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Report on Developing Clinical Measurement Conducted on behalf of the

Health Service Executive

June 2010

Resource
Employee Relations

Table of Contents

Background

Following ongoing discussions between the Health Service Executive and IMPACT on behalf of Clinical Measurement staff, a dispute in relation to certain aspects was referred to the Labour Relations Commission regarding a review of the Grade to cover issues such as

- career structure,
- professional title,
- workplace title,
- quality awareness and standards, and
- training and development.

Agreement was not reached between the parties in conciliation and the dispute was referred to the Labour Court on the 31st October 2006 in accordance with Section 26.1 of the Industrial Relations Act 1990. The Labour Court hearing took place on February 13th 2007. Following this hearing the Labour Court recommended that a review of the profession should be carried out in relation to the areas identified by the Union.

It was also recommended that an independent person/body should be agreed to conduct this exercise. It also indicated that if there were outstanding issues following this review which could not be agreed between the parties that they may be referred back to the court for a definitive recommendation. Following further discussions between the parties over a period of time it was agreed that the review would be conducted by Mr. Sean McHugh, Resource Employee Relations.

At the commencement of the exercise, it was agreed that the undersigned would meet with IMPACT, the HSEEA and also with nominated representatives of staff who work in the area of Clinical Measurement.

A total of three meetings took place with representatives as follows:

- IMPACT Representatives of Clinical Measurement Technicians
- Representatives of Pulmonary Technicians
- Representatives of the Irish Society of Cardiological Technology

Review

In the course of the review I initially examined the outcome of the working party and specifically its draft report, which had previously been agreed in part. The HSEEA and Impact indicated, as set out in the Labour Court Recommendation that Chapters 1 to 6 had been agreed by the working party and the issues specifically for review in this exercise related to elements contained in the draft seventh Chapter which had not been agreed.

The draft Working Party Report on Clinical Measurement is contained in Appendix A of this report.

Chapter 1 of the report set out the historical context in relation to the Working Party Report, defined its membership and set out the Terms of Reference. These indicated that the review would be evidence based, that written submissions would carry the weight of professional experience and, where possible, would be referenced. It stated that the contribution of economic argument would be encouraged.

It was also indicated that any recommendation of the review relating to the career structure and/or pay and conditions of Clinical Measurements should be examined in the context of Public Services Benchmarking process.

Chapter 2 dealt with the issue of Clinical Measurement Technicians in this country. It outlined the development of specialties and a requirement for specific diagnostic tests over the past fifty years.

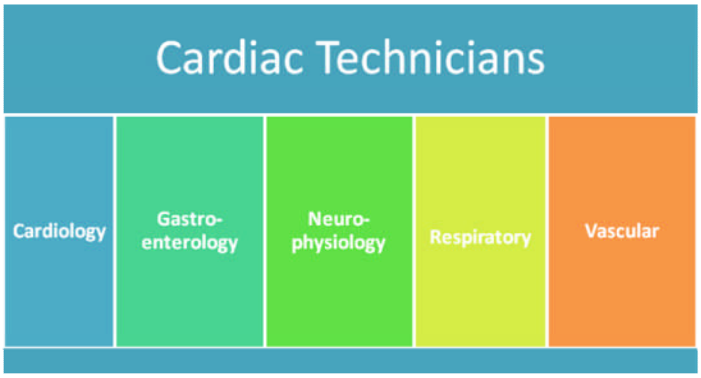

Figure 1

In each of the Clinical Measurement specialties i.e. Cardiology, Gastroenterology, Neurophysiology, Respiratory and Vascular, research laboratories were established by Consultants to develop early methods of diagnostic testing.

Early testing was carried out by staff within the Health Service ranging from Research Scientists to Nurses. Laboratories worked within their own hospital and only carried out testing on a referral basis from a specific consultant.

Subsequently, as each field developed and became more functional, advances in technology were used to increase the accuracy of diagnostic testing and a demand to provide the service through hospitals increased.

New staff were trained on a location by location basis in established laboratories. New staff had various levels of education ranging from school leavers to staff who had third level education. Many existing staff entered into the system during this phase. Indeed up to the late 1970s there was no professional title for individuals working in the clinical measurement field.

Around this time the Institute of Technology in Kevin Street set up a part time certificate course in Medical Physics and Physiological Measurement in response to the unquestioned requirement to standardise the entry level for training of Technicians. In order for the student to register for training with the Institute they had to be employed on a full time basis in a Laboratory. Most Technicians were employed on the equivalent of ECG Technician pay scale. After a further period of time the Department of Health introduced a Cardiac Catheterisation Grade and, subsequently, all Clinical Measurement Technicians were brought in line with this scale.

The Clinical Measurement field was also growing in a hap hazard way in other countries during this time. In the US and the United Kingdom the need to amalgamate these groups was recognised. Professional societies were set up and, in order to address the fact that persons working within the field had a range of differing qualifications, new professional exams for accreditation were developed. These became increasingly recognised internationally and a number of Irish Technicians have undertaken these exams in order to obtain professional qualification.

Since the 1980s medical consultants returning from training abroad to take up new posts in Ireland were keen to expand services. A number of Laboratories were set up. However there was a lack of qualified technical staff. As time went on the major Dublin teaching hospitals increased the number of trainees and as services expanded many of these technicians moved to provide services in other hospitals. The demand for diagnostic testing also was increasing.

Historical Key Development of Clinical Measurement Laboratories

Figure 2

[Source Draft Working Party Report]

	Cardiac	GI	Neurophysiology	Respiratory	Vascular
1950—1970	First Cardiac laboratory established in Baggot Street Hospital. Cardiology Department set up in Richmond Hosp.		Laboratory established in the Richmond Hospital. Others established: Our Lady's Crumlin, the Mater the Adelaide and St. Vincent's	First laboratory established in Baggot Street Hospital	First laboratory established in the College of Surgeons and later moved to St. Mary's Hospital.
1970—1980	Laboratories established in: The Mater Hospital, St James Hospital, St. Vincent's Hospital. 1976 — Cardiac Rehab unit established in Richmond Hospital, training for Cardiac rehab provided.		Laboratories established in Limerick Regional, Cork University Hospital and the Bon Secours (Dublin)	Laboratory established in St Vincent's Hospital	Laboratory established in St. James Hospital
1980—1990	Rationalisation of Dublin Hospitals. Richmond and Jervis Street amalgamated to form Beaumont Hospital.	1986: Surgical oesophageal laboratory established in St. James Hospital	Laboratory in the Bon Secours hospital closes. Laboratories established in The Mercy Cork, Temple Street, Galway University Hospital, the Mater, Beaumont and Blackrock Clinic.	Laboratories established in: Limerick, Beaumont, The Mater, Our Lady of Lourdes, Drogheda, Peamount, St. James and Harcourt Children's Hospital.	St. Mary's laboratory moved to James Connolly Memorial Hospital Laboratories established in: Blackrock Clinic, Beaumont, the Mater, Tullamore General and Limerick Regional hospital
1990—Present	1991 — New Cardiac cash lab opened in St. Vincent's Hospital. New Cardiac Dept and Cath lab opened in AMNCH, Tallaght. 1999 — Cardiac Cath Lab opened in Beaumont Hospital. With the cardiovascular Strategy more regional laboratories opened	Amalgamation of medical and surgical specialties lead to expanded GI Function Unit in St. James's. Laboratory established in Mater Private and Tallaght. Limited service in Wexford General and Galway University Hospital	Laboratories established in St. James Hospital and Tallaght.	Laboratories established in: Ardkeen, The Bon Secours (Dublin and Cork), Merlin Park, James Connolly Memorial, St. Michaels, Blackrock Clinic, Cavan, Our Lady's Crumlin, Sligo General, Clonmel, Wexford General and Tallaght. First sleep laboratory opened in St Vincent's	Laboratories established in Tallaght and Galway University Hospital.

In 1994 work commenced on the development of a degree programme and this bore fruition when the first intake of students to the BSc in Clinical Measurement occurred in 2001. The degree course is a full time programme with a component of clinical training in Years 3 and 4.

It was hoped that the implementation of the degree programme would enable students to meet future demands as clinical measurement techniques continued to develop. The Irish Institute of

Clinical Measurement Science was established in March 2004 and the first annual meeting took place in September 2004. The aims and objectives of the institute were to unite the five disciplines into a single body to promote and raise the professional profile, to support professional education and to prepare for statutory legislation. When it was formed there were close to three hundred and eighty Clinical Measurement Technicians on the Institute's register between the public and the private sector.

The Historical Key Development of Clinical Measurement Laboratories are set out in Figure 2 above.

Chapter 3 of the Working Party Draft Report sets out a description of Clinical Measurement disciplines and these are outlined below.

Role of the Clinical Measurement Technician:

The role of the Clinical Measurement Technician has changed considerable over the years and the scope and responsibility of this profession is now a clear and distinct group of diagnostic services. In a similar manner to the Health and Social Care Professionals, the role is patient focused and carries responsibilities for the care and management of patients.

The services provided by the clinical measurement technicians are primarily consultant led. In some situations the consultant is actively involved in the laboratory and in other situations the consultant acts as Director of the laboratory.

The Clinical Measurement profession is primarily a patient/clinical-oriented profession and the job role has expanded over the years to now include the following:

- To provide expert clinical physiological tests for patients
- To communicate test procedures, relate information to patients, parents or guardians where appropriate.
- Responsibility for analysing and assessing test results against accepted criteria
- Factual reporting of the examinations
- To impart clinical results
- Provide advice to clinicians on the diagnostic investigations and their interpretation
- Develop new diagnostic tests and their protocols following peer research
- To have a duty of care to respond appropriately to the discovery of abnormal pathology in relation to concomitant presenting symptoms
- Manage patient groups where follow-up programmes are in place, often discharging them from follow-up or referring on to the appropriate clinician

- To provide education and training to members of the multi-disciplinary teams
- Taking part in departmental research projects and, where relevant, lead studies based on diagnostic testing.

Patients are initially assessed in the laboratory with a detailed clinical history. Where the test requested is contra-indicated, due to the patient's co-morbid condition the technician must modify or discontinue the test. The procedure is carefully explained to the patient and consent obtained to perform the investigations requested. Once performed, a working diagnosis is made and the necessity to proceed with further investigations is noted according to agreed protocols. In some cases these tests are carried out before the patient leaves the laboratory.

Specific investigations require the administration of prescribed drugs under agreed protocols and it is the responsibility of the technician to highlight this need and take appropriate action. If significant abnormality is noted, it is the responsibility of the technician to alert the appropriate medical personnel.

There is some variation amongst disciplines and between laboratories in relation to the completion of reports. In some services the technician writes the technical/factual report, while others are reported as part of the full clinical diagnosis, which is made by the consultant in charge.

Cardiology

Cardiology is the study of the heart and its functions and is used in the diagnosis and treatment of heart disease. The development of clinical measurement cardiology has led to more accurate basis for the diagnosis of cardiac disease. This in turn has led to more effective patient management. All cardiology procedures performed by the technician are non invasive. Some procedures are carried out Ina clinical setting; with the support of medical doctors. The technician assists the cardiologist in some invasive cardiac procedures such as Trans-oesophageal Echo, Coronary Angiography, PCIs.

Gastrointestinal (GI)

Gastro-Intestinal (GI) physiology is the diagnosis of intestinal disease such as primary motility disease, Gastro-oesophageal reflux disorder, and ano-rectal dysfunction. GI physiology can be divided into two main branches - Upper GI and Lower GI. The majority of Upper GI referrals come from the Gastroenterology, Surgery, Cardiology, Endocrinology, Respiratory and Ear Nose Throat (ENT) services. The Colo-Rectal Surgeons and

Gynaecology services would mainly refer patients to the Lower GI Investigation Units. All GI procedures (except electrogastrography (EGG) and Breath test) are invasive. They require the technician to insert investigative catheters into the unsedated, fasting patient, both nasally and anally, without medical supervision.

Neurophysiology

Neurophysiology studies the function of the central and peripheral nervous system including the brain, spinal cord, nerves and muscle. Investigations are performed in diseases such as encephalitis, meningitis, epilepsy, stroke and multiple sclerosis. Most of the current tests lead to a more timely diagnosis, which allows for earlier interventional treatment. Disorders may be monitored during treatment to assess progression or improvement of the disorder.

Respiratory

Respiratory tests give an overall assessment of lung function. Tests are used to evaluate and monitor patients with various lung disorders such as asthma and chronic obstructive pulmonary disease (COPD). Sleep evaluation is also an important part of the Respiratory Technician's job, as patients who suffer from Obstructive Sleep Apnoea Syndrome (OSAS) are at risk of developing more serious conditions, such as hypertension, if left untreated.

Vascular

The vascular laboratory diagnoses the presence of disease within the arteries and veins. Investigations are for cerebrovascular disease (stroke), peripheral vascular disease such as claudication and deep vein thrombosis (DVT) and abdominal vascular investigations. Investigations are generally non-invasive and are carried out using continuous wave Doppler, plethysmography, pressure measurements and real time ultrasound imaging with Doppler colour flow.

Chapter 4 of the Working Party Draft report dealt with quality assurance and standards.

It indicated that Quality Assurance is an essential part of the modern health care system. It is increasingly important that all users of the health service have confidence in the high standards of service delivery. In the health care environment it is imperative that patients are given the best available care in line with the health strategy.

Clinical measurement laboratories are guided by the protocols of their professional bodies, which are determined by evidence based medicine. The five disciplines adhere to guidelines issued by the following professional bodies:

- Cardiology – Association of the Society of Cardiological Science and Technology, British Society of Echocardiography, and British Society of pacing.
- G.I. laboratories – Association of Gastro-intestinal Physiology and the British Society of Gastroenterology.
- Neurology - The Electro-physiology Technologists Association (EPTA) (U.K.).
- Respiratory – American Thoracic Society and European Respiratory Society guidelines.
- Vascular – The Society for Vascular Technology of Great Britain and Ireland

Statutory Registration

The Working Party Draft Report indicated an eagerness to develop the profession to the stage where the profession is a registered profession under the Health and Social Care Professionals Act 2005. This Act came into effect at the end of 2005. While the system of statutory registration applies initially to 12 health and social care professions, the law allows the Minister for Health and Children to include additional professions in the system.

The purpose of establishing this system is to ensure that members of the public are protected and informed so that they can be confident that the professional providing the service is properly qualified, competent and of good standing. The system will also ensure professional conduct and the promotion of high standards of professional education and training among health and social care professionals.

The system of statutory registration applies to the following 12 health and social care professions, regardless of whether they work in the public/private sector or are self-employed;

- clinical biochemists
- medical scientists
- psychologists
- chiropodists/podiatrists
- dieticians
- orthoptists
- physiotherapists
- radiographers
- speech and language therapists
- occupational therapists
- social care workers
- social workers.

The main elements of the system of statutory registration are a Health and Social Care Professionals Council (HSCPC) for the system overall with a Registration Board for each of the professions to be registered. There will also be a set of common statutory committees relating to the protection of the public - these committees will comprise a Preliminary Proceedings Committee, a Professional Conduct Committee and a Health Committee.

The Health and Social Care Professionals Council was appointed in 2007 and has commenced work in putting the registration in place. It is, of course, primarily focused on putting in place registration for the twelve named professions.

While it may be an issue for the second phase of development for the HSCPC, it is clear that all parties to this area would see it as a desirable development for this group to acquire registration for the profession.

Chapter 5 set out the background and detail of range of courses and qualifications available over the years culminating with the introduction of the B.Sc. (Hons) in Clinical Measurement , the current course being provided by the Dublin Institute of Technology. These are set out in Figure 3 below.

Figure 3

Course	Entry requirements	Course Duration	Qualification
Certificate in Medical Physics and Physiological Measurement.	Leaving Certificate Employment as a trainee in clinical measurement laboratory	2 years part-time	Certificate in Clinical Measurement
Degree Course in Physiological Measurement	Leaving Certificate	4 years full-time	B.Sc. in Clinical Measurement
Degree Course for Mature Students (in planning)	Certificate or equivalent At least two years experience in clinical measurement Full time employment in clinical measurement laboratory	2 years part-time	B.Sc. in Clinical Measurement
Masters Degree by Research	Certificate or equivalent At least two years experience in clinical measurement. Full-time employment in laboratory Clinical supervisor Ethical approval for research	Minimum of 2 years	M.Sc. in Clinical Measurement
Professional Accreditation Available for Cardiology, GI, Neurophysiology and Vascular	Member of Relevant Professional Association with a minimum number of years experience Full time employment Appropriate qualifications	Exams usually held annually	Accreditation in relevant discipline

B.Sc. (Hons) in Clinical Measurement

The Bachelor of Science (Honours) in Clinical Measurement provided by Dublin Institute of Technology is designed to educate and train Clinical Measurement Scientists who will gain employment principally in hospital laboratories performing diagnostic tests in the areas of Cardiology, Neurophysiology, Pulmonary or Vascular Technology. There is also a part time programme offered for advanced entry students which is offered over two years (part time).

The programme normally takes over four years full-time. It is modularised, so a student may choose to take a longer time period to undertake the programme. Many modules are delivered within a single semester, but, where appropriate, some modules are linked over two semesters.

Applicants are selected by reference to the Leaving Certificate points in accordance with the CAO scale. Applicants must hold a Leaving Certificate, or equivalent, with a minimum of six subjects and fulfil the following minimum entry requirements:

- A minimum grade C3 at Higher level in two subjects, one of which must be in a subject from the following list: Physics and Chemistry, Biology, Mathematics, Applied Mathematics, Agricultural Science or Engineering
- A minimum grade of B3 in Ordinary Level Mathematics
- A minimum grade of D3 in Ordinary Level Irish or English

Chapter 6 dealt with the future development of diagnostic services. It set out that the establishment of Clinical Measurement Laboratories in the past was mostly driven by consultants who tended to be mostly in the larger teaching hospitals.

Following the Hanly Report which was published in 2003 recommending investment in hospitals at a regional level to provide more services, there was an expectation that these would develop in a full range of acute hospitals available within each region.

Additionally reference is made in Chapter 6 that the implementation of the Hanly Report could greatly benefit the health service, it would have the potential to diagnose and fast track patients to the appropriate services, to reduce waiting lists, monitor disease and offer greater management of therapy.

In the HSE Report on Consultant Staffing in January 2005 there were 1947 approved permanent Consultant posts. It is clear that services have developed somewhat differently to what was envisaged in the Hanly Report. More recent developments in relation to the introduction of the new Consultants contract are also likely to further alter the manner in which services develop.

Figure 4

CONSULTANT AND NON-CONSULTANT HOSPITAL DOCTORS EMPLOYED WITHIN THE PUBLIC HEALTH SERVICES, 2000 TO 2009

Grade Category	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009*	%Change 2000-2009	%Change 2008-2009
Consultants	1,433	1,572	1,691	1,754	1,871	1,966	2,094	2,218	2,245	2,268	58.3	1.0
Non-Consultant Hospital Doctors:												
House Officer/ House Officer Senior	1,480	1,615	1,727	1,708	1,764	1,802	1,910	1,918	1,876	1,866	26.1	-0.6
Intern	414	440	466	471	485	486	502	512	505	504	21.7	-0.2
Registrar	1,167	1,240	1,308	1,241	1,250	1,387	1,508	1,606	1,699	1,641	40.7	-3.4
Senior Registrar /Specialist	287	431	593	668	699	701	729	818	856	828	188.7	-3.2
Sub-Total Non-Consultant Hospital Doctors	3,348	3,727	4,093	4,087	4,199	4,376	4,649	4,854	4,937	4,839	44.5	-2.0
Total	**4,781**	**5,299**	**5,784**	**5,841**	**6,070**	**6,342**	**6,745**	**7,072**	**7,182**	**7,107**	**48.7**	**-1.0**

Source: Personnel Census, Department of Health and Children.

Since the setting up of the HSE there has been a greater degree of streamlining of services through a focus on cost effectiveness and efficiency. It is likely that the development of diagnostic services will run hand in hand with the development and restructuring of HSE services, more generally, and decisions made regarding specific services to be provided within each hospital.

It is not possible for a review such as this to comprehensively address the likely outcomes of such developments. It is therefore necessary for this review to concentrate on the issues identified by the Labour Court relating to the grade being developed as opposed to dealing with issues of service delivery. However, the issue of how this might be progressed on an agreed basis in the recommendations.

Recommendations

As indicated earlier, the issues identified in the Labour Court recommendation setting out the matters to be addressed by the review were:

- The Career structure
- Professional Title
- Workplace Title

- Quality, Awareness and Standards
- Training and Development

In making recommendations I am conscious of the strong case put forward by the HSEEA in relation to the current context in which this report is being issued. All parties will be aware that there has been a significant deterioration in the general economic climate since the process commenced.

Each of the recommendations outlined in this report should be read in the context of this current climate. It may not be possible to progress matters as promptly or as expeditiously as might have been envisaged in other circumstances. The recommendations set out in this Review should form an agenda of issues to be addressed in a reasonable time frame given the current economic climate.

Implementation of recommendations which might impact on pay and/or grading may well present significant challenges which all parties should address sensibly and realistically.

Career Structure

The current career structure ranges over four levels; Basic Grade, Senior, Chief 1 and Chief 2. There are eight points on each of the scales including two long service increments that require three years service to progress from the maximum point of the scale and then from the first long service increment to the second long service increment. Impact sought that the long service element be removed from the scales.

Current Salary scales Figure 5

BASIC	1/01/10	37,466	38,273	39,168	41,511	42,931	44,355	**47,866**	**51,320**	**LSIs**
BASIC	1/09/08	39,693	40,566	41,533	44,066	45,602	47,141	**50,936**	**54,670**	**LSIs**
SENIOR	1/01/10	42,611	43,914	45,291	46,700	48,151	49,498	**52,830**	**56,167**	**LSIs**
SENIOR	1/09/08	45,255	46,663	48,152	49,675	51,244	52,700	**56,302**	**59,910**	**LSIs**
CHIEF 1	1/01/10	46,521	47,507	48,817	50,088	51,360	52,619	**55,874**	**59,194**	**LSIs**
CHIEF 1	1/09/08	49,482	50,548	51,964	53,338	54,713	56,075	**59,593**	**63,183**	**LSIs**
CHIEF 2	1/01/10	47,888	50,265	52,583	54,913	57,280	60,332	**63,787**	**67,053**	**LSIs**
CHIEF 2	1/09/08	50,960	53,530	56,036	58,555	61,114	64,413	**68,148**	**71,725**	**LSIs**

During the course of discussions prior to the Labour Court hearing, IMPACT had sought agreement to a structure with basic, senior, and manager grades only with the Chief 1 and Chief 2 to be merged into one higher rate. They also identified that there were a small number of sites where both Chief 1 and Chief 2 posts exist which would require to be dealt with on an individual basis in order to ensure a workable structure.

In the course of consultations during this review, Cardiac Technicians indicated their support for the maintenance of the Chief 1 position in order to allow for the continuation of the deputy role in some hospitals, where necessary. While local discussions may be required to implement changes resulting from the merging of the Grades, Hospitals would not be precluded from assigning, or reassigning if necessary, appropriate duties to relevant Clinical Measurement Scientists at the appropriate level.

During the course of consultations it also became clear that, due to the increase in demand within services, many technicians are expected to specialise in one particular area. It became clear that the need for clinical specialists is necessary. The case was made by some technicians that some method of payment should be made for these specialisations. The most appropriate way in my view is that the grade of Clinical Specialist should be introduced.

This grade was first identified in the Expert Group Report for Allied Health Professionals, and has since been put in place across a range of professions. There is clearly a case in this area for the development of the structure to allow for Clinical Measurement Scientists to specialise in particular areas.

I recommend that

- ***The long service element of the pay scales be removed resulting in the final two increments being converted into annual increments***

- ***The Chief 1 and Chief 2 levels should be merged into a Chief Clinical Measurement Scientist grade and that any resultant anomalies in relation to the assignment of duties be resolve through local discussions.***

- ***Given the stage of development of this grade, the feasibility of progressing the issue of specialism within the profession may require further discussion and clarification between the parties. Direct discussions should commence within a reasonable time frame with a view to reaching agreement for the introduction of arrangements in this area consistent with, but not necessarily identical to, developments in other professions. As highlighted earlier, it will not be possible for this aspect to be concluded outside of the framework of changing staffing levels, location and diversity of positions within the profession. Any***

further developments will have to be carefully considered in the context of the changing environment and any developments must be rational and cost efficient.

Professional Title

IMPACT has made the case that the reference to Technician in the job title no longer reflects the responsibilities and status of the profession and that the minimum requirement for future basic posts should be the B. Sc. in Clinical Measurement.

IMPACT sought that the title Clinical Measurement Scientist should be used for all personnel to reflect the degree necessary for entry to the profession and its developing role and responsibilities. Management indicated that it was open to looking at the title in this area and was anxious that there should be one title within the discipline.

In consultation with Technicians during the course of this exercise, Cardiac Technicians raised a strong concern that the title Scientist was inappropriate and that the more appropriate title would be Physiologist. In consultation with other Technicians there was a good degree of understanding of the position as set out by Cardiac Technicians by others consulted with.
In order to get a more comprehensive understanding of the appropriate title I examined the position in the NHS in the UK. In the NHS there has been much progress in this area and a number of reports addressing a variety of issues have been conducted. The structure of Health Care Scientists in the UK is quite different from the situation in this country. Here certain grades such as Biochemists and Audiologists are grouped into the Allied Health Services Professionals. In the UK some of these are indicated as Health Care Scientists. There are a range of other variations relating to Physiologists in the NHS. In order for this country to reflect the UK it would require a much broader review of the groupings within Health Care professions in this country. In the UK the Health Care Science work force comprises of a number of distinct disciplines and these are grouped into three divisions.

These divisions are:

- Life Sciences
- Physiological Sciences
- Physical Sciences

It seems clear that the Clinical Measurement group in this country would all come under the Physiological Sciences grouping within a more comprehensive structure. It may be the case that as the professions develop into the future that this will become clearer and more identified. This, however, would be a very extensive exercise requiring the restructuring of many of the professional groupings in the Health Service. At this stage the only sensible approach in my view is to deal with the matter in a pragmatic way.

- ***Therefore, I recommend that the appropriate title for this grade should be Clinical Measurement Scientist.***

Workplace Title

IMPACT raised the issue that the use of the term Laboratory is confusing for patients and does not reflect the diagnostic procedures carried out. It sought that a review of the title in the workplace should be carried out within a three year period.

In consultation with the parties during the course of this review no specific alternative title was suggested. It may be necessary to examine this on a location by location basis. I do note from the view of the various documentation from each of the groups, from course documentation provided by the DIT and in the documentation relating to this area in the UK, that the most common term used is Laboratory.

- ***In the review of documentation and submissions to the Labour Court, I am not aware of any objection to an appropriate title being applied within Hospitals where there is agreement to this.***
  I recommend that this issue be dealt with on a location by location basis.

Quality and Awareness Standards

Impact made the case that unqualified staff should be phased out and reduced into the future by recruiting staff only who hold the relevant degree qualification. It also sought that no new Laboratory should be set up without suitably qualified staff. The Irish Institute for Clinical Management Science has been set up to progress the correct standards and protocols and to ensure that they are applied. Claims sought that the ICCMS needed to be recognised as a professional body representing the profession including working closely with governing bodies and the Department of Health and Children to facilitate statutory registration.

Having reviewed all the documentation I recommend

- ***That the Qualification for new entrants as Clinical Measurement Scientist positions should be the B. Sc. (Honours) Clinical Measurement Science, or equivalent.***
- ***That the ICCMS be recognised as a professional body representing the profession***

- ***That a joint working group including relevant stakeholders including the HSE, Department of Health and Children, Impact and DIT be set up to progress the professionalisation of the grade with a view to attaining professional registration within a reasonable timeframe. This group should also address issues relating to Training and Development.***

Training and Development

It appears that there is no formal structure for clinical placement of students within the hospitals at present and that there are no training facilities available for students in Gastrointestinal Laboratories. In consultation with the parties it was clear that what was being sought was a process between the DIT and the HSE and the relevant profession regarding student placement and training to ensure an adequate supply of trained staff for recruitment.

In addition to the recommendation above relating to this area, I recommend that the area of gastrointestinal service should be specifically reviewed in that process to examine the future development of the field and to assess the need to provide training and supervision to students.

Sean McHugh
June 18th 2010