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# RETAINING OUR DOCTORS

MEDICAL WORKFORCE  
EVIDENCE, 2013-18

FULL REPORT





# **Retaining our Doctors**

**Medical Workforce Evidence, 2013-18**

**RCSI Health Workforce Research Group**

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# **Retaining our Doctors**

## **Medical Workforce Evidence, 2013-18**

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# Summary

## Focus of this report

This report summarises original research findings on the scale and causes of outward migration of non-consultant hospital doctors (NCHDs<sup>1</sup>) from Ireland. It draws on findings from five mixed methods research studies undertaken by the Royal College of Surgeons in Ireland's (RCSI's) Health Workforce Research Group 2014-18, together with an analysis of routine data published since 2011 by Ireland Health Service Executive (HSE) National Doctor Training and Planning Unit (NDTP) and the Irish Medical Council (IMC).

A consistent picture emerges of the factors that 'push' Irish and international medical graduates to leave Ireland, namely poor working conditions, and inadequate training and career opportunities. Research findings from 2018 show that, while trainees report improvements in mentoring and supervision of their training, they also report a worsening of work-related stress and staffing levels in Irish hospitals. Furthermore, there is evidence to suggest that shortages of consultants<sup>2</sup> are contributing to NCHD emigration.

This report starts with a summary of the Challenges and Responses that emerged from a policy dialogue of key national stakeholders conducted at the Royal College of Surgeons (RCSI) in November 2017. Each chapter summarises different dimensions of the evidence, ending with questions that were proposed and discussed at the policy dialogue, with a view to framing interventions to retain Ireland's doctors, specifically NCHDs.

Most of the focus of the report and much of the research has been on trainees, who are NCHDs in post-graduate training programmes. However, the report and some of the research and routine data also focus on non-trainees, on whom Ireland is increasingly reliant for the delivery of its health services. Most NCHDs in long-term non-training posts are international medical graduates (IMGs), who are recruited to non-training posts, to which Irish-trained doctors will not apply.

## The evolving profile of NCHDs in Ireland

The number of Irish and EU medical graduates doubled from 370 in 2006 to 730 by 2015, in line with national targets; and there have been modest increases in the numbers of doctors enrolled in postgraduate training programmes since 2011. However, the pace of recruitment of IMGs (doctors who qualified from medical schools outside of Ireland) to non-training posts greatly exceeds the rate of recruitment to training posts. Historically, most IMGs have been non-EU nationals, who graduated from medical schools outside of the EU. However, since 2012, routine data show that significant

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<sup>1</sup> Non-consultant hospital doctors (NCHDs) comprise medical graduates who have not yet completed specialist training. Their grades range from intern to specialist registrar.

<sup>2</sup> In the documents reviewed, the terms consultant and specialist are often used synonymously. Most consultants are hospital-based, while some work in the community (e.g. in mental health services). The term specialist in this report generally includes fully trained GPs, unless a hospital role is specified.

numbers of non-EU and some Irish nationals graduate from central European medical schools and then migrate to Ireland.

The main reason for the rapid rise in recruitment to non-training posts, which takes place mainly in small hospitals that are not suitable for training, is the need for Irish health services to be compliant with the European Working Time Directive (EWTD). This, together with the high rates of emigration by graduates of Irish medical schools – before, during and towards the end of their postgraduate training – is compounding the current medical workforce crisis.

Between 2012 and 2015, 7-9% of doctors aged 25-34 years and 6-7% of doctors aged 35-44 years exited the Medical Council register, annually. Most exits in these age groups are believed to be due to doctors emigrating. About 20% of a sample NCHD trainees left Ireland within 2 years of being surveyed (between 2014 and 2016); and a further 20% of trainees, surveyed in 2016, planned to leave on completion of their training. See Section 3 of this report for details.

### **Findings on doctor migration**

Recent research findings (Chapter 3) show that while around half of Irish medical students and NCHD trainees are considering working abroad, most wish to make their careers in Ireland ultimately. Of 483 Irish Final Med students surveyed in 2017, 54% planned to leave and return, 37% planned to remain and train in Ireland; and only 9% intended to leave and not return – see Section 3.3 of this report. Of 784 NCHD trainees who responded to a question on migration intentions in an early 2018 survey, 42% planned to leave and return, 41% intended to remain to train and take up posts in Ireland; and 14% intended to leave Ireland and not return – see Section 3.2.

These 2017-18 findings point to higher proportions of Irish medical students and trainees wishing to make their careers in Ireland than were reported in earlier studies. However, the associations between poor experiences of training and working conditions in Ireland and an intention to leave and not return remain significant and strong. Quantitative and qualitative research, published by the RCSI Health Workforce Research Group between 2013 and 2016, reported that almost half (47%) of surveyed foreign doctors<sup>3</sup> working in Ireland intended to migrate onward to a third country; 30% intended to stay in Ireland and only 23% intended to return to their home countries – for similar reasons to why Irish doctors leave (see sections 4.4 and 5.2).

Routine statistics from the IMC, 2012-15, show that exit rates from the Medical Council register were 3-times higher for doctors in the General Division, where most non-trainees and most IMGs are registered, than from the Specialist Division – see Table 4.7. Exit rates for IMGs in 2015 were 2-3 times higher than for graduates of Irish medical schools, with 3-4 times higher exit rates among graduates of other non-Irish EU medical schools – see Table 4.6.

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<sup>3</sup> The study surveyed doctors working in Ireland who were foreign nationals. The sample comprised 85% IMGs (foreign nationals who had graduated outside of Ireland) and 15% foreign nationals who had graduated from Irish medical schools.

These statistics support the view that Ireland's high level of reliance on recruitment of IMGs (foreign-trained doctors) to fill NCHD posts that are not recognised for training is not an effective strategy for staffing our health services. Mostly, these doctors are from low- and middle-income countries who take up posts in smaller (model 2 and some model 3) hospitals, that would otherwise be unfilled. This practice, while understandable on the part of a hospital that needs to deliver essential services, suggests questionable compliance with the WHO Code on the International Recruitment of Health Personnel.

On a positive note, however, Ireland is a global leader through developing a successful model of international recruitment of doctors from low and middle income countries. The International Medical Graduate Training Initiative (IMGTI) is an initiative, run by the HSE and the RCPI, that provides bespoke postgraduate training to medical graduates from Pakistan, who must return home to receive their qualifications – see Section 4.2.

### **Reasons why NCHDs emigrate**

The body of evidence from the mixed methods research studies reviewed for this report, which were undertaken by the RCSI Health Workforce Research Group (HWRG), points to the same constellation of factors that *push* trainee NCHDs to leave Ireland:

- stressful working conditions, aggravated by low staffing levels and NCHDs having to undertake non-core tasks, which are an inefficient use of their skills;
- lack of designated and supervised training, aggravated by consultant shortages, which means training gets displaced by service demands; and
- failure to match NCHDs who are exiting training to suitable permanent posts.

The results from two RCSI research studies show that what attracts (*pulls*) Irish trained doctors<sup>4</sup> to go abroad is the perception and experience that working, training and career opportunities are better abroad. The findings also show that the lack of substantive improvements in conditions back in Ireland keeps them there. Over time, the likelihood of Irish-trained doctors returning to Ireland diminishes, as they set down roots.

Similar factors – lack of career opportunities, poor access to training and short-term contracts – were significantly associated in IMGs who were working as doctors in Ireland with an intention to migrate onwards to another country, rather than remain in Ireland or return home – see section 5.2.

### **Consultant numbers**

The HSE's NDTP Unit has published medical workforce planning reviews on the Future Demand for General Practitioners (2015), Emergency Medicine (2017), and Paediatrics (2017), which estimate the future demand and supply of GPs and specialists in Ireland. These confirm that for both Emergency Medicine and Paediatrics, Ireland has lower ratios of specialists to population than the UK; and much lower ratios than Australia.

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<sup>4</sup> A further complexity in the field of medical workforce planning (and research) is that the term 'Irish-trained doctors' includes Irish nationals, other EU nationals and non-EU nationals who have undertaken undergraduate and/or postgraduate training in Ireland. In the 2016 *Doctor Emigration Project*, 20% of trainees were non-nationals, with most being international medical graduates (IMG). In the 2018 *MedTrack* project, the proportion had risen to 25%, the great majority of whom had done their undergraduate training outside of Ireland.

In Ireland in 2016, approximately 15% of specialist posts were filled by non- permanent staff; there were low ratios of trainees to non-trainees in the two hospital specialties; and projected exits from training programmes were around 25-40% of the numbers needed to meet demand. A particular challenge in General Practice is the increasing demand for GP services, due to Ireland's ageing and growing population. Vacant GP posts continue to increase in numbers nationwide, despite many GPs continuing in post after retirement. The planning reviews detail some of the consequences of specialist shortages:

- failure to deliver on Ireland's health policy goal of a specialist-delivered service;
- an over-reliance on service delivery by NCHD trainees, which impacts negatively on their training;
- an over-reliance on service delivery by non-trainees who are mostly IMGs, especially in Level 2 and 3 hospitals;
- an over-reliance on locum and temporary consultant staff, contributing to a reduction in consultant positions available to those who have completed specialist training; and
- unnecessary admissions to and delayed discharges from hospitals, long patient waiting times and less efficient patient throughput.

Of interest is a pilot programme in Paediatrics and Neonatology, at University Hospital Waterford (see Annex 2). This programme was designed to overcome the above negative consequences of consultant shortages, through increasing the number of consultant appointments, reducing the numbers of NCHDs, and aiming towards all NCHD posts being training posts. Section 6.6 summarises and Annex 2 details the benefits and potential positive outcomes of a specialist-delivered service.

## **Health Workforce Policy Framework**

The May 2017 *Houses of the Oireachtas Committee on the Future of Healthcare SláinteCare* Report states that the transition towards new models of integrated, primary and community care will require significant increases in the numbers of specialists, both in hospitals and in community health and general practice settings. The report recommends the appointment of an additional 593 consultants and 235 GPs, as part of a 6-year strategy.

The National Strategic Framework for Health and Social Care Workforce Planning (November 2017) provides a framework which is grounded in the principles of the WHO Global Code of Practice on the International Recruitment of Health Personnel and focuses on the importance of health workforce self-sufficiency. It provides a policy direction for Ireland's future medical workforce, working in multidisciplinary teams as part of a comprehensive health and social care workforce.

The policy frameworks are detailed in the following section of this report, which summarises the challenges and responses that were identified by national stakeholders at the November 2017 policy dialogue.

Ruairi Brugha, May 2018

# Ireland's Medical Workforce Challenges and Responses

## Introduction

The RCSI Health Workforce Research Group held a policy dialogue in November 2017 at the Royal College of Surgeons in Ireland. The event was attended by senior staff of the Department of Health, the Health Service Executive, postgraduate medical training bodies, NCHD representatives and other national stakeholders with an interest in, or remit for, medical workforce strategy.

Copies of the evidence pack, *Retaining our Doctors, Medical Workforce Evidence, 2013-17*, which forms the body of this report, were provided to attendees. The report, which we have updated with new 2018 research findings, incorporates a summary of research evidence on the intentions, migration patterns and reasons why many NCHDs leave Ireland to train and work abroad; and why they often do not return.

A brief summary of the most recent findings, together with questions used to stimulate discussion, was presented at the November 2017 event. In order to assist and encourage free discussion, the meeting was held under the following interpretation of the Chatham House Rule: issues discussed in the meeting can be discussed outside of the meeting but ideas, views and any positions expressed in the meeting will not be attributed to either organisations or individuals attending the meeting.

A summary of the Challenges and Responses that emerged during the stakeholder discussions was prepared and sent to those who participated, which engendered further feedback. It should be noted that nothing stated in the following summary can be attributed to any individual, agency or body that participated in the event.

## Challenges

1. Challenges and responses aimed at retaining our NCHDs have, to date, been framed by the 2014 **Strategic Review of Medical Training and Career Structures** (SRMTCS) recommendations. An Implementation Monitoring Group, led by the Department of Health, has monitored the implementation of the recommendations since January 2015. The principle investigator (PI) of the RCSI Health Workforce Research Group (HWRG), who led the research that is summarised in this report, is a member of the SRMTCS Implementation Monitoring Group.

Implementation has been successful, in part, although some critical recommendations have not been fully implemented, or implementation has not had the desired impact (see Annex 1). In some cases, actions need to be taken by stakeholders, e.g. government departments, which are not represented on the Implementation Monitoring Group. The frustrations of trainees is evidenced from the biennial consultations with trainees that are captured in a series of progress



reports published between July 2014 and July 2017 that are on the Department of Health website – see [here](#); and specifically in section 2.2 of the most recently published sixth progress report (July 2017) – see [here](#). Recent RCSI research confirms the representativeness of these findings (see Section 5.5 of this report).

New and longstanding challenges – see a) through e) below – which did not emerge in the 2014 stakeholder consultations, or were not adequately addressed in the Strategic Review recommendations, have worsened. These include new drivers and patterns of staff recruitment (see 2.a below and Section 4.3 of this report) that conflict with the policy goal of a specialist-delivered service.

Additional challenges include insufficient numbers of consultants and consultant posts, which the analysis in this report proposes as a root cause of the three major obstacles to trainee retention – unsatisfactory training, working conditions and career opportunities – see a. and 2.e below.

Longstanding hospital configuration problems, which were the focus of SRMTCS Recommendation (Rec) 2.5, have been aggravated by EU employment legislation, distorting hospital recruitment practices (see 2.e below). Critical challenges, as discussed and agreed at the November 2017 policy dialogue at RCSI, included:

- a) **Designated training time for trainees** is being impacted by the **shortage of consultants** at training sites, in comparison to international norms (see Section 6. *Medical Workforce Planning, Specialty Reviews*):
  - i) A lack of consultants is placing **excessive service demands on trainees**, impacting on the time available to them for training and for opportunities to develop competencies required to become specialists.
  - ii) **Consultant shortages** and inconsistent structuring of their participation in training impact negatively on the **quality and consistency of training** that some NCHDs currently experience – see Section 5.5 and Table 5.2 of this report. This is despite training bodies recognising the importance of – and consultant contracts including clauses to deliver on – NCHD training.<sup>5</sup>
- b) Performance of **non-core tasks** continues to take up a significant amount of trainees' time, particularly at the earlier stages of training. This involves carrying out a range of basic non-medical tasks that are often not expected of trainees in the countries to which NCHDs emigrate. This is a poor use of Ireland's valuable, highly trained medical workforce; and it impacts negatively on their training. Industrial relations obstacles, relating to the positions adopted by professional associations, have hampered progress in tackling this issue.
- c) Participants at the RCSI November 2017 policy dialogue reported that **intern induction** practices are inconsistent, and generally there is a lack of monitoring of tasks undertaken by interns. For example, interns, who should be the best-protected and supported hospital doctors, sometimes do not know who has been allocated to them as a specialist trainer (see Sections 3.3 and Section 5.4

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<sup>5</sup> 'Protected training' and 'non-core tasks' were the focus of the 2014 SRMTCS Recommendations 1.1 and 1.2 respectively. The implementation monitoring group assessed the delivery of Rec 1.1 (protected training) as 'Green', but the impact of the recommendation as 'Amber'. Rec 1.2 (non-core tasks) was judged to be 'Amber'.

of this report). Many doctors go abroad directly after internship where they often report more positive experiences. Examples of good practice internship programmes were discussed, e.g. structured entry and exit events in the North East of Ireland.

- d) Participants corroborated the view of trainees (see Section 5.4) that there is a lack of clarity regarding upcoming career opportunities, and often an **absence of suitable consultant posts** in Ireland, as trainees approach the end of training. This situation can be critical when a trainee is abroad, e.g. undertaking a specialty or sub-specialty fellowship in North America or the UK, and is about to complete their training. Local (foreign) employers often offer employment to these about-to-be qualified specialists near to, or at the end of, their fellowship. This is in contrast to Ireland where this about-to-be qualified specialist in whom Ireland has invested 10-15 years or more of training may not have been matched to an available post and; or may be waiting for months while a suitable post is being established. Many of our newly qualified specialists won't wait.

While progress has been made in establishing fellowship programmes in Ireland (SRMTCS Rec 2.6b – status 'Amber'), which can be more suitable for generalist training, sub-specialty fellowships in international centres of excellence are often necessary for consultant posts in model 4 hospitals and national centres.

- e) Unsatisfactory terms and conditions-of-service and an absence of formal training/Continuing Professional Development (CPD) programmes for many **non-trainees**, continue unchecked, because action to address this issue has been tied to the renegotiation of the NCHD contract. Numbers of non-trainees continue to grow rapidly (see Sections 2.b and 2.e.i below). In 2014, SRMTCS Rec 3.4a estimated that there were “900 doctors in service posts in the acute hospital sector” (see Annex 1). The number of non-trainees working in public sector posts<sup>6</sup> had risen to 2,199 by 2017 (see Table 4.4) with an estimated 2,497 by 31/3/18. Furthermore, NCHD representatives at the November 2017 policy dialogue reported that disparities in terms and conditions of service and training opportunities were causes of workplace friction between trainees and non-trainees.

### In summary:

- the working conditions of trainees need to be improved;
- trainees need to be respected for the level of training, skills and commitment they bring to their jobs; and
- their training needs to be acknowledged and prioritised, as they are the future medical workforce in a specialist- and GP-delivered health service.

In addition, the training pipeline needs to be matched to sufficient numbers of suitable and attractive permanent posts in the right places, in order to stem the exodus of highly trained Irish doctors and retain them to serve the health of the population of Ireland.

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<sup>6</sup> A significant proportion of non-trainees are in long-term non-training posts (personal communication NDTP), with a small minority being NCHDs temporarily out of training programmes. This corresponds with the term 'service posts'. Some NCHDs are temporarily outside of training programmes.

The complex set of reasons why trainees intend to leave or have left Ireland to make their careers abroad means that actions are needed on many fronts. The evidence on this is summarised in Section 5. *Doctor Emigration from Ireland: Push and Pull factors*.

2. The **medical workforce configuration** and recruitment trends in Ireland are incompatible with the national policy goal of a specialist-delivered service. Rather than making slow progress, Ireland is moving in the opposite direction, away from a specialist-delivered health service. The slow rise in the numbers of specialists and training posts is being out-stripped by a faster rise in the establishment of non-training posts. Factors contributing to this, which were unpacked and discussed at the November Policy Dialogue, include:

a) the **European Working Time Directive** (EWTD). While this has brought benefits through controlling excessively long working-hours of NCHDs, the approach to EWTD implementation has resulted in a steep increase in non-trainee posts (usually international medical graduates) in smaller, model 2 and 3 hospitals. As rosters now need to be EWTD-compliant, these roles are necessary to provide 24x7 care. However, these posts have a limited positive impact on service provision, contributing little to e.g. elective and day case surgery.

SRMTCS Rec 2.5 proposed that “Hospital Group strategic plans incorporate proposals for rationalisation of services with unscheduled care rosters”. The Implementation Monitoring Group deemed delivery of the recommendation as ‘Green’ and impact as ‘Amber’. This illustrates how policy decisions outside the control of the health services (and in this case at the level of the EU) have had major, unanticipated negative effects on Ireland’s medical workforce planning.

b) **International medical graduates** (IMGs) provide most of the staff numbers to achieve EWTD compliance for on-call cover. However, most have not undergone speciality training in Ireland. They are therefore less effective than trained specialists at addressing waiting lists and making clinical decisions so as to reduce unnecessary admissions. The majority of IMGs are not in specialist or training posts and are therefore a transient and unsustainable response to the shortage of doctors. Because most IMGs do not get access to structured postgraduate training<sup>7</sup>, the research has found that they are more likely than locally trained doctors to **migrate onwards** – see Section 4.4 *Onward migration of doctors out of Ireland*, later in this report.

c) Consultant and NCHD representatives at the November Policy Dialogue reported that there had been a **fragmentation of the medical team-work** needed for optimal clinical care, and for the training of trainees. This was seen as an outcome of the approach adopted in some training hospitals to achieve EWTD compliance. In addition, there has been fragmentation of General Surgical and General Medical on-call rotas, as most sub-specialties no longer participate in ‘general rotas’ and instead have established ‘sub-specialist on-

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<sup>7</sup> “Access to specialist training posts is to be given the green light for non-European Union (EU) qualified doctors, under new proposed priority legislative changes due to be published shortly...” Irish Medical Times, 2<sup>nd</sup> May 2018 – see [here](#). This is a useful example of how political commitment, from the highest levels, can bring about positive and timely changes.

call rotas'. Experienced trainees report that they are now less likely to develop close working relationships with a range of consultant trainers.

- d) The status of SRMTCS Rec 2.1, "Agreement on a more differentiated Consultant career structure and associated rates of remuneration", was deemed to be 'Green'. However, differences between pre- and post-2012 contracts continue to rankle, despite efforts to recruit consultants into higher entry points of the new consultant contract. Differences in salary scales and terms and conditions of service are felt to be inequitable, which continues to impact negatively on the morale of new consultants. An additional disincentive to trainees taking up permanent posts in Ireland are the growing disparities in salary levels between Irish public sector consultant posts and salaries in countries that compete for Irish trained specialists.<sup>8</sup>
- e) **Medical workforce recruitment** processes are driving two unwanted phenomena: i) the rising ratio of non-trainees to trainees, and ii) the appointments of locums, including not-fully trained specialists, as consultants – see Section 4 and Section 6.5 of this report.
  - i) The recruitment of trainees is controlled centrally by the HSE in collaboration with the training bodies, and the number of training posts is linked to projected medical workforce requirements. However, the **recruitment of non-trainees is the responsibility of each individual hospital / agency** (e.g. Mental Health services). Some model 2 and 3 hospitals, are under pressure to recruit non trainee doctors in order to address service demands.
  - ii) The Consultant Applications Advisory Committee (CAAC) advises the HSE centrally on applications for medical consultants and advises on qualifications for consultant posts. Where posts are approved significant **delays can occur in this translating into a filled, permanent consultant post at hospital level**. These delays may impact on attracting good quality applicants or may lead to a creation of temporary or locum consultant posts in an effort to maintain service delivery.
  - iii) Recent Medical Workforce Planning Reviews for General Practice (Section 6.2), Emergency Medicine (Section 6.3) and Paediatrics (Section 6.4) report that in these specialties in 2016, about **15% of consultant posts were filled by locums** who had not completed specialist training. More recent data for these particular specialties may result in lower estimates; and other specialty reviews (to be published), may show different rates.
  - iv) **Model 2 and some 3 hospital consultant positions** do not attract applications from trainees who have completed national training programmes. Reasons for this, as proposed at the November 2017 policy dialogue, include that such posts do not allow the opportunity to

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<sup>8</sup> Mudiwa, Lloyd (2018) "Large pay discrepancy' between Ireland and elsewhere'. Irish Medical Times. 12<sup>th</sup> January. Available at: <https://www.imt.ie/news/large-pay-discrepancy-ireland-elsewhere-15-01-2018/> (Retrieved April 2018).



utilise recently acquired specialist skills, smaller consultant teams and the lack of trainees assigned to these hospitals.

Local politics sometimes intervenes, with some of these hospitals considered to deliver less than optimal acute hospital services. However, it was recognised that the lack of rapid access for communities to more distant specialised hospitals explained why such hospitals were kept open and needed to be staffed. Therefore, model 2 and 3 hospitals are sometimes under pressure to recruit internationally, and/or fill consultant positions with temporary or locum staff in order to address service demands.

**3. Hospital configuration** factors, as alluded to in the previous point, have been identified in national reports since the 1960s. These make specialist careers outside of the larger university hospitals unattractive for Irish medical graduates.

- a) **Model 2** (and for less common specialties, model 3) **hospitals** lack sufficient patient through-put and resources to make full use of trained specialists. In some specialties (notably surgery), there is a need for a critical mass of surgeons and patient volumes to maintain skills. A strong volume-outcome relationship has been reported across a wide range of services, especially in the case of more complex surgical procedures. For the same reasons, such hospitals have limited potential and cannot be accredited as training sites for trainees.
- b) Despite successive reports and a clear consensus that more specialised hospital care can best (and in some cases can only safely) be delivered in larger model 3 and model 4 hospitals, **political interests**, compounded by difficulties for some communities in **accessing hospitals with a better range of specialties** can mean that what is best for patients is overridden. Optimal hospital configuration for better patient care does not mean that model 2 hospitals should be closed. However, it does mean that imaginative solutions need to be found to ensure service quality and safety, efficient use of resources, and access to care (see 4.a below).

## Responses

**4. Implementation of a Hospital Groups** strategy could enable imaginative approaches for reconfiguring care and sharing specialist staff across model 4, 3 and 2 hospitals.

- a) One suggestion to attract top-class newly-qualified specialists is to ensure that **newly appointed consultants** are provided with prime opportunities to apply their specialised skills **in model 4 hospitals**, providing major acute and complex care, regionally and nationally. Scheduled staff rotations, with senior specialists taking a lead, would allow outreach day-care and simple elective procedures take place in peripheral hospitals. Shared rotas in providing weekly OPD and elective sessions at model 2 hospitals, working from a base in a model 4 or large model 3 hospital, could overcome the fear, especially for newly appointed consultants, that they may get 'stuck' on the periphery,

isolated from the model 4 hospitals where they can utilise, develop and maintain their specialty skills.

- b) Highly trained, motivated, and well-managed health professionals – doctors, nurses and other health and social care professionals – are the critical determinant of excellent patient health outcomes. It was generally agreed that **hospital groups**, even if they are not a perfect approach, need to be funded (and have the budget flexibility) to **hire, manage, motivate and deploy staff** to work in adequate sized clinical teams. Implementation would need to avoid introducing differences in terms and conditions of service that could lead to unwanted effects of competition between hospital groups.
  - c) Hospital Groups, with concentrations of highly specialised consultants at the centre, should not be seen as a panacea. In Surgery, most demand is for the least complex procedures and there is a challenge in ensuring that the **hospital specialist workforce** that are trained and appointed have the **right skill sets** to meet population needs. Hospitals require:
    - i) optimal ratios of trained and trainee specialists – including a balance of generalists and more specialised staff – with a strategy for reducing reliance on non-trainees over time (see Section 5a Consultant-delivered Paediatric Service Pilot Scheme);
    - ii) multi-disciplinary teams that provide optimal, integrated, cost-effective care through networks that span primary care and community services, with appropriate access to hospital services as outlined in the *SláinteCare Report* and the *National Strategic Framework for Health and Social Care Workforce Planning* (see below and Section 6 of this report).
  - d) Hospital Groups could provide opportunities for piloting new workforce models to address dysfunctional workforce configurations and to operationalise new policy directions (see section 6). Delays in establishing and making Hospital Groups functional, in some form or other, mean that these opportunities are being missed.
5. The *Business Case for Implementation of a **Consultant-delivered Paediatric Service Pilot Scheme**, University Hospital Waterford Paediatric Department, May 2016<sup>9</sup>* captures many of the features of the health models envisaged in the new policy directions (see Section 6.6 and Annex 2 of this report). Amongst other recommendations, it specifies performance indicators that can be used to measure the benefits of a consultant-delivered specialist service.

The *Business Case* outlines new roles for Clinical Nurse Specialists and Advanced Nurse Practitioners; extended roles for nurses in areas such as IV cannulation and phlebotomy (and other non-core tasks that doctors are currently being tasked with); and it aims to achieve improved links and integration with primary care. As such, it envisages many of the features of multidisciplinary health service delivery that are

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<sup>9</sup> The pilot programme has been developed by the National Clinical Programme for Paediatrics and Neonatology, the HSE Acute Hospitals Division and the NDTP. It is being funded under the HSE Corporate Plan 2015-2017 goal to “provide fair, equitable and timely access to quality, safe health services that people need”.

envisioned in the *National Strategic Framework for Health and Social Care Workforce Planning* report.

**6. New policy directions.** Two important reports, a) the May 2017 *Houses of the Oireachtas Committee on the Future of Healthcare SláinteCare* and b) the November 2017 *National Strategic Framework for Health and Social Care Workforce Planning*, recognise (explicitly in the case of the former and implicitly in the latter) the need for a substantive increase in the complement of consultants. However, both reports envision a new health workforce model that will require that hospital specialists are trained to work in new ways alongside community care and primary care providers, working in multi-disciplinary teams with other health and social care professionals.

**a) The *SláinteCare Report*** (see [here](#) and Section 7 of this report) envisages a shift towards: (i) interdisciplinary, cross-professional integrated care; (ii) a primary and community model of care in the medium term; and (iii) Integrated Care Regional Organisations. The Report:-

- i) estimates that an “additional 20% (593) consultants will be put in place by year 4” (of implementation) (Page 69). And €235m cost for GPs will be needed as part of a 6-year Transitional and Legacy Funding package (See *Table 3 p11*) the report recommends that: “recruitment of hospital consultants and NCHDs should be to Hospital Groups rather than to individual hospitals, as part of meeting the medical staffing needs of smaller hospitals”.
- ii) recommends a move away from professional ‘silos’ towards integrated workforce planning, with an emphasis on developing appropriate skill-mixes across cadres and professions; and that specialist appointments be made not only to hospitals, but also to Community Health Organisations.
- iii) proposes that new Integrated Care Regional Organisations be given responsibility for staff recruitment, working within the National Strategic Framework for Health, under a Health Service National Centre, delivering a National Service Plan.

**b) *Working Together for Health. A National Strategic Framework for Health and Social Care Workforce Planning***, published by the Department of Health in November 2017 – see [here](#), states that “the provision of high quality health and social care services depends on having a sufficiently numerous and appropriately trained workforce in place at national, regional and local levels”.

The Framework reiterates the importance of a consultant-provided service; and emphasises the importance of multidisciplinary, team-based approaches whereby doctors, nurses and other health and social care professionals work in teams to achieve the policy goal of integrated, cross-disciplinary care across the hospital, primary and community care continuum.

## **7. Implementation**

The new HSE **Health Workforce Planning Unit**, noted for establishment under the National Strategic Framework for Health and Social Care Workforce Planning, once

fully established, will bring together and forge links between national clinical care programmes, national specialty training colleges and faculties, and other health professions bodies. New interdisciplinary ways of working should start with doctors and nurses, piloting models that link hospitals, primary and community care.

## **8. The need for commitment**

Both *SláinteCare* and the *National Strategic Framework for Health and Social Care Workforce Planning* provide a vision and complementary blue print for a health workforce model that meets the needs of the population of Ireland. There is potential and need for a 10-year cross-party health programme encompassing a new approach to health and social care workforce planning, protected from the short-termism of the government cycle. This will require cross-party political commitment that transcends the electoral cycle.

Ruairí Brugha, May 2018



# Table of Contents

Summary .....	i
Ireland's Medical Workforce Challenges and Responses .....	v
Table of Contents .....	xiv
List of Tables.....	xv
List of Figures .....	xvi
Acronyms .....	xvii
Chapter 1 Introduction .....	2
Chapter 2 Methods.....	6
Chapter 3 Doctor Emigration from Ireland .....	9
3.1 Scale of outward migration of doctors from Ireland .....	10
3.2 Migration intentions of Irish NCHDs .....	11
3.3 Migration intentions of Irish medical students .....	13
Chapter 4 International Recruitment of Doctors .....	17
4.1 Scale of inward migration of doctors into Ireland .....	18
4.2 International Medical Graduate Training Initiative .....	20
4.3 Changing profile of NCHDs in Ireland .....	22
4.4 Onward migration of doctors out of Ireland .....	23
Chapter 5 Doctor Emigration from Ireland: Push and Pull factors.....	27
5.1 'Push' factors for why trainees might leave Ireland .....	28
5.2 'Push' factors for why foreign doctors would leave Ireland .....	31
5.3 'Push' factors for why trainees had left Ireland .....	31
5.4 Unpacking trainees' experiences of working in Ireland.....	32
5.5 Experiences of training and working in Ireland and intentions to leave: 2018 findings ...	36
5.6 'Pull' factors explaining why Irish-trained doctors choose to work abroad .....	39
5.7 Likelihood that Irish doctors abroad will return home.....	41
Chapter 6 Medical Workforce Planning – Specialty Reviews .....	45
6.1. Estimating the demand for consultants.....	46
6.2 General Practice.....	47
6.3 Emergency Medicine.....	47
6.4 Paediatrics and Neonatology .....	48
6.5 Commentary on consultant profiles .....	50
6.6 New models of care - a consultant-delivered Paediatric Service Pilot Scheme .....	51
Chapter 7 SláinteCare Report .....	54
Chapter 8 National Workforce Strategic Framework .....	58
Annex 1 Medical Training and Career Structure Recommendations.....	62
Annex 2 A consultant-delivered Paediatric Service Pilot Scheme .....	97

# List of Tables

Table 3-1 Exit rates from the Medical Council Register by age group for 2012-2015 .....	10
Table 3-2 Proportions of doctors who had emigrated 2 years after YTC survey (2014).....	11
Table 3-3 Response rates and trainees' intention to practice in Ireland (2014-16) .....	12
Table 3-4 Migration intentions (numbers and rates) for trainees and non-trainees .....	13
Table 4-1 Source of basic medical qualification of MCI registration, (2012–15).....	19
Table 4-2 Location of basic medical qualification for new entrants to the MCI register.....	20
Table 4-3 Annual International Medical Graduate Training Initiative members .....	21
Table 4-4 Non-consultant hospital doctor numbers, 2011–2017 .....	22
Table 4-5 Age profiles of trainees and non-trainees, 2015–2016.....	23
Table 4-6 Age category of doctors exiting the Medical Council Register, 2014–2015 .....	24
Table 4-7 Exit rates by Registration Division, 2012–2015 .....	24
Table 5-1 Factors predicting doctors intentions to practice abroad .....	30
Table 5-2 Trainees' views on whether training conditions are better, the same or worse .....	36
Table 5-3 Trainees' views on whether working conditions are better, the same or worse.....	37
Table 6-1 Ratios of consultants per 100,000 populations: Australia, UK & Ireland .....	48
Table 6-2 Consultant background; Ratio to Trainee: and Non trainees, by Specialty. ....	49
Table 6-3 Consultant age profile and training pipeline .....	50

## List of Figures

Figure 3-1 MedTrack Intention of Irish/ EU/ EEA final med students by age.....	14
Figure 5-1 Career progression ‘push’ factors rated as influencers in decision to emigrate. ...	29
Figure 5-2 Working conditions ‘push’ factors rated as influencers in decision to emigrate ...	29
Figure 5-3 Training ‘push’ factors rated as influencers in decision to emigrate .....	30
Figure 5-4 : Factors associated with an intention to migrate onward/elsewhere .....	31
Figure 5-5 ‘Push’ factors rated as influencing doctor’s decision to practice abroad (n=91)...	32
Figure 5-6 ‘Pull’ factors rated as having influenced doctors’ decision to practice abroad .....	39
Figure 5-7 Emigrated doctors’ comparisons of working in current country v. Ireland. ....	40
Figure 5-8 Correlation of original intention and current intention (to stay abroad).....	41

# Acronyms

BMQ	Basic Medical Qualification
BrainDrain	<i>Brain Drain to Brain Gain</i> research project (EU-WHO-funded 2015-17)
BST	Basic Specialist Training
CAAC	Consultant Applications Advisory Committee
CCST	Certificate of Completion of Specialist Training
CPSP	College of Physicians and Surgeons Pakistan
DEP	<i>Doctor Emigration Project</i> (HRB funded, 2014-2017)
ED	Emergency Department
EU	European Union
EWTD	European Working Time Directive
F2R	<i>Failure to Retain</i> (RCSI seed-funded, 2013-15)
GEM	Graduate Entry Medicine
GMS	General Medical Services
GP	General Practitioner
HC	Head Count
HSE	Health Services Executive
HST	Higher Specialist Training
IMC	Irish Medical Council
IMG	International Medical Graduates (aka Foreign Trained Doctors)
IMGTI	International Medical Graduate Training Initiative
MedTrack	<i>Medical Career Tracking Study</i> (HRB funded, 2016-2019)
MET	Medical Education and Training Unit (now the NDTP)
NCHD	Non-Consultant Hospital Doctor
NDTP	National Doctor Training and Planning Unit, HSE (previously MET)
OPD	Out-Patient Department
RCPI	Royal College of Physicians in Ireland
RCSI	Royal College of Surgeons in Ireland
RCSI HWRG	RCSI Health Workforce Research Group
SRMTCS	Strategic Review of Medical Training and Career Structure
TCD	Trinity College Dublin
WHO	World Health Organisation
WTE	Whole Time Equivalent
YTC	<i>Your Training Counts</i> (Irish Medical Council annual survey of trainees)



# Chapter 1 Introduction

## Background and Outline of Report

Short term migration for periods of training, together with permanent emigration, have been common career and life paths taken by Ireland's doctors and nurses over the last half century. For doctors, a period of time in a centre of excellence, usually in North America or the UK, was – and continues to be – seen as an essential step towards top hospital specialty posts in Ireland. For nurses, a new form of migration emerged at the start of the millennium when Ireland began a programme of **active recruitment of nurses**, mainly from India and the Philippines, to fill a growing gap (a “supply–demand mismatch”) in Irish hospitals (Humphries *et al*, 2008, 2009, 2012).

From 2000 and perhaps earlier, a silent and mainly **passive recruitment of doctors** – international medical graduates (IMGs) – developed, with most in the early years migrating to Ireland from Pakistan and India (Bidwell *et al*, 2013). Underlying and driving this phenomenon was an increasing rate of silent outward migration by graduates of Irish medical schools; the phenomenon was silent because it was not captured by routine data sources. The scaling up of domestic production of doctors from 2007 through graduate entry medicine programmes, as recommended by the Working Group on Undergraduate Medical Education and Training, 2006, resulted in new cohort of graduates from Irish medical schools since 2012. However, there was a concomitant increase in outward migration by Irish doctors, which was subsequently reported as emerging from 2008 (Humphries *et al*, 2017) .

These three phenomena – international recruitment of nurses, increasing inward migration of IMGs and outward migration of Irish trained doctors – have been the subject of research by the RCSI Health Workforce Research Group (HWRG) since 2007. This report summarises the main findings and conclusions from the research on the connected phenomena of inward migration of IMGs and the underlying outward migration of Irish-trained doctors.

**Chapter 3** of this report provides a summary of findings from three research projects on **Irish doctor emigration**: (i) RCSI seed-funded *Failure to Retain* (2013-15), (ii) the Health Research Board (HRB)-funded *Doctor Emigration Project* (2014-17), and (iii) the ongoing HRB-funded *Medical Career Tracking Study (MedTrack)*, 2016-19). Research findings are complemented by summaries of routine data collected and published by the Irish Medical Council (IMC) and Ireland's Health Service Executive (HSE) National Doctor Training and Planning Unit (NDTP – formerly the MET). These two bodies have been collaborators on three of RCSI's HRB-funded projects on doctor migration.

The work to analyse and triangulate routine data was supported by a fourth project: *Brain Drain to Brain Gain Supporting the WHO Code of Practice on the recruitment of health personnel project* (2014-17), funded by the European Union (EU) and NORAD through the World Health Organization (WHO). See Chapter 3 for a detailed description of the four projects.

*MedTrack* is measuring the specialty choices and migration intentions of Final Med students who graduated in 2017. To date, it has produced baseline findings of Final Med

students' career intentions in early 2017. A survey of all NCHDs took place in early 2018 and collected data on costs of training for NCHDs, their migration intentions and their experiences of working in Ireland. This present report includes provisional findings from these two *MedTrack* surveys. Together, the studies have been and are continuing to quantify the scale of outward migration and migration intentions of Irish trained doctors and medical students; and provide insights into the root causes of doctor emigration from Ireland.

**Chapter 4** summarises findings that quantify the trends and scale of **inward migration by foreign doctors** – mainly IMGs (foreign trained doctors) – from research and routine data, as described above; and the evidence of onward migration of this mobile workforce.

**Chapter 5** draws on qualitative and quantitative findings from the four mixed methods research studies on doctor migration. It unpacks, measures and explores the root causes – the **push and pull factors** – that account for outward migration of doctors from Ireland and the inward and onward migration of IMGs. It includes 2018 findings that suggest that more trainees report that training experiences have improved than do those who report they are worse. However, on balance more trainees report a deterioration in key dimensions of working conditions.

**Chapter 6** provides a summary of **medical workforce planning** reviews, published by the HSE NDTP. This work aims to project the future demand for specialists (consultants and GPs), by specialty, and includes comparator data on specialist norms (numbers per 100,000 population) for the UK and Australia. The reviews provide summary statistics on consultant shortfalls; on head counts versus whole-time equivalents; the ratios of specialists to trainees, and trainees to non-trainees; and they estimate projected trainee pipeline exits in relation to population need.

**Chapter 7** includes a summary of relevant findings including projected workforce needs that were identified from the May 2017 *Houses of the Oireachtas Committee on the Future of Healthcare SláinteCare Report*. The *SláinteCare Report* proposed that actions on workforce numbers and distribution need to be considered in the light of the proposed shift towards integrated care and primary and community models of care.

**Chapter 8** sets the findings and implications of this report in the context of the Department of Health's October 2017 *Working Together for Health. A National Strategic Framework for Health and Social Care Workforce Planning*. This Framework will frame future actions to address the challenges of doctor retention. Current efforts to improve doctor retention – including implementation of Medical Training and Career Structure recommendations – need to align with the structures and processes that will be established under the new Framework

Each chapter includes a summary of key findings, provisional conclusions, and questions for consideration by the national medical workforce stakeholders who attended the November 2017 Policy Dialogue at RCSI.

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## Chapter 2    Methods

## Overview

Since 2012, the RCSI Health Workforce Research Group (RCSI-HWRG) has completed a number of studies focussing specifically on the experiences, migration intentions and migration decisions of doctors working in, or who had recently left, Ireland. Mixed methods techniques, consisting of in-depth interviews and on-line surveys were used to explore and measure the underlying factors driving this migration phenomenon (Humphries *et al*, 2015; McAleese *et al*, 2016; Clarke *et al*, 2017). In addition, the RCSI-HWRG undertook a data linkage study in 2015-16, triangulating findings and linking routine data compiled and published by the Medical Council and the HSE NDTP. The on-going *MedTrack* study (2016-19) is a longitudinal study that commenced with a baseline of Final Med students' career intentions established in 2017.

- (i) The HRB-funded *Doctor Migration Project* (2012 and 2014), conducted by researchers from RCSI and TCD's Centre for Health Policy and Management, was a mixed methods study. In 2012 the lead researcher conducted in-depth interviews of 37 non-EU nationals who were practicing as doctors in Ireland. A follow-up survey in 2013 survey was completed by 366 such doctors, a subsection of whom were non-nationals who had qualified from Irish medical schools (n=59). Findings from the *Doctor Migration Project* are summarised in Section 5.2; and in detail in the published paper by Brugha *et al* (2016) <sup>10</sup>.
- (ii) In 2014, the RCSI Health Workforce research group, together with a researcher from Dublin City University School of Nursing, conducted an RCSI-funded semi-structured survey of 388 health professionals (307 doctors and 81 nurses/midwives) who had trained in Ireland and were working abroad. Findings are summarised in Sections 5.6.2 and 5.7; and in published papers by Humphries *et al* (2015) and McAleese *et al* (2016) <sup>11</sup>.
- (iii) The first annual 'Your Training Counts' (YTC) survey of trainees conducted by the Medical Council (2014), included a set of questions on migration intentionality that was drafted by the RCSI HWRG. Of the 1,636 respondents, 90% agreed to share their data with the RCSI HWRG and 63% of the 1,413 who completed those questions agreed to be followed up by the RCSI researchers. In 2015, as part of the HRB-funded *Doctor Emigration Project* (DEP), the RCSI researchers undertook

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<sup>10</sup> Brugha R, McAleese S, Dicker P, Tyrrell E, Thomas S, Normand C, *et al*. Passing through – reasons why migrant doctors in Ireland plan to stay, return home or migrate onwards to new destination countries. Hum Resour Health . 2016;14(S1). <https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-016-0121-z>.

<sup>11</sup> Humphries N, McAleese S, Matthews A, Brugha R. "Emigration is a matter of self-preservation. The working conditions . . . are killing us slowly": qualitative insights into health professional emigration from Ireland. Hum Resour Health. 2015;13(1). <http://human-resources-health.biomedcentral.com/articles/10.1186/s12960-015-0022-6>.

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in-depth interviews with 50 of the trainees who had agreed to be followed by the RCSI researchers. Findings are summarised in Section 5.4.

- (iv) In 2016, respondents to the 2014 Medical Council ‘*Your Training Counts*’ (YTC)<sup>12</sup> annual trainee survey, who had agreed to be contacted again, were surveyed by the RCSI ‘*Doctor Emigration Project*’. The aim was to determine the rates of intention to emigrate, the factors influencing those intentions; and the location of respondents. 523 doctors responded (59% response rate). Nineteen percent (n=93) of these doctors had already emigrated, with a further 22% definitely or probably intending to leave. Findings are summarised in Section 3.2 and Sections 5.1, 5.3, 5.4 and 5.6; and in Clarke *et al* (2017)<sup>13</sup>.
- (v) In 2015, RCSI researchers, as part of the ‘*Brain Drain to Brain Gain*’ project (co-funded by the European Union and Norad and coordinated by the WHO), triangulated medical registration data from annual reports of the Irish Medical Council (IMC) with data on the medical workforce compiled by the HSE NDTP. The team also undertook a data linkage exercise, linking data on nationality and country of qualification compiled by the IMC with data on NCHDs in public sector posts in Ireland. Findings from this exercise are summarised in Section 4.
- (vi) From October 2016 to February 2017, the RCSI HWRG conducted a survey of all Final Med students as part of the HRB-funded *MedTrack (Medical Career Tracking)* Study, 2016-19, to establish baseline career (specialty and migration) intentions; 483 (66%) of Irish and EU / EEA students responded. Findings are summarised in Section 3.3
- (vii) A second component of the *MedTrack Study* was a survey of 5,710 NCHDs (response rate 28%; n=1586) including trainees and non-trainees, which was conducted between December 2017 and February 2018. Provisional findings on trainees’ migration intentions are presented in Section 3.2 and Table 3.4; and on their experiences of changes in training and working conditions in Section 5.5 and Tables 5.2, 5.3 and 5.4.

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<sup>12</sup> Of those who agreed to share their data with RCSI DEP project

<sup>13</sup> Clarke N, Crowe S, Humphries N, Conroy R, O’Hare S, Kavanagh P, *et al*. Factors influencing trainee doctor emigration in a high income country: a mixed methods study. *Hum Resour Health*. 2017;15(1). <https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-017-0239-7>

## Chapter 3 Doctor Emigration from Ireland

### 3.1 Scale of outward migration of doctors from Ireland

#### Summary

Routine data from the main destination countries for Irish graduates show that large numbers of doctors had left or were likely to leave Ireland for these countries during the period 2008-2014. Routine data from Ireland show high exit rates from 2012 in the age categories 25-34 and 35-44 years, i.e. among early career doctors. A repeat survey showed the highest rates of leaving Ireland among those who had been interns and in Higher Specialist Training (HST), two years earlier. Half of those doing HST fellowships were not planning to return to Ireland.

#### Findings

Between 2008 and 2014, approximately 3,800 doctors previously registered in Ireland registered to practice and/or completed immigration processes in five major destination countries. This number exceeded the numbers of Irish / EU graduates from Irish medical schools during this period (Humphries *et al*, 2017).

IMC annual Medical Intelligence Reports capture exits from the medical register by age categories and Division on the register (Medical Council, 2013, 2014, 2015a, 2016a). Between 2012 and 2015, annual exit rates averaged 8.5% in doctors aged 25-34 years and 6.6% in those aged 35-44 years - see Table 3.1. Disaggregated data show that exit rates were lower among graduates of Irish medical schools (Table 4.6).

*Table 3-1 Exit rates from the Medical Council Register by age group for 2012-2015*

Year	Less than 25 years	25-34 years	35-44 years
2012	0.0%	9.0%	7.1%
2013	10.4%	9.0%	6.8%
2014	0.0%	7.2%	5.9%
2015	6.3%	8.7%	6.4%

Source: (Medical Council, 2013, 2014, 2015a, 2016a)

Respondents to the 2014 Medical Council 'Your Training Counts' (YTC)<sup>14</sup> annual trainee survey were surveyed in 2016, as part of RCSI's HRB-funded 'Doctor Emigration Project'. By 2016, 17% of 25-34 year old doctors (n=63) and 24% of 35-44 year old doctors (n=20) had left Ireland to practice medicine abroad, two years after the baseline survey. This is equivalent to around 10% per annum; however, this includes those undertaking training abroad who might return to Ireland, and those who did not intend to return to Ireland.

<sup>14</sup> Of those who agreed to share their data with RCSI DEP project

Table 3.2 shows the training stage of 478 trainees who completed the YTC survey in 2014 and their location in 2016 – in Ireland or abroad<sup>15</sup>. There is a bimodal distribution with high rates of doctors working or training abroad<sup>16</sup> within two years of internship (n=19, 25%); and high rates two years after reporting being in HST (n=42, 27%). Whereas 91 (91%) of those who were GP trainees were still in Ireland.

*Table 3-2 Proportions of doctors who had emigrated 2 years after YTC survey (2014)*

	Abroad in 2016		In Ireland in 2016	
	N	%	N	%
Intern	19	25	57	75
BST	18	17	89	83
GP Registrar	9	9	91	91
HST	42	27	110	72
Registrar	0	0	25	100
Run Through	0	0	18	100
Total	88	18	390	82

Of the 42 respondents abroad in 2016, who had been in HST in Ireland in 2014, 34 (81%) were in fellowship programmes, which would suggest an intention to return to Ireland. However, only 53% (n=18) of those doing fellowships reported an intention to return. See 5.7 for findings on likelihood that Irish-trained doctors working abroad would return to Ireland.

## 3.2 Migration intentions of Irish NCHDs

### Summary

Three surveys of trainees conducted between 2014 and 2016 (Medical Council, 2015b, 2016b; Clarke *et al*, 2017) reported levels of intention to emigrate, ie to make a long term career outside of Ireland, in the region of 20-22% of trainees. The Medical Council's third (2016) annual survey of trainees reported that emigration intention had fallen to 14% (Medical Council, 2017). The 2018 *MedTrack* survey also reported that 14% of trainees intended to leave and not return, with non-trainees (24%) more likely than trainees not to return. Similar rates of trainees intend to go and return (42%), or remain in Ireland (41%)

### Findings

#### 3.2.1 Findings from annual surveys, 2014-16

The percentage of respondents to the Medical Council's YTC annual surveys who stated they definitely or probably did not see themselves practicing medicine in Ireland in the foreseeable future were 21% in 2014, 20% in 2015 and 14% in 2016 (Medical Council,

<sup>15</sup> Unpublished *Doctor Emigration Project* data

<sup>16</sup> 4 participants were taking a career break. Age data missing on 1.

2015b, 2016b, 2017). There were corresponding increases in those definitely or probably planning to practice in Ireland, rising from 54% in 2014 to 66% in 2016. However, it should be noted that response rates to the Medical Council's YTC annual surveys have been falling – see Table 3.3.

At the time of the RCSI *Doctor Emigration Project's* (DEP) 2016 survey, among the 523 respondents, 423 were still in Ireland. Of these, 22% stated they definitely or probably did not see themselves practicing medicine in Ireland in the foreseeable future (Clarke *et al*, 2017); and a further 22% were undecided about this – see Table 3.3. The 2016 RCSI DEP sample is a subset of the trainees who responded to the 2014 YTC survey, 93 (19%) of whom had already emigrated with a further 22% definitely or probably leaving.

*Table 3-3 Response rates and trainees' intention to practice in Ireland (2014-16)*<sup>17</sup>

Survey	Survey Response		Definitely/ Probably leaving	Undecided	Definitely/ Probably staying
	n	%	%	%	%
YTC 2014	1636	58	21	25	54
YTC 2015	1035	37	20	23	58
YTC 2016	828	26	14	19	67
DEP 2016	523	59	22	22	56

### 3.2.2 Findings from 2018 survey of all NCHDs

The RCSI's *MedTrack* study (2016-19) is using a new set of questions on migration intentions, which was introduced to the Final Med baseline survey, delivered from November 2016 to February 2017 (see Section 3.3 including Figure 3.1); and was used again in a follow-up survey of all NCHDs, December 2017 to February 2018 (see Table 3.4). These questions were designed to be simpler and more direct than those employed in the Medical Council (2014, 2015, 2016) and *Doctor Emigration Project* (2016) surveys, eliciting the same information in a more precise way.

Our 2018 findings matched those of the 2016 Medical Council survey: the same percentage of trainees (14%) reported they intended to leave and not return. Non-trainees<sup>18</sup> in the 2018 survey were more likely than trainees to remain in Ireland (52% v 41%); but if they left, they were much more likely not to return (22% v 14%).

<sup>17</sup> The DEP 2016 sample is a sub-sample of the YTC 2014 cohort, who were surveyed on 2 occasions.

<sup>18</sup> Non-trainees are an heterogeneous group, including NCHDs in service-type posts who are unlikely to gain entry to training programmes; and post-internship NCHDs who are intending to apply to undertake Basic Specialist Training (BST), or are between BST and Higher Specialist Training (HST) posts.

Table 3-4 Migration intentions (numbers and rates) for trainees and non-trainees

	Trainee		Non-trainee		Total	
	N	%	N	%	N	%
Go abroad and not return	111	14	88	22	199	17
Go and return	330	42	90	23	420	36
Leave medicine	21	3	12	3	33	3
Remain	322	41	204	52	526	45
Total	784	100	394	100	1178	100

Note: n=408 respondents did not respond (significantly higher proportion of interns did not respond). (Source: Unpublished *MedTrack* 2018 data)

### 3.3 Migration intentions of Irish medical students

#### Summary

A 2016-17 survey, conducted as part of the HRB *MedTrack* project, found that over half (54%) of Irish and EU/EEA Final Med students intend to leave Ireland at some point after their internship, but intend to return to make their careers in Ireland; 37% plan to remain in Ireland; and only 9% plan to leave Ireland and not return<sup>19</sup>. These findings represent an improvement in the rates of ‘intention to emigrate’ reported in an earlier study.<sup>20</sup> Younger graduates are more likely to leave and are more likely to return.

#### Findings

The RCSI HWRG conducted a baseline survey of all final year medical students between November 2016 and February 2017 (HRB *MedTrack* Project). Respondents were asked about career (specialty) choices and migration intentions. Among Irish/ EU nationals there was a response rate of 66% (n=483). Over half (54%, N=259) intended to leave but return to make their careers in Ireland; 37% (N=175) intended to remain and only 9% (N=42) of Irish/EU final med students intended to leave after graduation and not return.

Younger (21-24 year old) final med students were more likely than those aged 25 and over to leave with a view to returning (68% v 36%). Whereas, if older students intended to leave, they were more likely not to return (13% v 7%). See Figure 3.1.

<sup>19</sup> Unpublished *MedTrack* finding on final med career intentions

<sup>20</sup> A 2012 survey of undergraduate medical students in Ireland (Gouda *et al*, 2015) reported that 88% of Irish students (N=1332, 37% response rate) were ‘definitely or contemplating migrating following graduation or after their internship year’. The students were not asked about their intentions to return to practice in Ireland. However, the findings were conveyed in the media as: “90% of Irish medical students considering emigration after they qualify” <http://www.thejournal.ie/medical-students-emigrating-1987638-Mar2015/>

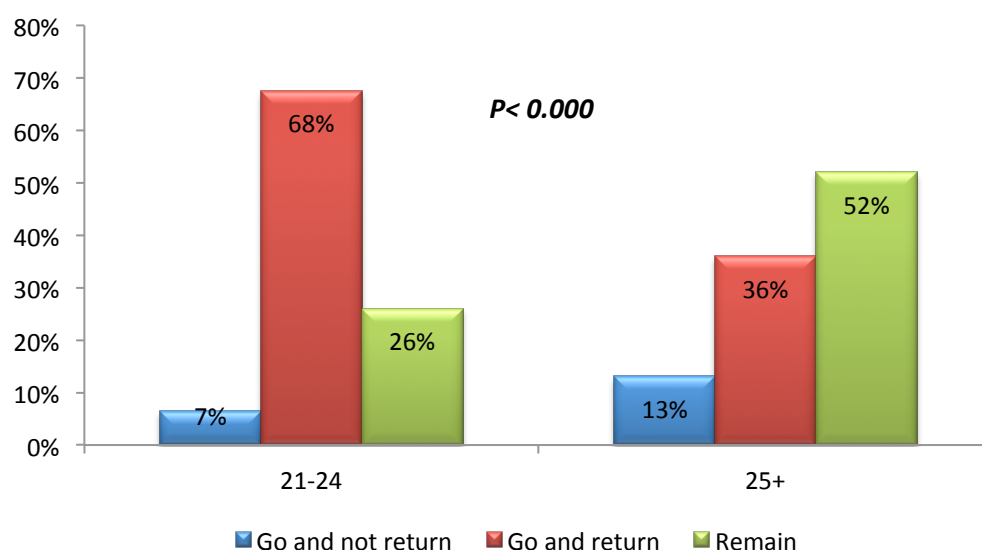


Figure 3-1 MedTrack Intention of Irish/ EU/ EEA final med students by age

## Conclusions

Survey findings and routine data portray Ireland's highly mobile medical workforce: (i) 6-9% of doctors between 25 and 44 years of age exit the register annually, which is a proxy for emigration; (ii) the rate of those intending to leave and not return fell from 20% in 2014-15 to 14% in 2016-18; and (iii) while many graduates (especially younger doctors), intend to leave after internship, most plan to return to make their careers in Ireland.

The high rate of interns and of trainees who wish to ultimately make their future careers in Ireland, often after a period of time abroad, is encouraging. However, large scale outward migration after internship makes the planning of training programmes difficult; and further measures to facilitate entry while abroad to training programmes in Ireland, are needed.

The research findings show two critical postgraduate periods for medical workforce planners to note. The first is the period after completion of internship, where a decision by NCHDs to leave Ireland could lead to permanent emigration if measures are not in place to attract them back to Ireland. The second is the cohort of doctors who are close to completing specialist training, especially those doing fellowships abroad, where suitable permanent posts need to be available and matched to their training.

## Questions

1. *Is enough being done (can more be done) to ensure that Irish graduates who travel after internship are being kept informed of, and encouraged to apply for, vacancies, and training programmes that are available to them in Ireland.*
2. *Is training (e.g. fellowships) abroad always necessary? Is it necessary for those who wish to be generalists? (See 'Culture of emigration' – Section 5.4)*



3. *Are the processes sufficiently streamlined whereby those who need to undertake fellowships abroad can be assured of permanent posts to return to in Ireland?*
4. *What other or additional conclusions can be drawn from the findings? Do the findings point to other questions that should be addressed?*

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## Chapter 4 International Recruitment of Doctors

## 4.1 Scale of inward migration of doctors into Ireland

### Summary

Despite a doubling in the numbers of graduates from Irish medical schools, through the establishment of Graduate Entry Medicine programmes, there has been a rapid rise in the numbers and an inexorable rise in the proportion of international medical graduates (IMGs) registered with the Irish Medical Council. In 2015, fewer Irish graduates than IMGs registered for the first time with the IMC, with IMGs now including non-EU nationals and some Irish nationals who have graduated from Central European medical schools. International recruitment is driven by an increasing need for doctors in Ireland, as in other countries.

### Findings

The Fottrell Medical Education Targets (established as part of the Working Group on Undergraduate Medical Education and Training, 2006) have been achieved, with the number of Irish (and EU) graduates up from 370 in 2006 to 730 in 2015, largely through the establishment of shorter duration (4-year) Graduate Entry Medicine programmes. There have also been modest increases in postgraduate training numbers.

Despite these achievements, the proportion of IMGs registered with the Medical Council rose from 13.4% in 2000 to 33.4% in 2010 and 37.9% in 2015 (Bidwell *et al*, 2013, Medical Council, 2016). Most of this increase was due to recruitment of doctors from outside the EU, which increased from 7.4% to 25.3% of those on the register during this period. IMGs accounted for 30-35% of those registered during the period 2010-2015, with the biggest growth in those registered in the General Division (i.e. working outside of training programmes (see Table 4.7).

Pakistan is the country where active recruitment by Irish hospitals took place around 2012; and from which managed medical migration to Ireland occurs through the International Medical Graduate Training Initiative (IMGTI) – see Section 4.2. The proportion of Pakistani-graduated doctors on the Irish Medical Council register remained stable between 2000 and 2015, at 22%. However, the numbers increased 4-fold, from 375 doctors in 2000 to 1481 doctors in 2015. This goes some way to illustrate the increase in demand for health services and doctors within Ireland during this period (Walsh & Brugha, 2017).

Despite a slight upward trend in the numbers of doctors who graduated from Irish medical schools from 2012 to 2015 (see Table 4.1), the proportion of Irish-graduated doctors on the Medical Register fell from 65% to 62%. In the same period, there were rises in the proportions of registered doctors who were awarded their basic medical degrees in the Eastern Mediterranean<sup>21</sup> (13% to 15%) and Europe (10% to 13%).

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<sup>21</sup> Pakistan is included in the WHO Eastern Mediterranean Region.

Table 4-1 Source of basic medical qualification of MCI registration, (2012–15)

Source	2012		2013		2014		2015	
	N	%	N	%	N	%	N	%
Ireland	10656	65	10624	66	10715	64	10906	62
Eastern Mediterranean	2187	13	2055	13	2242	14	2656	15
Europe	1575	10	1761	11	1993	12	2325	13
Africa	1227	8	1111	7	1022	6	969	6
South-East Asia	492	3	430	3	446	3	438	3
Western Pacific	168	1	125	1	159	1	166	1
The Americas	66	0.4	76	0.5	85	0.5	99	0.6

Source: (Medical Council, 2013, 2014, 2015, 2016; Walsh & Brugha, 2017)

Changes in the profile of doctors registered with the Medical Council reflect increasing numbers of doctors with EU Central European medical school qualifications, which is a phenomenon that had begun to appear by 2010 (Bidwell *et al*, 2013). Between 2012 and 2015, the number of doctors on the register with Romanian medical qualifications increased from 193 to 488; and doctors with Hungarian medical qualifications from 130 to 210 years (Walsh & Brugha, 2017). There were also registered doctors who had graduated from medical schools in Poland, Czech Republic and Slovakia.

Graduates comprised nationals of these Central European countries, but also non-EU nationals, especially from India and Pakistan. Among 301 Romania-graduated doctors working in HSE posts in 2015, 119 were nationals from outside the EU (primarily nationals of Pakistan (n=37), India (n=36) and Nigeria (n=20)). A new phenomenon was that of Irish nationals who graduated abroad who then registered to practice in Ireland.<sup>22</sup> Of 40 graduates of Czech medical schools who were working as doctors in Ireland in 2015, 13 were Irish nationals, a further 15 were non-EU nationals, 5 were Czech and 3 were Slovakian nationals.

Results for location of basic medical qualification by country / region of training of new entrants to the medical register are shown in Table 4.2. Between 2012 and 2015, the numbers of new entrants to the IMC's medical register more than doubled (increasing from 1,256 to 2,576). Factors likely to account for this include the high turnover of doctors, due to high exit rates of Irish and International Medical Graduates (see Tables 4.6, 4.7 and Section 5); and an increasing demand for doctors in Ireland.<sup>23</sup>

Between 2014 and 2015, Irish entrants to the register increased by 11.3%, from 772 to 859 (Table 4.2). Likely reasons for this were the additional doctors coming from Ireland's new Graduate Entry Medicine (GEM) programmes; and perhaps Irish nationals graduating from non-Irish medical schools and Irish doctors who had withdrawn from the register, while

<sup>22</sup> This pattern has also been reported in the United Kingdom (UK) with UK nationals.

<sup>23</sup> One of the questions put to the stakeholders at the November 2017 was about effect of the European Working Time Directive (EWTD) – see Questions at end of this section. The effect of the EWTD is covered in more detail in the Challenges and Responses section of this report.

working abroad, who had returned to work in Ireland. However, new entrants to the register who graduated outside of the EU increased by 98%, from 552 in 2014 to 1,095 in 2015.

*Table 4-2 Location of basic medical qualification for new entrants to the MCI register*

Location of BMQ	2012	2013	2014		2015	
			N	%	N	%
Ireland	–	–	772	39	859	33
Outside Ireland and the EU	–	–	552	28	1095	43
EU medical school (EU national)	–	–	437	22	428	17
EU medical school (non-EU national)	–	–	196	10	194	8
Total	1256	1576	1958	100	2576	100

Source: (Medical Council, 2013, 2014, 2015, 2016; Walsh & Brugha, 2017)

## 4.2 International Medical Graduate Training Initiative

### Summary

As part of a joint initiative of the HSE, Royal College of Physicians of Ireland (RCPI) and the College of Physicians and Surgeons Pakistan (CPSP), the International Medical Graduate Training Initiative (IMGTI) was established in 2013. The IMGTI provides bespoke postgraduate training in Irish hospitals to doctors from Pakistan, who are awarded their professional qualification on their return to Pakistan. While some doctors who have enrolled on this initiative report mixed experiences, the general consensus of Pakistani trainees and graduates – and of the national stakeholders in both countries – is that the Initiative is achieving its objectives of providing internationally recognised postgraduate training to an eager and enthusiastic cohort of trainee doctors. Studies are needed to evaluate how well the IMGTI contributes to the long-term retention of doctors in Pakistan.

### Background

The International Medical Graduate Training Initiative (IMGTI), launched in 2013, enables suitably qualified medical graduates from selected non-EU countries to undertake a fixed period of active postgraduate training in clinical services in Ireland. Costs of relocation and training are covered by the HSE. Following two years of postgraduate training in Ireland, trainees must return to their country of origin to be awarded their qualification.

Between 2013 and 2017 a total of 223 doctors have taken part in the programme, with the majority of doctors originating from Pakistan. Recruits to the IMGTI have increased annually (Table 4.3). Since 2017, additional government-sponsored doctors – mainly from Middle East countries – have become participants in the Initiative (Table 4.3) (HSE NDTP, 2017).

Table 4-3 Annual International Medical Graduate Training Initiative members

Year	CPSP	Fully sponsored	Total IMGTI Doctors in Health Service
2013/2014	28	0	28
2014/2015	81	6	115
2016/2016	73	35	195
2016/2017	41	35	184

Source: (HSE NDTP, 2017); \* IMGTI doctors are on multi-year programmes

As part of the '*Brain Drain to Brain Gain*' project (2015-17), the RCSI HWRG evaluated the IMGTI from the perspectives of Pakistan trainees participating in the programme (2013-2015 cohorts). Key stakeholders in Ireland and Pakistan who were involved in its development and implementation were also consulted. During 2016 and 2017, 28 in-depth interviews (21 trainees and 10 key stakeholder) were undertaken (Walsh & Brugha, 2017).

## Findings

IMGTI trainees' experiences of Irish training were generally positive, with most reporting experiencing no difference in treatment compared to Irish trainees, good professional support, and positive experiences with supervisors, staff and the wider community. Some considered that their training needs were given less priority than those of Irish trainees and in a small number of cases they perceived that the Irish trainees were given preference over Pakistani trainees.

Initially, there were some reports detailing incidences of hospital consultants not being aware that doctors who were recruited through the IMGTI were trainees, instead considering them to be non-trainee NCHDs. These incidences reduced over time as the IMGTI became more widely known. Some IMGTI trainees reported that they felt they were placed in smaller peripheral (model 2 and smaller model 3) hospitals in order to address staff shortages in those hospitals. Some stakeholders considered that the IMGTI should acknowledge the needs of Irish and Pakistani trainees as different, and that more dedicated programme support was needed for the Pakistani trainees.

A principle of the IMGTI is that while the two years of Irish postgraduate training is recognised for the purposes of specialisation in Pakistan, it is not recognised in Ireland. This means that if an IMGTI-trained doctor wishes to return to Ireland in the future, s/he cannot enrol for specialist training or gain a certificate of completion of specialist training. The extent to which this was considered ethical differed amongst stakeholders. However, many IMGTI trainees expressed their plan to return to Ireland or another European country, after completing their exams in Pakistan, to gain further experience, with the longer-term intentions of returning to Pakistan.

Stakeholders reported that the HSE has actively engaged with hospital sites throughout Ireland, communicating that it is critical that posts cannot be offered to trainees following their two years of IMGTI training in Ireland. Documentation and contracts have been



strengthened since the inception of the IMGTI to emphasize that the IMGTI trainees must return to the source country (in the majority of cases, Pakistan) once they have completed their training. It was not within the remit of the 'Brain Drain to Brain Gain' study to establish if onward migration to other countries or recruitment to work in Irish hospitals, after completion of training, had taken place.

Overall, both trainees and stakeholders were positive about the initiative. While it was recognised that there was room for improvement, most respondents view the Initiative as being in its infancy, and that it was a good model and structure for IMGs who wished to train in Ireland. Future studies might consider collecting routine data to track IMGTI trainees' short, medium and long term career decisions to inform policy going forward.

### 4.3 Changing profile of NCHDs in Ireland

#### Summary

Over a four year period up to 2016, the number of non-trainees who were registered with the Irish Medical Council increased four times as quickly as the number of trainees. Non-trainees were generally older and were likely to be in service posts with little or no prospect of entry to formal training programmes.

#### Findings

The Irish Medical Council (IMC) maintains a register of doctors registered to practice in Ireland. Information is held on the doctor's medical school and country of qualification, and the division of the register the doctor belongs to (General, Specialist, Trainee and Supervised). The IMC database does not record if, or where within the Irish health system, the doctor is employed.

New processes to capture details of doctors working in Public Sector posts were established from 2011 by the National Doctor Training and Planning (NDTP) Unit (previously known as the HSE Medical Education and Training (MET) Unit).

Table 4.4 shows that the number of trainees in Public Sector posts increased by 12.5% between 2011 and 2017, compared with a 44% rise in non-trainees. Therefore, trainees as a proportion of the total NCHD workforce fell from 69% to 64% during this period.

*Table 4-4 Non-consultant hospital doctor numbers, 2011–2017*

Year	Trainees	Non-trainees	Total NCHDs
2011/2012	3412	1524	4936
2012/2013	3458	1447	4905
2013/2014	3370	1549	4919
2014/2015	3504	1798	5302
2015/2016	3706	2011	5717
2016/2017	3838	2199	6037

Source: HSE (NDPT, 2017)

Age profiles for 2015 and 2016 (Table 4.5) show that non-trainees are generally older than trainees, with close to one third of non-trainees aged over 45 years of age. This supports the anecdotal view that non-training or ‘service posts’ are becoming destination posts for some NCHDs – primarily those NCHDs who are IMGs and who are unlikely to compete successfully for entry to training programmes.

*Table 4-5 Age profiles of trainees and non-trainees, 2015–2016*

	2015				2016			
	Trainee		Non-trainee		Trainee		Non-trainee	
	N	%	N	%	N	%	N	%
Under 35	1555	79	1979	36	1535	78	2249	39
35-44	369	19	1438	26	390	20	1490	26
45-54	32	2	1039	19	33	2	1018	12
55-64	1	0	704	13	2	0	717	12
65+	0	0	284	5	0	0	311	5
Total	1957	100	5444	100	1960	100	5785	100

Source: Medical Council Annual Retention Survey (2015-2016)

## 4.4 Onward migration of doctors out of Ireland

### Summary

Exit rates from Ireland by country of qualification is lowest among graduates of Irish medical schools, followed by graduates of non-EU medical schools (Table 4.6). The highest exit rate is among graduates of other EU medical schools (Walsh & Brugha, 2017). Exits from the general division of the register (Table 4.7), where non-EU graduates are more likely to be registered, are around three times higher than exits from the specialist register. In a 2013 survey of foreign doctors, conducted by the RCSI HWFRG as part of the HRB Doctor Migration study, almost half (47%) plan to migrate onwards to a third country (Brugha *et al*, 2016).

### Findings

The Medical Council Medical Intelligence Reports report high exit rates from the register in the 25-34 and 35-44 year age categories, with higher rates among medical school graduates of non-EU and other EU medicals, compared to graduates of Irish medical schools (Table 4.6):

In the 25-34 year old age category, Medical Council exit rates for graduates of Irish medical schools, were 5.5% in 2014 and 6.4% in 2015, compared with non-EU medical graduates exit rates of 7.8% and 8.6%. Similarly, in the 35-44 age category, exit rates among Irish

medical school graduates were 4.3% in 2014 and 3.5% in 2015, compared with non-EU medical school exits rates of 7.8% and 8.6% for the same periods.

*Table 4-6 Age category of doctors exiting the Medical Council Register, 2014–2015*

Age	Exit rate 2014								Exit rate 2015							
	Irish medical school		EU medical school: EU national		EU medical school: non-EU national		Medical school outside EU and Ireland		Irish medical school		EU medical school: EU national		EU medical school: non-EU national		Medical school outside EU and Ireland	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
25–34	157	6	74	16	28	9	48	8	191	6	107	19	50	11	79	9
35–44	131	4	54	10	5	5	113	8	107	4	80	13	21	15	129	9

Source: (Medical Council, 2015, 2016; Walsh & Brugha, 2017)

Between 2012 and 2015, the exit rate (or annual turnover) among doctors registered in the General Division was 3 times higher (11.2%) compared with exits from the Specialist Division (3.7%). There were much lower exits in the Trainee division (Table 4.7: (Walsh & Brugha, 2017)). Of note is the fact that over half (55%) of doctors registered in the General Division qualified outside of Ireland and the EU.

Exit rates of Trainee Specialists are much less frequent than from doctors on the Specialist Division, suggesting that most trainees remain on the register and complete their training, with emigration occurring once they have received their Certificates of Completion of Specialist Training (CCST).

*Table 4-7 Exit rates by Registration Division, 2012–2015*

Division	2012		2013		2014		2015	
	N	%	N	%	N	%	N	%
General	936	14	772	11	709	9	855	11
Specialist	276	4	277	4	280	4	318	4
Supervised	28	12	6	81	2	25	2	2
Trainee Specialist	10	1	4	0.2	4	0.2	20	1

Source: (Medical Council, 2013, 2014, 2015, 2016; Walsh & Brugha, 2017)

In 2013, the HRB RCSI Doctor Migration study conducted a survey of 366 foreign doctors working in Ireland, which reported that 47% (n=161) planned to migrate onwards, 23% planned to return to their country of origin, and only 23% planned to remain in Ireland (Brugha *et al*, 2016). The reasons why both Irish and foreign doctors leave Ireland are presented and discussed in Chapter 6. *Doctor emigration from Ireland – push and pull factors*.

## Conclusion

Despite a doubling in domestic medical graduate numbers, the recruitment of IMGs to Ireland remains high, including graduates from Central European as well as non-EU medical schools. Findings from surveys and routine data indicate a higher turnover among IMGs who, having worked for a period in Ireland (usually in non-training posts), are likely to leave. This confirms the view that international recruitment of doctors from low and middle-income countries (LMICs) is not a sustainable strategy. In addition, it raises questions regarding Ireland's compliance with the WHO Global Code of Practice on the International Recruitment of Health Personnel (World Health Organisation, 2010). However, Ireland's IMGTI programme is an example of best practice in promoting training and circular migration of LMIC doctors to their home countries.

## Questions

1. *How sustainable is this faster upward trend in the recruitment of doctors outside of training programmes? What are the reasons for the trend?*
  - *To what degree is it due to the pressure to be European Working Time Directive (EWTD) compliant?*
  - *Given that Ireland has a statutory requirement to be EWTD compliant, are there better or other ways for HSE hospitals to achieve compliance?*
  - *Is it partly an effect of hospital configuration, whereby small hospitals are not suitable for training, and face challenges in recruiting consultants, and require greater numbers of NCHDs to be EWTD compliant?*
2. *How can this trend be reversed?*
3. *Could changes in specialist location patterns help to increase the number and ratios of training to non-training posts (issue of specialist numbers is considered in Ch.6)?*
4. *Are there better ways for HSE hospitals to address service delivery needs?*
5. *Do the findings point to other questions we should be asking?*

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## Chapter 5 Doctor Emigration from Ireland: Push and Pull factors

## Summary

The body of evidence from four recent mixed methods research studies identifies common factors that *push* doctors to leave Ireland: stressful working conditions (related to having to undertake non-core tasks, combined with staff shortages); lack of designated and supervised training time (with training getting displaced by service demands); and lack of suitable posts at the end of training, and unclear and unattractive career opportunities in Ireland.

While 2018 survey findings suggest that there had been, on balance, improvements in some dimensions of training (notably in supervision and mentoring supports), over half reported that training costs had got worse. Around half of trainees reported that stress and staffing levels were worse.

The perception and experience that working, training and career opportunities are better abroad *pull* Irish doctors to go abroad to train and work; and the lack of substantive improvements in conditions back in Ireland keeps them abroad. Over time, the likelihood of Irish trained doctors returning to Ireland diminishes. Similar factors, especially the lack of access to training programmes, account for the high turnover of foreign doctors in Ireland. Irish and foreign doctors provided rich, qualitative narratives that illustrated the negative dimensions of training, career opportunities and working conditions in Irish hospitals.

### 5.1 ‘Push’ factors for why trainees might leave Ireland

In a RCSI-funded 2014 study ‘*Failure to Retain*’, rich, qualitative responses were given by over 90% of respondents to an open question asking why the doctor had emigrated from Ireland: emigration was a result of the search for better working conditions, clearer career progression pathways and a better practice environment (Humphries *et al*, 2015).

The responses were used to draft Likert scale items that were administered in the 2015 IMC ‘*Your Training Counts*’ survey (Medical Council, 2016); and were used to develop an expanded set of statements in the 2016 RCSI *Doctor Emigration Project* survey of 523 trainee doctors, 423 of whom were in Ireland with the rest working abroad (Clarke *et al*, 2017).

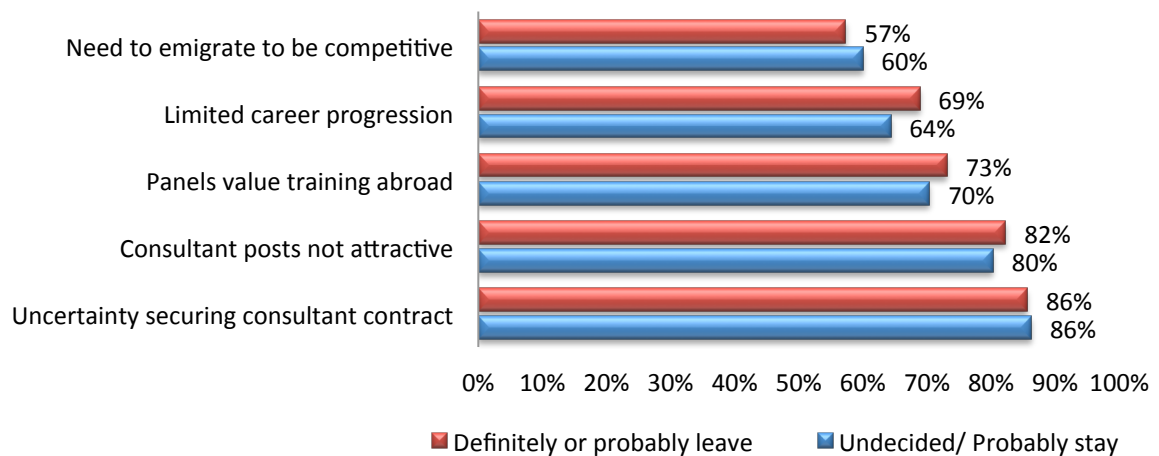
Both the IMC and RCSI DEP surveys asked respondents to rate on a scale of 1 through 5 how important each dimensions of working conditions, training and career opportunities would be in any decision to emigrate. (Clarke *et al*, 2017). Results of responses to ‘push’ factors, from the DEP survey, are presented in Figures 5.1, 5.2 and 5.3 below.<sup>24</sup>

Figure 5.1 displays factors that would influence trainees’ decision to emigrate, with over 80% of respondents selecting as influential in the category ‘career progression’: ‘uncertainty securing a consultant contract’ and ‘consultant posts not attractive’.

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<sup>24</sup> ‘Pull’ factors are presented in Section 5.6

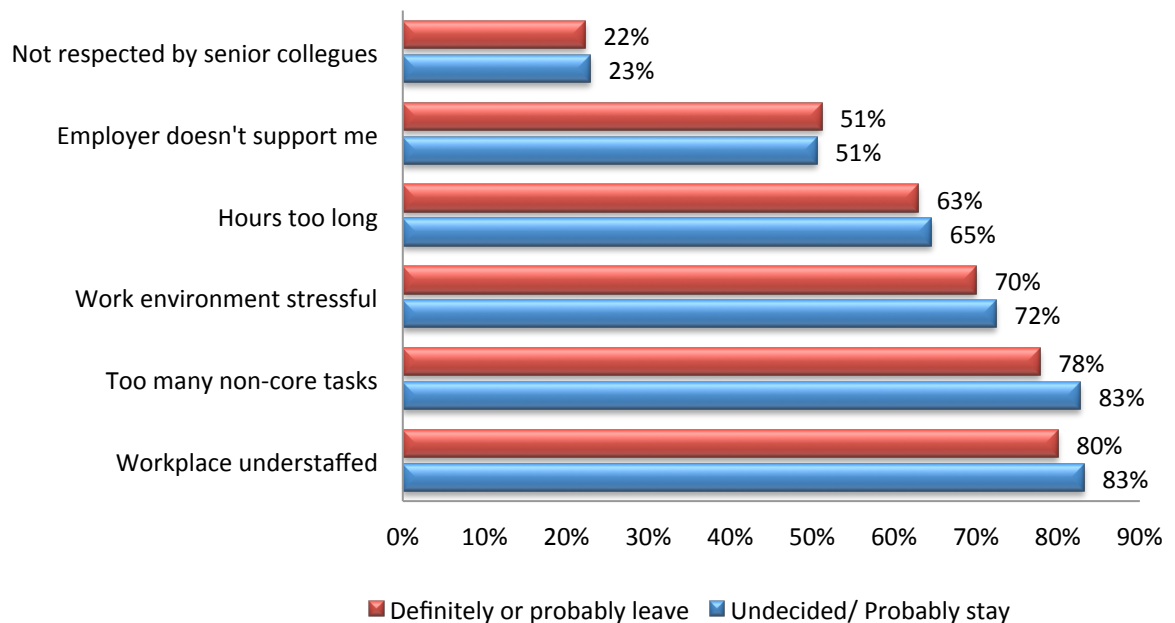




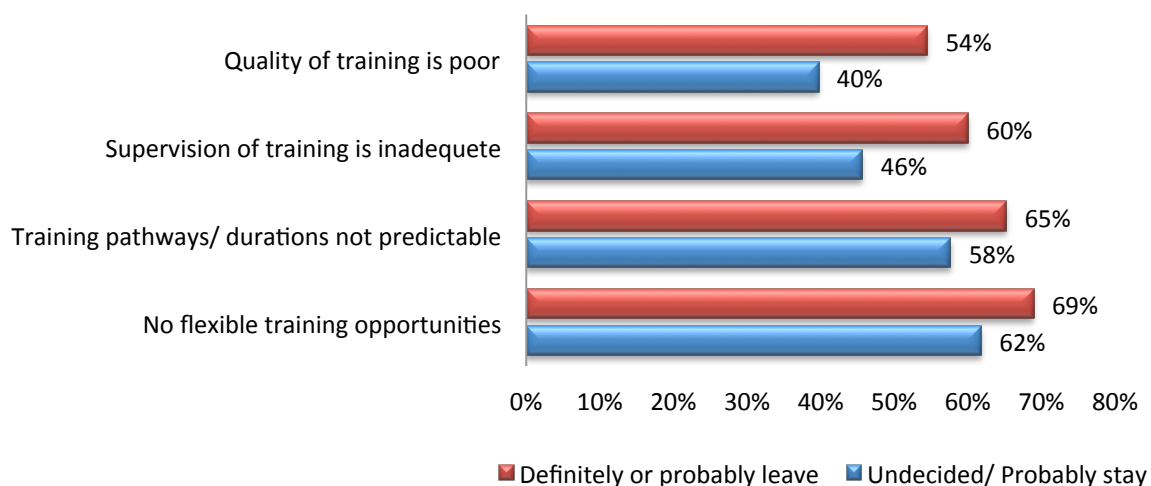
*Figure 5-1 Career progression 'push' factors rated as influencers in decision to emigrate.*

Statements related to 'Working conditions' that elicited highest levels of agreement (around 80%) were: 'under-staffed workplace' and 'too many non-core tasks' (Figure 5.2).

However, the factors that elicited the greatest dissatisfaction did not discriminate between those who were likely to emigrate and those undecided or likely to remain in Ireland. In other words, those who were definitely or planning to leave, and those who were undecided or probably staying had similar and almost equally critical experiences of working in Ireland.



*Figure 5-2 Working conditions 'push' factors rated as influencers in decision to emigrate*



*Figure 5-3 Training 'push' factors rated as influencers in decision to emigrate*

Push factor statements related to training elicited less high levels of agreement as reasons for leaving (Figure 5.3 above). However, two of those factors – 'Quality of training is poor' and 'Supervision of training is inadequate' did discriminate at a statistically significant level between those definitely or probably leaving, and those undecided or probably staying.

The above factors tested in a multivariable logistic regression model (Table 5.1), along with two other factors that were statistically significant: 'Poor work life balance' and 'Family and personal reasons' for leaving. The latter was significantly associated with doctors being older, married and with children (Clarke *et al*, 2017).

*Table 5-1 Factors predicting doctors intentions to practice abroad*

	Univariable		Multivariable	
	OR	P	OR	P
<b>Remainers vs Leavers</b>				
<i>Happy with current work-life balance</i>				
Yes	1.00		1.00	
No	2.51	<0.001	2.51	<0.001
<b>Undecided vs Leavers</b>				
<i>Quality of training available here is poor</i>				
Disagree	1.00		1.00	
Agree	1.82	0.021	1.82	0.022
<i>Leave for family/ personal reasons</i>				
Disagree	1.00		1.00	
Agree	1.80	0.031	1.85	0.027
<i>Supervision of training inadequate</i>				
Disagree	1.00		-	-
Agree	1.79	0.025	-	-

## 5.2 ‘Push’ factors for why foreign doctors would leave Ireland

For the *Doctor Migration Project* (2013) 345 foreign (non-EU) doctors working in Ireland, were surveyed and responded to questions on future migration intentions. Almost half (47%) of respondents reported that they intended to migrate onwards to another country; 30% planned to remain in Ireland and only 23% planned to return to their country of origin (Brugha *et al*, 2016). Discriminant analysis identified factors that were independently associated with an intention to migrate onwards (see Figure 5.4).

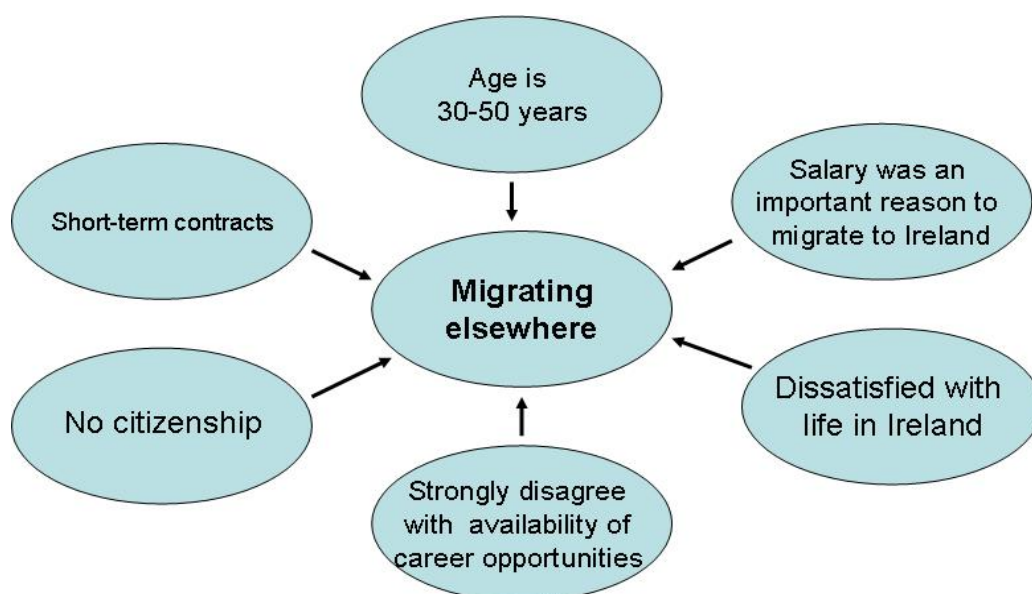


Figure 5-4 : Factors associated with an intention to migrate onward/elsewhere

## 5.3 ‘Push’ factors for why trainees had left Ireland

For the *Doctors Emigration Project* (DEP, 2016), of the 523 respondents, 91 doctors had left Ireland between 2014 and 2016. Figure 5.5 (below) presents responses to the factors they reported as very important in their decision to leave included ‘working conditions’ (71%), a ‘better work-life balance abroad’ (66%), ‘career progression’ (64%) and ‘post-graduate training’ (55%)<sup>25</sup>.

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<sup>25</sup> Unpublished DEP results

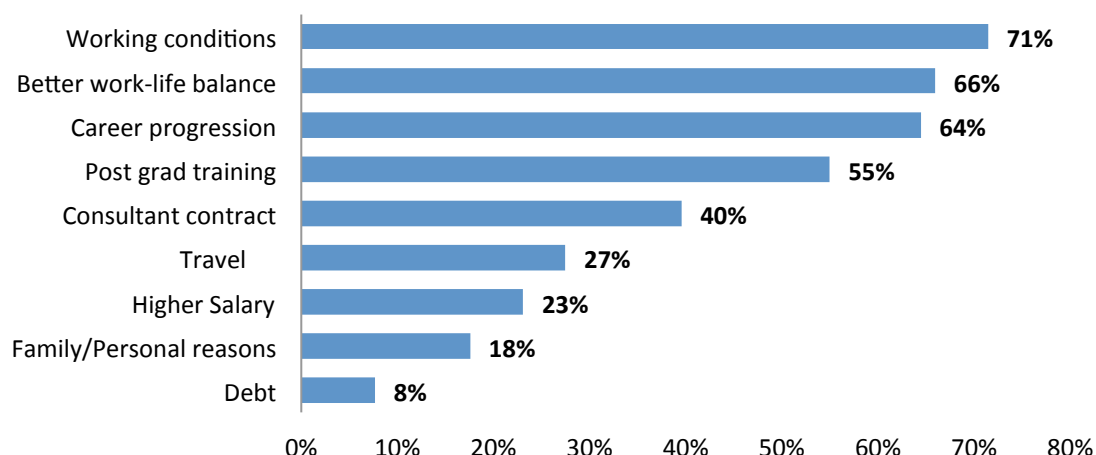


Figure 5-5 'Push' factors rated as influencing doctor's decision to practice abroad (n=91)

## 5.4 Unpacking trainees' experiences of working in Ireland

In 2016, respondents to the 2014 Medical Council 'Your Training Counts' (YTC)<sup>26</sup> annual trainee survey who had consented to be followed up, were surveyed as part of the *Doctor Emigration Project*. The RCSI research team conducted in-depth interviews of 50 trainees. This qualitative analysis explored and unpacked themes, some of which had emerged in the earlier study of Irish doctors abroad; and uncovered new themes that were emerging.

### Training

Trainees identified deeper issues around their experiences within the clinical training environment including: lack of consultant supervisors, stress associated with lack of supervision of training, service provision demands were overriding training; and a lack of structure in training.

Trainees discussed how their training was being adversely impacted due to low availability of consultants to provide training. This contributed to the demands of service provision superseding and often crowding out training. Inadequate supervision and weak formal training structures combined to create a high level of dissatisfaction among trainees, which some compared (unfavourably) with reports or experiences of trainees in other jurisdictions:

"It just seems like that, that there's no clear structure to it, that it's hit or miss, that it's very dependent on the site and on the consultant that you'd be training with."

"I know in the UK you're much more supervised and you progress a lot more slowly and in a much more controlled fashion."

These limited training opportunities, as perceived by IMGs working in Ireland and also by Irish graduates in Ireland and abroad, have been described in detail in Humphries *et al*, (2013, 2015) and McGowan *et al*, (2013).

<sup>26</sup> Of those who agreed to share their data with RCSI DEP project

“Yes I had a great expectations, I thought . . . they will train me. Rather than training me I have been losing my skills you know, so it was a really, really upsetting”

“I was in shock when I first arrived to the UK when I saw how well doctors in training are supported and treated”

### ***Career progression***

Doctors who were working in Ireland at the time of the 2016 DEP survey, whether intending to leave or to remain, agreed that career progression was a strong influential factor in any decision to emigrate (Figure 5.5 above). Analysis of qualitative findings from in-depth interviews that were conducted in 2015, as part of the DEP project, revealed a number of deeper issues in relation to doctors’ career progression, as follow:

#### ***Employability: when is enough enough?***

A particular focus on ‘employability’ compels trainee doctors to go beyond what is necessary to make themselves employable. This often generates anxiety around the possibility that one’s peers might have ‘done something better’ in terms of training or experience (Crowe & Brugha, 2018). This anxiety is further compounded by the worry surrounding the uncertainty doctors feel about securing a desired consultant post on their return in Ireland.

Interviewees saw the building of a Curriculum Vitae, through getting additional qualifications, as vital in order to add value to potential employability; and this an important determinant of the decision to look for work experience abroad so as to make a candidate more competitive.

#### ***Lack of opportunity***

The Strategic Review of Medical Training and Career Structure (SRMTCS) Implementation Monitoring Reports (Department of Health, 2013, 2014, 2015, 2016, 2017) identified a lack of clearly defined career pathways for doctors who were exiting training, together with a perceived lack of career opportunities in Ireland for doctors who had left to practice abroad.

During the in-depth interviews for the DEP project in 2015, the lack of career structure, and dearth of opportunities continued to feature as reasons for a decision to leave Ireland to practice medicine abroad (Humphries *et al*, 2015). These factors were also associated with onward migration of foreign trained doctors from Ireland (Humphries *et al*, 2013).

“They could be working as Registrars for 10 years in Ireland and will never get a Consultant post and I think that is not fair . . . They have families, they have to move every 6 months or every year, it is just not right”.

## ***Culture of emigration***

Training in some specialties requires trainees to gain exposure to subspecialties that Ireland is unable to provide (Clarke *et al*, 2017, Humphries *et al*, 2017). However, the increasing numbers leaving since 2008 suggests that spending time abroad has become the 'norm' and is considered by some to be essential to securing a consultant post in a model 4 or large model 3 hospital in Ireland. This culture of emigration, and how it is contributing to permanent emigration, is explored in detail in Humphries *et al* (2017):

"Irish doctors . . . are encouraged to go abroad to train . . . but I don't even think it ever really occurs to the people encouraging us that we might not come back. So that's the danger".

## ***Bullying: Anger, fear, intimidation and humiliation***

Successive annual '*Your Training Counts*' surveys of trainees have reported high levels of bullying (Medical Council, 2017). Interns were more likely to experience bullying from nurses, while those in training programmes (such as HST), were more likely to experience bullying from a consultant or another trainee (Medical Council, 2015, 2016).

Crowe *et al* describe how respect for hierarchy, anger and fear, intimidation, and disillusion were key themes in participants' narratives of relationships with senior staff who were supervising their postgraduate training (Crowe *et al*, 2017).

"You do not cross them because if you cross them that's the end of your employment opportunities in Ireland".

Alienation and disillusion experienced by trainees, associated with stressful work conditions and exploitative treatment, were reported as reasons that encouraged Irish-trained doctors to emigrate, during and after completion of training.

"It feels very much like a kind of an assembly line, it's just in, work, out, sleep, you know, and that can wear you down an awful lot at times".

## ***Understaffing and non-core tasks***

The Department of Health-led Strategic Review of Medical Training and Career Structure (SRMTCS) reported in January 2017 that training requirements and staffing shortages had delayed implementation of the recommendation to tackle the problem of non-core task allocation. Working environments continued to be "very stressful due to fewer staff"; this impacted not only on trainees but also on consultant trainers (Department of Health, 2017).

Low staffing levels and associated workload stress potentially contribute to behaviours such as bullying. Furthermore it increases the expectations, reported by trainees, that they should be able to cope – despite the inadequate supervision and stressful conditions (Humphries *et al*, 2015; Crowe *et al*, 2017).

“No point having days off when you have to spend the whole time recuperating from the exhaustion of your working days”.

### ***Demonstrating competence***

Many trainees reported that the necessity to present a facade of ‘competence’ - particularly for doctors in the early stages of training – required them to hide signs of struggle and uncertainty.

“You were afraid of what you were going to hear at the end of the phone... ‘You’re just ringing me because you don’t know what you’re doing’... I always thought that was a sign of weakness ... letting on that you didn’t know what was wrong”.

The need to demonstrate an image of competence undermined self-care practices. Crowe *et al* suggest that if reforms in medical culture (to promote emotional wellbeing and self-care among doctors) are to be realised, concepts underpinning the image of ‘medical invincibility’ must be deconstructed (Crowe & Brugha, 2018).

The 2015 in-depth interviews and 2016 structured survey of trainees, both conducted as part of the DEP study, support the overarching conclusion in successive Department of Health SRMTCS monitoring reports, namely that trainees have seen:

“...little tangible change or impact on their day-to-day working lives and training experience .... (where) protected training time is not a reality; service needs continue to take precedent over training requirements; concerns re inadequate mentoring; doctors at all grades are over- stretched and under pressure” (Department of Health, 2017).

Hayes *et al* in the *National Study of Wellbeing of Hospital Doctors in Ireland* conducted in 2014, report risk factors for, and dimensions of, actual burnout among doctors at all levels, with some dimensions worse among Basic Specialist Training (BST) trainees and others among those in HST (Hayes *et al*, 2017).

- 1 Work life balance was worst among HSTs (71%) and poor among BSTs (65%) and consultants (63%);
- 2 Burnout was highest among HSTs (38%) and BSTs (38%), but not inconsiderable among consultants (24%);
- 3 There were similar effort: reward ratios, as a measure of work stress: 1.5 in HSTs, and 1.4 in BSTs and among consultants.

## 5.5 Experiences of training and working in Ireland and intentions to leave: 2018 findings

### 5.5.1 Are training and working conditions improving?

As part of the 2013-14 SRMTCS, a set of recommendations was developed with the aim of improving retention rates among NCHDs (see Annex 1). An Implementation Monitoring Group, led by the Department of Health, was established in January 2015 to monitor implementation of the recommendations.<sup>27</sup>

The design in 2017 of a survey of the costs of postgraduate training to be delivered to all NCHDs, as part of the RCSI HRB-funded *MedTrack* project, presented a good opportunity to elicit the views of NCHDs (trainees and non-trainees) regarding how their experiences had changed in the initial three years of implementation of the recommendations. An 8-item measure was designed and incorporated into the study.

NCHDs were asked to rate changes in four aspects of their training conditions (protected training time, supervision, mentoring supports and training costs); and four aspects of their working lives (non-core tasks, stress levels, bullying and staffing levels), since they began working in Ireland<sup>28</sup>. Respondents were asked to rate each item on a five-point scale ranging from 'much better' to 'much worse' (See Tables 5.2 and 5.3). Provisional findings from trainees (Table 5.2) and non-trainee (data not tabulated) are discussed.

*Table 5-2 Trainees' views on whether training conditions are better, the same or worse*

	Much better (%)	Better (%)	About the same (%)	Worse (%)	Much worse (%)	TOTAL N
Protected training time	5	20	40	20	15	687
Supervision	7	25	48	13	7	680
Mentoring supports	8	29	41	14	8	675
Training costs	1	6	37	23	32	658

Source: Unpublished findings, HRB MedTrack (Medical Careers Tracking Study)

NOTE: N = 1178 (784 trainees) answered Q.26 on migration. The numbers of trainees responding to Qs 28 and 29 have fallen to a range of 669 to 730

Trainees reported improvements (ratings of 'much better' and 'somewhat better') for: 'mentoring supports in my training programme', where 37% reported improvements and 41% reported these as 'about the same'; and for 'level of supervision of my training' where 32% reported improvements and 48% reported 'no change'. Whereas, 55% of trainees reported that 'costs associated with training in my specialty' were worse or much worse.

<sup>27</sup> The principle investigator of the RCSI Health Workforce Research Group is a member of this Group.

<sup>28</sup> Some of the NCHDs who responded to the survey would have started working in Ireland prior to the start of implementation of the recommendations; and others during the implementation period.



*Table 5-3 Trainees' views on whether working conditions are better, the same or worse*

	Much better (%)	Better (%)	About the same (%)	Worse (%)	Much worse (%)	TOTAL N
Non-core tasks	3	21	45	18	13	701
Levels of stress	3	16	33	27	21	714
Bullying	6	17	59	10	7	684
Levels of staffing	2	13	35	26	23	713

Source: Unpublished findings, HRB MedTrack (Medical Careers Tracking Study)

Trainees reported two aspects of working conditions as being worse (ratings of 'somewhat worse' and 'much worse'): 'staffing levels in my workplace' (49%); and 'level of stress in my working environment', which 48% of respondents reported as somewhat or much worse.

**Non-trainees** reported similarly negative experiences to those of trainees in respect of 'staffing levels' and 'non-core tasks' (data not tabulated). However, higher proportions of non-trainees reported the following dimensions as worse or much worse: 'protected training time', 'supervision', 'mentoring supports', 'level of stress' and 'bullying'. It should be noted that 31% of non-trainees reported 'bullying' as 'somewhat worse' or 'much worse' compared with 17% of trainees, among whom there had been a slight positive shift, with 23% reporting 'bullying' as 'better' or 'much better'.

Interestingly, there was a perception among half of both categories of NCHDs that staffing levels had become worse. This is notable as there has been a period of rapid growth in the numbers of non-trainees (44% increase in numbers in five years – see Table 4.4). This would appear to suggest that the increase in non-trainees as a mechanism to become EWTD-compliant has had limited impact on reducing service workload.

### **5.5.2 Associations of training and working experiences with intentions to leave**

Table 5.4 shows the association of the eight dimensions of training and working condition experiences with the respondents' career plans around migration. Intentionality was recoded as a binary variable, combining 'Remain in Ireland to practice medicine' with 'Go abroad to practice medicine, but return to Ireland to continue my medical career'. This is compared with 'Go abroad to practice medicine and not return to Ireland'. Responses to the eight dimensions of training and working condition experiences have been recoded, combining 'Much better' and 'Better'; and likewise 'Much worse' and 'Worse'.

An intention to emigrate (go abroad and not return) was significantly associated with the experience that six dimensions of training and working condition were worse, most notably: lack of protected training, supervision and mentoring supports; and levels of stress in the workplace. The finding that the experience of lack of protected training time discriminates between trainees who will stay or leave is consistent with the findings we reported in our 2017 paper (Clarke *et al*, 2017).

*Table 5-4: Associations of Trainees' training and working condition experiences with intention to migrate*

	Intention <sup>29</sup>	Better (%)	About the same (%)	Worse (%)	TOTAL N	p =
Training time	'Remain' + 'Go & return'	27	42	31	565	0.001
	'Go abroad, will not return'	16	35	49	100	
Supervision	'Remain' + 'Go & return'	33	50	17	99	0.004
	'Go abroad, will not return'	27	41	31	559	
Mentoring supports	'Remain' + 'Go & return'	40	44	17	556	<0.001
	'Go abroad, will not return'	26	30	44	97	
Training costs	'Remain' + 'Go & return'	8	39	54	544	0.201
	'Go abroad, will not return'	4	33	63	94	
Non-core tasks	'Remain' + 'Go & return'	26	46	29	580	0.055
	'Go abroad, will not return'	17	43	40	98	
Levels of stress	'Remain' + 'Go & return'	20	36	43	590	<0.001
	'Go abroad, will not return'	12	23	65	101	
Bullying	'Remain' + 'Go & return'	25	60	15	565	0.029
	'Go abroad, will not return'	19	56	26	97	
Levels of staffing	'Remain' + 'Go & return'	16	38	46	591	0.031
	'Go abroad, will not return'	11	28	61	99	

Source: Unpublished findings, HRB *MedTrack* (Medical Careers Tracking Study)

<sup>1</sup> The question asked was: 'What is your long term plan in relation to your decision to practice medicine in Ireland?'. The response set consisted of: 'Remain in Ireland to practice medicine', 'Go abroad to practice medicine, but return to Ireland to continue my medical career'; 'Go abroad to practice medicine and not return to Ireland'; and 'Leave medicine'. Those who chose 'Leave Medicine' (n=33) are excluded from this analysis.

## 5.6 'Pull' factors explaining why Irish-trained doctors choose to work abroad

### 5.6.1 Irish trainees' perceptions of training and having careers abroad

The 2016 *Doctor Emigration Project* survey asked respondents to indicate their agreement or disagreement with statements which would influence their decision to practice medicine abroad. These pull factors (Figure 5.6) mirror the push factors (see Section 5.1).

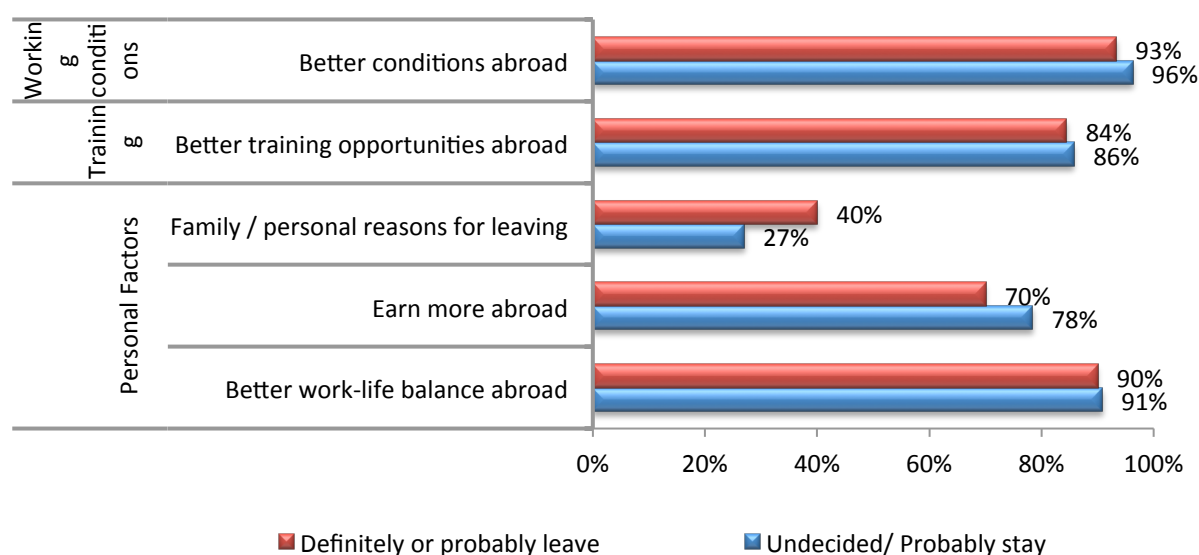


Figure 5-6 'Pull' factors rated as having influenced doctors' decision to practice abroad

It should be noted that those who were 'undecided' about leaving or would 'probably stay in Ireland' had as good or marginally better views of working conditions, training opportunities, earning potential and work-life balance abroad (Clarke *et al*, 2017). Those who indicated they were 'probably' or 'definitely' leaving were statistically significantly more likely ( $p < 0.05$ ) to agree they would leave for family or personal reasons (see Table 5.1).

### 5.6.2 Irish trained doctors' experiences of working, training and careers abroad

Two recent research projects by the RCSI HWRG – the *Failure to Retain* project (2014) and the *Doctor Emigration Project* survey (2012-16) – are rich sources of data on the experiences of Irish-trained doctor who are abroad.

In the seminal paper from the 2014 RCSI *Failure to Retain* project, Humphries *et al* reported that few of the 300+ Irish trained doctors who were working abroad expressed regrets, in terms of their working lives, about leaving (Humphries *et al*, 2015). Doctors reported that their decisions to leave had been vindicated by their experiences of training and the working conditions they had experienced in the destination country – against which Ireland compared poorly

In the *Doctor Emigration Project* survey (2012-2016), 91 of the 450 respondents had left Ireland between 2014 and 2016. They reported experiencing better staffing levels, better training opportunities and more flexible training options in the destination countries, compared with those they had experienced in Ireland (Figure 5.7)<sup>30</sup>.

In in-depth interviews, Irish-trained doctors working abroad described the joy of working in well-funded health systems, greater appreciation and support in their workplace, less stressful working conditions, less burnout and better morale. One doctor reported the rediscovery of the “joy of practising their profession without having to contend with a difficult work environment”. Others reported that they felt vindicated in the decision to emigrate, which made it more difficult to envisage returning to Ireland (Humphries *et al*, 2015).

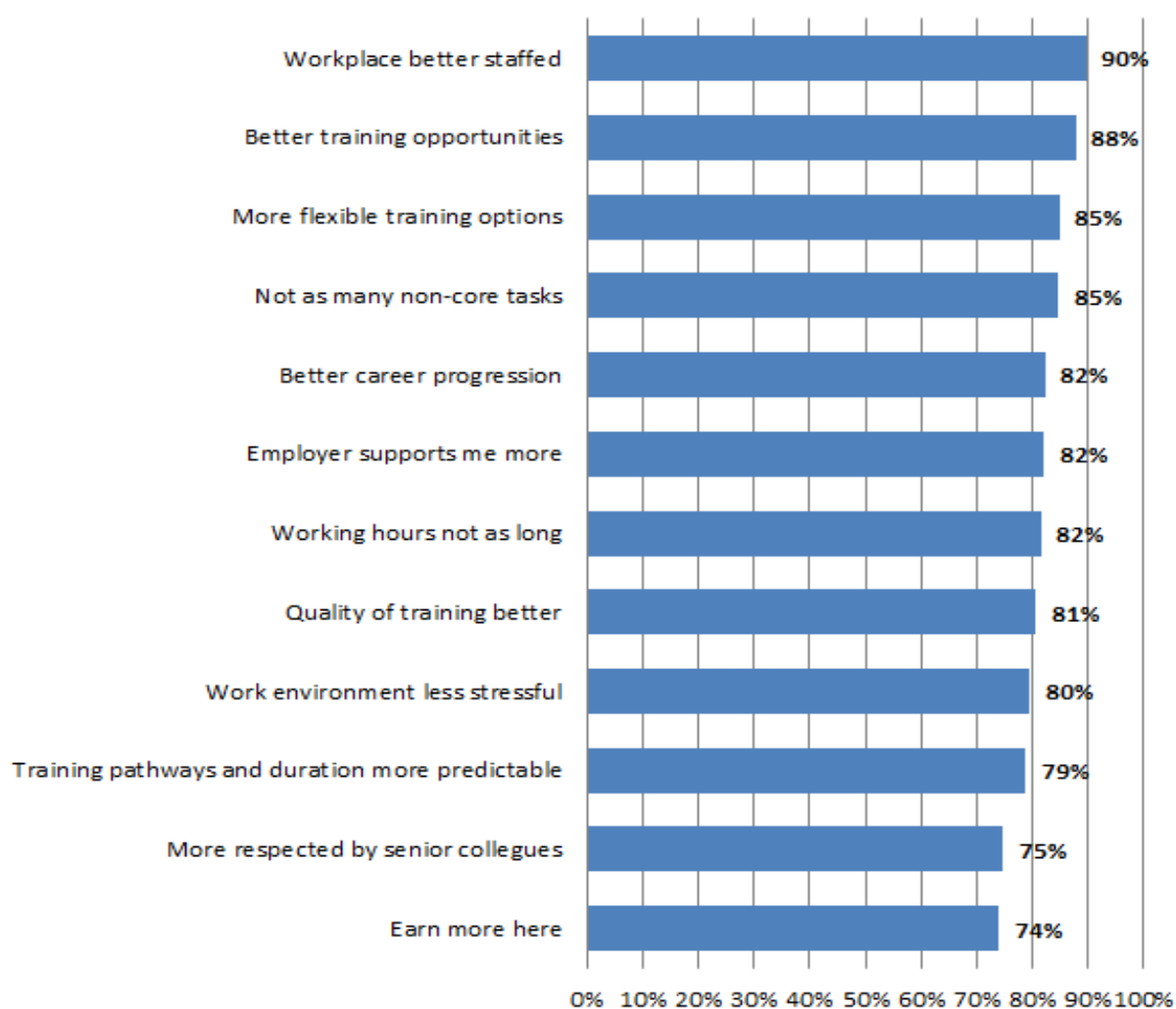


Figure 5-7 Emigrated doctors' comparisons of working in current country v. Ireland.

<sup>30</sup> Unpublished DEP results

## 5.7 Likelihood that Irish doctors abroad will return home.

The *Failure to Retain* project reported that the longer a health professional remained abroad, the less likely they were to return to make their careers in Ireland (McAleese *et al*, 2016). On arrival in the destination country, 10% of doctors who had trained in Ireland had planned to stay permanently. At the time of the survey (between 1 and 5 years after they had left Ireland), 34% of respondents planned to stay permanently in the destination country (Figure 5.8). There was also greater uncertainty on future plans among those who originally had intended to migrate for a short period (McAleese *et al*, 2016).

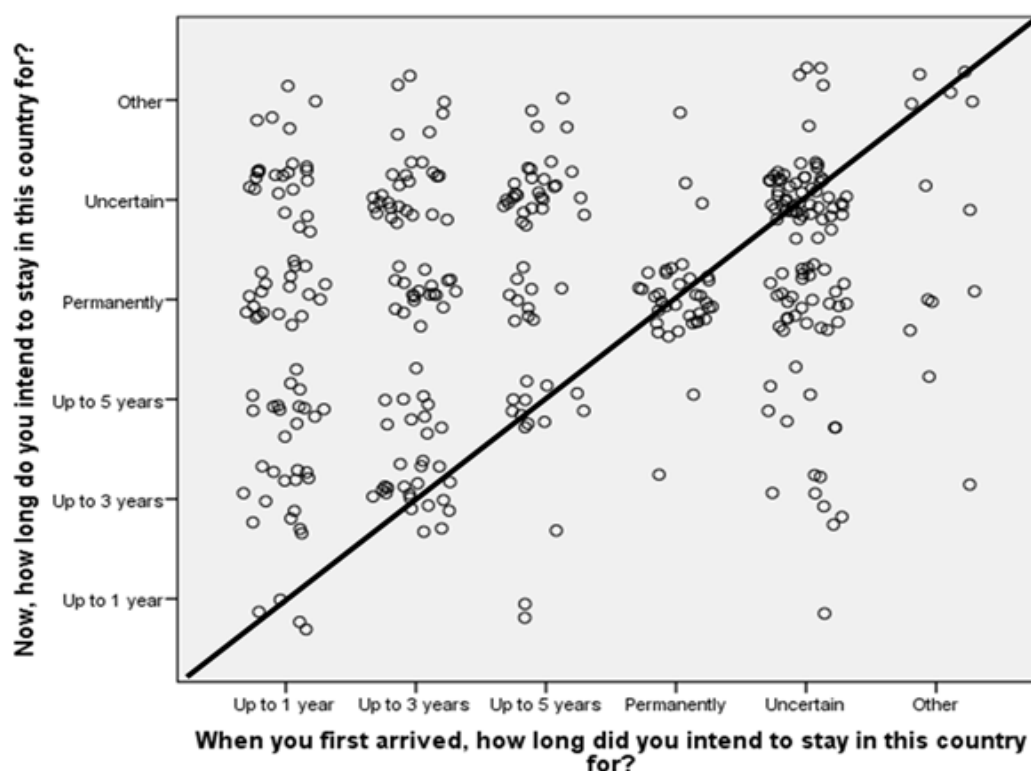


Figure 5-8 Correlation of original intention and current intention (to stay abroad).

For Irish-trained doctors who have emigrated, returning to Ireland was viewed through the lens of the working environments abroad – most of which were considered superior to Ireland's. Many doctors were interested in returning to work in Ireland but this was contingent upon evidence of a significant improvement in the working conditions in Ireland (Humphries *et al*, 2015). Factors included improvements in staffing levels – in particular additional consultants; improvements in morale, more support staff and better technology (e.g. computerised patient records).

In the 2016 *Doctor Emigration Project* survey, of the 91 doctors working abroad, 24% (n=22) stated that they did not intend to return to Ireland, 41% (n=38) were undecided, and 35% (n=32) reported that they would return<sup>31</sup>. However, as reported in Section 3.1, only 53% (n=18) of those doing fellowships reported an intention to return to Ireland. This

<sup>31</sup> Unpublished DEP findings

suggests that increasing duration abroad, the opportunities abroad that come from completion of one specialisation-training; and ongoing comparisons that are made between conditions and opportunities in Ireland with those in their current country.

## Conclusions

Findings from surveys of Irish trainees and of foreign doctors in Ireland, together with findings from two studies that surveyed Irish-trained doctors working abroad, present a consistent picture: working conditions, training and career opportunities are perceived to be significantly worse in Ireland than in the countries to which they might emigrate to work. This combination of mirror-imaged push and pull factors means that Ireland will continue to struggle to retain its trainees. This is confirmed by the 2018 findings from the *MedTrack* survey of trainees, where poor experiences of lack of protected training, mentoring and stressful working conditions continued to be a predictor of intentions to leave and not return. These responses emerged three years after the start of implementation of the Strategic Review of Medical Training and Career Structures recommendations.

It is essential to implement the recommendations around protected training, working conditions and the matching of the training pipeline with permanent posts, along with addressing additional factors such as the need for more consultants. If this can be achieved, employment in the Irish health services can become more attractive so as to retain and attract back doctors who are abroad, during the 'critical period' in the early years after they have left.

## Questions

- 1. Is there evidence of improvements on the ground relating to working conditions, training and career opportunities, noting that the 6-monthly consultations with NCHDs report "little tangible change or impact on their day-to-day working lives and training experience"?*
- 2. Findings on 'push' and 'pull' factors, are based on studies conducted in 2014 (Failure to Retain) and 2016 (Doctor Emigration Project). Is there more recent evidence to show improvements, i.e. effectiveness and impact from implementation of the SRMTCS recommendations?*
- 3. Do the appointment processes need to be reviewed? Are the requirements of a vacant post assessed in terms of the needs of the target patient-group and matched to the applicants' skills set? Are appointment processes driven by inappropriate levels of competitiveness, whereby perceived criteria for appointment are not necessarily required for the post?*
- 4. To what extent are young doctors driven, unofficially, to build up clinical experience (building a Curriculum Vitae and demonstrating competence) prior to being appointed as a trainee? Is this driving stress-related workplace friction and if so, how can this be dealt with?*

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## Chapter 6    Medical Workforce Planning – Specialty Reviews

## Summary

Recent medical workforce planning specialist reviews of Paediatrics and Emergency Medicine in Ireland show lower ratios of consultants to population compared to ratios in the UK and Australia (countries with comparable health systems). In Ireland, around 15% of consultant posts in these specialties are filled by non-permanent staff; there are low ratios of consultants to NCHDs; low ratios of trainees to non-trainees; and the projected exits from training programmes are around 25-40% of the numbers needed to meet current health-care demand. Findings from a medical workforce planning report on General Practice highlighted the ageing GP population. Many GPs continue to practice post retirement.

The reports detail some of the consequences of consultant shortages including rostering difficulties; over-reliance on service delivery by trainees, which impacts on training; over-reliance on non-trainees who are mostly IMGs, especially in Level 2 and 3 hospitals; and an over-reliance on locum and non-permanent staff. A best practice model currently being piloted in the Paediatrics Department of Waterford Hospital, aims to demonstrate benefits to training and patient care, through addressing most or all of these negative aspects.

### 6.1. Estimating the demand for consultants

In 2014, the HSE MET (now the HSE NDTP) published a *Medical Workforce Planning* report that included 'Population Based Ratios of Specialists in Ireland and Internationally' (HSE MET, 2014). This was a first step in the implementation of the recommendations outlined in the *Strategic Review of Medical Training and Career Structures* (Recommendation 2.6a: Annex 1): "Medical workforce planning model developed and implemented (to improve) clarity around availability of Consultant posts by specialty and location (acknowledging) the ongoing work of HSE MET (now the NDTP)".

In 2015, the HSE-NDTP began producing medical workforce planning reports for individual medical specialties, starting with the report on General Practice (HSE NDTP, 2015). These reports, drawing on data from other countries and using consultations with expert stakeholders for each specialty, outlined<sup>32</sup>:

- how each specialty functions and if there was any unmet demand for specialists to support current service delivery requirements;
- the major environmental drivers of change to the future of the specialty;
- the number of specialists required to resource service-delivery in the medium to longer term (accounting for future drivers of change); and
- the gap between the estimated supply and demand for specialists over a 10-year projection period.

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<sup>32</sup> This report summarises findings from the published NDTP reports; however, it should not be considered as representing the views of the NDTP.

## 6.2 General Practice

The pressure on General Practice service provision is increasing as a result of Government policy, an ageing population and an upsurge in GP visitation rates, stimulated by the introduction of free GP care for under sixes. It is anticipated that there will be a further increase in future demand for GP services across Ireland (HSE NDTP, 2015) driven by the implementation of the *SláinteCare* Oireachtas Report, which recommends a shift in service delivery to primary and community care (see Chapter 8).

Evidence of a significant undersupply of GPs in Ireland is seen in the heavy reliance on doctors from abroad (IMGs) to provide locum and short-term cover, particularly for out-of-hours services, annual leave and sickness cover (HSE NDTP, 2015). Due to the fluid nature of this work, accurate figures are difficult to establish. However, the Medical Council reported that, in 2013/14, 4.5% of GPs had practiced both in and outside Ireland in the previous year (approximately 217 doctors), with 142 being IMGs from South Africa (HSE NDTP, 2015). Other doctors contributing to the locum/temporary/short-term GP workforce include NCHDs who are not engaged in training, with some working as locum GPs when they are not working in the acute hospital sector. GPs who reach retirement age sometimes continue to work due to the inability to identify an appropriate replacement GP for their practice.

In 2015 there were approximately 21 General Medical Services (GMS) vacancies around Ireland, covering both urban and rural practices. Locum arrangements are integral for such vacancies to ensure continuity of services to the relevant communities. While it is not possible to accurately define the level of current unmet demand within the General Practice workforce, the NDTP has estimated it at approximately 500 posts. However the NDTP estimates that, depending on the pace of roll-out of planned free GP care to different cohorts of the population, the shortfall in GPs nationwide could range from a minimum of 493 (current estimates of unmet demand) to as high as 1380 by 2025 (HSE NDTP, 2015).

## 6.3 Emergency Medicine

Ireland is experiencing high demand for Emergency Medical services due to many factors including population ageing, an increasing burden of chronic disease and underdeveloped community and primary care services (HSE NDTP, 2017a). Comparisons of the number per 100,000 population of Emergency Medicine consultants in Ireland with Australia and the UK are shown in Tables 6.1 to 6.3 below. Key Emergency Medicine stakeholders in Ireland report two additional factors that contribute to long patient waiting times in Emergency Departments (EDs), delayed admissions and delayed discharges (Department of Health, 2015):

- an undersupply of senior decision makers on the ED floor, coupled with
- an over-reliance on non-training NCHDs, who may be less competent or confident at making patient management decisions.

The Emergency Medicine Taskforce (Department of Health, 2015) and the Emergency Medicine Programme state that increases in medical staffing levels at both consultant and non-consultant levels are needed to ensure:

- increased access to senior decision makers to increase efficiencies in patient care
- the reduction in onerous on-call rostering arrangements
- reduced reliance on agency staff including locum doctors
- reduced patient waiting times
- increased patient safety and better patient outcomes

*Table 6-1 Ratios of consultants per 100,000 populations: Australia, UK & Ireland*

Specialty	Consultants per 100,000 population Australia	Consultants per 100,000 population UK	Consultants per 100,000 population Ireland
General Practice	71	68	62
Emergency Medicine	6.8	4.3	2.2
Paediatrics	7	6.5	4.3

## 6.4 Paediatrics and Neonatology

The workforce planning specialist review on Paediatrics and Neonatology states that unmet demand for these specialist services in Ireland is resulting in challenges in consultant rostering, over-dependence on non-training NCHDs for service delivery (see Table 6.2) and long patient waiting times (HSE NDTP, 2017b).

**Consultant Rostering Challenges:** shortages of Paediatric and Neonatology specialists cause difficulties in staffing Paediatric rosters. Throughout the public sector – but most especially in peripheral hospitals – many paediatric rosters are 1-in-3 on-call, where a 1-in-6 on-call is preferable. Rostering of NCHDs is often required to meet rostering and service needs.

Many peripheral hospitals are staffed by as few as 3 to 4 consultants, some of whom will have a 50% commitment to Community Child Health, which may require them to work off-site. Furthermore, some of these hospitals will have co-located Obstetric Units requiring consultant neonatal cover. This small number of consultants in peripheral units is often required to provide 24/7/365 care for acute Paediatric and Neonatology patients, in addition to elective care responsibilities. This results in an unsustainable burden of work on consultants, unmet demand for consultant care and an over-reliance on locum cover.

**Overdependence on NCHDs for the Delivery of Services:** Nationally, Paediatrics is highly dependent on NCHDs to deliver care. The Paediatric NCHD workforce is made up of approximately 50% training and 50% non-training NCHDs, with the ratio of NCHDs to consultants nationally being approximately 2:1 (see Table 6.2). This ratio is high compared to other countries; is higher than the recommended Fottrell ratio of 1:1; and is high compared to other medical specialties in Ireland.

Ratios of NCHDs to consultants are higher in many peripheral hospitals where there are difficulties filling vacant consultant and NCHD posts. The National Clinical Programme for Paediatrics and Neonatology recommends rebalancing these ratios so that the number of NCHDs to consultants is much closer to 1:1, thereby facilitating the vast majority of NCHDs to participate in national training programmes.

Difficulties in recruiting NCHDs in smaller, peripheral units result in recruitment of locum doctors to ensure EWTB compliance and to maintain service provision. Locum recruitment is costly e.g. due to the higher costs incurred in agency fees. In addition, the quality and skills of locum doctors are variable, which has implications for patient safety.

**Waiting Times:** the Report provided estimates of large numbers of children waiting for a Paediatric specialty outpatient appointment over the 20 week target; and waiting for day case appointments and specialty-related elective procedures (HSE NDTP, 2017b). Exceptionally long waiting times were reported in some Paediatric sub-specialties including:

- Paediatric dermatology (where appointments in the tertiary hospitals are greater than 18 months (2016 figure)).
- Large centres delivering diabetes care (where they are unable to provide appointments every 3 months as recommended in the Diabetes Expert Advisory Group report due to insufficient staffing).

*Table 6-2 Consultant background; Ratio to Trainee: and Non trainees, by Specialty.*

Specialty	Male: Female	Part-time (WTE:HC)	International Medical Graduate	Permanent status	Consultant: Trainee ratios	Trainee: Non-trainee ratios
General Practice	F: 47% M: 53% Total: 3923	22% (All)*	16% IMGs * (630/ 3923)	78%*	4.6:1	01:01.7
Emergency	F: 24% M: 76% Total: 98	†22%(22 of 98)** ‡3% (33:518)*	14% IMGs (15/ 106)*	78%**	01:01.1	1:2.5 * 1:4 ***
Paediatric	F: 52% M: 48% Total: 194*	15% (44:294)* 31% (61:194)**	39% IMGs (112/ 284)*	82%**	01:01.1	01:02.6

\* Medical Council data 2015; \*\* HSE WAPI data 2016; \*\*\*Combination of Medical Council data and HSE NDTP data; † Consultant/ specialists only; ‡ Consultant/ specialists and NCHDs

Table 6-3 Consultant age profile and training pipeline

Specialty	Sex	55-64 years	65 yrs and over	Nos needed to meet current demand	Training Programme exits 2016	Training Programme exits 2017	Training Programme exits 2018
General Practice	Male	29%(432)	22%(331)				
	Female	14% (218)	4% (64)	500	157	157	157
	Total	25% (962)	11%(427)				
Emergency Medicine	Male	17% (12)	6%(4)				
	Female	10% (2)	0	41	6	10	8
	Total	17%(18)	5%(5)				
Paediatric	Male	27% (37)	5% (7)				
	Female	10% (14)	2% (3)	35*	13	16	22
	Total	19% (55)	3% (8)				

\*Based on ratio of service grade posts to consultants (i.e. 35 consultants in non-permanent posts)

## 6.5 Commentary on consultant profiles

The UK and Australia are two major destination countries for Irish graduates. Compared to Ireland, consultant to population ratios are higher in the UK; and much higher in Australia. These differences are particularly evident in the field of Emergency Medicine.

In Ireland, consultant posts filled by non-permanent staff range from 18% (Paediatrics) to 22% (General Practice and Emergency Medicine). This phenomenon is

- impacting on career opportunities for trainees post-CCST (Certificate of Completion of Specialist Training).
- possibly impacting on patient safety and the quality of care patients receive.

Consultant to trainee ratios are more favourable in General Practice; while consultant to NCHD ratios, and trainee to non-trainee ratios, are low in Emergency Medicine and Paediatrics, resulting in:

- an over-reliance on trainees to deliver services, which in turn impacts on training,
- an over-reliance on non-trainees (mainly IMGs) to deliver services, increasing workload pressure on consultants as they are required to supervise so as to ensure safety.

All three specialties (General Practice, Paediatrics and Emergency Medicine) experienced high numbers of training programme exits in 2016 and 2017, resulting in Irish-trained consultant numbers falling short or far short of the estimated need.

In addition to the training and supervision issues of other specialties, the ageing workforce of the General Practice cohort is of particular concern.

## 6.6 New models of care - a consultant-delivered Paediatric Service Pilot Scheme

The National Clinical Programme for Paediatrics and Neonatology, the HSE Acute Hospitals Division and NDTP have designed a pilot programme for a consultant-delivered<sup>33</sup> service in University Hospital Waterford. This programme is consistent with the HSE Corporate Plan 2015-2017 goal to 'provide fair, equitable and timely access to quality, safe health services that people need'.

Key features of the '*Business Case for Implementation of Consultant-delivered Paediatric Service Pilot Scheme. University Hospital Waterford Paediatric Department. May 2016*' include:

- A team of consultants provides an active consultant presence throughout the day, covering acute assessments and admissions (during times of peak clinical activity), seven days per week.
- Patients have early contact with a senior decision maker; most children are seen at time of admission and all patients within 8-10 hours of admission; regular reviews of children following admission (usually two per day), and use of 'short stay observation units' to reduce rates of admission.
- Adequate numbers of consultant General Paediatricians – working part-time and/or flexible hours; improved ratios of trained to non-trained staff, i.e. 1:1 or 1:1.2 consultant to NCHD ratio; adequate trainee numbers, rosters and training opportunities.
- Clearly defined roles for Clinical Nurse Specialists, Advance Nurse Practitioners and the extended role of the nurse in areas such as IV cannulation and phlebotomy.
- Improved links and integration with primary care (including rapid access clinics, telephone advice and improved collaboration and networking with GPs and Primary Care services).
- The new model aims to be EWTD compliant.

The pilot scheme is to be evaluated through comparing measurements at baseline and post-intervention, including key performance indicators (KPIs), covering:

- A range of safety, quality of care and patient experience measures (reduced waiting times, admissions, length of stay, etc.);

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<sup>33</sup> Consultant posts must be submitted to the HSE Consultant Appointment Advisory Committee (CAAC) <https://www.hse.ie/eng/staff/leadership-education-development/met/consultantapplications/consultant-jobs-approved/> for assessment and approval. Recent financial approval requirements require central corporate HSE sign-off. Centralisation of both the process and the funding has in the past resulted in low numbers of posts being approved. Paradoxically, there is no central regulation of NCHD posts. This is despite NCHD numbers increasing rapidly, despite a stated government policy of reversing the NCHD:consultant ratio by increasing consultant numbers while halting the NCHD growth rate. The increase in NCHD numbers acts as a pressure valve release for the slow growth in consultant numbers, as NCHDs are called upon to address some of the service demand.

- Costs (of increasing from 3 to 10 consultant paediatricians) and cost savings (through 4 fewer NCHDs, and reductions in locum consultant costs); and
- Impacts on staff including trainee training experiences and overall stress.

### **Questions:**

1. *Is the emerging evidence sufficient to determine that there are consultant shortages in some specialties? What further work needs to be done to determine the scale, nature and causes of such shortages?*
2. *Have optimal models of care (similar to that done for Paediatrics), been developed for all specialties and what needs to happen to take such work forward?*
3. *What are the rate-limiting steps to addressing consultant and GP shortages in the short term (see Chapters 7 to 8 for future directions)?*
  - *How can the current consultant appointment bottleneck and funding gap in the HSE be addressed.*
  - *Locum consultant recruitment by hospitals impacts on the career opportunities of Irish trainees, probably contributing to emigration. How can this practice be curtailed?*
4. *What other factors determine whether or not trainees, on securing CCSTs, will apply for permanent consultant / GP posts in Ireland? Are there further steps needed to attract good candidates?*
5. *Is there a need to reconfigure posts to attract more doctors who wish to work less than full time? Are there obstacles to this?*
6. *What can be done to compensate for the relatively low numbers of trainees coming through the training pipeline? What would entice trainees and specialists (including GPs) to return from abroad?*
7. *Are there other questions we should be asking. . . ?*



## References

Department of Health (2015) Emergency Department Task Force Report (Dublin: Department of Health).

HSE MET (2014) Medical Workforce Planning: Interim Report. (Dublin: HSE MET).

HSE NDTP (2015) Medical Workforce Planning Future Demand for General Practitioners 2015-2025 (Dublin: HSE NDTP).

HSE NDTP (2017a) Specialty Review: Emergency Medicine - Medical Workforce in Ireland 2017 (Dublin: HSE NDTP).

HSE NDTP (2017b) Specialty Review: Paediatrics and Neonatology - Medical Workforce in Ireland 2017 (Dublin: HSE NDTP).

## Chapter 7 SláinteCare Report

## Summary

The SláinteCare Report proposes developing new models of integrated, primary and community care (Committee on the Future of Healthcare, 2017). To achieve this, it estimates that a 20% increase in consultant numbers will be needed, with posts based in hospitals, community health and general practice settings. It proposes that recruitment of staff – consultants and NCHDs – be to Hospital Groups.

## The **SLÁINTECARE** Report

The May 2017 *Houses of the Oireachtas Committee on the Future of Healthcare SláinteCare Report* envisages a shift: (i) towards interdisciplinary, cross-professional integrated care; and (ii) towards a primary and community model of care in the medium term (Committee on the Future of Healthcare, 2017). In line with the October 2017 *National Strategic Framework* (see Chapter 8 (Department of Health, 2017)), *SláinteCare* recommends a move away from professional silos towards integrated workforce planning, with an emphasis on developing appropriate skill-mixes across cadres and professions.

The Report identifies some of the factors that account for difficulties in recruiting and retaining demotivated health workers, recognising the need for “a broad package of measures that relate to good training prospects, supportive management, appreciation and well-functioning infrastructure and not just better salary levels” (p. 98 Committee on the Future of Healthcare, 2017)

*SláinteCare* recommends “that the HSE and the Department of Health must develop their integrated workforce planning capacity so as to guarantee sufficient numbers of well-trained and well-motivated staff deployed in a targeted way to deliver care in the most appropriate care setting and that the Irish health system becomes a place where people feel valued and want to work. This will mean re-training of existing staff in many cases to ensure capabilities for integrated care” (p.25).

The Report recommends that specialist appointments be to Community Health Organisations as well as hospitals, and should include joint appointments where appropriate. Furthermore it proposes disentangling and removing privately financed health care from public hospitals, so as to free up consultant resources. A recommendation of relevance to addressing NCHD and consultant shortages is that: “recruitment of hospital consultants and NCHDs should be to Hospital Groups rather than to individual hospitals, as part of meeting the medical staffing needs of smaller hospitals”. The Report estimates that an additional 593 consultants and 235 GPs are needed as part of a 6-year Transitional and Legacy Funding package (See *Table 3 [p11], p.177, p.184*) – see Challenges and Responses for a more detailed outline of *SláinteCare*’s recommendations for consultants.

## Questions

1. *What thinking, planning and work has been done by the specialties in respect of the models of care needed to deliver on the policy objectives of integrated care and primary care models?*
2. *How do the specialties and professional bodies envisage working across the hospital - community care interface? How do they envisage working across the professions and health and social care boundaries to develop and implement these models?*
3. *What are the advantages, disadvantages and obstacles to a shift towards NCHD and consultant appointments being made to Hospital Groups? How might the Hospital Groups facilitate the development and implementation of these new models of care.*

## **References**

Committee on the Future of Healthcare (2017) Sláintecare Report (Dublin: Houses of the Oireachtas).

Department of Health (2017) Draft Consultation - Working Together For Health: A National Strategic Framework for Health Workforce Planning (Dublin: Department of Health).

## Chapter 8   National Workforce Strategic Framework

## Summary

The *National Strategic Framework* provides a framework that is grounded in the principles of the WHO Global Code of Practice on the International Recruitment of Health Personnel, whose cornerstone is the need for health workforce self-sufficiency. National decision makers need to agree how existing actions and structures (including the SRMTCS Implementation Monitoring Group), can be aligned to and work with the new HSE National Workforce Planning Unit.

*Working Together for Health. A National Strategic Framework for Health and Social Care Workforce Planning* (Department of Health, 2017) provides the overarching policy context for medical workforce education, training and planning in the future. The Framework will guide future action in respect of training and retaining Ireland's medical workforce, so as meet population need. The National Framework makes a number of important statements of particular relevance to doctor retention:

- “The provision of high quality health and social care services depends on having a *sufficiently numerous and appropriately trained workforce in place* at national, regional and local levels.” (Executive Summary, Background and Context)
- “Appropriate labour market policies and HR strategies are required to ensure, insofar as possible, *adequate workforce supply and absorption of graduates into the health workforce from within Ireland's own resources*, recognising the freedom of individuals to work where they choose”. (Executive Summary, International Context, p.1).
- “A national strategic framework for health and social care workforce planning should be grounded in the principles of the WHO Global Code, and take into account the need to *manage health workforce demand and supply sustainably* and insofar as possible within national resources”. (Executive Summary, International Context, p.1)

The Framework highlights (Chapter 5: Table 5.12; p 52) that earlier national reports have emphasised the importance of a consultant-provided service and that doctors, nurses and other health professionals need to work in multidisciplinary teams. It comments on the limitations of profession-specific, supply-demand gap approaches to estimating the need for more staff, but recognises that “a combination of short-, medium- and longer-term approaches . . . can support current and future sustainability of health workforce supply”.

Health workforce actions and solutions (be they human resource- or policy-based), are required to monitor and intervene to modify inflows, outflows and maldistribution of health workers. They need to be considered with an understanding of the underlying factors and determinants of such flows. The key challenges in moving forward lie in aligning existing profession-specific initiatives to the new structures and processes that are envisaged under the Framework. This will enable to the policy goal of integrated, cross-disciplinary care across the hospital, primary and community care continuum to be achieved.

## Questions

1. *Framework Implementation Action Area 3 envisages the establishment and operationalisation of a HSE National Workforce Planning Unit, tasked with building workforce planning capacity.*
  - a. *How will current structures and processes: (i) the SRMTCS implementation monitoring group; (ii) the HSE National Doctor Training and Planning Unit and (iii) the Nursing Task Force – work in conjunction with the new HSE National Workforce Planning Unit?*
  - b. *Will the operationalisation of the National Workforce Planning Unit involve links with other HSE divisions, such as Acute Hospitals and Clinical Programmes, which have important decision-making roles in staff recruitment and service configuration?*
  - c. *How will the National Medical Workforce stakeholders (including the bodies represented on the SRMTCS group), work with the broader range of stakeholders (including other health professional and social care cadres who need to be involved in integrated workforce planning).*
  - d. *Do the SRMTCS recommendations need to be revisited, so as to sign off on successes, re-fashion recommendations that are not achieving impact, and propose new recommendations to address medical workforce retention in a more comprehensive way?*
  - e. *Does a broader range of bodies need to be represented on the SRMTCS Implementation Monitoring Group, including the HSE Acute Hospital Division and Clinical Care Programmes?*
2. *Framework Implementation Action Area 5 proposes: Build the evidence base underpinned by research and evaluation.*
  - a. *How can the work of the HSE NDTP and of the Medical Council aid in improving routine medical workforce data and data systems and so contribute to the development of the evidence-based platform envisaged by the Framework*
  - b. *What added value can be brought to this work, for example through data triangulation and/or routine data linkage so as to summarise trends, as undertaken by RCSI's 'Brain Drain to Brain Gain' project?*
  - c. *What explanatory value can be brought to understanding trends, through consultation processes involving National Medical Workforce decision makers and NCHDs (the latter having been undertaken as part of the 2015-17 Medical Training and Career Structures implementation monitoring process)?*
3. *What other questions need to be asked about Medical Workforce Planning and doctor retention, in the context of the new National Strategic Framework?*



## **References**

Department of Health (2017) Draft Consultation - Working Together For Health: A National Strategic Framework for Health Workforce Planning (Dublin: Department of Health).

## Annex 1      Medical Training and Career Structure Recommendations

STRATEGIC REVIEW OF  
MEDICAL TRAINING AND CAREER STRUCTURE

SIXTH PROGRESS REPORT  
FEBRUARY 2017 – JULY 2017

DEPARTMENT OF HEALTH

10 NOVEMBER 2017

### **Background and Context**

In July 2013 a Working Group, chaired by Prof. Brian MacCraith, President, Dublin City University, was established to carry out a strategic review of medical training and career structure. The Working Group was tasked with examining and making high-level recommendations relating to training and career pathways for doctors with a view to:

- Improving graduate retention in the public health system;
- Planning for future service needs;
- Realising maximum benefit from investment in medical education and training.

The Working Group completed its work at the end of June 2014 and, in all, submitted three reports and made 25 recommendations (see p. 4). The reports address a range of barriers and issues relating to the recruitment and retention of doctors in the Irish public health system.

### **Implementation and Monitoring Arrangements**

The Strategic Review recommendations are being implemented through a range of structures and processes across the health system, involving multiple stakeholders. Each recommendation has an identified business owner (see pp 5–6.) and progress updates are sought by the Department of Health as required. The Department established an Implementation Monitoring Group (IMG) comprising key stakeholders (see p. 7) to oversee implementation. It held two meetings in the February – July 2017 period, and it also met two trainee doctor delegations in April – May 2017.

Progress was acknowledged in relation to the implementation of a number of recommendations, including those dealing with the National Electronic Record, the appointment of NCHD Leads, and concerning rotations. However, feedback received through the Implementation Monitoring Group suggests that progress in implementing many of the recommendations remains slow and/or varies between hospital sites, and that some recommendations, although implemented, have not had the desired outcome for NCHDs.

The HSE's Programme for Health Service Improvement (PHSI) undertook an exercise around implementation of the recommendations. This exercise highlighted the requirement for greater clarity on HSE 'ownership' and contribution to implementation in relation to Mental Health, Acute Hospitals, Public Health, and Primary Care, including at service delivery level. The IMG accepted the PHSI recommended programme management approach to the processing of the relevant MacCraith recommendations. It also agreed to aspects that require priority HSE attention in 2017. These have been communicated to the HSE Reform Leadership Team, i.e. the group that has now agreed to provide the governance for HSE implementation.

### **Progress in Implementing the Recommendations of the Strategic Review**

This is the sixth progress report to be submitted to the Minister for Health and covers the period from 1 February to 31 July 2017. Progress in implementing the recommendations is reported on a recommendation-by-recommendation basis in Table 4 (see p. 14). In response

to trainee feedback on earlier progress reports, where possible the RAG status for each process/deliverable has been included. Following feedback given at meetings with trainees, specific attention has been given to the reported RAG status of the recommendations in the report. The Monitoring Group decided that, if appropriate, it would allocate a different RAG status for (i) the delivery of a MacCraith recommendation, and (ii) the impact of the recommendation on the working / family lives of doctors.

The Strategic Review Working Group considered it important that the impact of the measures proposed in the reports be assessed regularly. The Terms of Reference of the Implementation Monitoring Group includes the assessment of the impact of the measures on the recruitment and retention of doctors in the Irish health system. The programmatic approach focuses more closely on the measurement of defined indicators of success. This includes a focus on governance, and delivering improvements in the working and training environment in relation to priority areas. Under the programme therefore there is a strengthened commitment to the implementation of the relevant recommendations.

# STRATEGIC REVIEW OF MEDICAL TRAINING AND CAREER STRUCTURE

## PROGRESS REPORT

SUMMARY	1
1. INTRODUCTION	4
1.1 Background and context	4
1.2 Embedding the recommendations in the work of the health service	5
1.3 Implementation and monitoring arrangements	5
1.4 Membership of the Implementation Monitoring Group	7
2. CONSULTATION MEETINGS WITH TRAINEE DOCTORS	8
2.1 Introduction	8
2.2 Summary of trainee feedback on implementation	8
3. IMPLEMENTING THE RECOMMENDATIONS OF THE STRATEGIC REVIEW	11
3.1 Introduction	11
3.2 Progress in implementing the recommendations of the Strategic Review	11
3.3 Assessing the impact	11
LIST OF TABLES	
Table 1: Overview of Strategic Review recommendations	4
Table 2: Implementing the Strategic Review recommendations	5
Table 3: Summary of trainee feedback at consultation meetings	9
Table 4: Progress update (as at 31 July 2017)	14

# 1 INTRODUCTION

## 1.1 Background and Context

In July 2013 a Working Group, chaired by Prof. Brian MacCraith, President, Dublin City University, was established to carry out a strategic review of medical training and career structure. The Working Group was tasked with examining and making high-level recommendations relating to training and career pathways for doctors with a view to:

- Improving graduate retention in the public health system;
- Planning for future service needs;
- Realising maximum benefit from investment in medical education and training.

Membership of the Working Group included representatives of the Department of Health, the Department of Public Expenditure and Reform, the HSE (including senior clinicians), the Medical Council, and the Forum of Irish Postgraduate Medical Training Bodies. The Group met with stakeholders on an on-going basis throughout the Strategic Review process; this included regular meetings with trainee doctors.

The Working Group completed its work at the end of June 2014 and, in all, submitted three reports and made 25 recommendations<sup>1</sup>. The reports address a range of barriers and issues relating to the recruitment and retention of doctors in the Irish public health system, as summarised in Table 1 below.

**Table 1: Overview of Strategic Review Recommendations**

REPORT	RECOMMENDATIONS	FOCUS OF REPORT
First report (December 2013)	1.1 – 1.9	On the basis of stakeholder consultations, the first report included nine recommendations which focused primarily on the quality of the training experience.
Second report (April 2014)	2.1 – 2.6b	The second report focused on medical career structures and pathways following completion of specialist training.
Final report (June 2014)	3.1 – 3.10	The final report addressed issues relating to strategic medical workforce planning, and career planning and mentoring supports for trainee doctors. It also addressed specific issues in relation to the specialties of Public Health Medicine, Psychiatry, and General Practice.

<sup>1</sup> See <http://health.gov.ie/future-health/tackling-the-capacity-deficit/strategic-review-of-training-and-career-pathways-for-doctors/> for the full reports and related papers).

## 1.2 Embedding the Recommendations in the Work of the Health Service

The Working Group acknowledged that ‘the recruitment and retention issues identified and addressed in these reports are complex and multifaceted, and that implementing the recommendations will take time to yield demonstrable results’<sup>2</sup>. They further recognised that ‘sustained effort will be required to take the recommendations of all three reports forward in order to ensure that they are embedded in the day-to-day business practice of the health system’<sup>3</sup>.

In this context, they recommended the following in their final report:

1. That the Department of Health and HSE jointly agree and put in place appropriate multi-stakeholder arrangements to oversee continued implementation of the Strategic Review recommendations;
2. The reporting on a quarterly basis of NCHD and Consultant retention rates in the public health system through the HSE Performance Assurance Report (PAR);
3. The submission, and subsequent publication, of six monthly implementation reports to the Minister for Health.<sup>4</sup>

Since the submission of the Working Group’s final report, the Department of Health has worked closely with stakeholders, including the HSE, to put in place the implementation and monitoring arrangements for the Strategic Review recommendations, in order to support implementation.

## 1.3 Implementation and Monitoring Arrangements

The Strategic Review recommendations are being progressed through a range of structures and processes across the health service, involving multiple stakeholders. Each recommendation has an identified business owner responsible for progressing implementation of that recommendation (see Table 2 below).

**Table 2: Implementing the Strategic Review Recommendations**

REPORT	IMPLEMENTATION	RECOMMENDATION OWNER
First report (December 2013)	Implementation is being progressed through the HSE / Forum of Irish Postgraduate Medical Training Bodies	<ul style="list-style-type: none"><li>• HSE National HR (1.1)</li><li>• HSE PHSI (1.2)</li><li>• HSE-NDTP<sup>5</sup>/Forum of Irish Postgraduate Medical Training Bodies (1.3, 1.4, 1.5, 1.9)</li><li>• HSE-NDTP (1.6, 1.7, 1.8)</li></ul>

<sup>2</sup> *Strategic Review of Medical Training and Career Structure: Final Report* (Department of Health, 30<sup>th</sup> June 2014), p. 16.

<sup>3</sup> *Ibid.*

<sup>4</sup> *Ibid.*

<sup>5</sup> HSE-National Doctor Training and Planning Unit (formerly HSE-Medical Education and Training Unit).



Second report (April 2014)	Implementation is being progressed through a range of structures and processes across the health system.	<ul style="list-style-type: none"> <li>• HSE National HR (2.1, 2.2, 2.3, 2.4)</li> <li>• Strategic Advisory Group on the Implementation of Hospital Groups (2.5)</li> <li>• HSE-NDTP (2.6a, 2.6b)</li> </ul>
Final report (June 2014)	Implementation is being progressed through a range of structures and processes across the health system.	<ul style="list-style-type: none"> <li>• Department of Health (3.1, 3.5)</li> <li>• HSE-NDTP (3.2, 3.3, 3.9)</li> <li>• HSE National HR (3.4a, 3.4b)</li> <li>• Department of Health/HSE Primary Care (3.6, 3.7)</li> <li>• HSE Mental Health (3.8)</li> <li>• Forum of Irish Postgraduate Medical Training Bodies (3.10)</li> </ul>

To support implementation monitoring, the Department of Health has developed an implementation monitoring schedule and updates are sought as required from business owners.

As part of the ‘appropriate multi-stakeholder arrangements’ recommended by the Working Group in their final report<sup>6</sup>, the Department of Health established an Implementation Monitoring Group, comprising key stakeholders including trainee doctors, the Forum of Irish Postgraduate Medical Training Bodies, the HSE, the IMO, the Medical Council, and the Health Workforce Research Group, RCSI.

In accordance with its Terms of Reference, the Implementation Monitoring Group is to:

- Oversee the implementation of the recommendations of the *Strategic Review of Medical Training and Career Structure*;
- Advise on the preparation, by the Department of Health’s National HR Unit, of six monthly progress reports to the Minister for Health;
- Undertake consultation meetings with trainee doctors on a twice yearly basis regarding progress in implementing the Strategic Review recommendations;
- Assess the impact of the measures proposed in the Strategic Review on the recruitment and retention of doctors (including trainees, Consultants and other specialists) in the Irish health system. (See paragraph 3.3, pp 11–12.)

The PHSI programme management approach to the processing of the MacCraith recommendations (adopted in November 2016) aims to improve implementation, and result in noticeable positive changes in the working lives of doctors, resulting in increased recruitment and retention of doctors in the public health system. While risks associated with implementation of the recommendations of the Strategic Review should be managed and addressed by the relevant business owners at project/programme level, where appropriate, the Implementation Monitoring Group has an escalation role in order to support risk mitigation and recommendation implementation.

<sup>6</sup> *Strategic Review . . . Final Report*, p. 16.

The Implementation Monitoring Group is chaired by an officer of the Department of Health's National HR Unit, and meets on a quarterly basis.

The Group met twice in the February to July 2017 period, on 3 March and 16 June 2017.

In line with its Terms of Reference, the Group also met with two trainee doctor delegations during the above period – in April and May 2017.

#### **1.4 Membership of the Implementation Monitoring Group**

As at 31 July 2017, membership of the Implementation Monitoring Group was as follows:

Sorcha Murray, Department of Health (Chair);  
Paddy Barrett, Department of Health;  
Ruairi Brugha, Royal College of Surgeons;  
Andrew Condon, Health Service Executive;  
Vacancy\*, Health Service Executive;  
Paddy Hillery, Irish Medical Organization;  
Vacancy\*\*, Forum of Irish Postgraduate Medical Training Bodies Trainee Sub-Committee;  
Eilis McGovern, Health Service Executive;  
Cathleen Mulholland, Forum of Irish Postgraduate Medical Training Bodies;  
Vacancy\*, Medical Council;  
Ellen O'Sullivan, Forum of Irish Postgraduate Medical Training Bodies;  
Vacancy\*\*, Forum of Irish Postgraduate Medical Training Bodies Trainee Sub-Committee;  
Anthony Owens, Irish Medical Organization.

\* Both the PHSI and the Medical Council provided temporary representation, as previous nominees have transferred to other work areas.

\*\*Awaiting nominations from the Forum.

## 2 CONSULTATION MEETINGS WITH TRAINEE DOCTORS

### 2.1 Introduction

In keeping with its Terms of Reference, the Implementation Monitoring Group meets trainee doctors on a twice yearly basis regarding progress in implementing the Strategic Review recommendations.

The fifth round of consultation meetings took place in April and May 2017, as follows:

- 26 April 2017 (Forum Trainee Sub-Committee delegation); and
- 10 May 2017 (IMO delegation).

In advance of the meetings, and noting the contents of an advanced draft fifth progress report on implementation, the Implementation Monitoring Group prepared the following set of questions around which the meetings were structured:

1. In the context of the draft fifth progress report, what are your views regarding how the Strategic Review recommendations are being implemented? Do you think that the initiatives and approaches being undertaken address the report recommendations?
2. With regard to the progress reported, what, if any, changes have you noticed in:  
(a) the training environment; (b) the working environment?
3. In the context of the recruitment and retention of doctors, what are your views on the implementation of the recommendations to date, including but not confined to issues such as (i) protected training time, (ii) family-friendly arrangement, (iii) funding for training, and (iv) mentoring (as a means of both assisting career development and / or counteracting bullying)?
4. What are your views on the draft fifth progress report as presented? In what ways could the next progress report be enhanced?

### 2.2 Summary of Trainee Feedback on Implementation

Trainee delegations continued to give their strong support for the process of engagement and the recommendations of the Strategic Review reports, noting that while some recommendations have been implemented, a significant number have not, and if implemented in full they would have the potential to improve both patient outcomes and the quality of medical training.

Trainee delegations, however, clearly signalled that while the published progress reports indicated progress on many of the recommendations, there had been little tangible change or impact on their day-to-day working lives and training experience. Trainees highlighted: the high costs associated with training and the inadequacy of the training supports in place; that protected training time is not a reality; service needs continue to take precedent over training

requirements; concerns re inadequate mentoring; doctors at all grades are over-stretched and under pressure; the difficulty in retaining doctors in service posts; the lack of tangible improvement in the working environment arising from task transfers; the delay in addressing the public health recommendation; and the need to develop flexible training posts.

A summary of trainee feedback on implementation of the Strategic Review recommendations is set out in Table 3 below.

**Table 3: Summary of Trainee Feedback at Consultation Meetings in April and May 2017**

QUESTION	SUMMARY FEEDBACK
<p>1. (a) In the context of the draft fifth progress report, what are your views regarding how the Strategic Review recommendations are being implemented?</p> <p>(b) Do you think that the initiatives and approaches being undertaken address the report recommendations?</p>	<ul style="list-style-type: none"> <li>• Improvements in the working lives of trainees in the areas of Lead NCHDs; the National Electronic Record (NER); the careers website; and in many rotations.</li> <li>• Little has changed for trainees since the last update;</li> <li>• Absence of practical change in working environment since the start of the MacCraith process;</li> <li>• Disappointing slow progress re public health specialists – lack of parity re salaries and consultant status;</li> <li>• New fellowships and career planning welcomed;</li> <li>• Need for new GP contract;</li> <li>• Many doctors from abroad need structured training;</li> <li>• Concerns that certain doctors could not access specialist training, due to the country of origin of their medical degrees;</li> <li>• Recruitment of consultants remains a problem, and trainees still indicating they will emigrate;</li> <li>• No noticeable changes in mentoring post MacCraith reports – and consultants need to be allocated time to mentor.</li> </ul>
<p>2. With regard to the progress reported, what, if any, changes have you noticed in: (a) the training environment?; (b) the working environment?</p>	<ul style="list-style-type: none"> <li>• Little impact of MacCraith on training;</li> <li>• Lack of training supports remains a major issue – many (expensive) courses did not qualify for refunds;</li> <li>• Family-friendly training needs to be published and progressed;</li> <li>• Service requirements continue to take priority over education / training;</li> <li>• Working environment / time pressures remain stressful – this led to bullying of NCHDs but both pers and staff / supervisors;</li> <li>• Concerns re safety in the workplace for psychiatry trainees;</li> <li>• Training not always ‘bleep free’;</li> <li>• Complaints that clinics are over-booked, and too few consultants were being appointed;</li> <li>• Absence of panic buttons for doctors working in mental health areas a cause for concern.</li> </ul>
<p>3. In the context of the recruitment and retention of doctors, what are your views on the implementation of the recommendations to date, including <u>but not confined</u> to issues such as (i) protected training time, (ii) family-friendly arrangement, (iii) funding for training, and (iv) mentoring (as a means of both</p>	<ul style="list-style-type: none"> <li>• Protected training time still problematic – varied from speciality to speciality;</li> <li>• Problem with underfunding of training;</li> <li>• Some improvement re streamlining of training;</li> <li>• Some improvements re mentoring;</li> <li>• Trainee-friendly arrangements were in place in psychiatry;</li> <li>• Mentoring was having some effect on bullying – but still a significant issue in some specialities, yet there was a reluctance to discuss it;</li> <li>• Service needs take precedence over training requirements;</li> </ul>

<p>assisting career development and / or counteracting bullying)?</p>	<ul style="list-style-type: none"> <li>• Absence of adequate couple-matching was regretted;</li> <li>• No mentoring in some specialities;</li> <li>• Six-monthly rotations in paediatrics caused additional problems for trainees;</li> <li>• Course expenses should be paid up-front, rather than subsequently refunded;</li> <li>• Study leave often not facilitated- varies from site to site;</li> <li>• Training time should be recorded and audited at all sites;</li> <li>• Time was being deducted at some sites for protected training time – but the training time was not being provided;</li> <li>• Some specialities limited the number of years that could be taken for flexible training;</li> <li>• Streamlined training not available in all specialities;</li> <li>• Full refunds should be provided for mandatory courses.</li> </ul>
<p>4. What are your views on the draft fifth progress report as presented? In what ways could the next progress report be enhanced?</p>	<ul style="list-style-type: none"> <li>• IMG reports should have clear timelines.</li> </ul>

## 3 IMPLEMENTING THE RECOMMENDATIONS OF THE STRATEGIC REVIEW

### 3.1 Introduction

In line with the Working Group's recommendation, this is the sixth progress report to be submitted to the Minister for Health, and covers the period from 1 February to 31 July 2017.

### 3.2 Progress in Implementing the Recommendations of the Strategic Review

Progress in implementing the recommendations is reported on a recommendation-by-recommendation basis in Table 4 (p. 14)<sup>7</sup>. In response to trainee feedback on an earlier progress report, where possible, the RAG status for each process/deliverable has been included.

A number of Monitoring Group members expressed the view that the RAG status applied to some of the recommendations by their business owners, while perhaps reflecting the processing of the recommendations (e.g. production of a document), do not reflect the actual impact / lack of impact of same on doctors' training or working environments. Consequently, re certain recommendations, the Monitoring Group has allocated two RAG Statuses, viz. one reflecting the delivery of the MacCraith recommendation, the other reflecting factors such as impact on the actual working lives of doctors.

### 3.3 Assessing the Impact

The MacCraith Strategic Review Working Group considered it important that the impact of the measures proposed in the reports be assessed regularly. They noted a number of existing data sources and research instruments which could assist in this regard, including the following:

- HSE-NDTP Unit's NCHD and Consultant databases;
- the Medical Council's register, which captures key information on the total medical workforce, and associated annual workforce intelligence reports;
- the Medical Council's annual trainee experience survey;
- publications by the Health Workforce Research Group, RCSI;
- surveys undertaken by the training bodies.

While many of the recommendations remain to be implemented, in part or in whole, there have been positive developments which have addressed some of the issues raised in the report. For example, a careers and training website has been launched, which gives information about each specialty, including details of training pathways and training durations. The HSE has agreed to double the number of family-friendly training places over a three-year period. NCHD numbers continue to increase, with the recruitment of additional NCHDs. The online National Employment Record has streamlined processes and eliminated the paperwork burden associated with rotations. It is now used by circa 6,000 NCHDs. There are 45 Lead NCHDs across the 31 acute hospital sites, and the initiative has been extended to include the areas of mental health and general practice. There are however, still difficulties attracting and recruiting NCHDs into certain posts, particularly those in geographically

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<sup>7</sup> Note: Recommendations 2.6 and 3.4 have been sub-divided to facilitate the identification of multiple deliverables. Two deliverables have been identified in relation to both recommendations 1.2 and 3.6.

remote areas. Similarly, there are ongoing difficulties in filling consultant posts, including pivotal clinical and academic positions.

The views summarized in Table 3 (pp 9–10 above) are in practice reflected in the finding published in the Medical Council’s July 2016 publication, *Your Training Counts*, which shows, *inter alia*, that in 2015, 20% of trainees were unlikely to practise medicine in Ireland for the foreseeable future.<sup>8</sup> (This shows a slight decrease from 21% in 2014.<sup>9</sup>) Major reasons for intending not to practise medicine in Ireland were: understaffing in the workplace; carrying out too many non-core tasks; limited career progression opportunities in Ireland; and ability to earn more abroad.<sup>10</sup>

The size of the challenge faced by health recruiters in Ireland has been set out in a number of publications by stakeholders, who have surveyed health professionals and reported on their findings. For example, one paper draws attention to the worrying situation where ‘no appointable applicants are applying for previously highly sought-after hospital consultant posts in national specialist hospitals’<sup>11</sup>. Another paper, dealing with postgraduate training, highlighted topics such as respect for hierarchy, anger and fear, intimidation, and disillusionment.<sup>12</sup> This paper argues that the negative implications of these emotional issues for the quality of training, patient care, and a willingness of junior doctors to pursue careers in Ireland, require urgent attention, otherwise conditions ‘may encourage Irish-trained doctors to emigrate, during and after completion of training’<sup>13</sup>.

These publications, in conjunction with the summary of trainee feedback highlighted in section 2.2 and Table 3 above, give the Monitoring Group continuing grounds for concern.

The exercise by the HSE’s Programme for Health Service Improvement (PHSI) Unit to review the MacCraith programme, HSE HR ‘owners’, and contributors to implementation, was completed in 2016. This exercise highlighted the requirement for greater clarity on HSE ‘ownership’ and contribution to implementation in relation to Mental Health, Acute Hospitals, Public Health, and Primary Care, and the need for an increased focus on implementation at service delivery level.

A number of issues were raised during this review process that highlighted the requirement for the Implementation Monitoring Group to work with the HSE to clarify cross-sector governance and programme management issues, with a focus on MacCraith programme outcomes and benefits realisation. The IMG, at its November 2016 meeting supported the PHSI’s proposal to prioritize in 2017 certain agreed recommendations, and noted that the HSE’s Reform Leadership Team has assumed responsibility for the implementation of the MacCraith recommendations that fall under the remit of the Executive. The programmatic approach focuses more closely on governance. It also focuses on delivering improvements in the working and training environment, particularly in relation to the priority areas. Under the

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<sup>8</sup> Medical Council, *Your Training Counts. Spotlight on trainee career and retention intentions* (Dublin, 2016), p. 6.

<sup>9</sup> Medical Council, *Your Training Counts. Spotlight on trainee career and retention intentions* (Dublin, 2015), p. 6.

<sup>10</sup> Medical Council, *Your Training Counts*. . . (Dublin, 2016), p. 24.

<sup>11</sup> Sara McAleese, Barbara Clyne, Anne Matthews, Ruairí Brugha, Niamh Humphries, “Gone for good? An online survey of emigrant health professionals using Facebook as a recruitment tool”, *Human Resources for Health* 2016, 14 (Suppl 1):34, p. 136.

<sup>12</sup> Sophie Crowe, Nicholas Clarke, Ruairi Brugha, “‘You do not cross them’: Hierarchy and emotion in doctors’ narratives of power relations in specialist training”, *Social Science & Medicine*, 186 (2017), pp 70-77.

<sup>13</sup> *Ibid.*, p. 76.

programme, therefore, there is a strengthened commitment to the implementation of the relevant recommendations.



**Table 4: Progress Update (as at 31 July 2017)**

RECOMMENDATION	KEY DELIVERABLES/ TARGET DATES	OWNER	PROGRESS UPDATE
<p><b>1.1</b></p> <p>With regard to the quality of the training experience, and pending implementation of the hospital reconfiguration programme, the Working Group suggests that interim measures be identified by the HSE, employers and the training bodies with a view to protecting training time for both trainees and trainers.</p>	<p>Measures to protect training time identified</p> <p><i>Q2 2014</i></p> <p>Measures implemented</p> <p><i>Q4 2014</i></p>	<p>HSE</p> <p>National HR</p>	<p><i><b>RAG Status: Delivery of recommendation: Green</b></i></p> <p><i><b>Impact of Recommendation: Amber</b></i></p> <p>HSE HR issued formal guidance to hospitals, Integrated Service Areas (ISAs), training bodies and health agencies on delivery and recording of protected training time for immediate implementation on 11 July 2014 which included reporting template for same. This guidance recommended the provision of rostered, protected training time for NCHD on-site regular scheduled educational and training activities including conferences, grand rounds, morbidity and mortality conferences. Time should also be allowed for trainees to observe and, subject to consultant approval, participate under supervision, in certain planned clinical procedures. The agreed annual limit for the rostered protected training time is as follows: Interns – 246 hours; specialist trainees – 328 hours; NCHDs on Professional Competence Schemes – 123 hours.</p> <p>On 9 July 2015 the European Court of Justice ruled that protected training time was not working time for European Working Time Directive (EWTd) purposes. The joint HSE/IMO/DoH EWTd Verification and Implementation Group has incorporated an audit of protected training time into its work, and will be progressing that as part of sites visits to each hospital.</p> <p>In April 2016, the National EWTd Verification and Implementation Group (which includes the HSE, DoH and IMO) adopted a series of standard performance measures in relation to implementation of protected training time which are now used as part of the reporting and assessment process for each hospital / agency that the Group visits.</p> <p>This recommendation – that interim measures are identified – has been implemented in full. However, implementation of the measures identified, something the MacCrath Report doesn't address, remains underway. In this context it is suggested that responsibility for this issue no longer rests with the Implementation Monitoring Group, and rests instead with the National EWTd Verification and Implementation Group. Representatives of the Forum / Trainee doctors would be a useful addition to the Verification Group in that context.</p>

				In summary, notwithstanding implementation of the recommendation, the intent behind it has not yet been achieved.			
1.2	In relation to non-core task allocation, the Working Group recommends that a national implementation plan should be put in place by the HSE to progress this matter. Examples of good practice exist at various clinical sites nationally and the plan should take account of these. The Working Group also notes the on-going process under the Haddington Road Agreement in this regard.	<table><tr><td>National implementation plan developed <i>Q1 2014</i></td><td>HSE National HR / Programme for Health Service Improvement</td></tr><tr><td>Plan fully implemented <i>Q3 2014</i></td><td></td></tr></table>	National implementation plan developed <i>Q1 2014</i>	HSE National HR / Programme for Health Service Improvement	Plan fully implemented <i>Q3 2014</i>		<p><b>RAG Status: <i>Amber</i></b></p> <p>This work is being progressed in a programmatic way via the PHSI in collaboration with HSE National HR and other stakeholders. The fundamental principle is patient-centred, shared-care i.e. that the right person undertakes the task at the right time given the particular circumstances.</p> <p>There are two complementary and mutually supportive aspects to the work:</p> <p>(i) <b>The Medical-Nursing Interface Industrial Relations (IR) Process</b> (Haddington Road Agreement (HRA)) involving nursing/midwifery practice expanding to incorporate four tasks traditionally undertaken by NCHDs.</p> <p>(ii) <b>The Task Allocation (Shared Care Framework) Project</b> to deliver a National Guidance Framework and Implementation Plan for Task Allocation.</p> <p>Progress made within the Industrial Relations process facilitated the Project Work to advance and it is anticipated that the project work will support the practical implementation of the IR Agreement.</p> <p>(i) <b>Medical-Nursing Interface IR Process</b></p> <p>Arising from agreement under the HRA and following Public Service Pay talks the HSE, Department of Health, Irish Medical Organisation (IMO), Irish Nurses &amp; Midwives Organisation (INMO), and the Services Industrial Professional and Technical Union (SIP TU) agreed – with effect from 1 January 2016 – to the transfer of four tasks from Non-Consultant Hospital Doctors (NCHDs) to nurses / midwives, including: Intravenous cannulation; Phlebotomy; Intra Venous drug administration — first dose; and Nurse led delegated discharge of patients (in line with patient-centered, shared care principle).</p> <p>HSE HR Circular 003/2016 formally conveyed approval from the Minister for Health for the Transfer of Tasks from Non-Consultant Hospital Doctors to Nurses/Midwives under the Nursing /Medical Interface Section of the Haddington Road Agreement (Appendix 7, Point 4). The sanction was granted on the basis that implementation will follow the terms of the document “Final</p>
National implementation plan developed <i>Q1 2014</i>	HSE National HR / Programme for Health Service Improvement						
Plan fully implemented <i>Q3 2014</i>							

				<p>Agreement on "Transfer of Tasks" under Nursing/Midwifery Interface Section of the Haddington Road Agreement. The Agreement is now being implemented in the Acute Sector. Delays in the provision of the required training and staffing shortages have hindered implementation at many sites.</p> <p><b>(ii) Project Progress:</b></p> <p>A Project Working Group was established and operational from November 2015 to December 2016. Its purpose was to guide, oversee and deliver the project with the support of the PHSI. This was a high-level group and comprised representation from NCHDs/Training Forum, Consultants, Nursing/Midwifery Practice, Health and Social Care Professionals, Health Care Assistants, HSE Employee Relations, HSE/Department of Health National HR Unit, Quality Improvement, PHSI etc.</p> <p>The HSE PHSI had put a Service Level Agreement (SLA) in place with the Royal College of Surgeons in Ireland (Faculty of Nursing and Midwifery) to support the Project. This primarily involved the provision of research expertise to the project to ensure that the Framework was clearly evidence-based.</p> <p>The Project Work Plan comprised of five work packages that were successfully completed.</p> <p>Work package 1 involved the identification and collation of existing good practice. A Report on the findings and key characteristics of sites with good practices was completed in February 2016.</p> <p>Work package 2 involved the analysis and synthesis of similar international frameworks. A report on the findings and the identification of core Framework elements, based on 10 similar type frameworks and plans, was completed in April 2016.</p> <p>Workpackage 3 was completed by mid-June 2016 and involved the development of a 'Draft National Framework on Task Allocation based on Shared Care' and Recommendations for Implementation. It is based on the above national and international evidence and input from the Working Group. The Framework applies to all healthcare staff in all healthcare services in support of a collaborative approach to integrated person-centred care.</p>
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				<p>Workpackage 4 involved wider consultation on the Draft Framework and the incorporation of feedback into the Draft Framework and Recommendations for Implementation. The consultation process was undertaken between June and September 2016 and the results were reviewed by the WG at its meeting on 13 September 2016. On the basis agreed at that meeting, the next Draft version of the Framework was completed and presented to the Trade Unions at the Joint Information and Consultation Forum (JICF) on 20 October 2016.</p> <p>Workpackage 5 involved the sign-off by the Working Group on 1 December 2016 of the Proposed <i>'National Framework on Task Allocation based on Shared Care'</i> and recommendations for implementation. This was submitted formally to the Head of the PHSI on 13 December 2016 for onward submission to the DoH IMG. This completed the work of the group on the basis that ongoing consultation with the trade unions would be undertaken via the HSE Corporate Employee Relations unit.</p> <p>This is work in progress, beginning with stakeholder engagement in order to agree a governance structure and operating model for implementation.</p>
1.3	<p>With regard to duration of training, the Working Group recommends that specialties that have not already done so should urgently review their programmes in line with international norms. Due regard should be taken of patient safety and competence to practise independently at the end of training.</p>	<p>Reviews completed</p> <p><i>Q2 2014</i></p> <p>Measures implemented (as appropriate)</p> <p><i>Q2 2015</i></p>	<p>HSE-NDTTP / Forum of Irish Postgraduate Medical Training Bodies</p>	<p><b>RAG Status: <i>Amber</i></b></p> <p>From July 2015, 15 training programmes offer streamlined postgraduate training (Surgery and subspecialties, Anaesthetics, Psychiatry and subspecialties, Emergency Medicine, General Practice and Ophthalmology). The following specialties, Medicine, Paediatrics, Obstetrics and Gynaecology, Pathology, Occupational Medicine, and Public Health, have removed the necessity for gap year in these training programmes from July 2016. The Monitoring Group, however, understands that there are significant blockages as regards moving seamlessly through Obstetrics and Gynaecology.</p> <p>There is now no subdi-vision between BST/HST in the specialty of Radiology.</p>
1.4	<p>The Working Group considers that greater predictability at the outset of training schemes regarding locations of rotation would be beneficial for trainees and their</p>	<p>Measures implemented on a specialty-by-specialty basis</p>	<p>HSE-NDTTP / Forum of Irish Postgraduate</p>	<p><b>RAG Status: <i>Green (but requires on-going monitoring)</i></b></p> <p>Of the 50 training programmes (Basic Specialist Training (BST), Higher Specialist Training (HST), Streamlined), all programmes will offer pre-defined</p>

	<p>families. The Group recommends that HSE-Medical Education and Training (HSE-MET) and the Forum of Irish Postgraduate Medical Training Bodies continue to work together to progress this on a specialty-by-specialty basis, so that all newly-appointed trainees are informed in advance of their placements/locations for the first two years of a training scheme. This should result in multi-year training agreements between the training body and trainee.</p>	Q2 2014	Medical Training Bodies	<p>rotations of at least two years in duration from July 2016.</p> <p>As part of service agreement discussions with training bodies for the training year 2016/2017, HSE National Doctors Training and Planning (NDTP) have requested all training bodies to extend the duration of pre-defined rotations for trainees to include year 3 &amp; year 4, with a view to where practical and possible, to having placements/locations available for the duration of the training programme.</p> <p>At quarter year review meetings, feedback was received from the majority of training bodies in relation to the status of pre-defined rotations as follows:</p> <ul style="list-style-type: none"> <li>• The College of Anaesthetics has pre-defined rotations for the entire streamlined training programme.</li> <li>• The Faculty of Radiology has pre-defined rotations in place for 4 years for all trainees commencing training from July 2017.</li> <li>• The College of Psychiatry have confirmed that pre-defined rotations are in place for the first 3 years of HST.</li> <li>• Emergency Medicine already executes predefined rotations for all BST trainees and the first 2 years of HST training. The specialty is currently reviewing the possibility of extending this to year 3 of HST.</li> <li>• From July 2017 the ICGP has in place a minimum of 2 years pre-defined rotations.</li> <li>• RCPI has implemented predetermined rotations for the 2 years of BST and for the first 2 years of HST training. In order to facilitate career choice, implementing a third pre-determined year for HST is proving challenging and efforts are on-going.</li> </ul> <p>NDTP has requested, as part of the 2017-18 SLA process, that each Training Body submit evidence to demonstrate that the notification of a minimum of 2 years pre-defined rotations have been issued to trainees a minimum of 13 weeks prior to commencing training/entry to the programme and that trainees entering year 3 of a training scheme received a minimum of 2 years pre-defined rotations to be notified a minimum of 13 weeks prior to commencing year 3.</p>
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1.5	In view of the feedback from stakeholders and the emerging evidence from the Medical Council's Workforce Intelligence Report, the Working Group considers that more flexible and differentiated approaches and options during training that take account of family, research or other constraints should be explored by HSE-MET and the Forum of Irish Postgraduate Medical Training Bodies. In this regard, the Working Group suggests that HSE-MET and the Forum of Postgraduate Irish Medical Training Bodies explore the implementation of a couple matching/family-friendly initiative for the July 2014 intake.	Exploration of options for couple-matching initiative completed <i>Q2 2014</i>	HSE-NDTP / Forum of Postgraduate Medical Training Bodies	<b>RAG Status: <i>Amber</i></b>  In October 2016 NDTP and representatives from the Forum agreed on a set of draft principles and a policy on flexible working. Flexible training being an umbrella term to include post re-assignment, job-sharing, less than full-time working and the HSE funded supernumerary flexible training scheme. The document also included recommendations around governance and promotion of flexible training to increase the number of doctors availing of such arrangements, for example the appointment of a National Chair/Dean of Flexible Training to lead and drive Flexible Training. These recommendations have recently progressed through the Forum and are now with the Training Bodies Councils for approval. NDTP have offered to fund the Chair/Dean of Flexible training immediately.  In the interim, the training bodies will continue to publicize and implement their own job sharing and post-reassignment policies.
1.6	In relation to training supports, the Working Group considers that a more differentiated model that takes account of the needs of and costs associated with various specialties and stages of training would be beneficial. It recommends, in this regard, that HSE-MET review the funding mechanism for additional training requirements (such as examinations and courses) with a view to addressing disparities affecting certain trainees/specialties.	Funding mechanism reviewed and measures implemented <i>Q2 2014</i>	HSE-NDTP	<b>RAG Status: <i>Amber</i></b>  A review of the schedule of courses and exams covered by the clinical course and exam refund scheme was completed. From January 2015 an increase in funding was made available to NCHDs who by virtue of the training programme, are required to undertake exams outside of Ireland.  NDTP have been working with training bodies on an individual basis looking at specialties where costs associated with training may be higher for individual trainees.  Management and the IMO will undertake a review of the continuing education requirements of NCHDs in order to ensure that the requisite financial and related resources are administered to NCHDs to meet their ongoing professional development needs. This review will be undertaken under the auspices of the Workforce Relations Commission, and will follow terms of reference agreed between the parties.



1.7	With regard to the paperwork burden associated with rotations, the Working Group recommends that the HSE and employers should jointly explore how this issue would improve the quality of the employment experience for trainees, as rotations tend to be 6-monthly or annual.	Issues associated with rotation identified <i>Q2 2014</i> Measures implemented <i>Q4 2014</i>	HSE-NDTP	<p><i>RAG Status: Green – recommendation implemented</i></p> <p>National Employment Record (NER) is now fully rolled out. Over 6,000 NCHDs have now opened NER portal accounts.</p> <p>Improvements to the system based on feedback from NCHDs and Medical Manpower Managers continue to be implemented e.g. NCHDs may now use their mobile device or tablet to take a photo of documents and upload directly – there is no longer a requirement for a scanner. Automated email reminders have also been included to remind NCHDs and/or Medical Manpower Departments when documents are expiring.</p> <p>Now that the majority of NCHDs have opened NER accounts, further modules of the Doctors Integrated Management System (DIME) are planned. For example, an Occupational Health (OH) module for use by Occupational Health Departments only, to allow smooth transfer of NCHDs from sites without any additional OH paperwork. The project group involved NDTP, Clinical Lead for Workforce Health and Wellbeing Unit Dr Lynda Sisson, OH Consultants, OH Nurses, OH Spr, National Lead NCHD, MMM and OH Admin.</p> <p>The new Occupational Health module went live on 24 May 2017, in advance of the July 2017 NCHD changeover.</p> <p>An on-line educational portal for mandatory training courses is also being considered. NDTP plans to continue to develop the database and to develop further modules and functionality to benefit NCHDs.</p> <p>This recommendation as envisaged is Green and is now closed. As outlined NDTP intend to make further enhancements to improve the rotation experience of NCHDs, however these are in addition to the initial recommendation.</p>
1.8	With regard to improving communication, the Working Group recommends that measures to improve communication should be rolled out on a consistent basis by the HSE and hospital managements. The Working Group considers that the NCHD Lead initiative to be implemented during 2014 is an important step in this regard.	NCHD Lead initiative implemented <i>Q1 2014</i> Measures to improve communication	HSE-NDTP	<p><i>RAG Status: Green for Lead NCHDs</i></p> <p><i>Green for communication</i></p> <p><b>Lead NCHDs</b></p> <p>In 2016/2017 there were 45 Lead NCHDs across the 31 acute hospital sites. The job description for the role was reviewed and updated for 2017/2018 and the process of appointing lead NCHDs for this period is currently in course. Hospitals with more than 150 NCHDs are encouraged to appoint more than</p>

		identified and implemented <i>Q3 2014</i>	<p>one Lead NCHD, with a 12 month tenure recommended.</p> <p>An increase in the number of leads is expected as the initiative has been rolled out to include eight posts in Mental Health, and a further two posts being piloted in General Practice.</p> <p>There are four workshops over the course of the year focusing on leadership and personal development, culture and quality improvement initiative planning and execution. The Values in Action initiative will be rolled out to the NCHD community through this forum in December 2017.</p> <p>The Monitoring Group notes that Lead NCHDs are entitled to four hours protected time per week, supported by a HR directive, although this is difficult to achieve in practice.</p> <p>Lead NCHDs are invited to attend Clinical Director Workshops and to liaise with E-Health Ireland, Quality Improvement Division, Department of Health – National Patient Safety Office, Acute Hospital and Mental Health Divisions, and others as needed.</p> <p>The first National Lead NCHD/NDTP Fellow, Catherine Diskin, was appointed for the period July 2016 to July 2017. This post was considered very useful and her successor, Louise Hendrick took up the post in July 2017.</p> <p>A quarterly newsletter directed to all NCHDs was launched in February 2017 reflecting the ongoing work of the Lead NCHD programme and areas of interest to NCHDs. Following positive feedback this initiative will be continued through the 2017/18 period.</p> <p>The future vision for the lead role is reviewed on a regular basis with input from all stakeholders including Quality Improvement Division, Clinical Director programme and NDTP along with Lead NCHDs.</p> <p>Annual Lead NCHD Awards were presented in September 2016 and are planned for September 2017. The focus is on demonstrating quality improvement, NCHD engagement and projects which can be expanded beyond the initial site.</p>
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				<p>A Lead NCHD Handbook to facilitate succession has been developed and distributed by local hospitals to their Lead NCHDs on appointment, with Lead NCHDs encouraged to engage in one-to-one handovers at their specified sites.</p> <p>All information in relation to the Lead NCHD initiative is available on a specially created Lead NCHD tab on the NDTP website, including details of award submissions, winners, workshops etc <a href="http://www.hse.ie/doctors">www.hse.ie/doctors</a></p> <p><b>Improving Communication</b></p> <p>HSE-NDTP continues to fund the annual Medical Careers Day for medical students and current interns. More people than ever have registered their interest in attending the event in September 2017. NDTP appreciates the support of the Minister of Health in the annual success of this event.</p> <p>NDTP has appointed a National Innovation Fellow who commenced in post in July 2017 for a one year term in order to encourage NCHD innovation nationwide to improve the health service in every area and specialty. The Fellow is an NCHD and communicates directly with NCHDs on behalf of HSE-NDTP through electronic communication, clinical site visits, and structured events.</p>
1.9	<p>With a view to supporting career planning, the Working Group notes the importance of improving the feedback loop between HSE-MET and the training bodies and, in this regard, the Group welcomes HSE-MET's plans to develop and implement a careers and training website for graduates, to be introduced on a pilot basis in early 2014.</p>	<p>Phase 1 of careers and training website live</p> <p><i>Q1 2014</i></p>	<p>HSE-NDTP / Forum of Irish Postgraduate Medical Training Bodies</p>	<p><b>RAG Status: <i>Green – recommendation implemented</i></b></p> <p>The HSE has developed a careers website (<a href="http://www.medicalcareers.ie/">http://www.medicalcareers.ie/</a>). The purpose of the website is to provide specific information regarding all the specialist training programmes. The benefit of such a website is that it provides all the relevant information in one place, making it easier for medical students and trainee doctors to navigate the different training options available in Ireland. The user views information by specialty. Each specialty page provides information on training pathway, exams, career options, and how to apply. A link to the training body is also provided as well as a named individual for the user to contact if more information is required.</p> <p>The Forum, in collaboration with NDTP Unit, and the training bodies, is progressing a review of new and existing website content.</p>

2.1	<p>The Working Group recommends that the relevant parties commence, as a matter of urgency, a focused, timetabled IR engagement of short duration to address the barrier caused by the variation in rates of remuneration between new entrant Consultants and their established peers that have emerged since 2012. It further recommends that the relevant parties explore options, within existing contractual arrangements, to advance a more differentiated Consultant career structure as outlined in Section 5.3 (i.e. clinical service provision, clinical leadership and management, clinical research, academic, quality improvement and other roles).</p>	<p>Agreement on a more differentiated Consultant career structure and associated rates of remuneration</p> <p>July 2014</p>	<p>HSE National HR</p>	<p><b>RAG Status: <i>Green</i></b></p> <p>Sanction for implementation of the new pay rates issued on 19 May 2015, alongside provision for application of incremental credit. Subsequently the IMO, health service management, and the Forum of Postgraduate Medical Training Bodies, agreed a framework setting out the extent to which credit can be assigned. The agreed framework issued by way of HSE HR Circular 013/2015 on 30 September 2015 for implementation. It provides for recognition of certain pre- and post-CSCST qualifications and post-CSCST experience.</p> <p>In the period since implementation, a number of applications for award of incremental credit above the sixth point have been received by the HSE.</p> <p>Interim increased pay rates for 'new entrant' Academic Consultants were agreed in April 2017 and were implemented in July 2017 via HSE HR Circular 12/2017 with backdating of payment to November 2016.</p> <p>In addition, revised pay rates for NCHDs were introduced with effect from 1<sup>st</sup> July 2017 following agreement between the HSE, DoH, DPER and IMO regarding incorporation of the Living Out Allowance into base pay. HSE HR Circular 17/2017 and DoH Circular 11/2017 refer.</p> <p>The effectiveness of the response has not yet been established.</p>
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2.2	With regard to developing opportunities for flexibility within the Consultant's work commitment, the Working Group recommends the development and introduction of a system of accountable personal development/work planning for all Consultants, aligned with professional competence schemes, as appropriate. This system should build on the existing Clinical Directorate Service Plan process and take into account similar processes in other jurisdictions. In relation to quality improvement, the Working Group notes that there is a comprehensive programme of work in the health service to train people in quality improvement skills and it would be desirable for provision to be made in work plans for those who will lead in this field.	Personal development/work planning system developed and implementation date agreed  <i>Q4 2014</i>	HSE National HR	<i>RAG Status: Green</i>  The Consultant Recruitment Group Report was approved by the HSE Leadership Team in July 2016 and published in February 2017. It provides for introduction of a system of work planning for consultants.
2.3	With regard to family-friendly flexible working, the Working Group recommends that more individually-tailored time commitments should be made available, and facilitated where possible, for both new and existing Consultant posts. With regard to all new Consultant posts, the Working Group recommends that recruitment notices should indicate that a flexible working facility is possible.	All recruitment notices to reflect availability of flexible working facility  <i>Q3 2014</i>	HSE National HR	<i>RAG Status: Process Identification: Green Process Implementation: Amber</i>  Revised approval letters began issuing in October 2015, providing for advertisement and filling of all posts on a flexible working basis.  This recommendation has been implemented as of July 2016.
2.4	In relation to improving supports for newly appointed Consultants, the Working Group recommends that the personal development/work planning process for Consultants outlined in Recommendation 2 above, should include an outline of the resources required to achieve the service and personal objectives set out in the plan. These should be agreed at time of appointment and should be reviewed annually by the Consultant and Clinical Director/Employer in the context of changing objectives and the resources available to the Consultant team.	Personal development/work planning system developed and implementation date agreed  <i>Q4 2014</i>	HSE National HR	<i>RAG Status: Green</i>  The Consultant Recruitment Group Report was approved by the HSE Leadership Team in July 2016 and published in February 2017. It provides for an individualised induction programme for consultants on appointment, and a system of work planning for them.  Under arrangements introduced, employers have to confirm that the funding to support the post is available.

	<p><b>In addition, in tandem with the development of work plans, the Working Group recommends that all newly appointed Consultants should be offered the opportunity to avail of an appropriately individualised induction programme upon appointment.</b></p>			
2.5	<p>The Working Group recommends that the reconfiguration of hospital services should be used as an opportunity to address the barrier of the unattractiveness of the working environment in some Level 2 and Level 3 hospitals. In this regard, the Working Group recommends that Hospital Group strategic plans should include proposals for rationalisation of services with unscheduled care rosters. The Strategic Advisory Group (SAG) on the Implementation of Hospital Groups should define this as one of the criteria for the development and evaluation of these plans.</p>	<p>Hospital Group strategic plans incorporate proposals for rationalisation of services with unscheduled care rosters</p> <p><i>Within 1 year of establishment of Hospital Group</i></p>	<p>Strategic Advisory Group</p>	<p><b>RAG Status: <i>Delivery of Recommendation: Green</i></b> <b><i>Impact of Recommendation: Amber</i></b></p> <p>Significant progress has been made in the implementation of the Hospital Groups, to progress from disparate individual hospitals towards an integrated group with a more a co-ordinated approach to the planning and delivery of services across all the hospitals within the group. Hospitals are now starting to work together to support each other, providing a stronger role for smaller hospitals in delivering less complex care, and ensuring that patients who require true emergency or complex planned care are managed safely in larger hospitals.</p>
2.6a	<p>With regard to improving clarity around availability of Consultant posts by specialty and location, the Working Group recommends more centralised and coordinated workforce planning and better matching of new posts to service requirements and existing trainee capacity. The Group acknowledges the on-going work in HSE-MET to develop a model of medical workforce planning, which will be of significant assistance in this regard and will support appropriate, competitive succession planning.</p>	<p>Medical workforce planning model developed and implemented</p> <p><i>Q2 2015</i></p>	<p>HSE-NDTP</p>	<p><b>RAG Status: <i>Amber</i></b></p> <p>Workforce planning has become an ongoing work stream within NDTP Unit. The completed workforce planning model and supporting methodology is now being used to make workforce projections for medical specific specialties. This methodology is based on international systems review and consultation with health workforce planners at an international level. It is therefore in line with international health workforce planning systems.</p> <p>A simple guide to developing a medical workforce plan <i>Medical Workforce Planning Ireland</i>, has been developed, launched and posted on the NDTP website. This is a useful resource for training bodies, Clinical Programmes and other stakeholders involved in the planning process.</p> <p>In September 2015, a report on GP workforce planning was published. Planning for Paediatrics and Neonatology is at an advanced stage. Publication of the report for this specialty will be subject to finalisation of the staffing</p>

				<p>requirements for the new children's hospital, and the new national model of care. A review of recommended staffing requirements at HSE level is currently in train.</p> <p>Planning for Emergency Medicine is at an advanced stage.</p> <p>Planning for Anaesthesia and Critical Care is at an early stage.</p> <p>It is critical that the pace of work in the area of medical workforce planning is accelerated in order to complete the first round of specialty-specific reports, a significant workload for NDTP Unit.</p> <p>Two new appointments have been made at both Administrative Grade VII and VIII level in order to support and expedite the development of workforce plans.</p> <p>Medical workforce planning for the HSE is at a stage whereby the unit is now assisting at a wider HSE and Department of Health level, to inform the development of an integrated workforce planning system for the health service.</p> <p>In January 2017, NDTP hosted a seminar entitled "Planning the Medical Workforce of the Future: Strategic Medical Workforce Planning for Ireland". This seminar provided insights and experiences of medical workforce planning from international experts from the Netherlands and the UK along with Irish experts from the Department of Health and the Expert Group on Future Skills Needs to an invited audience of national key stakeholders.</p> <p>Beginning in Q4 2016 and ongoing, NDTP is updating its 2014 <i>Medical Workforce Planning: Population Based Ratios of Specialists in Ireland and Internationally – An Information Source to Support Medical Workforce Planning</i> report. The updated report will be produced as an online repository comprising individual medical specialty reviews. These reviews will be high-level and act as a companion piece to the more in-depth specialty specific workforce planning reports published by NDTP. All of the workforce planning reports published by NDTP intend to inform intake into specialist training programmes so that the future requirements can be met.</p> <p>NDTP will use the data now collected via the Consultant's Module in the Doctors Integrated E-Management (DIME) system to produce a quarterly newsletter, beginning in Q4 2017, with statistics on consultants working in the public health system in Ireland. Furthermore, from Q1 2018, NDTP will produce an annual report, akin to the Annual Assessment of NCHD Posts, on</p>
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				consultants in Ireland. This report will indicate, among other variables, the anticipated retirements per specialty, which can assist in succession planning for each specialty.  The intent behind the recommendation has yet to be achieved.
2.6b	While recognising the value of international experience, the Working Group recommends the continued development of post-CSCST fellowship capacity in Ireland in order to retain specialist medical expertise in the public health system in advance of appointment to Consultant posts.	Proposals for development of post-CSCST fellowship capacity <i>Q4 2014</i>	HSE-NDTP	<b>RAG Status: <i>Amber</i></b>  A HSE policy document was circulated to all training bodies. Nine posts were filled from July 2015. Twelve post-CSCST fellowships were advertised and seven commenced in July 2016.  The HSE introduced a new pay rate to increase the attractiveness of such positions.  There are now 32 Post-CSCST Fellowships approved, though not all will be filled each year. NDTP is continuing to actively promote post-CSCST fellowships with training bodies. As of July 2017, 25 post-CSCST Fellowships have been filled.
3.1	In the context of the current and future needs of the health system and Action 46 of <i>Future Health</i> (DoH, 2012), the Working Group recommends that an appropriate workforce planning structure is established at national level led by the Department of Health, in collaboration with other Government Departments and national agencies, to support <i>inter alia</i> strategic medical workforce planning on a cross-sectoral basis. This structure should	Proposals for structure developed by Department of Health in consultation with other relevant parties <i>Q4 2014</i>	Department of Health	<b>RAG Status: <i>Amber</i></b>  In June 2016, the Department of Health convened a cross-sectoral Steering Group to begin the work on developing a national integrated strategic framework for health workforce planning. The Framework is intended to reshape Ireland's future health workforce planning structures, to support the productivity of the existing workforce, the recruitment and retention of a highly-valued workforce, and the expansion of the size, skills, competences,



	Link with any structures established by HSE-MET in the context of the MWP model being developed by the MWP Project.	Structure established <i>Q1 2015</i>		and behaviours of the future workforce to meet current and emerging demands.  Following the completion of a draft report, a process of consultation with stakeholders took place during summer 2017. Submissions are being assessed and an amended report will be presented to the steering group on 12 September. It is envisaged that the final report will be presented to the Minister along with a high-level implementation plan by the end of Q3 2017.
3.2	As the availability of appropriate and accurate data is an essential tool for high-quality workforce planning, and in the context of the NCHD/Consultant databases developed by HSE-MET, the Working Group recommends that additional resource – including technical/specialist support – is provided for the HSE-MET medical workforce planning function in order to support its strategic objectives.	Resource needs identified and action taken <i>Q3 2014</i>	HSE-NDTP	<b>RAG Status: <i>Amber</i></b>  A Database Manager has been appointed to HSE-NDTP. Extensive work in relation to the NDTP NCHD and Consultant Database has been underway for the last 24 months. NDTP is now able to track 99% of all NCHDs employed in the public health service, providing valuable data for Medical Workforce Planning (WFP). Work to improve the consultant data is ongoing, the recently rolled out consultant post matching module of DIME is currently being populated by clinical sites and stands at 84% complete. NDTP are following up with the few remaining acute hospital and mental health to ensure 100% completion. The modifications to the database include enhanced reporting capabilities.  NDTP acknowledge challenges related to getting clinical sites to accurately and fully input NCHD and consultant data. This challenge is being addressed. Additional resources have also recently been appointed to Medical WFP, however the lack of a senior resource at Deputy Director level remains a challenge for the unit. This post has been approved by the DOH/DPER and will be advertised in the coming weeks.
3.3	<b>With regard to the current multi-step Consultant appointment process, the Working Group recommends that it should be re-designed and modernised as a matter of priority. A systems and service-wide approach to posts – both new and replacement – should be incorporated, that better balances local autonomy and national coordination – in line with the Hospital Group structures.</b>	Proposals developed in consultation with other relevant parties <i>Q4 2014</i>  Proposals implemented <i>Q2 2015</i>	HSE-NDTP	<b>RAG Status: <i>Green</i></b>  The Consultant Recruitment Group's (CRG) recommendations around a simplified consultant recruitment document have been implemented by NDTP. From the February 2017 CAAC meeting, the new style of application was implemented fully and is the only type of application now considered by the Committee.  The development of an online solution for consultant recruitment applications is also a recommendation of the CRG report. NDTP has scoped this project and approval for expenditure on the new on-line consultant applications

				module was agreed in Mid-July at the ICT/DOH/DPER ICT committee. The specification is now complete and work on the on-line consultant application module will begin in early September 2017. The system will provide visibility to clinical sites on the status of applications and will significantly reduce the amount of data to be populated manually. The module will also allow national reporting.
3.4a	The Working Group recognises that, currently, there are in the region of 900 doctors in service posts in the acute hospital sector (...) and notes that career structures and pathways for these doctors are limited. The Group recommends that processes are put in place by the HSE, as a matter of priority, to consider how best to address this issue, having due regard to the following: <ul style="list-style-type: none"> <li>• The needs and requirements of the public health system, including service reconfiguration and integrated models of care;</li> <li>• Patient safety and quality of the patient experience;</li> <li>• Registration, qualifications and training, clinical governance, CPD and supervisory arrangements.</li> </ul>	Proposals developed <i>Q4 2014</i>	HSE National HR	<b>RAG Status: <i>Amber</i></b>  The HSE, the Department of Health, and the IMO discussed the issues in this recommendation. The IMO position is that any revised contract should provide for all NCHDs in both training and non-training posts. This was reaffirmed on foot of a motion passed at its AGM in April 2016.  Given the IMO's position, the Chair of the Implementation Monitoring Group wrote to the National Director HR-HSE, requesting that the HSE commences a review of (a) the position of service doctors under the terms of this recommendation, and (b) the need to support their retention. The National Director has confirmed that the HSE will carry out the required review.
3.4b	The Working Group recognises that, currently, there are (...) c. 260 public and community health doctors, and notes that career structures and pathways for these doctors are limited. The Group recommends that processes are put in place by the HSE, as a matter of priority, to consider how best to address this issue, having due regard to the following:	Proposals developed <i>Q4 2014</i>	HSE National HR	<b>RAG Status: <i>Amber</i></b>  While discussions commenced with the IMO on this issue in 2015, it has not been possible to address it in the intervening period.  One strand, the position of AMOs is being addressed through the industrial relations dispute resolution process (the Workplace Relations Commission).



	<ul style="list-style-type: none"> <li>The needs and requirements of the public health system, including service reconfiguration and integrated models of care;</li> <li>Patient safety and quality of the patient experience;</li> <li>Registration, qualifications and training, clinical governance, CPD and supervisory arrangements.</li> </ul>	Proposals implemented <i>Q2 2015</i>		
3.5	<p>In the context of Action 46 of <i>Future Health</i> (DoH, 2012), <i>Healthy Ireland</i> (DoH, 2013) and emerging service developments, as well as national and regional demand for public health expertise, the Working Group recommends that a working group is established to examine matters including the following and make recommendations as appropriate:</p> <ul style="list-style-type: none"> <li>The current and future role of the public health specialist in Ireland, including the appropriate skill mix in relation to public health functions;</li> <li>The attractiveness of Public Health Medicine as a career option;</li> <li>The curriculum and content of the specialist training scheme, and associated administrative arrangements relating to the rotation of trainees around the system;</li> <li>Any requirement for post-CSCST sub-specialisation;</li> <li>The replacement rates required to fill existing public health specialist posts in order to ensure the viability of the specialist training scheme and any expansion that may be required to plan for future service developments;</li> <li>Measures to enhance the awareness of public health medicine as a career option at undergraduate level and during the Intern year.</li> </ul>	<p>Working Group established <i>Q3 2014</i></p> <p>Report finalised and submitted to Minister <i>Q2 2015</i></p>	Department of Health	<p><b>RAG Status: <i>Red</i></b></p> <p>Business consultants are currently working to produce a report in connection with this recommendation. They are operating in accordance with the Terms of Reference which were amended to take account of the IMO's and other stakeholders' suggestions.</p> <p>It was envisaged that the report from the consultants would be delivered as soon as possible.</p>

3.6	<p>In the context of trainee feedback regarding current barriers to the establishment of practices on completion of specialist training and preferences for patterns of work in the future, the Working Group recommends that the appropriate parties further investigate these issues. This could usefully involve exploration of the following:</p> <ul style="list-style-type: none"> <li>• Introduction of GMS contracts that allow for flexible working;</li> <li>• Measures to encourage newly qualified GPs to remain in Ireland at the end of training.</li> </ul>	<p>Agreement on introduction of flexible GMS/GP contracts</p> <p><i>Q4 2014</i></p> <p>Relevant parties to consider in context of discussions on new GMS/GP contract</p> <p><i>To commence by Q4 2014</i></p>	<p>Department of Health/HSE Primary Care</p>	<p><b>RAG Status: <i>Amber</i></b></p> <p>On 30 June 2015, the Minister for Health approved changes to the entry provisions to the GMS Scheme to accommodate flexible/shared GMS/GP contracts and to the retirement provisions for GPs under the GMS/GP contracts.</p> <p>Any medical practitioner who is eligible to hold a GMS contract is entitled to apply to become a party to a flexible/shared contract arrangement in accordance with the terms and conditions of the scheme.</p> <p>GPs who hold a GMS/GP contract and who were compulsorily required to resign at 70 years of age may from 1 July 2015 continue to hold their contract(s) until their 72<sup>nd</sup> birthday.</p> <p>The annual number of GP training places available has been increased from 120 in 2009 to an intake of 170 in 2017. The Government is committed to further increasing this number in future years.</p> <p>In 2016 the HSE and the ICGP agreed in principle to transfer operational responsibility for GP training from the HSE NDTP unit to the ICGP and to restructure the organisation of training programmes so as to maximise efficiency and provide a basis for further expansion. Significant progress has been made in advancing implementation of these changes, though some practical matters are still in the process of being resolved by the HSE and the ICGP. Implementation of the a new SLA is dependent upon the cessation of the current arrangement for delivering GP Training within the HSE and this is subject to an ongoing process involving the WRC.</p> <p>Officials from the Department of Health and the HSE are working closely with the ICGP to put in place arrangements which will ensure that the future GP workforce needs, including GP training, are met. In addition, the GP contracts review process which is currently underway will seek to arrive at contractual arrangements which will ensure that general practice is an attractive, fulfilling and rewarding career option into the future.</p>
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		Secure email facility in place to support secure communication between GPs and hospital clinicians <i>Q4 2014</i>	HSE Primary Care	<b>RAG Status: <i>Green</i></b>  A secure e-mail solution called Healthmail went live on 10 November 2014. There is no cost to GPs to register or use a Healthmail account. The system allows GPs and their support staff to communicate patient identifiable clinical information securely with clinicians in primary and secondary care. Healthmail improves electronic communications to the benefit of patients and clinicians. The number of users has increased from 547 in November 2014 to 1,447 in February 2017. Over 100,000 secure emails were transmitted by Healthmail in 2016.
3.7	In the context of the Framework Agreement concerning the GMS/GP contract, and in line with the Programme for Government, the Working Group recommends that the GMS contract should reflect the needs of the patients, including <i>inter alia</i> the need to provide structured chronic disease management in primary care.	Introduction of new GP contract to provide for introduction of universal primary care <i>Q4 2014 (for under 6s)</i>	Department of Health/HSE Primary Care	<p><b>RAG Status: <i>Amber</i></b></p> <p>The development of a new, modernised contract for general practice is a priority for 2017. The effective prevention and management of chronic disease is one of the issues to be considered in the context of the development of a new GP contract.</p> <p>In recent years, agreements have been reached in relation to universal GP care without fees for all children under the age of 6 years and those aged over 70, a specific Diabetes Cycle of Care for adult patients with Type 2 Diabetes who hold either a medical card or a GP visit card, a new Rural Practice Support Framework and a revised list of special items of service that can be provided by GPs. The effect of these measures has been an increase in State funding to general practice, as well as improving services and accessibility for patients.</p> <p>The next phase of discussions on a new GP contract is under way. The Minister has put in place a process for further engagement with GP representatives which honours the Framework Agreement in place with the IMO and includes formal consultation between the State side and the National Association of General Practitioners (NAGP).</p> <p>The overall goal is to develop a new, modern contract for general practice – one that has a true population health focus, providing for health promotion, disease prevention, and for the structured, continuing care of chronic conditions.</p>

3.8	The Working Group notes HSE Mental Health Division's plans to address foundational issues within mental health services (HSE, 2014: 48) and recommends that this work should include appropriate consideration of the working environment and physical safety aspects.	Proposals developed and implemented <i>Q2 2015</i>	HSE Mental Health	<b>RAG Status: <i>Red</i></b>  A survey of OPD facilities is being undertaken to ensure panic buttons or their equivalent are available in all offices used by NCHDs.  The Mental Health Services were requested to arrange for a safety audit to be carried out in their area including remedial actions/timeframes for resolution and feedback the results of this audit. However response rate and detail was poor so the HSE are communicating again with locations to ensure that comprehensive timebound action plans are in place.  Update awaited.
3.9	In the context of HSE-MET's MWP project and the establishment of career planning supports, including the Medical Council and HSE careers websites, the Working Group recommends that outputs/projections from the MWP planning model are fed back through these and other media in order to provide greater clarity for medical students and trainees on opportunities for doctors in the health system on completion of specialist training.	Process developed and agreed <i>Q3 2015</i>	HSE-NDTTP	<b>RAG Status: <i>Green</i></b>  Upon completion and publication of the specialty based workforce plans, projections are posted on the medical careers website via the Forum.  Workforce planning reports are also circulated to the Medical Council, training bodies, and other relevant stakeholders for the specialty.  From March 2017, all posts approved at CAAC meetings are listed on the NDTTP website <a href="http://www.hse.ie/doctors">www.hse.ie/doctors</a> . This allows full transparency to NCHDs regarding upcoming jobs.  Data on expected specialty based retirements will be published on the medical careers website upon completion of the consultant database.  The Lead NCHD is well placed to further communicate workforce planning output to the wider NCHD community.

3.10	<p>The Working Group notes the work already commenced in relation to the development of mentoring supports and systems across all training programmes. The Group recommends that this work should continue and be expedited as part of the work programme of the multi-stakeholder retention steering group that that was established to address the recommendations of the December report. This work should also take cognisance of the HRB Review.</p>	Strategy and plan developed <i>Q1 2015</i>	Forum of Irish Postgraduate Medical Training Bodies	<p><b>RAG Status: <i>Amber</i></b></p> <p>Postgraduate training bodies are reviewing and updating their current mentoring strategies with a view to improving the mentoring programmes in place across the postgraduate training bodies.</p> <p>Currently many of the training colleges have systems in place to provide mentoring. This is voluntary in that the mentors are made known to the trainees, and the trainees may avail of mentoring support.</p> <p>The Forum is actively working with the National Lead NCHD and key stakeholders to explore options which will scope out options to better meet the mentoring needs of trainees.</p>
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## Annex 2      A consultant-delivered Paediatric Service Pilot Scheme

**University Hospital Waterford  
Paediatric Department**

**Business Case for Implementation of  
Consultant-delivered Paediatric Service Pilot  
Scheme**

**May 2016**

<b>Document Reference Number</b>		<b>Document Developed by</b>	<b>Dr N Goggin Dr A Das</b>
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# University Hospital Waterford

## Paediatric Department

### Business Case for Implementation of Consultant-delivered Paediatric Service Pilot Scheme

## 1. Proposal

The National Clinical Programme for Paediatrics and Neonatology, the HSE Acute Hospitals Division and National Doctors in Training Programme propose to pilot a consultant delivered service in University Hospital Waterford. This proposal is in line with the National Clinical Programme for Paediatrics and Neonatology Model of Care. It is consistent with the HSE Corporate Plan 2015-2017 goal to 'provide fair, equitable and timely access to quality, safe health services that people need'.

## 2. Introduction

### **2.1 Consultant Delivered Service**

The National Clinical Programme for Paediatrics and Neonatology document Review of Paediatrics and Neonatology Services and Framework for Future Development sets out a number of principles to underpin the future care of children and young people in Ireland, one of which is the enhancement of consultant delivered services. A consultant delivered service is a key element for delivering better patient care. In this model, the consultant paediatrician is clinically responsible for the care the patient receives. ***In essence it means that the consultant will either provide hands-on care or closely supervise, in the clinical setting, all aspects of the care received by the child.*** The successful implementation of a full consultant delivered service will require changes to current working practices and rosters and will require the consultant to NCHD ratio to be adjusted.

### **2.2 Key Features of a Consultant Delivered Service**

- The team of consultants will provide an active consultant presence throughout the day across all clinical work-streams.
- There is an active consultant presence for an extended period for acute assessments and admissions (during times of peak clinical activity), seven days per week
- Patients have early contact with a senior decision maker, with most children seen at time of admission (many seen and discharged in acute settings) and all seen within 8-10 hours of admission
- Regular reviews of children take place following admission – usually two per day
- Increased ambulatory care through the use of short stay observation units thus reducing the rate of admission
- There are adequate numbers of consultant general paediatricians to staff and provide flexibility
- Part-time or flexible working may be possible under this arrangement
- Improved ratio of trained to non-trained staff, i.e. 1:1 or 1:1.2 consultant to NCHD ratio
- Adequate trainee numbers, rosters and training opportunities
- Supporting roles for nurses and allied health care professionals are developed. This would include Clinical Nurse Specialists, Advance Nurse Practitioners and the extended role of the nurse in areas such as IV cannulation and phlebotomy.
- Consultant supervised handover, consultations and communications
- Improved links and integration with primary care (rapid access general paediatric clinics, telephone advice line and improved collaboration and networking with GPs and Primary Care services).



- Improved links and integration with community care services including Community Child Health Consultant Clinics.

### 3. Rationale

The Report of the National Task Force on Medical Staffing (Hanly Report) recommends a 'consultant-provided service' whereby consultants have a direct and substantial involvement in diagnosis, delivery of care and overall management of patients allowing important clinical decisions to be made faster and at a higher level. This model involves an improved ratio of consultants to non-consultant hospital doctors (NCHDs). The model will require a new type of team in which there are more consultants providing 'hands-on' care, a higher proportion of NCHDs on training programmes and more specialist nurses.

The provision of paediatric medical specialists is inadequate for the current population in Ireland. Current demand and activity is not reflected in the level of service development in recent years. The current National ratio of consultant to paediatric population is 15 per 100,000. International standards average at 29 per 100,000. It is a recommendation of the National Clinical Programme for Paediatrics and Neonatology and the Faculty of Paediatrics that the number of consultants increase to improve the consultant to paediatric population ratio. This was a recommendation of the Hanly Report also.

There are currently 3 Consultant Paediatricians, 8 Paediatric Registrars and 8 SHOs providing a service at University Hospital Waterford. The ratio of consultant to NCHD in Waterford is 1:5.3. The Clinical Programme recommends rebalancing this ratio, and a ratio of 1:1.2 is proposed for University Hospital Waterford.

The proposed model of service delivery will:

- Improve the ratio of trained to non-trained medical staff, decreasing the reliance on junior doctors
- Improve EWTD compliance

### 4. Model principles relating to University Hospital Waterford

#### 4.1 *Changes in Working Practices*

The paediatric consultant delivered service model will require a change in working practices in University Hospital Waterford to ensure that patients will have increased and earlier contact with a senior decision maker. There will be a significant increase in consultant numbers with a decrease in NCHD numbers to improve the ratio of consultants to NCHD's (Table 1) to reflect the new model of care to be provided.

The increase in consultant numbers would allow the following new initiatives and changes in consultant work practices to take place.

- **Short Stay Paediatric Assessment Unit**

The increase in consultant posts would allow the establishment of a short stay paediatric assessment unit which would be governed by a consultant throughout all the hours it is open.

It is expected that the short stay PAU will lead to a reduction in admissions to the inpatient ward and improve the patient and parent experience. A clinical area adjacent to the inpatient paediatric ward

has been identified and recently refurbished for this purpose. There is an ANP in Ambulatory paediatrics in the department who will be available to work in this Paediatric Assessment Unit

- **Outpatient Paediatric Services**

The increase in consultant posts would allow the introduction of:

1. Regular scheduled rapid access general paediatrics clinics (scheduled urgent outpatient clinics) Rapid access clinics are essential to ensure that children who need to be seen by a paediatrician quickly are appropriately 'fast-tracked', thereby avoiding referral by their GP to the emergency department.
2. The increase in consultant numbers will allow an increase in the number of general paediatric and special interest outpatient clinics held in UHW, thus reducing waiting times and reducing DNA rates.
3. Nurse-led (ANP, CNS) or therapy-led clinics may also have a role and will be encouraged.

- **Special interest Areas**

The increase in consultant posts would allow the team to build on the areas of special interest already developed in Waterford and to develop new areas of special interest. Examples of special interest areas would include neonatology, ambulatory care, community child health (including neurodisability), endocrinology (specifically diabetes mellitus), allergy and cardiology. Extended roles for nurses as clinical nurse specialists in areas such as diabetes mellitus and asthma would be developed.

- **Active Consultant Presence in all Clinical Areas.**

The increase in consultant posts would allow an active consultant presence in all areas throughout the working day. All consultants would participate across all clinical work-streams. Each clinical area will be populated by a consultant – Inpatient Paediatrics, NICU / SCBU. Paediatric Assessment Unit, OPD.

## **4.2 Paediatric Medical Staffing Changes**

- There will be an increased number of consultants, from 3 to 10 WTEs, providing an active consultant presence during times of peak clinical activity, seven days per week. This increase in consultant numbers will be phased in over a three year period.
- There will be a registrar on duty on site over the 24 hour period to ensure senior cover at all times for the level 2 NICU and acute paediatric emergencies. A minimum of seven registrars will be required for EWTD compliance. All should be on a training programme, however it is recognised that this may not be possible
- There will be five senior house officers (SHOs) in the NCHD complement, all of whom will be on a training programme
- Clinics will be mainly consultant-delivered to allow rotas to be adjusted to ensure EWTD compliance. However, allocation of NCHD's to clinics for training purposes will be incorporated into the rosters.
- NCHD rosters will be designed in line with evidenced peak service activity.
- Training opportunities will be provided outside the 9am to 5pm working hours
- Locums will only be used in exceptional circumstances and will not be used to cover annual leave or study leave
- Development of extended roles for nurses and allied health professionals will be encouraged

**Table 1: Proposed UHW Paediatric Medical Staffing Levels**

UHW Current Staffing Levels	Consultant Paediatric	Regist S	Total No V R
	3	8	8 19 1
Proposed New Staffing Le	10	7	5 21 1
Balance WTE	+7	-1	-3 +3

***Planned Medical Rosters for the new Model of Care are outlined in Appendix 1. These will be phased in incrementally as the additional consultants are appointed over the next three years.***

## **5. Paediatric Department UHW**

### **5.1 Current Services and Infrastructure**

The department of Paediatrics at University Hospital Waterford (UHW) provides secondary paediatric and level 2 neonatal inpatient care to hospital and primary and community services, in the South East to a population of over 460,000 across five counties. In the South East the percentage of the population in this area who live within levels of deprivation is an average 10.5% and the percentage living marginally below average is 59% (compared to national averages of 6% and 44% respectively). The paediatric ward has 29 inpatient beds and provides inpatient care for children up to 16 years of age. Four newly refurbished isolation rooms were opened on the ward in 2014. A clinical area adjacent to the inpatient paediatric ward has been identified and recently refurbished for the development of a Short-Stay Paediatric Assessment Unit.

A purpose built area in the hospital Emergency Department with Audio visual separation from adults has been developed for paediatric patients. Future staffing development within the Emergency Department should incorporate paediatric trained staff nurses to facilitate the paediatric area within that department.

UHW is also a designated shared care centre for children with Cystic Fibrosis (CF) and children with Cancer. There are three general paediatric OPDs per week and there are 2 diabetes clinics and 1 CF clinic per month.

Paediatric ENT, Ophthalmology and Orthopaedic services for the region are also available at UHW and a regional DDH service is also provided by the Orthopaedic department. General non-specialist paediatric surgery is also carried out at UHW. A Consultant Radiologist with special interest in paediatrics will be taking up post during 2016

The Central Remedial Clinic is located in a new purpose built facility on the grounds of UHW and provides a comprehensive regional multidisciplinary service for over 600 children with physical disabilities.

UHW provides a Regional Neonatal Intensive Care Service (Level 2) for the South East. A new purpose built Neonatal Intensive Care Unit (NICU)/Special Care Baby Unit (SCBU) was opened in

2013. There are 10 NICU and 10 SCBU beds. Full intensive care is provided for gestations of >28 weeks. In-utero transfers and out-born transfers are accepted from South Tipperary General Hospital, St Luke's General Hospital, Kilkenny and Wexford General Hospital. As per the National model of Care for Neonatal Services - Cork University Maternity Hospital (CUMH) is the designated tertiary (Level 3) neonatal unit for the region. CUMH provides support and clinical guidance for level II care at UHW which include responsibility for accepting transfers of expectant high risk antenatal mothers. All infants requiring therapeutic hypothermia for HIE are transferred to the tertiary unit. Care is provided in accordance with best evidence and clinical care guidelines have been adapted for local use to deliver care which reflects the current international standards of neonatal care.

University Hospital Waterford is a teaching hospital of University College Cork (UCC) and the Royal College of Surgeons in Ireland (RCSI). Paediatric SpR trainees, Paediatric BST, Emergency Department and General Practice SHO trainees and Undergraduate medical students from RCSI and UCC undergo their paediatric rotations in Waterford on an ongoing basis.

University Hospital Waterford also provides comprehensive emergency department, inpatient, day-case and outpatient services across the following specialties general medicine, general surgery, maternity, Trauma Orthopaedics, Ophthalmology, Neurology, Nephrology, Rheumatology, Urology, Vascular Surgery, ENT and Neonatology, Radiology, Pathology and Microbiology.

## 5.2 Current Paediatric Department Activity Data 2014/2015

Activity	2014	2015
<b>Annual ED Attendance 0-16 Years</b>	8062	8694
<b>Annual Deliveries</b>	2119	2039
<b>Admissions to SCBU</b>	419	384
<b>No Babies &lt;1500gms</b>	39	36
<b>Paeds ALOS</b>	2.1	2.0
<b>Paeds Acute Assessments (GP /ED referrals)</b>	2697	2367
<i>Same Day Discharge</i>	1037	954
<i>Overnight Stay</i>	1660	1413
<b>Admission Rate</b>	23%	19%
<b>General Paeds OPD Attendances New</b>	680	570
<b>General Paeds OPD Attendances Review</b>	3165	3254
<b>Cystic Fibrosis</b>	73	73
<b>Diabetes Mellitus</b>	136	191
<b>Neuro-disability</b>	422	287*
<b>OPD Waiting Time Urgent</b>	1-2 weeks	1-2 weeks
<b>OPD Waiting Time Soon</b>	6-8 weeks	3 months
<b>OPD Waiting Time Routine</b>	6 months	7 months
<b>Paeds Medical Day Case Investigations</b>		814

\*Reduction in Neuro-Disability numbers was due to reduced sessions as a result of increased clinical inpatient workload in 2016.

Table 2 identifies the total number of paediatric ‘admissions’ by referral source. The table also identifies the breakdown of overnight stays and same day discharges.

**Table 2: UHW Paeds Acute Assessments (GP /ED Referrals) 2015**

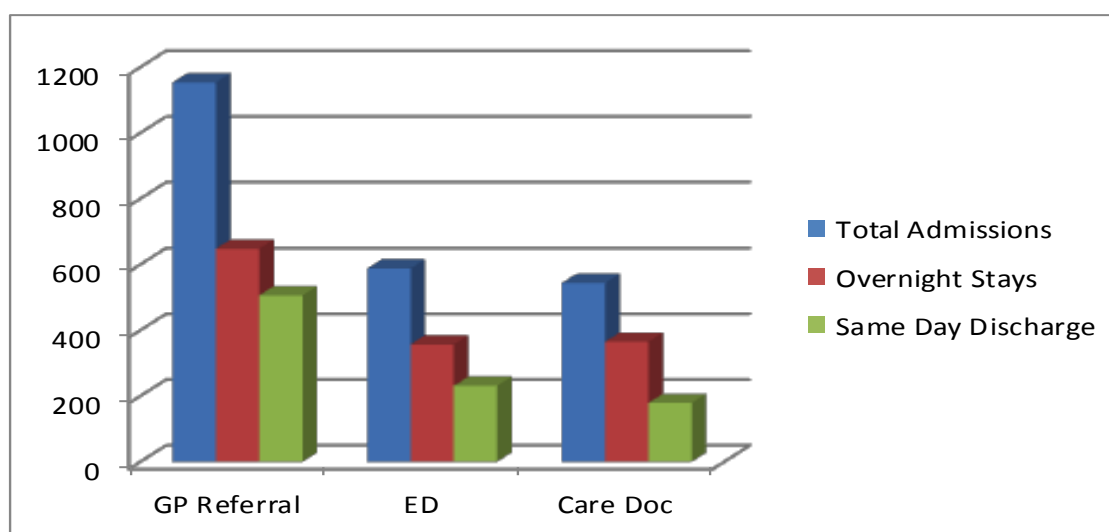
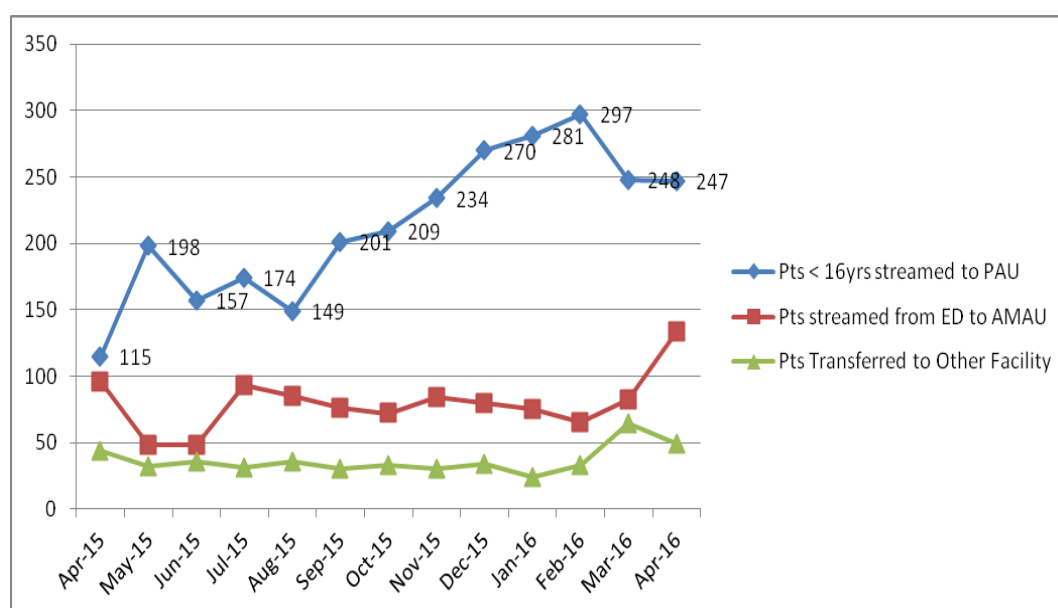
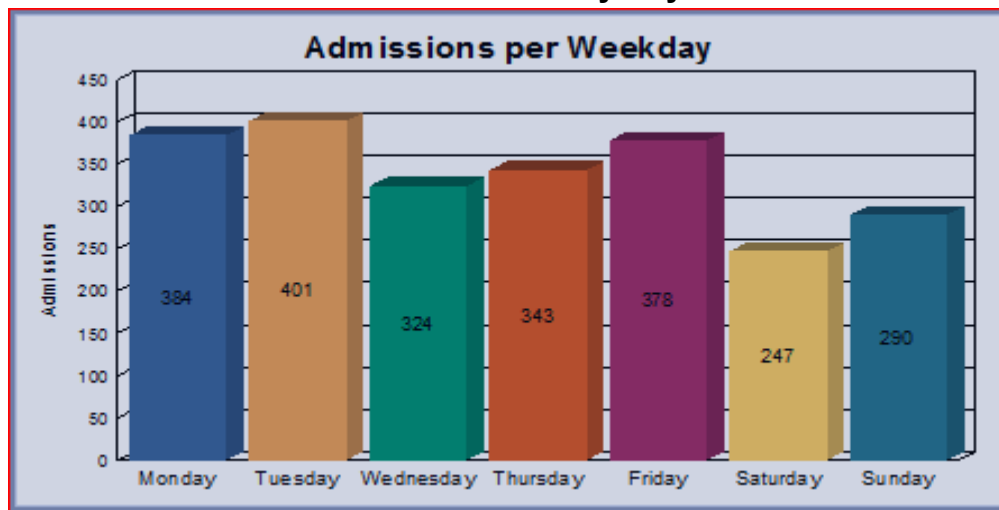


Table 3 identifies the number of patients referred from GPs and ED to the Paediatric Assessment Area from January 2015 to March 2016. Of note the new GP contact for free GP care to 0-6 children was introduced in August 2015 which has coincided with an increase in the number of paediatric referrals. The numbers of Paediatric patients streamed from ED for Paediatric Assessment is far greater than the numbers of General Medical Patients referred to MAU.

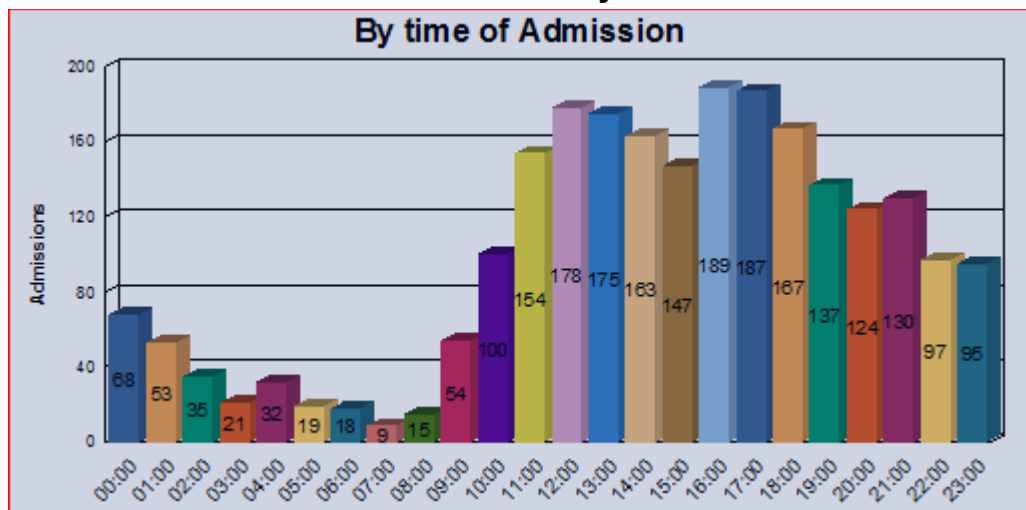
**Table 3: Comparison GP / ED Referrals to PAU and Adult General Medicine Referrals to AMAU. April 2015 – April 2016**



**Table 4: Paediatric Admissions 2015 by Day of Week**



**Table 5: Paediatric Admissions 2015 by Time of Admission**



## 6. Anticipated Benefits of the Consultant Delivered Model of Care for Paediatric Services in UHW

The anticipated benefits of the proposed consultant delivered model of care include;

1. Enhances safety, quality of care and patient experience
2. Significant reduction in acute overnight admissions
3. Decreased length of stay
4. Reduction in investigations (e.g. laboratory, radiology) leading to reduction in associated costs
5. Increased ambulatory care activity
6. Enhanced outpatient clinic service (more timely assessment in rapid access clinics and reduced routine OPD waiting times)
7. Consultant capacity to develop special interests for non-acute care
8. Improved staff satisfaction
9. Improved service delivery to referrers (primary care, community care, other UHW departments)
10. Part time work could be facilitated
11. Improved NCHD training experience and defined career pathways.

12. EWTD compliance
13. Reduced Consultant and NCHD locum costs.

## 7. Key Performance Indicators / Outcomes

A number of key performance indicators (KPI's)/outcomes have been identified, against which success of the delivery of the pilot consultant delivered model of care for paediatric services will be measured. The KPI's are as follows;

1. Enhanced safety, quality of care and patient experience
  - a) Reduction of waiting time for OPD appointments
  - b) Increased ambulatory care activity
  - c) Reported critical and near-miss incidents
  - d) Feedback from children and parents / carers
  - e) Feedback from referrers
  - f) Documented hand over sessions
2. A reduction in acute overnight admissions
3. Decreased length of stay
4. Reduction in investigations (laboratory, radiology and others)
5. Reduction in investigation and medication costs.
6. Improved consultant capacity to develop special interests for non-acute care
7. Improved staff satisfaction
8. Improved training experience for NCHD's
9. EWTD compliance rates
10. Reduced Consultant and NCHD locum costs

## 8. Costs and Expenditure Efficiencies Arising from New Service Model

Tables 6 & 7 below identify costs of additional posts and planned expenditure reductions resulting from a reduction in NCHD posts by 4 WTE, a resultant reduction in NCHD overtime and a reduction in Consultant Locum Costs due to reconfigured working rosters.

The total planned expenditure savings are **-€698,503** and the total overall cost over a period of 3 years is **€986,894**.

### 2016/2017 Consultant Pay Costs Only

Post	Unit	Cost	Cost
Consultant Paediatrician	€166,63	€124,97	€499,90
<b>Pay Cost</b>		<b>€124,97</b>	<b>€499,90</b>
<b>Expend Reduction</b>			
Less Consultant Locum Costs	-€166,63	-€41,65	-€166,63
Consultant Rest Day Savings		-€19,50	-€78,00
<b>Total Expend Reduction</b>		<b>-€61,15</b>	<b>-€244,63</b>
<b>Total</b>		<b>€15,95</b>	<b>€255,27</b>

### 2016 / 2017 Total Costs

Post	Unit	Cost	Cost
Consultant Paediatrician	€166,63	€124,97	€499,90
Consultant Secretary	€33,89	€16,94	€67,78
Ambulatory Care Ward Clerk	€33,89	€8,47	€33,89
Staff Nurse	€50,00	€31,25	€125,00
CNM2	€55,85	€13,96	€55,85
<b>Pay Cost</b>		<b>€195,60</b>	<b>€782,42</b>
<b>Expend Reduction</b>			
Less Consultant Locum Costs	-€166,63	-€41,65	-€166,63
Consultant Rest Day Savings		-€19,50	-€78,00
<b>Total Expend Reduction</b>		<b>-€61,15</b>	<b>-€244,63</b>
<b>Total</b>		<b>€134,44</b>	<b>€537,79</b>

### Overall Costs – 3 Year Plan

Post	Unit	Total
Consultant Paediatrician	€166,63	€1,166,43
Consultant Secretary	€33,89	€67,78
Ambulatory Care Ward Clerk	€33,89	€33,89
CNM2	€55,85	€55,85
Staff Nurse	€50,00	€250,00
CNS Diabetes	€55,85	€55,85
CNS Asthma	€55,58	€55,58
<b>Pay Cost</b>		<b>€1,685,39</b>
<b>Expenditure Reduction</b>		
Less SHO posts x3	€58,37	-€175,11
Less Registrar Post x 1	€81,74	-€81,74
Less Cons Loc / Agency Costs	€166,63	-€166,63
Less Reduction NCHD OT		-€50,00
Consultant Rest Day Savings		-€78,00
Reduction cost of NICU Care*		-€147,00
<b>Total Expend Reduction</b>		<b>-€698,50</b>
<b>Total Cost</b>		<b>€986,89</b>

\*Reduction Cost of 15 babies (VLBW) per year.



## 9. Project Governance

A Project Steering Group will be set up to direct and monitor the progress of the project. The Steering Group will consist of the National Clinical Advisor and Group Lead for the Acute Hospitals Division, Director of the National Doctors Training and Planning, the National Clinical Programme for Paediatrics and Neonatology Clinical Leads and Programme Manager and representatives from University Hospital Waterford and the South/southwest Hospital Group.

The project sponsor with responsibility for overall project sign off at key stages of implementation will be the National Clinical Advisor and Group Lead for the Acute Hospitals Division.

A local project management team will be established to manage project implementation and report to the National Clinical Programme for Paediatrics and Neonatology and the Acute Hospitals Division on a regular basis.

The Local Project Team membership will consist of:

- **Chairperson** – Lead Consultants Paediatrician
- **Members**
  - Project Manager / Business Manager
  - Clinical Director Women and Children's Directorate (When post established)
  - Consultant Paediatrician
  - ANP for Ambulatory Care
  - CNM III for Paediatrics and Neonates
  - CNM II for General Paediatrics
  - HSCP Representative
  - Hospital Operations Manager
  - Hospital Medical Manpower Manager
  - ED Representative
  - Primary Care Representative

\* Recruitment of a local project manager / business manager will be key to ensuring successful planning, implementation and evaluation of the project.

## 10. Project Evaluation

The project will be evaluated by assessing the KPI's using hospital level data and pre and post intervention type questionnaires. Evaluation will be carried out in conjunction with members of the MDT from the Paediatric Department in UHW as well as trainees, GP's, patient representatives and those responsible for the compilation and management of unit level data on patient length of stay, admission rates, OPD waiting times, staffing requirements etc. The local Project Manager / Business Manager will ensure KPI's are mapped throughout the process.

A pre-intervention analysis of the Paediatric Service in UHW can be carried out using baseline data prior to the introduction of the pilot of the Consultant delivered service.

Many of the KPI's (see section 7) can be measured using a pre and post intervention questionnaire, which would rate quality and safety, patient and parent/carer satisfaction with care, staff satisfaction, referrer satisfaction with care, training experience, consultant capacity to develop special interests. Hospital data can be used to measure changes in overnight admission rates, changes in patient length of stay, changes in numbers of investigations performed and associated cost savings, EWTD compliance and NCHD vacancy rates.

## Appendix 1 - Proposed New Rosters for Additional Paediatric Consultants

- I. 6
- II. 9
- III. 10

### (i) Proposed New Roster for 6 Paediatric Consultants

		<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>	<b>Saturday</b>	<b>Sunday</b>
<b>Consultant 1</b>	AM	Paeds IPs	Paeds IPs	Paeds IPs	Paeds IPs	Paeds IPs		
	PM	Paeds IPs	Admin	Paeds IPs	CPD	Paeds IPs	OFF	OFF
	Call	<b>On Call</b>						
<b>Consultant 2</b>	AM	OPD-Gen	OPD-Gen	Rapid Access	OPD-SI			
	PM	Admin	Admin	CPD	Admin	OPD-Gen	OFF	OFF
	Call		<b>On Call</b>					
<b>Consultant 3</b>	AM	NICU IPs	NICU IPs	NICU IPs	NICU IPs	NICU IPs		
	PM	NICU IPs	Admin	NICU IPs	CPD	Admin	OFF	OFF
	Call			<b>On Call</b>				
<b>Consultant 4</b>	AM	Rapid Acce	OPD-SI	PAU	PAU	PAU		
	PM	Admin	PAU	CPD	PAU	Admin	OFF	OFF
	Call				<b>On Call</b>			
<b>Consultant 5</b>	AM	PAU	PAU	OPD-SI	OPD-Gen	CPD		
	PM	PAU	Admin	PAU	Admin	PAU		
	Call					<b>On Call</b>	<b>On Call</b>	<b>On Call</b>
<b>Consultant 6</b>	AM							
	PM	Leave	Leave	Leave	Leave	Leave	Leave	Leave
	Call							

**AM: 08:30-12:30**

**PM: 12:30-16:30**

**Call: 16:30-08:30**

**(ii) Proposed New Roster for 9 Paediatric Consultants**

		<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>	<b>Saturday</b>	<b>Sunday</b>
<b>Consultant 1</b>	AM	Paeds IPs	Paeds IPs	Paeds IPs	Paeds IPs	Paeds IPs	OFF	OFF
	PM		Admin	Paeds IPs	CPD	Paeds IPs		
	Evening	PAU						
	Call	<b>On Call</b>						
<b>Consultant 2</b>	AM	PAU	Admin PAU <b>On Call</b>	OPD-GEN CPD	PAU Paeds IPs	Admin PAU	OFF	OFF
	PM	PAU						
	Evening							
	Call							
<b>Consultant 3</b>	AM	Rapid Access	Admin Paeds IPs	Admin PAU <b>On Call</b>	Admin OPD-Gen	PAU CPD	OFF	OFF
	PM	Paeds IPs						
	Evening							
	Call							
<b>Consultant 4</b>	AM	NICU IPs	NICU IPs NICU IPs	CPD OPD-SI	Admin PAU <b>On Call</b>	NICU IPs NICU IPs	OFF	OFF
	PM	NICU IPs						
	Evening							
	Call							
<b>Consultant 5</b>	AM	OPD-Gen	OPD-SI CPD	NICU IPs NICU IPs	NICU IPs NICU IPs	Admin PAU <b>On Call</b>	OFF	OFF
	PM	Admin						
	Evening							
	Call							
<b>Consultant 6</b>	AM	OPD-SI	OPD-Gen Admin	PAU PAU	CPD PAU	Rapid Access Admin	<b>On Call</b>	<b>On Call</b>
	PM	Admin						
	Evening							
	Call							
<b>Consultant 7</b>	AM	Admin CPD	PAU PAU	Rapid Access	OPD-SI OPD-SI	OPD-Gen Admin	OFF	OFF
	PM							
	Evening							
	Call							
<b>Consultant 8</b>	AM	Leave	Leave	Leave	Leave	Leave	Leave	Leave
	PM							
	Evening							
	Call							
<b>Consultant 9</b>	AM	Leave	Leave	Leave	Leave	Leave	Leave	Leave
	PM							
	Evening							
	Call							

**AM: 08:30-12:30**

**PM: 12:30-16:30**

**Evening: 16:30-20:30**

### (iii) Proposed New Roster for 10 Paediatric Consultants

		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
<b>Consultant 1</b>	AM	Paeds IPs	Paeds IPs	Paeds IPs	Paeds IPs	Paeds IPs	OFF	OFF
	PM	PAU On Call	Admin	Paeds IPs	CPD	Paeds IPs		
	Evening							
	Call							
<b>Consultant 2</b>	AM	PAU	Admin PAU On Call	OPD-GEN CPD	PAU Paeds IPs	Admin PAU	OFF	OFF
	PM	PAU						
	Evening							
	Call							
<b>Consultant 3</b>	AM	Rapid Acce Paeds IPs	Admin Paeds IPs	Admin PAU On Call	Admin OPD-Gen	PAU CPD	OFF	OFF
	PM							
	Evening							
	Call							
<b>Consultant 4</b>	AM	NICU IPs	NICU IPs NICU IPs	CPD OPD-SI	Admin PAU On Call	NICU IPs NICU IPs	OFF	OFF
	PM	NICU IPs						
	Evening							
	Call							
<b>Consultant 5</b>	AM	OPD-Gen Admin	OPD-SI CPD	NICU IPs NICU IPs	NICU IPs NICU IPs	Admin PAU On Call	OFF	OFF
	PM							
	Evening							
	Call							
<b>Consultant 6</b>	AM	OPD-SI Admin	OPD-Gen Admin	PAU PAU	CPD PAU	Rapid Ac Admin	On Call	PAU PAU
	PM							
	Evening							
	Call							
<b>Consultant 7</b>	AM	Admin CPD	PAU	Rapid Access OPD-Gen	OPD-SI OPD-SI	Admin Admin	PAU PAU	On Call
	PM							
	Evening							
	Call							
<b>Consultant 8</b>	AM	Admin Admin	CPD PAU	OPD-SI OPD-SI	Rapid Acces PAU	OPD-Ge Admin	OFF	OFF
	PM							
	Evening							
	Call							
<b>Consultant 9</b>	AM	Leave	Leave	Leave	Leave	Leave	Leave	Leave
	PM							
	Evening							
	Call							
<b>Consultant 10</b>	AM	Leave	Leave	Leave	Leave	Leave	Leave	Leave
	PM							
	Evening							
	Call							

**AM: 08:30-12:30**

**PM: 12:30-16:30**

**Evening: 16:30-20:30**

## Appendix 2 - Proposed Project Timeline

	2016				2017				2018			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Principles sign off by NCPP, NCAGL AHD and NDTP Director												
UHW develop project/business plan developed to include sign on clear measureable KPIs												
Steering Group Set Up												
Complete job descriptions, statement of need and submit to CAAC												
Stakeholder engagement												
Proceed with recruitment of consultant posts once CAAC approved												
Submit to HSE Service Plan for funding for continuation of project												
Plan to reduce two NCHD posts to take effect in 2017												
RCPI to carry out hospital inspection so that additional trainees could commence Q1 2017												
First 3 consultants in post												
Complete job descriptions, statement of need and submit to CAAC for another 3 consultant posts												
Proceed with recruitment of consultant posts once CAAC approved												
Second 3 consultants take up post												
Plan to reduce a further two NCHD posts to take effect in 2018												
Submit to HSE Service Plan for funding for continuation of project												
Complete job description, statement of need and submit to CAAC for final consultant post												
Final consultant post in place												
Project Implementation and monitoring												

	2016				2017				2018			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Project Evaluation												
Final Project Report												