving;

(The intellectual challenge of the work including:
- The range of problems the jobholder is expected to solve
- The degree of analysis required
- The degree of initiative and innovation required)

- Postholders must show the experience and ability to evaluate information and to make effective decisions especially with regard to service delivery
- The work is varied, with some diversity, and will involve reaching solutions to problems across a number of knowledge areas at clinical and management levels
- The work requires extensive inquiry and interpretation and some innovative thinking and problem solving in complex specialist areas where precedent may not always be available

4.2.3. Judgement and Decision Making;

(The type of decision making which the post holder is personally responsible and the effect of those decisions as well as the post holders impact on decisions of other people within the HSE)

- The work requires decision making relating to functional/discipline authority and includes involvement in setting objectives and targets which affect the multi- disciplinary operating group and which may affect strategic groups and larger projects
- Judgements and decision making which fall outside agreed objectives or the functional authority of the post will be referred to the Head of Service/ Consultant Medical Opthalmologist, where appropriate
- The post holder will provide full service analysis and recommendations which will inform decision making at strategic and policy making levels

4.2.4. Responsibility and Accountability:

(The extent to which the role contributes to team objectives, co-operates with other teams and disciplines and/or is responsible to lead others in the achievement of organisational objectives)

- The work will involve leading a number of multi-disciplinary teams with full management responsibility for supervision.
- The leadership role will include planning, directing and co-ordinating the work of multi –disciplinary staff, monitoring and reviewing work to ensure a consistently high clinical service standard.
- The leadership role will involve taking responsibility for the motivation, growth and productivity of multi-disciplinary staff and in ensuring the well-being of those staff, sustaining morale and fostering accountability
- The role will include the provision of clinical governance at multi- disciplinary team level within agreed objectives. Clinical governance requirements arising beyond those objectives, including risk escalations, for the overall clinical service will be for referral to the designated Consultant Medical Ophthalmologist
- The post is likely to have responsibility for the effective management of resources in the delivery of one of a number community ophthalmic services within a Community Health Organisation

4.2.5. Communications

(The responsibility to communicate with, respond to, and keep informed, other people inside and outside the organisation)

- The post holder is expected to maintain contacts with a wide range of people within and outside the HSE, and frequently at senior management levels
- The post involves exercising a high degree of communication, negotiation and persuasive skills on jointly addressing important challenges

4.3. *Comparative Exercise with other posts within clinical eye service delivery*

4.3.1. This comparison is based on direct interviews, and desktop examination. A bespoke scoring schedule will be utilised for the purpose of this Review only, broad identifiers in respect of comparative scoring ranges are outlined below.

	COPs	Medical Ophthalmologist (enhanced)	Consultant Medical Ophthalmologist	Consultant Ophthalmic Surgeon	Specialist Registrar
Professional & Clinical/Technical Competence	V	VI	VII	VII	IV
Problem Solving	V	VI	VII	VII	IV
Decision Making	V	VI	VII	VII	III
Responsibility & Accountability	IV	V	VII	VII	III
Communications	IV	V	VII	VII	III

4.4. Comparators in related clinical and community health settings (to be completed following confirmation of revised job description)

	Senior Area Medical Officer	Specialist in Public Health	Principal Dental Surgeon (Regional and additional Responsibilities)	Specialist in Orthodontics
Professional & Clinical/Technical Competence	V	VI	VI	VI
Problem Solving	V	VI	V	VI
Decision Making	IV	VI	VI	VI
Responsibility & Accountability	IV	V	V	V
Communications	IV	VI	V	V

4.5. Salary Scales as of 1/1/2019

Exiting Community Ophthalmic Physician	€95,134
Consultant Medical Ophthalmologist	€133,128-€175,082
Principal Dental Surgeon with regional and additional responsibilities	€92,594 -€111,859
Specialist in Orthodontics	€145,494
Specialist in Public Health	€113,000

4.6. *Findings*

4.6.1. On the basis of the review undertaken, the findings is that an examination of the identified factors, including accountability, scope and responsibility of the prospective Medical Opthalmologist posts, supports the establishment of such posts.

4.6.2. The establishment of the prospective Medical Ophthalmologist posts, is also supported by the specific recommendation of the Primary Care Eye Services Review Group Report (HSE April 2017) and is consistent with the findings and recommendations of the Slāintecare Report, which is informing HSE priorities in relation to the provision of high quality, accessible and safe care, including community-based care.

4.6.3. The review finds that the salary for the enhanced Medical Ophthalmologist post ought reasonably fall for consideration within a range below the current Type B Consultant salary, at entry level only (but not linked to such salary, which is the subject of separate review), and above the existing Public Health Specialist salary (but not linked to such salary, which is the subject of separate review).

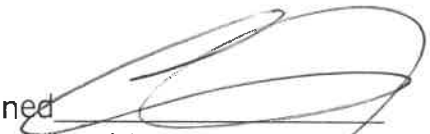
5. Recommendations on Enhanced Medical Ophthalmologist Posts

5.1.1. On the basis of the information examined in the course of this Review it is clear that a continuation of the historic salary linkage with the Senior Area Medical Officer is anomalous and requires to be regularised to reflect the enhanced role which will now be expected of all existing Community Ophthalmic Physicians, as Medical Ophthalmologists, but in particular those who will be at the forefront of primary eye care multi-disciplinary teams, both from a clinical and from a managerial perspective. In order to identify where existing post holders are already undertaking substantial elements of those enhanced duties, a post by post examination should be undertaken by the HSE to identify those posts where the following enhanced structures are in place and services are already being provided

I. A functioning multi-disciplinary team is in place, with the full involvement of the post holder (the Medical Ophthalmologist)
II. The post holder is on the Medical Ophthalmology Specialist Register of the Medical Council
III. The post holder is linked to a regional acute eye unit
IV. The post holder is actively involved in the provision of training to other eye care disciplines
V. The post holder is regularly engaged in continuing medical education appropriate to the delivery of community based eye services
VI. The post holder is either committed to provide emergency call out services or is undertaking such services as requested
VII. The post holder is either committed to the provision of outreach eye care services or is undertaking such services as requested
VIII. The post holder has a role in compiling and submitting service data for audit and service planning purposes
IX. The post holder is undertaking, and is qualified to undertake, a delegated geographical/ team lead clinical role for any one or more of the following service and eye disorder categories
    - Paediatric Eye Care
    - Eye Care for children and adults with special needs
    - Eye Care in respect of Advanced Macular Degeneration
    - Glaucoma Care (non-surgical)
    - Neuro Ophthalmology care (non-surgical)
    - Minor Injury/ corneal foreign body care
    - Diabetic Retinopathy

5.1.2. It is recommended that those posts that meet the criteria set out in section 5.I.1 ought to be regularised, with a defined working week, at an enhanced scale having regard to the agreed job description for the post. Where posts are not deemed to meet the criteria, such posts ought to be re-structured in accordance with the principles underpinning the enhanced model of care as recommended by the Review Group and to have regard to the criteria set out in paragraph 5.1.1 above. Such latter posts ought to be advertised and filled as normal and the full range of clinical, managerial and other responsibilities discharged within a defined working week and in accordance with the attached agreed job description. Where existing post holders are not successful in applying for enhanced posts or wish to remain on their existing terms and conditions as Community Ophthalmic Physicians, it is recommended that such posts be red –circled to the individuals concerned and advertised and filled in accordance with the enhanced Medical Ophthalmologist role, when vacant.

5.1.3. While it is recognised that many existing Community Ophthalmic Physicians are eligible to apply for the new Consultant Medical Ophthalmologist posts, as they become available, it is recommended that continuing medical education supports and facilities are put in place to ensure that there is a clear career pathway for Non Consultant Hospital Doctors undergoing higher specialist training, and for Medical Ophthalmologists, to advance to Consultant Medical Ophthalmologist , should post holders aspire to progress to Consultant status.

Signed 
Conal Devine, BCL Dip Arb

Date 13 Feb 2020