

STRATEGIC REVIEW OF  
MEDICAL TRAINING AND CAREER STRUCTURE

FINAL REPORT

DEPARTMENT OF HEALTH

30<sup>TH</sup> JUNE 2014



# STRATEGIC REVIEW OF MEDICAL TRAINING AND CAREER STRUCTURE

## FINAL REPORT

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## EXECUTIVE SUMMARY

### 1. Background

*Future Health: A Strategic Framework for Reform of the Health Service 2012-2015* (DoH, 2012) sets out the main healthcare reforms that will be introduced in the coming years. *Future Health* is about prioritising the needs of the patient, even as difficult decisions on health financing are made. This will involve moving towards a health service that provides access to care based on need rather than income, underpinned by a constant focus on health and well-being, a stronger primary care sector, a restructured hospital sector, and a more integrated social care sector, as well as a more transparent ‘money follows the patient’ system of funding, supported ultimately by Universal Health Insurance.

The Reform Programme will have to be delivered against a backdrop of extremely challenging economic and fiscal conditions for the State in general and the health services in particular.

It is against this backdrop that the Minister for Health decided, in July 2013, to establish a Working Group, chaired by Professor Brian MacCraith, President of DCU, to carry out a strategic review of medical training and career structure.

The Working Group will examine and make 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 full Terms of Reference for the Strategic Review and membership of the Working Group are set out in Sections 1.2 and 1.3 of this report respectively.

### 2. Focus of this Report

From May-June 2014, the Working Group considered issues including strategic workforce planning, and career planning and mentoring supports. It also examined issues relating to the specialties of public health medicine, general practice and the community-related aspects of psychiatry, in addition to exploring issues relating to career pathways and structures for doctors in non-training posts who have not completed specialist training.

### 3. Working Group Meetings and Stakeholder Consultation

The Working Group met on five occasions and also held consultation meetings with stakeholders including trainee doctors and the relevant training bodies. The Chair and members of the

Working Group would like to express their sincere thanks to all those who attended consultation meetings for their time, helpful inputs and positive engagement.

#### **4. Conclusions and Recommendations**

##### *4.1 Strategic Medical Workforce Planning*

As stated in the Working Group's April report (p.45), the Group wishes to reaffirm the public policy aim of a Consultant-provided service, i.e. 'a service delivered by teams of Consultants, where the Consultants have a substantial and direct involvement in the diagnosis, delivery of care and overall management of patients' (National Task Force on Medical Staffing, 2003: 43), and notes and welcomes the on-going efforts to increase Consultant numbers in order to achieve this public policy aim.

The Working Group also welcomes related efforts to increase the number of NCHD training posts over time in order to maximise the number of training posts and minimise posts outside specialist training schemes.

The Group notes and welcomes the expanded role of HSE-MET and considers that the centralisation of the functions of medical workforce planning, medical education and training, and the processing of new/replacement Consultant posts will facilitate a more efficient and integrated approach to medical workforce planning for the public health system. It also provides an opportunity to review the current multi-step Consultant appointment process, which the Working Group notes with concern, and considers both unwieldy and inefficient.

In the context of a Consultant-provided service and the extended working day, the Working Group acknowledges that a critical mass of Consultants is required at a given clinical site. A Consultant-provided model of care consists of a greater number of Consultants providing care over an extended 7-days per week, with a single tier of NCHDs on call. In this regard, the Working Group notes the recently approved Paediatric Care pilot, initiated by HSE-MET in collaboration with clinicians in Sligo Regional Hospital. This project will involve a team of 9-10 Consultant Paediatricians delivering first-line care during an extended 8.00 a.m.-10.00 p.m. day, on a 7-day per week basis and 9 NCHDs on an EWTD compliant roster.. The outcomes of this pilot project will be of assistance in informing further development of the Consultant-provided service model and support the implementation of the recommendations of the Working Group's previous report in relation to Consultant career structures and pathways upon completion of specialist training.

With regard to existing deficits in strategic medical workforce planning, which were clearly identified during consultations with stakeholders, the Working Group notes that this has had a number of impacts including:

- Lack of clarity on opportunities for doctors in the public health system on completion of specialist training;
- Limited matching of Consultant posts to emerging service needs and requirements;
- A largely static approach to trainee intake, which has not necessarily matched training intakes to future service requirements.

In this regard, and as noted in the Group's April (p.5), the Working Group welcomes HSE-MET's work to develop a medical workforce planning model to support strategic workforce planning in the future. The Group wishes to highlight a number of key policy and operational developments, which should inform the development of the methodology and tool notably:

- The planned reconfiguration of health services, including establishment of the Hospital Groups and community care organisations;<sup>1</sup>
- The development of integrated models of care and the establishment and roll-out of the Clinical Care programmes;
- The development, in line with models of care, of advanced nursing and other professional practice, and the potential for further expansion of same to contribute to an appropriate skill mix;
- Current patient safety and quality improvement initiatives;
- The legal requirement to maintain professional competence (in line with the continuing professional development [CPD] schemes accredited by the Medical Council and delivered by the training bodies).

The Group considers that the MWP model will provide a number of benefits including:

- Greater clarity in relation to future opportunities for medical graduates within the public health system;
- A more dynamic approach to trainee intake, based on emerging service needs and requirements, led by HSE-MET in collaboration with the training bodies.

It also offers the potential for the development of a sustainable approach to prioritisation and pre-approval of posts on a multi-year basis. However, for the model to operate optimally, planned strategic configuration of services will be an important element.

Finally, the Working Group wishes to acknowledge that, currently, there are in the region of 1,200 doctors working in the Irish public health system in non-specialist, non-training posts, notably in the acute hospital and community health sectors. The Group recognises that these doctors represent an important resource for the healthcare system and notes that, at present, there is lack of clarity around the career structure and role of these doctors. The Group considers it important that their role and work is appropriately structured in the future.

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<sup>1</sup> See Chapter 3 of *Report on Medical Career Structures and Pathways Following Completion of Specialist Training* (April 2014) for further detail.

Taking into account the above, the Working Group wishes to make the following recommendations in relation to medical workforce planning.

1. In the context of the current and future needs of the health system and Action 46 of *Future Health* (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 *inter alia* strategic medical workforce planning on a cross-sectoral basis. This structure should link with any structures established by HSE-MET in the context of the MWP model being developed by the MWP Project.
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.
3. 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.
4. The Working Group recognises that, currently, there are in the region of 900 doctors in service posts in the acute hospital sector and 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:
  - The needs and requirements of the public health system, including service reconfiguration and integrated models of care;
  - Patient safety and quality of the patient experience;
  - Registration, qualifications and training, clinical governance, CPD and supervisory arrangements.

In addition, with regard to any future consideration by the Department of Health and the HSE of roles in the public health system for doctors who have not completed specialist training and are in non-training posts, the Working Group recommends that the following be taken into account:

- The needs and requirements of the public health system;
- The features of such roles and the features of the system within which such roles would operate (including registration, qualifications and training, clinical governance, CPD and supervisory arrangements);
- Patient safety and quality of the patient experience;
- Standardisation of roles aligned to a clear career pathway;

- Criteria and qualifications for such roles;
- Interface with training pathway to facilitate temporary exit from specialist training and subsequent re-entry as appropriate;
- The further development and expansion, in line with emerging models of care and service requirements, of specialist and advanced nursing/midwifery and other clinical roles which can contribute to an appropriate skill mix and enable clinicians to practice to the optimum of their educational preparation.

#### *4.2 Public Health Medicine*

The Working Group acknowledges that public health medicine is a key component for planning the Irish health service. It notes that, as with other specialties, as the health system evolves, the role of the public health specialist is also evolving. For example, the direct input from public health medicine into the Clinical Care Programmes has recently been formalised through new roles and structures, and this represents a practical step towards achieving service integration and implementation of evidence-based models of care.

As with other specialties, the Working Group recognises that the nature and composition the public health doctor's work is likely to change over time as their career progresses, with opportunities for progression and personal development existing in areas including:

- Public health service provision;
- Public health leadership and management;
- Research, training and academia.

The Working Group considers that a broad range of activities and skills are required for the public health doctor to provide the expertise to deliver on *Future Health* (DoH, 2012) and *Healthy Ireland* (DoH, 2013), in addition to other roles that may emerge during the health reform process, notably in relation to patient outcome-based healthcare delivery systems and health economics in the context of healthcare commissioning. In this regard, the Group takes the view that the public health role should encompass activities relating to the following:

- Management and delivery of health protection services;
- Research methods and critical appraisal tools, including health needs assessment, health impact assessment and health technology assessment;
- Patient safety and clinical effectiveness;
- Health promotion and improvement;
- Health service planning, commissioning and quality assurance;
- Health intelligence and health information management.

With regard to the training of public health specialists, the Group considers that the model of training should keep pace with the needs of the system and considers it important that the learning environments included in the training scheme should provide adequate exposure to the broad spectrum of public health activities in order to ensure that the balance of skills at the end of specialist training reflects service requirements at both national and regional levels. In this regard, the Group notes the demographic profile of public health specialists and considers that it represents a significant risk to maintaining the viability of the training scheme and also limits opportunities for expansion of the training scheme in the near future.

The Working Group also notes with concern vacant training posts on the public health training scheme and takes the view that the status of the specialty and limited exposure to public health medicine at undergraduate level are both factors in this regard.

Taking into account, the Working Group wishes to make the following recommendation in relation to public health medicine.

5. In the context of Action 46 of *Future Health* (DoH, 2012), *Healthy Ireland* (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:
  - The current and future role of the public health specialist in Ireland, including the appropriate skill mix in relation to public health functions;
  - The attractiveness of public health medicine as a career option;
  - The curriculum and content of the specialist training scheme, and associated administrative arrangements relating to the rotation of trainees around the system;
  - Any requirement for post-CSCST sub-specialisation;
  - 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;
  - Measures to enhance the awareness of public health medicine as a career option at undergraduate level and during the Intern year.

#### *4.3 General Practice*

The Working Group recognises the pivotal role of the GP as the first point of contact for most of the population with the health system. It further recognises that, in the context of *Future Health* (DoH, 2012) and Universal Health Insurance (UHI), the landscape for GPs is changing significantly.

In view of the demographic profile of GPs in Ireland, and the likelihood that significant numbers of GPs will retire in the coming years, the Working Group welcomes the recent Framework Agreement between the Minister for Health and the IMO in relation to engagement concerning

the GMS/GP contract and other publicly funded contracts involving GPs. It considers that this framework provides the mechanism to consider and address many of the issues identified by trainees in the consultation meetings.

The Group notes the feedback from trainees in relation to current barriers to the establishment of practices on completion of specialist training and preferences for patterns of work in the future. In view of the importance of building a robust primary care sector as the cornerstone of a reformed health system, the Group considers that these issues merit further investigation by the appropriate parties.

The Working Group also notes the comments of trainees regarding challenges in timely access to diagnostic results. The Group considers that continued enhancement of Healthlink capacity in order to increase the number and range of messages flowing between GP practices and acute hospitals is important in this regard.

Finally, the Working Group notes that the draft contract for the provision of services to all children aged under 6 published by the HSE on 31<sup>st</sup> January 2014 proposes that the scope of services should not be limited to diagnosis and treatment, but should also include participation in active health promotion, disease surveillance, prevention and appropriate management of chronic conditions. The Working Group supports this approach and would wish to see this apply to the GMS contract.

Taking into account the above, the Working Group wishes to make the following recommendations in relation to general practice.

6. 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 include exploration of the following:
  - Introduction of GMS contracts that allow for flexible working;
  - Measures to encourage newly qualified GPs to remain in Ireland at the end of training.
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 *inter alia* the need to provide structured chronic disease management in primary care.

#### 4.4 Psychiatry

The Working Group recognises the central role played by Consultant psychiatrists in the delivery of mental health services in both the acute and community-based settings. In this regard, it considers that the recommendations previously made in relation to medical career structures and

pathways following completion of specialist training will assist in addressing the recruitment and retention issues being experienced by the specialty.<sup>2</sup> The Group does, however, note the particular challenges posed by the working environment for clinicians and, in particular, the physical safety concerns raised by trainees.

With regard to the CMHTs, the Group notes the issues raised by trainees in relation to current challenges in transferring resource from the institutional setting to the community-based setting in line with the *A Vision for Change* recommendations. It further notes the impact of non-filling of vacant CMHT therapy and nursing posts on clinician morale. While outside the Terms of Reference of this Review, and recognising the investment in community mental health services in recent years, these issues are a matter of concern from a recruitment and retention perspective and require further examination by the relevant parties. Forthcoming work by the Department of Health and the HSE in relation to Action 46 of *Future Health* (DoH, 2012) is relevant in this regard.

Finally, the Working Group recognises that there are specific challenges in recruiting trainees to the specialty training programme and welcomes the efforts of HSE-MET and the College of Psychiatrists in Ireland to raise the profile of psychiatry as a specialty.

Taking into account the above, and having due regard to recommendations previously made by the Working Group in relation to career structures and pathways following completion of specialist training, the Group wishes to make the following recommendation in relation to psychiatry.

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.

#### *4.5 Career Planning and Mentoring Supports*

The Working Group recognises that, historically, career planning information for medical students and trainee doctors has been limited. The Working Group, therefore, welcomes the work that has been undertaken in this regard by the Forum of Irish Postgraduate Medical Training Bodies, HSE-MET, the training bodies and the Medical Council. The Group welcomes the specialty-specific/cohort-specific initiatives outlined in Section 6.2.1, and sees the potential to develop further joint initiatives, such as National Medical Careers Day, as such initiatives are a 'one-stop-shop' for medical students and trainees.

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<sup>2</sup> See recommendations of *Report on Medical Career Structures and Pathways Following Completion of Specialist Training* (April 2014).

With regard to mentoring, the Working Group notes the conclusion of the HRB Review that ‘mentoring is an important influence on personal development, career guidance, and career choice and research productivity’ and, in this context welcomes the work that has been undertaken by the training bodies in response to trainee feedback.

Taking into account the above, the Group wishes to make the following recommendations in relation to career planning and mentoring supports.

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.
10. 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.

#### 4.6 Implementing the Recommendations of the Final Report

To advance the implementation of the recommendations of this report, the Working Group has prepared the following high level implementation plan, which includes key deliverables and suggested dates for implementation of all recommendations, in addition to indicative lists of the parties responsible for their successful delivery.

	RECOMMENDATION	RELEVANT PARTIES	KEY DELIVERABLES	TARGET DATE
STRATEGIC MEDICAL WORKFORCE PLANNING				
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	Department of Health  Other Government Departments  HSE	Proposals for structure developed by Department of Health in consultation with other relevant parties	Q4 2014

	<i>inter alia</i> strategic medical workforce planning on a cross-sectoral basis. This structure should link with any structures established by HSE-MET in the context of the MWP model being developed by the MWP Project.	HEA	Structure established	Q1 2015
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.	HSE	Resource needs identified and action taken	Q3 2014
3	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.	HSE-MET	Proposals developed in consultation with other relevant parties	Q4 2014
			Proposals implemented	Q2 2015
4	The Working Group recognises that, currently, there are in the region of 900 doctors in service posts in the acute hospital sector and 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: <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>	HSE	Proposals developed	Q4 2014
			Proposals implemented	Q2 2015

PUBLIC HEALTH MEDICINE

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>Department of Health HSE Faculty of Public Health Medicine</p>	Working Group established	Q3 2014
			Report finalised and submitted to Minister	Q2 2015

GENERAL PRACTICE

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>	<p>Department of Health HSE Staff associations</p>	Agreement on introduction of flexible GMS GP contracts	Q4 2014
		<p>Department of Health</p>	Relevant parties to consider in	To commence

	<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>	HSE Staff associations	context of discussions on new GMSGP contract	by Q4 2014
		HSE	Secure email facility in place to support secure communication between GPs and hospital clinicians	Q4 2014
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.	Department of Health HSE Staff associations	Introduction of new GP contract to provide for introduction of universal primary care	Q4 2014 (for under 6s)
<b>PSYCHIATRY</b>				
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.	HSE	Proposals developed and implemented	Q2 2015
<b>CAREER PLANNING AND MENTORING SUPPORTS</b>				
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.	HSE Medical Council Training bodies	Process developed and agreed	Q3 2015

10	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.	HSE  Training Bodies	Strategy and plan developed	Q1 2015
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## 5. Progress in Implementing Recommendations of Previous Reports

In order to support progress in implementing the recommendations of the previous Strategic Review reports, published in December 2013 and April 2014 respectively, the Working Group sought an update from the relevant parties on developments during the January-June 2014 period. These are set out in detail in Appendix One.

With regard to the interim report (December 2013), the recommendations are being taken forward through the HSE System Reform Group. In relation to the report on career structures and pathways on completion of specialist training (April 2014), the recommendations are being progressed through a number of structures/processes, as appropriate.

## 6. Monitoring Implementation and Assessing the Impact

The Working Group acknowledges 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.

The Group warmly welcomes the progress that has been made to date in advancing the recommendations of previous reports and recognises 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.

In this context, the Group recommends that:

- As a matter of priority, the Department of Health and HSE jointly agree and put in place appropriate multi-stakeholder arrangements to oversee continued implementation of the recommendations of the Review;
- NCHD and Consultant retention rates in the public health system are reported on a quarterly basis through the *Health Service Performance Assurance Report*;
- Six monthly implementation reports are submitted to the Minister for Health, and subsequently published.

It further considers it important that the impact of the measures proposed is regularly assessed. To do this, both lead and lag indicators will be required. The Working Group notes that a number of valuable data sources and research instruments exist within the system which would assist in this regard, including the following:

- HSE-MET'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;
- Annual surveys undertaken by the training bodies.

# 1 INTRODUCTION

## 1.1 Background

*Future Health: A Strategic Framework for Reform of the Health Service 2012-2015* (DoH, 2012) sets out the main healthcare reforms that will be introduced in the coming years. *Future Health* is about prioritising the needs of the patient, even as difficult decisions on health financing are made. This will involve moving towards a health service that provides access to care based on need rather than income, underpinned by a constant focus on health and well-being, a stronger primary care sector, a restructured hospital sector, and a more integrated social care sector, as well as a more transparent ‘money follows the patient’ system of funding, supported ultimately by Universal Health Insurance.

The Reform Programme will have to be delivered against a backdrop of extremely challenging economic and fiscal conditions for the State in general and the health services in particular.

It is against this backdrop that the Minister for Health decided, in July 2013, to establish a Working Group, chaired by Professor Brian MacCraith, President of DCU, to carry out a strategic review of medical training and career structure.

## 1.2 Terms of Reference

The Working Group will examine and make 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.

In this context, consideration will be given to the following areas.

DEVELOPMENTS IN RECENT YEARS
<ul style="list-style-type: none"><li>• Progress in implementing recommendations on medical training and workforce planning from key reports, including the Fottrell and Buttimer reports.</li></ul>
POSTGRADUATE TRAINING AND EMPLOYMENT EXPERIENCE
<ul style="list-style-type: none"><li>• Assessment of the changes needed to improve the training and retention of graduates, while maintaining quality, including consideration of:<ul style="list-style-type: none"><li>➤ provision of a clear pathway for training at every level from Intern to Specialist;</li><li>➤ the potential for reducing the duration of specialist training;</li><li>➤ appropriate task allocation between health professionals.</li></ul></li></ul>

- Measures to improve the quality of the training and employment experience.

#### CAREER PATHS, STRUCTURES AND SUPPORTS

- Measures to improve career planning, mentoring supports and efficacy of communication.
- Measures to improve the career structures and flexibility of options for doctors following training, including the range of specialist (e.g. Consultant, GP, public health doctor etc.) and other hospital or community posts.

In examining these issues, the Working Group will take account of:

- The need to ensure quality, safe, patient-centred healthcare, grounded in the key domains of healthcare<sup>3</sup>, and a safe and healthy working environment for doctors;
- Developments in the Clinical Programmes and recent reports and recommendations relevant to patient safety;
- Opportunities arising from the Health Reform Programme (for example, the development of Hospital Groups and the expansion of primary care services);
- Achievement of value for money for State investment in medical education and training;
- International good practice in regard to medical training and developments, including EU requirements.

The Working Group will also take into account:

- Relevant reports, and previous processes and engagement with key stakeholders;
- The statutory roles, remits and responsibilities of key stakeholders;
- The views of trainee doctors arising from consultation.

Any implications for terms and conditions of employment will be dealt with subsequently through normal industrial relations channels.

### 1.3 Membership of Working Group

As at 30<sup>th</sup> June 2014, membership of the Working Group was as follows:

- Prof. Brian MacCraith, President, DCU (Chair);
- Ms Oonagh Buckley, Assistant Secretary, Department of Public Expenditure and Reform;
- Dr Áine Carroll, Director of Clinical Programmes, HSE;
- Dr Philip Crowley, Director, Quality and Patient Safety, HSE,
- Mr Eunan Friel, Secretary, Forum of Irish Postgraduate Medical Training Bodies;

<sup>3</sup> Patient-centredness, safety, effectiveness, efficiency, access, equity

- Dr Colm Henry, National Lead, Clinical Director Programme, HSE;
- Dr Tony Holohan, Chief Medical Officer, Department of Health;
- Mr Leo Kearns, National Lead for Transformation and Change, System Reform Group, HSE;
- Prof. Eilis McGovern, National Programme Director for Medical Education, Medical Education and Training Unit, HSE;
- Mr Barry O'Brien, National Director, Human Resources, HSE;
- Dr Siobhan O'Halloran, Chief Nursing Officer, Department of Health;
- Ms Caroline Spillane, Chief Executive Officer, Medical Council;
- Ms Frances Spillane, Assistant Secretary, Department of Health;
- Dr Barry White, Consultant Haematologist, St James's Hospital.

Secretariat to the Working Group is provided by Ms Gabrielle Jacob, Assistant Principal, Department of Health.

#### **1.4 Meetings of Working Group (May-June 2014)**

The Working Group held 5 meetings during the period from 1st May 2014 - 26th June 2014 as follows. During this period, the Group considered issues including strategic workforce planning, and career planning and mentoring supports. It also examined issues relating the specialties of public health medicine, general practice, and the community-related aspects of psychiatry, in addition to exploring issues relating to career pathways and structures for doctors in non-training posts who have not completed specialist training.

DATE	MEETING
1 <sup>st</sup> May 2014	Sixteenth meeting
14 <sup>th</sup> May 2014	Seventeenth meeting
10 <sup>th</sup> June 2014	Eighteenth meeting
18 <sup>th</sup> June 2014	Nineteenth meeting
26 <sup>th</sup> June 2014	Twentieth meeting

To inform the Working Group's deliberations, the following presentation was made to the Group at its meeting of 1<sup>st</sup> May 2014:

- Mentoring in postgraduate medical education and specialist training: a rapid evidence assessment (Mr Martin Keane, Health Research Board).

## 1.5 Stakeholder Consultation

In keeping with the Terms of Reference of the Strategic Review, and in order to inform the development of the report, members of the Working Group met with stakeholders including trainee doctors and the relevant training bodies during the May-June 2014 period.

The full list of meetings held by members of the Working Group with stakeholders during the period from 1<sup>st</sup> May 2014 - 30<sup>th</sup> June 2014 is included below.

DATE	CONSULTATION MEETING
11 <sup>th</sup> June 2014	Meeting with nominees of the Forum of Irish Postgraduate Medical Training Bodies Trainee Sub-Committee
13 <sup>th</sup> June 2014	Meeting with representatives of the College of Psychiatrists of Ireland
16 <sup>th</sup> June 2014	Meeting with nominees of the Irish Medical Organisation NCHD and Public Health and Community Health Doctors Committees
20 <sup>th</sup> June 2014	Meeting with representatives of the Faculty of Public Health Medicine

The Chair and members of the Working Group would like to express their sincere thanks to all those who attended the consultation meetings for their time, helpful inputs and positive engagement.

## 2 STRATEGIC MEDICAL WORKFORCE PLANNING IN IRELAND

### 2.1 Introduction

The purpose of this chapter is to provide an overview of strategic medical workforce planning in Ireland and the policy context within which it takes place, to examine current issues in relation to strategic workforce planning and to make recommendations in that regard, as appropriate to the Terms of Reference of the Review.

### 2.2 Composition of the Medical Workforce in Ireland

#### 2.2.1 *Non-Consultant Hospital Doctors (Training and Non-Training Posts)*

In the public health system, a Non-Consultant Hospital Doctor (NCHD) is a collective term referring to doctors employed as Interns, Senior House Officers (SHOs), Registrars, Senior Registrars, Specialist Registrars or otherwise for the purpose of providing medical or dental services and/or for the purpose of medical or dental training. As of March 2014, the public health system employed in the region of 4,910 NCHDs – an increase of 966 in the last decade.

A key objective for the health service in recent years has been not to increase NCHD numbers, but rather to increase the proportion of those posts designated as training posts. Taking that into account, since 2007, the HSE has worked with the postgraduate medical training bodies and the Medical Council to increase the proportion of training posts from less than 40% in 2007 to 80% in 2014.

Approximately 80% of NCHDs are registered on the Specialist Trainee Division of the Medical Council's register and are employed in training posts. In the context of the recommendations of the Fottrell report (see Section 2.3.2), in recent years the number of Intern posts has increased by 29% from 520 to 685 posts, with an additional 45 Intern posts approved for the academic year 2014-2015. 1,627 Basic Specialist Training (BST) posts and 1,453 Higher Specialist Training (HST) training posts were filled for the academic year 2013-2014. 70 additional training posts have been approved for the 2014-2015 academic year.<sup>4</sup>

The remaining 20% of NCHDs are not in training schemes and are registered in either the Supervised or General Divisions of the Medical Council's register, as appropriate. Typically, posts are designated as SHO or Registrar. There are currently in the region of 900 such posts in the public health system. Such doctors are employed in posts for service purposes and must participate in professional competence schemes to remain on the register.

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<sup>4</sup> Further information about the medical training pathway is set out in Section 2.4.1 of the *Report on Medical Career Structures and Pathways Following Completion of Specialist Training* (April 2014).

HSE-MET (see Section 2.4.1), in collaboration with the Medical Council and the training bodies, maintains an NCHD database, which seeks to capture information in relation to both training and non-training NCHD posts.

### 2.2.2 Consultants

In the public health system, a Consultant is a clinically independent medical practitioner registered on the Specialist Division of the Medical Council’s register<sup>5</sup> who by reason of his/her training, skill and expertise in a designated specialty, is consulted by other registered medical practitioners and who has a continuing clinical and professional responsibility both for patients under their care or those patients on which they have been consulted. Specialist registration is ‘specifically for medical practitioners who have completed specialist training recognised by the Medical Council and can practise independently (unsupervised) as a specialist’ (Medical Council, 2012: 6).

As at 25<sup>th</sup> June 2014, there were 2,708 established Consultant posts in the public health system; an increase of 977 over the last decade. Table 2.1 provides an overview of Consultant numbers in wholetime equivalent terms (including Academic Consultants and Clinical Directors) as at 31<sup>st</sup> May 2014.

**Table 2.1: Consultant numbers (as at 31<sup>st</sup> May 2014)**

SPECIALTY	CONSULTANT NUMBERS (WTES)
Anaesthesia	353
Dentistry	16
Emergency Medicine	75
Intensive Care Medicine	2
Medicine	625
Obstetrics and Gynaecology	127
Paediatrics	145
Pathology	205
Psychiatry	355
Radiology	235

<sup>5</sup> This is a requirement since 2008.

Surgery	449
Other	1
<b>Total</b>	<b>2,588</b>

Source: Health Service Personnel Census

HSE-MET has expanded its NCHD database to include a dataset on Consultants/Consultant posts, however data is not yet being inputted into the system.

### 2.2.3 General Practitioners (GPs)

As at 31<sup>st</sup> December 2013, 2,840 GPs were registered on the Specialist Division of the Medical Council's register. In the public health system, the GP is the first medical practitioner whose advice a patient seeks. GPs provide a broad service to patients on all health issues and may refer patients to see other medical specialists if more specific investigations are required.

### 2.2.4 Public Health Specialists

In the public health system, a Specialist in Public Health Medicine is an independent medical practitioner registered on the Specialist Division of the Medical Council's register who occupies a senior role in the management and delivery of population health services. As at 31<sup>st</sup> May 2014, there were 53 Specialists in Public Health Medicine and 8 Directors in Public Health Medicine employed in the public health system.

### 2.2.5 Other Public and Community Health Medicine Roles

A number of other public and community health clinical roles exist in the Irish healthcare system, with staff working principally in the area of child health in Primary Care Division. The day-to-day work of these doctors includes medical screening and the delivery of large-scale vaccination programmes. As at 31<sup>st</sup> May 2014, the WTE numbers were as set out in Table 2.2 overleaf.

**Table 2.2: Public and community health doctor numbers (as at 31<sup>st</sup> May 2014)**

CLINICAL ROLE	WTEs
Area Medical Officer	59
Area Medical Officer, Senior	58
Director of Community Care	2
Medical Officer	95
Medical Officer, Principal	4
Medical Officer, Senior	45
<b>Total</b>	<b>263</b>

Source: Health Service Personnel Census

## **2.3 Policy Context for Strategic Medical Workforce Planning**

### *2.3.1 Report of the National Task Force on Medical Staffing (Hanly Report), 2003*

The National Task Force on Medical Staffing was established in 2002 to:

- Devise an implementation plan for reducing substantially the average working hours of NCHDs to meet the requirements of the European Working Time Directive (EWTD);
- Plan for the implementation of a Consultant-provided service;
- Address the medical education and training needs associated with the EWTD and the move to a Consultant-provided service.

The Task Force reported in June 2003 and its key messages included the following:

- The priority must be to provide a safe, high quality service to all patients at all times. The current organisation, structure and staffing of the hospital system is failing to deliver the care, that at its best, the Irish system is capable of giving;
- NCHD working hours must be reduced in line with the EWTD. Appropriately implemented, this will help improve patient care and introduce safer working conditions for doctors;
- Health agencies should not attempt to meet the terms of the EWTD by recruiting more NCHDs. This would actually worsen the situation for both patients and doctors;
- Substantially more Consultants should be appointed as part of a move to a team-based Consultant-provided service. This would give patients improved access to senior clinical decision makers;
- Considerations about capacity, workload and a critical mass of patients must influence where hospital services can be safely provided. Patients have better outcomes when

treated in units with appropriate numbers of specialist staff, high volumes of activity and access to the right diagnostic and treatment facilities;

- The organisation and staffing of acute hospitals must be restructured to allow for the safe provision of emergency and elective care. The safe provision of specialist services, reductions in NCHD hours and the appointment of additional Consultants will require significant changes to service provision. It is also important to ensure that all patients, whether public or private, have equal access to services based on clinical need;
- Health professionals should work as part of a multi-disciplinary team, centred on delivering quality patient care over the full 24-hour period within an integrated network of hospitals. This will entail revised working arrangements for Consultants and NCHDs. It will also have implications for other health professionals and will involve the appointment of some new grades of staff;
- The number of hospital doctors should be regulated nationally through a single agency. Each NCHD post should also be subject to approval by a central training authority. While the number of Consultant, Specialist Registrar and Intern posts are regulated at present, uncontrolled growth in the number of Registrars and Senior House Officers is very undesirable. It can have implications for the quality of service to patients, and has affected the ability of individual doctors to access further training and achieve specialist registration. It has also hampered the efficient deployment of finite resources;
- Reductions in NCHD hours, the appointment of more Consultants working in teams, reorganisation of the acute hospital system and the provision of high quality medical education and training are all part of the implementation process. Compliance with the EWTD and the provision of a sustainable acute hospital service are possible only if measures are taken to meet each of these goals (National Task Force on Medical Staffing, 2003: 17-19).

As noted in the Working Group's April report (p.34), to date, implementation of the key messages of the Hanly Report is further advanced in some areas than in others.

With regard to NCHD numbers, the Taskforce considered that there should be significant reduction in the number of NCHDs as the numbers of Consultants increased, with the objective being (as stated in the Tierney report) 'to reverse the current ratio of more than two NCHDs for every one Consultant' (National Task Force on Medical Staffing, 2003: 33). While there has been an increase in Consultant numbers over the past decade in order to move towards a Consultant-provided service, there has also been an increase in NCHD numbers over the same period – which is not entirely accounted for by an increase in the number of training posts. In this regard, the gradual, incremental nature of the increase in Consultant numbers, has been insufficient to generate the critical mass required to move to a fully Consultant-provided service as foreseen in the Hanly report, in particular in services with onerous unscheduled care rosters. The twin drivers of demographic growth and demographic change have exacerbated the situation, as the demand for services has also increased during the 2003-2013 period.

Inhibitors to expanding Consultant numbers over the past decade have included:

- The protracted negotiations relating to the Consultant Contract 2008;
- The staffing and activity-generated costs associated with the creation of new Consultants posts, in particular prior to agreement on the 2008 Contract;
- the effects of the economic crisis, including the requirement in recent years to suppress NCHD posts to create Consultant positions.

While there has been an increase in training posts over the 2003-2014 period, the overall increase in NCHD numbers over the period cannot be entirely accounted for by same, and would appear to be largely related to service needs. In addition, until recently, training intakes have tended to remain static year on year and have not been adjusted to reflect service needs and requirements.

### *2.3.2 Fottrell and Buttimer Reports on Medical Education and Training, 2006*

The *Report of the Working Group on Undergraduate Medical Education and Training*, chaired by Prof. Patrick Fottrell and the *Report of the Postgraduate Medical Education and Training Group*, chaired by Dr Jane Buttimer, both published in 2006, made a series of comprehensive recommendations for the development and reform of medical education and training.

The reports set out an integrated implementation strategy to enhance and modernise medical education and training across the continuum from undergraduate education through to specialist training, with the aim of ensuring that Ireland had a sufficient number of highly trained doctors to service the needs of its growing population. They aimed to underpin the wider health reform programme, including the shift from a Consultant-led to a Consultant-provided service and an increasing emphasis on doctors, nurses and other health professionals working in multi-disciplinary teams.

Following on from the publication of the reports, a programme of action was set out in 2006 with a €200m implementation package to reform medical education and training, and enable doctors to be trained in an improved training system from undergraduate education to specialist training.

At undergraduate level, the package of reforms included:

- A more than doubling of the number of medical places for Irish and EU students over a four year period from 305 to 725;<sup>6</sup>
- The introduction of a new graduate entry programme for medicine from 2007 as part of the overall expansion of places;
- Curriculum and clinical training developments aimed at enhancing the quality of undergraduate medical education;

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<sup>6</sup> In 2003/2004 the annual intake of medical students was 782, of whom 305 (39%) were EU and 477 were non-EU in origin.

- The development of a new aptitude test for selection for graduate entry to medicine;
- Devising proposals for a new selection mechanism for entry to undergraduate medicine to involve a combination of CAO points and suitability test performance from 2008 at the earliest;
- The creation of new academic clinician posts to be jointly funded by the education and health sectors.

At postgraduate level, the reforms included:

- Improved retention of graduates from Irish medical schools through a range of measures to enhance the quality and attractiveness of postgraduate specialist training;
- Phasing out NCHD posts with limited training value within a feasible and realistic timeframe;
- Better workforce planning to align the numbers of doctors in training with projected consultant vacancies;
- Inclusion in the Medical Practitioners Bill of provisions to assign appropriate medical education and training functions to the HSE and, where appropriate, the Medical and Dental Councils;
- Implementing the Training Principles to be Incorporated into new Working Arrangements for Doctors in Training;
- The development of research in the health sector.

Implementation of the reports and associated programme was overseen by the Joint National Implementation Committee, which reported to the Interdepartmental Policy Steering Group (IDPSG) on Medical Education and Training in this regard. The Steering Group comprised of officials of the Department of Education and Skills (DES), the Department of Health (DoH), the Higher Education Authority (HEA) and the HSE, and its remit included responsibility for overseeing the ongoing development of strategy and policy on undergraduate and postgraduate medical education and training in accordance with Government policy.

Implementation status assessments undertaken for the information of the IDPSG in 2011 indicated that the recommendations of both reports had been advanced – in many instances significantly – over the intervening 5 year period. In this context, the IDPSG has been less active in recent times than previously.

### *2.3.3 An Integrated Workforce Planning Strategy for the Health Services 2009-2012*

The Department of Health is responsible for formulating overall policy in relation to workforce planning in the health services. In this context, a Joint DoHC/HSE Working Group on Workforce Planning in the Health Services was established in June 2006. The joint working group included representatives from the Departments of Health and Children, Finance, and Education and Science, as well as the HSE and the HEA.

In December 2007, the Expert Group on Future Skills Needs was requested by the Department of Health and Children and the HSE to review the *Healthcare Skills Monitoring Report* (2005). The report *A Quantitative Tool for Workforce Planning in Healthcare* was undertaken by the Skills and Labour Market Research Unit in FÁS for the Expert Group and was published in June 2009. The study provided detailed projections of future demand and supply for twelve healthcare occupations, including medicine. It also made a number of general recommendations based on the findings in the study, including the adoption of an integrated and on-going approach to workforce planning. *An Integrated Workforce Planning Strategy for the Health Services 2009-2012* (DoHC, 2009) was developed by a Workforce Planning Strategy Group and was coordinated through the Joint Working Group.

#### 2.3.4 Workforce Planning in the Context of Future Health and the Health Reform Programme

Action 46 of *Future Health* (DoH, 2012) commits the Department of Health and the HSE to work together to implement an approach to workforce planning and development that includes:

- Recruiting and retaining the right mix of staff;
- Training and upskilling the workforce;
- Providing for professional and career development;
- Creating supportive and healthy workplaces.

Such an approach should contribute to developing national self-sufficiency and meeting Ireland's ethical recruitment commitments under the WHO Global Code of Practice on the International Recruitment of Health Personnel (as adopted at the 63rd World Health Assembly).

Action 46 is a key enabler for and essential to achieving many of the goals of *Future Health* and the Integrated Reform Plan for the Health Sector. It is envisaged that this approach will be grounded in a successor strategy to the *Integrated Workforce Planning Strategy for the Health Services 2009-2012* (DoHC, 2009).

DoH Workforce Planning Unit and HSE Workforce Planning, Analytics and Informatics Unit are working together to build a coordinated DoH/HSE approach to progressing Action 46. This will include identifying and putting in place the structures required to support the development of the national workforce planning strategy and framework. The strategy and framework will provide the overarching context for discipline-specific strategic workforce planning in the future, and will take account of disciplinary interdependence in the context of achieving optimum skill mix.

## **2.4 Strategic Medical Workforce Planning in the Health Sector**

### *2.4.1 HSE Medical Education and Training Unit*

The HSE's Medical Education and Training (HSE-MET) Unit is responsible for ensuring that:

- The HSE's legislative responsibilities in medical education and training are met appropriately. These responsibilities are set out in the Health Act 2004 and the Medical Practitioners Act 2007;
- Government policy and HSE strategies for the development of medical education are appropriately implemented;
- The current and future needs of the public health service, in terms of medical training and specialist medicine workforce planning, are addressed, in order to ensure safe, quality patient care;
- The HSE plays a central role in the organisation, structure, management, coordination and funding of medical education and training in Ireland;
- Resources for the support and delivery of medical education and training in the Irish public health service are managed in a coordinated, cost effective manner;
- The medical education and training system reflects, and is responsive to, the changing needs of the health service on a national and on-going basis.

Since its establishment, the work of the Unit has expanded, with medical workforce planning being added to its remit in 2012 and the Consultants Appointment Unit (CAU) being re-positioned within HSE-MET in 2014.

HSE-MET works closely with the Department of Health, a number of other Government Departments, the Medical Council and the Forum for Irish Postgraduate Medical Training Bodies in the performance of its functions.

### *2.4.2 The Strategic Medical Workforce Planning Project*

Traditionally, there has been limited advance/forward planning of medical specialist posts in the public health system. In order to address this deficit, in July 2013, HSE-MET commissioned the Strategic Medical Workforce Planning (MWP) Project.

The core objective of the MWP Project is to develop a workforce planning model that will produce medical workforce projections based on the health needs of the population. These projections will be updated regularly based on drivers including changes in healthcare delivery, patient needs and supply of doctors. The projections will also be used to inform the annual intake into the various postgraduate medical training programmes and will facilitate the alignment of training intakes with service requirements.

The timeline for the MWP is July 2013-July 2015 and it is underpinned by a number of principles as follows.

1. Project recommendations should be aligned with national policy including:
  - The public policy aim of a Consultant-provided service
  - More patient care to take place in the community
  - Self-sufficiency in the production of medical graduates, with reduced dependency on International Medical Graduates<sup>7</sup>
  - A gradual reversal in the ratio of NCHDs to Consultants;<sup>8</sup>
2. Project recommendations should be consistent with the WHO Global Code on the International Recruitment of Healthcare Personnel, of which Ireland is a signatory;
3. MWP recommendations should incorporate future health need. This will require the incorporation of projections relating to, for example, demographic changes, alterations in disease incidence and prevalence, medical and therapeutic innovations, policy initiatives and technological advances;
4. MWP recommendations should incorporate the implications of existing, and where known, future healthcare policy e.g. the Clinical Programmes, the establishment of the Hospital Groups etc.;
5. Trainee numbers for each specialty should be based on MWP projections for that specialty. Recommendations should be made on an annual basis regarding the intake into postgraduate medical training programmes in order to align the supply of specialists to projected demands;
6. Training capacity should match the recommended training numbers. Where recommendations are made to increase the intake of trainees into a particular specialty, additional training posts may be required;
7. Where appropriate, innovative models of care should be explored, for example, new team structures, new medical roles and skills transfer.

To inform the development of the MWP model, HSE-MET has undertaken a current state analysis of the medical workforce, and a review of Irish and international benchmarks and ratios used in MWP. While this preliminary work will not form the basis for medical workforce planning in the future, the preliminary findings of this exercise indicate that, despite an increase in Consultant numbers of c.1000 over the last decade, the ratios recommended in the Hanly report (2003) have not been reached in many specialties. In addition, the research-informed ratio ranges for the period to 2024 would suggest that a further increase in numbers in some specialties will be required.

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<sup>7</sup> IMGs – doctors who graduate from medical schools outside Ireland

<sup>8</sup> Currently approximately 1.7:1

### 2.4.3 Consultant Appointment Process

Currently, and in the absence of a sufficiently sophisticated medical workforce planning model, applications from clinical sites for Consultant posts tend to come through the system singly. There is a protracted multi-step process to appoint a Consultant as set out in Table 2.3 below. While no average length of process data is currently available, it can take a considerable period of time for an application to advance through the various stages of the process.

**Table 2.3: Overview of the Consultant appointment process**

STAGE ONE: CLINICAL SITE
<ul style="list-style-type: none"> <li>• Application for a new or replacement Consultant post is drafted by the clinical site.</li> <li>• Application is approved by the medical board.</li> <li>• Application is forwarded on to the Group CEO for consideration.</li> </ul>
STAGE TWO: OFFICE OF THE GROUP CEO
<ul style="list-style-type: none"> <li>• Application is assessed taking into consideration the annual service plan, compliance with Circular 005/13 and funding for the post.</li> <li>• Application is then signed off by the Group CEO (or equivalent) and forwarded on to the Consultant Appointments Unit.</li> </ul> <p><i>or</i></p> <ul style="list-style-type: none"> <li>• The application is returned to the clinical site (if not approved or requires further input)</li> </ul>
STAGE THREE: CONSULTANT APPOINTMENTS UNIT
<ul style="list-style-type: none"> <li>• The application is assessed for completeness and accuracy. If information is missing or incorrect this is communicated back to the Office of the Group CEO and the application is placed on hold.</li> <li>• Completed applications are sent out to representatives of the National Clinical Programmes for comment</li> </ul> <p><i>and</i></p> <ul style="list-style-type: none"> <li>• Placed on the agenda of the Consultant Applications Advisory Committee (CAAC) for consideration.</li> <li>• A recommendation is made by the CAAC for each application. Items may be recommended, recommended subject to specified actions, deferred pending further action or rejected.</li> <li>• Recommendations of the CAAC are actioned by the CAU.</li> <li>• Recommendations of the CAAC are submitted to the National Director of Human Resources for consideration.</li> <li>• Decisions of the National Director of HR are communicated back to the CAU.</li> <li>• The CAU implement the decisions of the National Director of HR</li> </ul> <p><i>and</i></p> <ul style="list-style-type: none"> <li>• Where applications have been approved, letters of approval are issued by the CAU to the Group CEOs and copied to CEOs of the voluntary hospitals.</li> </ul>
STAGE FOUR: RECRUITMENT
<ul style="list-style-type: none"> <li>• The Letters of Approval are used to trigger the recruitment process i.e. sent to NRS for HSE employers or processed locally by the voluntary hospitals.</li> <li>• Approved posts are then advertised, candidates are shortlisted, interviewed and panelled, as appropriate.</li> <li>• Successful candidates are contracted, contracts signed and a start date agreed.</li> </ul>

## 2.5 Conclusions and Recommendations

### 2.5.1 Observations and Conclusions

As stated in the Working Group's April report (p.45), the Group wishes to reaffirm the public policy aim of a Consultant-provided service, i.e. 'a service delivered by teams of Consultants, where the Consultants have a substantial and direct involvement in the diagnosis, delivery of care and overall management of patients' (National Task Force on Medical Staffing, 2003: 43), and notes and welcomes the on-going efforts to increase Consultant numbers in order to achieve this public policy aim.

The Working Group also welcomes related efforts to increase the number of NCHD training posts over time in order to maximise the number of training posts and minimise posts outside specialist training schemes.

The Group notes and welcomes the expanded role of HSE-MET and considers that the centralisation of the functions of medical workforce planning, medical education and training, and the processing of new/replacement Consultant posts will facilitate a more efficient and integrated approach to medical workforce planning for the public health system. It also provides an opportunity to review the current multi-step Consultant appointment process, which the Working Group notes with concern, and considers both unwieldy and inefficient.

In the context of a Consultant-provided service and the extended working day, the Working Group acknowledges that a critical mass of Consultants is required at a given clinical site. A Consultant-provided model of care consists of a greater number of Consultants providing care over an extended 7-days per week, with a single tier of NCHDs on call. In this regard, the Working Group notes the recently approved Paediatric Care pilot, initiated by HSE-MET in collaboration with clinicians in Sligo Regional Hospital. This project will involve a team of 9-10 Consultant Paediatricians delivering first-line care during an extended 8.00 a.m.-10.00 p.m. day, on a 7-day per week basis and 9 NCHDs on an EWTD compliant roster.. The outcomes of this pilot project will be of assistance in informing further development of the Consultant-provided service model and support the implementation of the recommendations of the Working Group's previous report in relation to Consultant career structures and pathways upon completion of specialist training.

With regard to existing deficits in strategic medical workforce planning, which were clearly identified during consultations with stakeholders, the Working Group notes that this has had a number of impacts including:

- Lack of clarity on opportunities for doctors in the public health system on completion of specialist training;
- Limited matching of Consultant posts to emerging service needs and requirements;

- A largely static approach to trainee intake, which has not necessarily matched training intakes to future service requirements.

In this regard, and as noted in the Group's April (p.5), the Working Group welcomes HSE-MET's work to develop a medical workforce planning model to support strategic workforce planning in the future. The Group wishes to highlight a number of key policy and operational developments, which should inform the development of the methodology and tool notably:

- The planned reconfiguration of health services, including establishment of the Hospital Groups and community care organisations;<sup>9</sup>
- The development of integrated models of care and the establishment and roll-out of the Clinical Care programmes;
- The development, in line with models of care, of advanced nursing and other professional practice, and the potential for further expansion of same to contribute to an appropriate skill mix;
- Current patient safety and quality improvement initiatives;
- The legal requirement to maintain professional competence (in line with the continuing professional development [CPD] schemes accredited by the Medical Council and delivered by the training bodies).

The Group considers that the MWP model will provide a number of benefits including:

- Greater clarity in relation to future opportunities for medical graduates within the public health system;
- A more dynamic approach to trainee intake, based on emerging service needs and requirements, led by HSE-MET in collaboration with the training bodies.

It also offers the potential for the development of a sustainable approach to prioritisation and pre-approval of posts on a multi-year basis. However, for the model to operate optimally, planned strategic configuration of services will be an important element.

Finally, the Working Group wishes to acknowledge that, currently, there are in the region of 1,200 doctors working in the Irish public health system in non-specialist, non-training posts, notably in the acute hospital and community health sectors. The Group recognises that these doctors represent an important resource for the healthcare system and notes that, at present, there is lack of clarity around the career structure and role of these doctors. The Group considers it important that their role and work is appropriately structured in the future.

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<sup>9</sup> See Chapter 3 of *Report on Medical Career Structures and Pathways Following Completion of Specialist Training* (April 2014) for further detail.

### 2.5.2 Recommendations

Taking into account the above observations and conclusions, the Working Group wishes to make the following recommendations in relation to medical workforce planning.

1. In the context of the current and future needs of the health system and Action 46 of *Future Health* (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 *inter alia* strategic medical workforce planning on a cross-sectoral basis. This structure should link with any structures established by HSE-MET in the context of the MWP model being developed by the MWP Project.
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.
3. 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.
4. The Working Group recognises that, currently, there are in the region of 900 doctors in service posts in the acute hospital sector and 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:
  - The needs and requirements of the public health system, including service reconfiguration and integrated models of care;
  - Patient safety and quality of the patient experience;
  - Registration, qualifications and training, clinical governance, CPD and supervisory arrangements.

In addition, with regard to any future consideration by the Department of Health and the HSE of roles in the public health system for doctors who have not completed specialist training and are in non-training posts, the Working Group recommends that the following be taken into account:

- The needs and requirements of the public health system;
- The features of such roles and the features of the system within which such roles would operate (including registration, qualifications and training, clinical governance, CPD and supervisory arrangements);
- Patient safety and quality of the patient experience;

- Standardisation of roles aligned to a clear career pathway;
- Criteria and qualifications for such roles;
- Interface with training pathway to facilitate temporary exit from specialist training and subsequent re-entry as appropriate;
- The further development and expansion, in line with emerging models of care and service requirements, of specialist and advanced nursing/midwifery and other clinical roles which can contribute to an appropriate skill mix and enable clinicians to practice to the optimum of their educational preparation.

## 3 PUBLIC HEALTH MEDICINE

### 3.1 Introduction

The purpose of this chapter is to examine current recruitment and retention issues and challenges in relation to public health medicine, and to make recommendations in this regard, as appropriate, in the context of the Terms of Reference of the Strategic Review.

### 3.2 Overview of Public Health Medicine in Ireland

#### 3.2.1 About Public Health Medicine

Public health is ‘the science and art of preventing disease, prolonging life and promoting, protecting and improving health through the organised efforts of society’ (Acheson, 1988).

Public health professionals use epidemiology to describe the occurrence of disease and what the causes may be. The underpinning rationale for public health activities is that the more that is understood about the cause of diseases, the more the public health system can do to prevent them, detect them at an early stage or provide the most appropriate health services.

Just as a clinical doctor cares for the individual patient by examining, diagnosing, treating and curing or providing continuing care, a public health doctor cares for their population (members of their catchment area) by examining the population, diagnosing their needs, determining a ‘treatment’/intervention, providing continuing care and monitoring outcomes to ascertain if their intervention has had the desired impact.

#### 3.2.2 Where Public Health Doctors Work

In the main, public health doctors are employed in the public health system, working at both national and regional levels.

At national level, there are five units in the health service with a national remit that employ specialists in public health medicine:

- The National Immunisation Office (NIO);
- The Health Protection Surveillance Centre (HPSC);
- The National Cancer Control Programme (NCCP);
- HSE Quality and Patient Safety (QPS) Directorate;
- Health Intelligence Unit (HIU).

Public Health Specialists also provide input to the national Clinical Care Programmes and support the activities of the recently established Health and Wellbeing Division.

At regional level, there are eight departments of public health across the country: the South East, the East, the North East, the North West, the South, the West, the Mid-West and the Midlands. Each department is led by a Director of Public Health (DPH), and is staffed by Specialists in Public Health Medicine (SPHM) and Senior Medical Officers (SMOs), along with other grades of staff. Traditionally, in regional departments of public health, there has been a significant focus on health protection issues; in particular, the mitigation of infectious disease related public health concerns. This arises, in part, from statutory obligations in relation to the surveillance and mitigation of infectious disease related issues.<sup>10 11</sup> Restrictions on recruitment, reducing resources and increasing demands arising from the emergence of new viruses e.g. SARS, novel coronaviruses etc. have also been drivers in this regard.

As at 28<sup>th</sup> February 2014, there were 53 Specialists in Public Health Medicine and 8 Directors in Public Health Medicine employed by the HSE.

Specialists in Public Health Medicine are also employed by a number of national bodies and agencies outside the public health system. This includes the Department of Health, the Department of Children and Youth Affairs, Safefood, the Institute of Public Health and Public Health academia. Other national agencies have expressed an interest in recruiting public health expertise but capacity to fill this increasing need has been limited.

### *3.2.3 The Role of the Public Health Specialist*

A Specialist in Public Health Medicine is an independent medical practitioner registered on the Specialist Division of the Medical Council's register who occupies a senior role in the design, management and/or delivery of population health services. This role can include:

- Assessing the health status of the population or of specific groups within that population;
- Identifying population health needs and strategies to address those needs;
- Participating in the prevention, surveillance and control of infectious diseases;
- Responding to environmental incidents which may affect public health.

The demographic profile of the current cohort of public health doctors is set out in Table 3.1 overleaf. In this regard, it should be noted that almost 44% of SPHMs are aged 55+ years.

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<sup>10</sup> Infectious Diseases Regulations, 1981 (SI No 390/1981)

<sup>11</sup> Health Act, 1947 to 2004

**Table 3.1: Demographic profile of public health doctors in Ireland (2012)**

AGE GROUP	ALL <sup>12</sup>	SPECIALIST
<= 24 years	0.0%	0.0%
25-34 years	3.3%	0.0%
35-44 years	15.1%	12.9%
45-54 years	40.1%	43.6%
55-64 years	31.9%	37.6%
65+ years	9.5%	5.9%

Source: Medical Council

With regard to trainee numbers, 11 HST posts in public health medicine were filled for the academic year 2013-2014, out of an available total number of 12 places. Currently, training in public health mainly takes place in a HSE setting; largely in regional public health departments, with a rotation through the HIU or HPSC. In the final year of the training scheme, trainees also spend a 6-month rotation in the Department of Health.

### 3.3 Policy Context

*Future Health* (DoH, 2012) is built on four key inter-dependant pillars of reform; Health and Wellbeing, Service Reform, Structural Reform and Financial Reform. With regard to Health and Wellbeing, *Future Health* proposes that:

*‘There will be a new focus on the need to move away from simply treating ill people, to a new concentration on keeping people healthy. The health and wellbeing pillar recognises the need for a whole-of-government approach to addressing health issues and commits to the development of a comprehensive health and wellbeing policy framework and the establishment of a Health and Wellbeing Agency’.*

*Healthy Ireland* (DoH, 2013) provides the framework for improving health and wellbeing by setting out the goals, ethical principles, framework for actions and guiding principles for implementation. Figure 3.1 shows some key elements of the Healthy Ireland framework. Public health expertise is needed to support the delivery of the Healthy Ireland framework, particularly in relation to themes 3 to 6 of the framework for action and the guideline principles for implementation.

<sup>12</sup> All doctors (Specialist Division/Trainee Specialist Division/General Division etc) who identified this speciality area as the area in which they are practising.

**Figure 3.1: Framework for improving health and wellbeing (DoH, 2013)**



The reforms set out in both *Future Health* (DoH, 2012) and *Healthy Ireland* (DoH, 2013) aim to return the focus to health rather than disease and to ameliorate the burden of chronic illness in our population. In this context, the recently established Health and Wellbeing Division is focusing its work in the following areas:

- supporting people and communities to protect and improve their health and wellbeing;
- turning research, evidence and knowledge into action;
- acting as the authority on health, wellbeing and policy development;
- building an intelligent health system and a healthier population.

As noted above, *Future Health* (DoH, 2012) proposes the establishment of a stand-alone Health and Wellbeing Agency in 2015. It is envisaged that the Agency will continue and build on the work with other relevant sectors to produce inter-sectoral plans to address risk factors and social determinants of health. It will move forward integrated initiatives to promote for example, healthier diet and physical activity, as well as building on the Substance Misuse Strategy in relation to alcohol and implementing tobacco policy with a view to making Ireland a tobacco free society.

### 3.4 Consultation with Trainee Doctors

In the course of the consultation meetings, trainees identified a number of issues that they considered are impacting on recruitment and retention rates in public health medicine, and these are summarised in Table 3.2 below.

**Table 3.2: Summary of views regarding public health medicine expressed by trainee doctors**

THEME	KEY POINTS
<i>Status of the specialty</i>	<ul style="list-style-type: none"> <li>• Absence of grade/title parity of esteem with other specialties is a significant barrier to recruitment and retention.</li> <li>• The present situation in Ireland is in contrast to the UK where public health clinicians are designated as consultants.</li> <li>• Public health specialists are moving to posts in other jurisdictions – including the UK and Northern Ireland.</li> </ul>
<i>Quality of the training experience</i>	<ul style="list-style-type: none"> <li>• Greater alignment of training with key policy developments including <i>Future Health</i> and <i>Healthy Ireland</i> is required.</li> <li>• There is a significant focus on health protection activities in the training scheme, with other elements of the public health specialist role less evident.</li> <li>• The number of trainers is decreasing and this is having an impact on training opportunities for trainees.</li> <li>• The balance between training needs and service requirements is often weighted towards service requirements.</li> </ul>
<i>Workforce planning</i>	<ul style="list-style-type: none"> <li>• The numbers in training are very low relative to the requirements of the service.</li> <li>• A more strategic approach to public health medicine is required than has been the case in the past.</li> </ul>
<i>Career planning</i>	<ul style="list-style-type: none"> <li>• Exposure to public health medicine at undergraduate level is limited and work needs to be done to increase awareness of the specialty as a career option at this level.</li> </ul>

## 3.5 Conclusions and Recommendations

### 3.5.1 Observations and Conclusions

The Working Group acknowledges that public health medicine is a key component for planning the Irish health service. It notes that, as with other specialties, as the health system evolves, the role of the public health specialist is also evolving. For example, the direct input from public health medicine into the Clinical Care Programmes has recently been formalised through new roles and structures, and this represents a practical step towards achieving service integration and implementation of evidence-based models of care.

As with other specialties, the Working Group recognises that the nature and composition the public health doctor's work is likely to change over time as their career progresses, with opportunities for progression and personal development existing in areas including:

- Public health service provision;
- Public health leadership and management;
- Research, training and academia.

The Working Group considers that a broad range of activities and skills are required for the public health doctor to provide the expertise to deliver on *Future Health* (DoH, 2012) and *Healthy Ireland* (DoH, 2013), in addition to other roles that may emerge during the health reform process, notably in relation to patient outcome-based healthcare delivery systems and health economics in the context of healthcare commissioning. In this regard, the Group takes the view that the public health role should encompass activities relating to the following:

- Management and delivery of health protection services;
- Research methods and critical appraisal tools, including health needs assessment, health impact assessment and health technology assessment;
- Patient safety and clinical effectiveness;
- Health promotion and improvement;
- Health service planning, commissioning and quality assurance;
- Health intelligence and health information management.

With regard to the training of public health specialists, the Group considers that the model of training should keep pace with the needs of the system and considers it important that the learning environments included in the training scheme should provide adequate exposure to the broad spectrum of public health activities in order to ensure that the balance of skills at the end of specialist training reflects service requirements at both national and regional levels. In this regard, the Group notes the demographic profile of public health specialists and considers that it represents a significant risk to maintaining the viability of the training scheme and also limits opportunities for expansion of the training scheme in the near future.

The Working Group also notes with concern vacant training posts on the public health training scheme and takes the view that the status of the specialty and limited exposure to public health medicine at undergraduate level are both factors in this regard.

### 3.5.2 Recommendations

Taking into account the above observations and conclusions, the Working Group wishes to make the following recommendation in relation to public health medicine.

5. In the context of Action 46 of *Future Health* (DoH, 2012), *Healthy Ireland* (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:
  - the current and future role of the public health specialist in Ireland, including the appropriate skill mix in relation to public health functions;
  - the attractiveness of public health medicine as a career option;
  - the curriculum and content of the specialist training scheme, and associated administrative arrangements relating to the rotation of trainees around the system;
  - any requirement for post-CSCST sub-specialisation;
  - 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;
  - measures to enhance the awareness of public health medicine as a career option at undergraduate level and during the Intern year.

## 4 GENERAL PRACTICE

### 4.1 Introduction

The purpose of this chapter is to examine current recruitment and retention issues and challenges in relation to general practice, and to make recommendations in this regard, as appropriate, in the context of the Terms of Reference of the Strategic Review.

### 4.2 Overview of General Practice

#### 4.2.1 Primary Care Services

The Primary Care Strategy defined primary care as:

*‘... being an approach to care that includes a range of services designed to keep people well, from promotion of health and screening for disease to assessment, diagnosis, treatment and rehabilitation, as well as personal social services. The services provide first-level contact that is fully accessible by self-referral and have a strong emphasis on working with communities and individuals to improve their health and social well-being’* (DoHC, 2001: 15).

A key objective of the Primary Care Strategy was the development of integrated multi-disciplinary teams of GPs, nurses, healthcare assistants, home helps, occupational therapists and others. The Primary Care Team (PCT) is intended to be the central point for service delivery, which actively engages to address the medical/social care needs of a defined population in conjunction with a wider range of Health and Social Care Network services. As at 31<sup>st</sup> December 2013, 419 PCTs were operating (as measured by regular clinical team meetings held on individual client cases, involving GPs and HSE staff).

In addition to their role in the PCTs, GPs are also contracted by the public health service to provide services to medical card and GP visit card holders under the General Medical Services (GMS) Scheme.

#### 4.2.2 General Practitioners

The GP plays a central role in the health system and is the first medical practitioner whose advice a patient seeks. GPs provide a broad service to patients on all health issues and may refer patients to see other medical specialists if more specific investigations are required.

The majority of GPs in Ireland are private contractors who provide services to the public health system under the Primary Care Reimbursement Service (PCRS), which includes the General Medical Services (GMS) Scheme. As at 31<sup>st</sup> December 2013, 2,413 GPs were contracted to provide services under the GMS Scheme.

GP co-operatives also provide out-of-hours services to c. 90% of the population.

As at 31<sup>st</sup> December 2013, 2,840 GPs were registered on the Specialist Division of the Medical Council’s register, though it is noted that holding registration does not necessarily mean that the medical practitioner is active in General Practice at this time.

The demographic profile of the current cohort of GPs is set out in Table 4.1 below.

**Table 4.1: Demographic profile of GPs in Ireland (2012)**

AGE GROUP	ALL <sup>13</sup>	SPECIALIST
25-34 years	15.3%	11.8%
35-44 years	26.9%	28.8%
45-54 years	23.6%	24.8%
55-64 years	22.8%	24.2%
65+ years	11.5%	10.4%

Source: Medical Council

Specialist training for general practice is a four-year programme that aims to produce doctors who, on completion of training, can provide personal and continuing care to individuals and families in the community. GP training is organised through 14 training schemes across the country, with the majority of training taking place in a designated practice. For the academic year 2013-2014, there were in the region of 650 GP trainees.

### 4.3 Policy Context

#### 4.3.1 Changing Models of Care

*Future Health* (DoH, 2012) envisages the creation of integrated models of care that treat patients at the lowest level of complexity that is safe, timely, efficient and as close to home as possible. The aim of increasing integration is to shift the emphasis from episodic reactive care to care based on needs which is evaluated as to its impact on outcomes.

Integrated service delivery is required in order to respond to the challenges of growing numbers of people with chronic conditions and the increasing prevalence of co-morbidity in the population (i.e. patients with two or more diseases or disorders).

*Future Health* states that:

*‘... the first point of contact for a person needing healthcare will be primary care, which should meet 90%-95% of people’s health and personal social care needs’.*

<sup>13</sup> All doctors (Specialist Division/Trainee Specialist Division/General Division etc) who identified this speciality area as the area in which they are practising.

It is envisaged that patients will be referred from primary care only when they require specialist intervention; otherwise they will be managed through primary care.

Structured Chronic Disease Management Programmes will shift the management of chronic diseases such as diabetes, stroke, heart failure, asthma and chronic obstructive pulmonary disease from hospitals to the primary care and the community. The focus of such programmes will be on primary prevention, early identification, simple and early interventions, patient empowerment, care in the community and on preventing acute episodes from occurring.

Improved management of chronic diseases will involve a reorientation towards primary care and the provision of integrated health services that are focused on prevention and returning individuals to health and a better quality of life. The main elements of the programmes will include:

- Models of shared care which set out the roles and responsibilities of primary care and specialist services;
- Clinical protocols and guidelines for use in primary care and specialist services;
- Programmes of self-care for patients to encourage better self-monitoring and treatment of chronic disease;
- Clinical information systems, quality assurance and evaluation.

#### *4.3.2 Framework Agreement in Respect of Process for Engagement Concerning the GMS/GP Contract and Other Publicly Funded Contracts Involving GPs*

On 4<sup>th</sup> June 2014, a Framework Agreement was signed between the Minister of Health, the HSE and the Irish Medical Organisation (IMO) setting out a process for engagement and negotiations concerning the GMS/GP contract and all other publicly funded contracts for service involving GPs. The Agreement commits *inter alia* that:

*‘... the Department and/or HSE and the IMO shall conjointly carry out a comprehensive review of the contractual issues arising from the introduction of new GP services, and, in the first instance, those issues surrounding the provision of GP care free at the point of use to all children under 6’.*

## 4.4 International Evidence Review

### 4.4.1 Overview of HRB Review

As an input to its deliberations, the Working Group sought information on career structures for publicly funded tenured medical posts – including general practice – in other countries that were relevant to the situation in Ireland. The Health Research Board (HRB) conducted the international evidence review on behalf of the Working Group and submitted its finalised report on 25<sup>th</sup> March 2014.

The countries selected for the Review were five European countries (Finland, France, Germany, The Netherlands and the United Kingdom [with particular reference to England]), Australia, Canada and New Zealand.

### 4.4.2 HRB Review Findings Relating to General Practice

#### Europe

All general practitioners are self-employed except in Finland where most general practitioners work in municipal health centres and are salaried but many are paid fee-for-service for overtime work. In France, Germany, the Netherlands and the UK the number of general practitioners working in salaried service (employed by practices or more senior general practitioners) is increasing but self-employed independent contractors are still the majority. In the UK, the Netherlands and Finland, general practitioners act as gatekeepers to specialist services whereas in France and Germany, they do not. Income for general practitioners is derived mainly from salary in Finland but in the remainder of the European countries it is derived from fee-for-service payments, capitation payments or payment for performance or a combination of these methods.

In the UK, individual general practitioners are no longer required to provide after-hours care to their patients (a small minority still do so), but are required to ensure that adequate arrangements are in place. In practice, this means that Community Care Groups (CCGs) contract most of these services to general practitioner cooperatives and private companies.

In France, after-hours care is delivered by a number of entities including: the emergency departments of public hospitals; contracted private hospitals that have signed an agreement with the regional health agency and receive financial compensation for care provided; self-employed physicians who work for emergency services; and, more recently, after-hours public facilities (*maisons de garde*) financed by social health insurance funds and staffed by health professionals on a voluntary basis. Doctors are paid an hourly rate when working at *maisons de garde*, regardless of the number of patients seen.

In Germany, after-hours care is organised by the regional physician associations to ensure access to ambulatory care around the clock. Physicians are obliged to provide after-hours care though the regulations differ across regions. After-hours care assistance is also available via a

nationwide telephone hotline. Payment of ambulatory after-hours care is based on the above-mentioned fee schedule, again with differences in the amount of reimbursement for social or private health insurance.

In the Netherlands, after-hours primary care is organised at the municipal level in general practitioners 'posts'—centralised services typically run by a nearby hospital that provide general practitioners care between 5:00 pm and 8:00 am. Specially trained assistants answer the phone and perform triage. General practitioners decide whether or not patients need to be referred to the hospital. The general practitioner post sends the information regarding a patient's visit to his or her general practitioners.

There was no information on out-of-hours care found for Finland.

It was not possible to obtain information on working hours, responsibilities, conditions of employment and arrangements for general practitioners in these countries.

### Canada

Solo general practitioners (or solo family practice physicians), group practices or inter-professional practices are all present in Canada. Family Physicians in Canada work under a variety of remuneration models, from fee-for-service to capitation to capitation with shadow billing to salary. Income for family physicians varies widely depending on hours, location, incentives, and type of practice.. Because governments are now realising the importance of continuing comprehensive care, in many parts of the country there is compensation for chronic disease management, with family physicians receiving additional payments for providing such care.

Incentives for practicing in underserved areas range from higher salaries and higher fee-for-service payments to loan forgiveness, lump-sum payments, increased continuing medical education, and holiday support. Most rural physicians have lower overhead costs and the opportunity to earn higher income for performing procedures that would otherwise be carried out by specialists. The incentives are based upon the degree to which the community being served is classified as rural.

Family physicians have the most flexibility in terms of hours of work, when to work, and how to work. Most family physicians work in group practices that have daytime hours as well as evening and weekend hours, and they decide amongst themselves how to divide the responsibilities.

### Australia

General practitioners are self-employed with variable levels of remuneration depending on the number of hours worked and medical benefit scheme payments. On-call or unsocial hours are not required unless by agreement. If general practitioners choose to provide after-hours care they receive additional payments. The level of remuneration is variable depending on hours worked and medical benefit scheme payments. Additional payments are available for the treatment of patients with complex and chronic conditions. There is a practice incentives programme (PIP) aimed at supporting general practice activities that encourage continuing improvements, quality care, enhance capacity, and improve access and health outcomes for patients. The practice incentives programme is administered by Medicare on behalf of the Department of Health with ten individual incentives in the programme. There are also a variety of rural incentives for general practitioners who practice in rural areas.

### New Zealand

Most primary care is based in doctor-owned small group practices with general practitioners acting as gatekeepers. Their income is derived from patient charges and government subsidies. Conditions for general practitioners vary widely and are negotiated locally. In 2002 new primary care organisations (known as primary health organisations) were set-up. General practitioners act as gatekeepers to specialist care and are usually independent, self-employed providers, compensated predominantly by a capitated government subsidy paid through primary health organisations in addition to patient co-payments. Patient registration is not mandatory, but general practitioners and primary health organisations must have a formally registered patient list to be eligible for government subsidies.

Over recent years, there has been substantial funding to subsidize primary care and improve access to care. Primary health organisations receive additional per capita funding for promoting health, coordinating care, reducing barriers to care for patients with access difficulties, and providing additional services for people with chronic conditions. Primary health organisations also receive extra funding if general practitioners collectively reach quality and service delivery targets for cancer, diabetes, and cardiovascular disease screening and follow-up, as well as for vaccinations.

## 4.5 Consultation with Trainee Doctors

In the course of the consultation meetings, trainees identified a number of issues that they considered are impacting on recruitment and retention rates in general practice, and these are summarised in Table 4.2 below.

**Table 4.2: Summary of views regarding general practice expressed by trainee doctors**

THEME	KEY POINTS
<i>Uncertainty regarding the future</i>	<ul style="list-style-type: none"> <li>• Trainees reported significant uncertainty regarding the nature of the GP role in the future and how it will be resourced.</li> <li>• Upon completion of training, trainees are moving to posts in other jurisdictions – including Canada, Australia and New Zealand.</li> <li>• General practice in these jurisdictions is better resourced, including in relation to chronic disease management.</li> </ul>
<i>Establishing a practice on completion of specialist training</i>	<ul style="list-style-type: none"> <li>• Currently, there are funding barriers to establishing a new practice and no incentives are available for newly qualified GPs to establish practices.</li> <li>• Trainee preference is for larger practices of 4-5 GPs – this is likely to have a negative impact in rural areas as older GPs retire.</li> <li>• Many trainees are interested in flexible working options e.g. 3- or 4-day working arrangements, in order to pursue research or in the context of other commitments, but GMS lists are currently only available on a full-time basis.</li> </ul>
<i>Access to diagnostics</i>	<ul style="list-style-type: none"> <li>• Trainees expressed significant frustration at current arrangements for access to diagnostics and limited IT infrastructure in hospitals to support timely communication of diagnostic results.</li> <li>• Greater alignment between primary and secondary/acute care services is required to facilitate timely access to diagnostics and minimise the current bureaucratic burden.</li> <li>• Improving communication is particularly important for rural practices that are not linked to acute hospitals.</li> </ul>

## 4.6 Conclusions and Recommendations

### 4.6.1 Observations and Conclusions

The Working Group recognises the pivotal role of the GP as the first point of contact for most of the population with the health system. It further recognises that, in the context of *Future Health* (DoH, 2012) and Universal Health Insurance (UHI), the landscape for GPs is changing significantly.

In view of the demographic profile of GPs in Ireland, and the likelihood that significant numbers of GPs will retire in the coming years, the Working Group welcomes the recent Framework Agreement between the Minister for Health and the IMO in relation to engagement concerning the GMS/GP contract and other publicly funded contracts involving GPs. It considers that this framework provides the mechanism to consider and address many of the issues identified by trainees in the consultation meetings.

The Group notes the feedback from trainees in relation to current barriers to the establishment of practices on completion of specialist training and preferences for patterns of work in the future. In view of the importance of building a robust primary care sector as the cornerstone of a reformed health system, the Group considers that these issues merit further investigation by the appropriate parties.

The Working Group also notes the comments of trainees regarding challenges in timely access to diagnostic results. The Group considers that continued enhancement of Healthlink capacity in order to increase the number and range of messages flowing between GP practices and acute hospitals is important in this regard.

Finally, the Working Group notes that the draft contract for the provision of services to all children aged under 6 published by the HSE on 31<sup>st</sup> January 2014 proposes that the scope of services should not be limited to diagnosis and treatment, but should also include participation in active health promotion, disease surveillance, prevention and appropriate management of chronic conditions. The Working Group supports this approach and would wish to see this apply to the GMS contract.

### 4.6.2 Recommendations

Taking into account the above observations and conclusions, the Working Group wishes to make the following recommendations in relation to general practice.

6. 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 include exploration of the following:
  - Introduction of GMS contracts that allow for flexible working;

- Measures to encourage newly qualified GPs to remain in Ireland at the end of training.
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 *inter alia* the need to provide structured chronic disease management in primary care.

## 5 PSYCHIATRY

### 5.1 Introduction

The purpose of this chapter is to examine current recruitment and retention issues and challenges in relation to psychiatry, with particular reference to community-based mental health services, and to make recommendations in this regard, as appropriate, in the context of the Terms of Reference of the Strategic Review.

### 5.2 Overview of Mental Health Services

#### 5.2.1 Mental Health Services

The public health system in Ireland provides a wide range of community- and hospital-based mental health services for both adults and children. Services have changed significantly over the past twenty years, and are evolving from a hospital-based model to the provision of more care in communities and in clients' own homes.

*A Vision for Change: Report of the Expert Group on Mental Health Policy* (Expert Group on Mental Health Policy, 2006) sets out a comprehensive model of mental health service provision for Ireland. It describes a framework for building and fostering positive mental health across the entire community and for providing accessible, community-based, specialist services for people with mental illness.

Consultant psychiatrists provide services to people with mental health conditions in both acute and community-based settings.

#### 5.2.2 Community-based Mental Health Services and the Role of the Consultant Psychiatrist

With regard to community-based mental health services, *A Vision for Change* recommended that:

*'Specialist expertise should be provided by community mental health teams (CMHTs) - expanded multi-disciplinary teams of clinicians who work together to serve the needs of service users across the lifespan. CMHTs should serve defined populations and age groups and operate from community-based mental health centres in specific sectors throughout re-configured mental health catchments areas. These teams should assume responsibility for self-governance and be accountable to all their stakeholders, especially service users, their families and carers. Some of these CMHTs should be established on a regional or national basis to address the complex mental health needs of specific categories of people who are few in number but who require particular expertise'* (Expert Group on Mental Health Policy, 2006: 8).

With regard to the composition of CMHTs, recommendation 9.1 of *A Vision for Change* set out that:

*'To provide an effective community-based service, CMHTs should offer multi-disciplinary home-based treatment and assertive outreach, and a comprehensive range of medical, psychological and social therapies relevant to the needs of service users and their families. Each multi-disciplinary team should include the core skills of psychiatry, nursing, social work, clinical psychology, occupational therapy. The composition and skill mix of each CMHT should be appropriate to the needs and social circumstances of its sector population' (ibid.: 79).*

In terms of governance, *A Vision for Change* assigned the clinical leadership role to a lead clinician

*'... who will articulate the collective vision of the team and ensure clinical probity. In keeping with current legislation and contractual arrangements this role would be the remit of the consultant psychiatrist or psychiatrists attached to the team' (ibid.: 80).*

The statutory framework within which the Consultant psychiatrist operates includes the Mental Health Act 2001 and the Protection of Life During Pregnancy Act 2013.

## **5.3 Policy Context**

### *5.3.1 Continuing Reform of Mental Health Services*

The implementation of *A Vision for Change* (Expert Group on Mental Health Policy, 2006) is a continuing policy priority and the Government is committed to reforming the service delivery model of delivery so that more and better quality mental health care is delivered in the community.

Since 2012, the Government has prioritised the reform of mental health services in line with *A Vision for Change* with the provision of an additional €90 million and some 1,100 posts primarily to strengthen CMHTs for both adults and children and to enhance specialist community mental health services for older people with a mental illness, those with an intellectual disability and mental illness, and forensic mental health services.

*Future Health* (DoH, 2012) envisages the development of a social and continuing care system that maximises independence and achieves value for the resources invested. In this context, the Government is committed to continuing the move from the traditional institutional based model of mental health care, towards a patient-centred, flexible community-based service.

## 5.4 Consultation with Trainee Doctors

In the course of the consultation meetings, the trainees identified a number of issues that they considered are impacting on recruitment and retention rates in psychiatry, with particular reference to community-based mental health services. These are summarised in Table 5.1 below.

**Table 5.1: Summary of views regarding psychiatry and mental health services expressed by trainee doctors**

THEME	KEY POINTS
<i>Consultant appointments and pay</i>	<ul style="list-style-type: none"> <li>• The additional 30% reduction in pay for new entrant Consultants from October 2012 is impacting adversely on recruitment and retention rates.</li> </ul>
<i>Resourcing of community mental health teams</i>	<ul style="list-style-type: none"> <li>• The under-resourcing of CMHTs is having a significant impact on the recruitment and retention of Consultant psychiatrists and psychiatry trainees.</li> <li>• Trainees see beds being closed in psychiatric institutions but the resources are not transferring to community mental health teams.</li> <li>• Gaps in CMHTs, for reasons including non-cover of maternity leave for therapists and delays in filling nursing posts (as a result of the current national recruitment panel structure), are impacting on clinicians.</li> <li>• Under-resourcing of CMHTs is having a detrimental impact on trainee morale as they are committed to the aspirations of <i>A Vision for Change</i> in terms of community-based delivery of mental health services.</li> <li>• A further negative impact of current resourcing issues in CMHTs is that on some occasions, in order to treat and manage severely unwell service users, clinicians are having to ‘fall back’ on medication, which is suboptimal in the context of the biopsychosocial model proposed in <i>A Vision for Change</i>.</li> </ul>
<i>Career planning</i>	<ul style="list-style-type: none"> <li>• Exposure to psychiatry at undergraduate level takes place at a later stage in undergraduate medical programmes and further work needs to be done to increase awareness of the specialty as a career option at this level.</li> <li>• The creation of more Intern places in psychiatry has</li> </ul>

	<p>had a positive impact in terms of enhancing the visibility of the speciality.</p> <ul style="list-style-type: none"> <li>• Initiatives, such as MedFest and psychiatry summer schools for undergraduate medical students, are also having a positive impact.</li> </ul>
<i>Safety issues</i>	<ul style="list-style-type: none"> <li>• Physical safety is a concern for psychiatry trainees, which is having a negative impact on morale, as well as on recruitment and retention.</li> </ul>

## 5.5 Conclusions and Recommendations

### 5.5.1 Observations and Conclusions

The Working Group recognises the central role played by Consultant psychiatrists in the delivery of mental health services in both the acute and community-based settings. In this regard, it considers that the recommendations previously made in relation to medical career structures and pathways following completion of specialist training will assist in addressing the recruitment and retention issues being experienced by the speciality.<sup>14</sup> The Group does, however, note the particular challenges posed by the working environment for clinicians and, in particular, the physical safety concerns raised by trainees.

With regard to the CMHTs, the Group notes the issues raised by trainees in relation to current challenges in transferring resource from the institutional setting to the community-based setting in line with the *A Vision for Change* recommendations. It further notes the impact of non-filling of vacant CMHT therapy and nursing posts on clinician morale. While outside the Terms of Reference of this Review, and recognising the investment in community mental health services in recent years, these issues are a matter of concern from a recruitment and retention perspective and require further examination by the relevant parties. Forthcoming work by the Department of Health and the HSE in relation to Action 46 of *Future Health* (DoH, 2012) is relevant in this regard.

Finally, the Working Group recognises that there are specific challenges in recruiting trainees to the specialty training programme and welcomes the efforts of HSE-MET and the College of Psychiatrists in Ireland to raise the profile of psychiatry as a specialty.

<sup>14</sup> See recommendations of *Report on Medical Career Structures and Pathways Following Completion of Specialist Training* (April 2014).

### *5.5.2 Recommendations*

Taking into account the above observations and conclusions, and having due regard to recommendations previously made by the Working Group in relation to career structures and pathways following completion of specialist training, the Group wishes to make the following recommendation in relation to psychiatry.

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.

## 6 CAREER PLANNING AND MENTORING SUPPORTS

### 6.1 Introduction

The purpose of this chapter is to examine the current position in respect of career planning and mentoring supports for trainee doctors in Ireland, and to make recommendations in this regard, as appropriate, in the context of the Terms of Reference of the Strategic Review.

### 6.2 Overview of Career Planning and Mentoring Supports

#### 6.2.1 Career Planning Supports

There are a number of structures currently in place designed to provide medical students and trainee doctors with information on the next steps of their career. These are summarised in the sections that follow, with a particular focus on key transitions – from final year medical school to Intern, and from Intern to specialist training.

#### Information Nights

In September every year, HSE-MET undertakes an information session with each final year medical class in the country. The purpose of the session is to provide information about the Intern matching system, as well as providing an overview of postgraduate medical training in Ireland.

A number of training bodies, as follows, also hold information nights each year aimed at Interns:

- Royal College of Physicians (ICHMT, Faculty of Paediatrics, Faculty of Pathology, Faculty of Occupational Medicine, Faculty of Public Health Medicine and the Institute of Obstetricians and Gynaecologists);
- College of Psychiatrists of Ireland;
- Irish College of General Practitioners;
- Royal College of Surgeons in Ireland.

The purpose of these sessions is to provide further information about specialist training in a given specialty. Many of the sessions are attended by senior trainees who are on hand to speak with the Interns and answer any questions they may have about pursuing training in that specialty.

In addition to an information night, the College of Psychiatrists of Ireland runs an annual summer school aimed at medical students and Interns interested in a career in psychiatry.

#### National Medical Careers Day

The Forum of Irish Postgraduate Medical Training Bodies and HSE-MET held a career day in the Aviva Stadium on 28<sup>th</sup> September 2013 aimed primarily at Interns and final year medical

students. The purpose of the event was to provide practical information about postgraduate medical training structures in Ireland and specific information about specialist training programmes. The Medical Council also participated in the event.

Approximately 300 Interns and final year medical students attended the career day. The majority of the feedback from those who attended was very positive, with 88% saying that they would recommend the event to others and 86% were satisfied overall with the event and felt it met their expectations.

The event is scheduled to take place again in September 2014 and will be co-hosted by the Forum, HSE-MET and the Medical Council.

### Online and Print Resources

Each training body has a training section on their website, which provides information on the technical aspects of specialist training programmes, including specialty curricula, recruitment processes, levels of training, and information about exams. Training body websites are as follows:

- College of Anaesthesia - <https://www.anaesthesia.ie/index.php/training>
- College of Psychiatrists - [http://www.irishpsychiatry.ie/Postgrad\\_Training.aspx](http://www.irishpsychiatry.ie/Postgrad_Training.aspx)
- Faculty of Radiologists - <http://www.radiology.ie/training/>
- Irish College of General Practitioners - [http://www.icgp.ie/go/become\\_a\\_gp](http://www.icgp.ie/go/become_a_gp)
- Irish College of Ophthalmologists - <http://www.eyedoctors.ie/trainees/>
- Royal College of Physicians and related Faculties - <http://www.rcpi.ie/landing.php?locID=1.6.197>
- Royal College of Surgeons - [http://www.rcsi.ie/surgery\\_nstc](http://www.rcsi.ie/surgery_nstc)

The Medical Council and HSE-MET also maintain career information websites as follows:

- The recently launched Medical Council website (<http://www.medicalcouncil.ie/Education/>) provides useful information from undergraduate to postgraduate level. Users can view information by specialty with a brief overview of the specialty and a link to the relevant postgraduate training body website;
- The purpose of the recently developed HSE Careers Website (<http://www.medicalcareers.ie/>) is to provide specific information regarding all the specialist training programmes. The benefit of such a website is that provides all the relevant information in one place, making it easier for medical students and trainees 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.

With regard to print resources, each autumn a document prepared by the Forum of Irish Postgraduate Medical Training Bodies, with input from the training bodies, is circulated by HSE-MET to all Interns. It provides an overview of postgraduate medical training in Ireland and specifically provides information on BST programmes, including application dates for training programmes and contact information of the training bodies. A number of training bodies have also developed brochures aimed at medical students and Interns.

### *6.2.2 Mentoring Supports*

In December 2011, the Forum of Irish Postgraduate Medical Training Bodies and the HSE jointly hosted a multi-stakeholder workshop aimed at addressing retention issues. At that workshop, there was a clear message from trainees that the training bodies should consider developing a system of mentoring and guidance for doctors in training.

Responsibility for delivering postgraduate medical training in Ireland resides with the training bodies, who select, place, assess and certify doctors in training. The training bodies also recognise that their responsibility extends beyond the provision of training to appropriate mentoring supports.

The structures in place to provide support and mentorship to trainees vary between specialties and different approaches have been taken by the training bodies. The range of mentoring supports currently provided for trainees across the specialties include:

- Informal mentoring;
- Assignment of formal mentors;
- Access to Postgraduate Deans/Tutors/Programme Directors;
- Access to assigned educational supervisors (protected and unprotected sessions);
- Support from trainee representatives;
- Network support.

Each of the above resources can be made available for trainees to discuss career planning and progression. Through these mechanisms trainees should be able to contact a senior person to provide information, support and guidance to help promote their own professional development.

It is recognised that within a pure model of mentoring the ‘mentor’ should not be directly related to the doctor’s training post and some specialties have begun to move towards a more independent structure.

## **6.3 International Evidence Review**

### *6.3.1 Overview of the Review*

As an input to its deliberations, the Working Group sought information on the international evidence relating to mentoring supports for trainee doctors. The HRB conducted the international evidence review on behalf of the Working Group and submitted its finalised report on 13<sup>th</sup> May 2014.

A purposive iterative approach was taken to the research to identify relevant data sources to answer the four questions. Two systematic reviews, one containing studies using different designs and one containing only qualitative studies were used as index papers to unpack key concepts and identify other relevant studies; both reviews were also used to provide key evidence. From the citations in the index papers other relevant reviews and primary studies were identified. Papers were included in the review on the basis of the substantive contribution that they could make to answer the questions.

### *6.3.2 Overview of Review Findings*

#### Defining mentoring

There have been various attempts to define mentoring in the literature and a number of commonalities are noted among existing definitions which include a reciprocal relationship between an experienced person (mentor) and a less experienced person (mentee), which may or may not be formal and structured, but provides the mentee with guidance on personal and professional development and encourages reflection on and learning from decision-making. The literature identified a number of the attributes and skills of a mentor (such as expertise, professional integrity, honesty, accessibility, approachability and facilitation) and how mentors and mentees choose each other (such as assignment, matching and mentee-led selection). There is a strong recommendation in the literature that mentees should not be line managers or educational supervisors.

#### Processes for implementing mentoring programmes

Kashwagi *et al.* (2013), in a large systematic review, identified global objectives of mentoring programmes in the articles reviewed. These were professional or career development, academic success, increased networking and faculty retention. The authors also identified the focused objectives which were project completion, developing liaisons with other organisations and improving communication within the department. They also identified seven programme components in their synthesis of the literature: 1) mentor training and preparation; 2) management committee; 3) contracts or mission statements; 4) pairing mentors and mentees; 5) designing formal curricula for mentees (covering career development, research, teaching and clinical practice); 6) monitoring programme activities and evaluation and 7) programme funding including compensation for mentors and protected time for mentees.

An earlier report for the UK Department of Health prepared by the Doctors' Forum contained a number of useful insights into how mentoring was used to support post-graduate medical doctors in training (Department of Health UK, 2004). The Doctors' Forum reported that there were considerable variations in how mentoring was practised. This was reflected in the many schemes available. The authors noted that despite the variations in schemes, the central concepts of mentoring were consistent in that mentoring helps doctors to help themselves. In practice, mentoring was used both to help doctors' self-development and deal with difficulties. The outcomes for mentees were predominantly developmental, that is, a change in perspective and understanding.

### Mentees' experience of mentoring

There is a limited body of evidence reporting on the direct experience of mentees who have participated in mentoring programmes. The evidence that does exist tends to be primarily descriptive as illustrated by the most comprehensive review of qualitative studies in the literature. Sambunjak *et al.* (2010: 77) in their systematic review of qualitative studies points out that '... the largest gap in the existing body of research relates to the limited depth in which the phenomenon of mentoring in academic medicine has been explored. In most of the included studies, authors performed a thematic analysis of mentoring experiences as reported by the participations without providing a 'thick' description of events and circumstances pertinent to mentoring...[this] limited the level of conceptual innovation we could achieve in our systematic review'.

The evidence assembled suggest that for the most part, mentees perceive mentoring as a positive experience with some studies reporting that mentoring can help mentees develop concrete career goals, boost their self-confidence and enhance their ability to resolve problems. Some studies reported that mentees benefit from career progression and that for some mentoring is vital to career success. Mentees are perceived to have primary responsibility for finding a suitable mentor and informal rather than assigned mentoring relationships appear to be the preference. Characteristics of effective mentors include acting in the best interests of the mentee, being honest and trustworthy, being a good listener and being accessible and approachable; having the capacity to introduce the mentee to professional networks was also desirable. According to a number of authors, successful mentoring goes beyond a doctor's professional role and crosses the personal-professional interface and both mentors and mentees clearly benefit from the relationship. Many authors promote the need for compensation for mentors and protected time for mentees.

### Outcomes of mentoring programmes

Studies reporting on the outcomes of mentoring in medical contexts are scarce in the peer-reviewed literature. This scarcity has been identified beginning with Ehrich *et al.* (2003) and Allen *et al.* (2004), and continuing with Straus *et al.* (2006), Sambunjak *et al.* (2006), Frei *et al.* (2010) and Kashwagi *et al.* (2013). These reviews of mentoring in the medical context represent

an impressive body of evidence, however, they convey more about the nature of the work undertaken to evaluate mentoring than about the effectiveness of mentoring. It would appear that evaluations of mentoring have tended to assess the importance of mentoring, using self-report questionnaires that are completed by mentees either during or retrospective to their mentoring experience.

Sambunjak *et al.* (2006) undertook what they claim was the first systematic review to examine the evidence on the relationship between mentoring in academic medicine and career development in the form of career choice, career progression and scholarly productivity. The overall summary of the studies reviewed suggests that mentoring was an important influence on personal development, career guidance, and career choice and research productivity. Eight of the studies in their review, reported on the influence of personal development and career guidance while five studies reported that mentors were seen as an important career-enhancing factor. In addition, one study from Canada reported that those mentees with a mentor were more likely to achieve a promotion. Most included studies were self-report surveys (34 were cross-sectional), with heterogeneous measures, this meant that statistical pooling of the results was not feasible. The authors report that ‘the poor quality of the studies does not allow conclusions to be made on the effect size of mentoring on any aspect of academic and professional development [among medical students, residents, fellows, and staff physicians]...the limitations of this evidence preclude its use to suggest mentorship strategies that should be implemented at academic institutions...’ (Sambunjak *et al.*, 2006: 1113).

The most recent systematic review by Kashiwagi *et al.* (2013) identified objective outcomes of mentoring programmes as: retention rates; attendance at meetings; number of successful nominations to professional societies and committees; and promotions. Kashiwagi *et al.* included four papers in their review which they claimed measured ‘retention rates. These four papers were retrieved and reviewed for relevant data on the assessment of retention rates as an objective outcome.

Taking these four studies chronologically, Benson *et al.* (2002) reported that ‘our retention data show a trend towards greater retention of participating junior faculty: 38% who did not form preceptoring partnerships left the organisation, as compared with 15% of those who formed partnerships...’ (Benson *et al.*, 2002: 554). It should be noted that the numbers are quite small; from an invited faculty cohort of 144 potential preceptees, 33 applied and 20 formed partnerships. The paper is unclear in reporting on the numbers transitioning from the preceptor programme to the mentoring programme. Pololi *et al.* (2002) reported that ‘the mentoring programme affected faculty members’ retention in academic medicine...in part because it helped many participants find greater satisfaction in their work and improved their understanding about the nature and expectations of academic medicine. Although some indicated an unwavering commitment to academic medicine, with a desire to stay at the medical school that was relatively unaffected by the programme, a few experienced the programme as reinforcing...their decision

to stay...’ (Pololi *et al.*, 2002: 383). Wingard *et al.* (2004) report that...’ 85% remained in the University (10 left) and 93% remained in academic medicine (5 left) one to four years after participation a mentoring programme. A total of 10 participants left the University compared to the 14 expected to leave based on national estimates...the differences observed between those leaving and remaining are not statistically significant but in ‘the desired direction’. Kosoko-Lasaki *et al.* (2006) report that ‘...all faculty members in the mentoring programme at Creighton [one of the sites] have remained after 1 year...’ (Kosoko-Lasaki *et al.*, 2006: 1453). However, on closer inspection of this report, it appears three out of three were retained after 1 year which is quite small numbers.

In summarising the findings of these four papers, Kashiwagi *et al.* concluded that ‘...faculty retention appears to improve in systems with mentoring programs...’ (Kashiwagi *et al.* , 2010: 1036). However, it cannot be reliably concluded that mentoring programmes improve retention rates based on the poor quality of studies reporting to measure this outcome, what may be concluded is that mentoring programmes may be associated with improved retention.

### 6.3.3 Conclusions of Evidence Review

There are a variety of definitions in the literature and they contain common themes which include: professional support, personal support, supportive relationship, reflective practice and a partnership based on common bonds or interests. There is agreement in the literature that the overall outcomes from mentoring are professional or career development, academic success, increased networking and faculty retention. However mentees expectations differ and include having concrete career goals; having boosted self-confidence, and having enhanced ability to use their personal initiative. Seven components of mentoring programmes were identified in a large systematic review and these are: mentor training and preparation; management committee; contracts or mission statements; the selection of mentors for mentees; development of formal curricula; monitoring and evaluation; and programme funding including compensation for mentors and protected time for mentors. The characteristics of effective mentors and mentees are identified in the literature and emphasise confidentiality, listening, trust and an ability to reflect and change. The factors that facilitate successful mentoring are described and emphasise: reciprocity; clear expectations; mutual respect; personal connection; providing a wider perspective and opportunity for reflection, demonstrating a willingness to take risks and a commitment to resolve conflict. Two processes identified in the UK that help achieve successful mentoring are the use of problem solving and change management mechanisms. There is evidence that mentoring is an important influence on personal development, career guidance, and career choice and research productivity. Only one systematic review included retention rates as an outcome and their findings are based on four studies and the reviewer said that mentoring appears to increase faculty retention. However from evidence available currently, it cannot be definitely stated that mentoring improves retention.

## **6.4 Conclusions and Recommendations**

### *6.4.1 Observations and Conclusions*

The Working Group recognises that, historically, career planning information for medical students and trainee doctors has been limited. The Working Group, therefore, welcomes the work that has been undertaken in this regard by the Forum of Irish Postgraduate Medical Training Bodies, HSE-MET, the training bodies and the Medical Council. The Group welcomes the specialty-specific/cohort-specific initiatives outlined in Section 6.2.1, and sees the potential to develop further joint initiatives, such as National Medical Careers Day, as such initiatives are a ‘one-stop-shop’ for medical students and trainees.

With regard to mentoring, the Working Group notes the conclusion of the HRB Review that ‘mentoring is an important influence on personal development, career guidance, and career choice and research productivity’ and, in this context welcomes the work that has been undertaken by the training bodies in response to trainee feedback.

### *6.4.2 Recommendations*

Taking into account the above observations and conclusions, the Group wishes to make the following recommendations in relation to career planning and mentoring supports.

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.
10. 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.

## 7 IMPLEMENTING THE RECOMMENDATIONS OF THE STRATEGIC REVIEW

### 7.1 Introduction

The purpose of this chapter is to set out a high-level implementation plan for the recommendations of this report, provide a progress update in relation to the implementation of the recommendations of previous reports, and identify possible mechanisms for monitoring implementation and the impact of the measures proposed in the future.

### 7.2 Implementing the Recommendations of the Final Report

To advance the implementation of the recommendations of Chapters 2-6 of this report, the Working Group has prepared the following high level implementation plan, which includes key deliverables and suggested dates for implementation of all recommendations, in addition to indicative lists of the parties responsible for their successful delivery.

	RECOMMENDATION	RELEVANT PARTIES	KEY DELIVERABLES	TARGET DATE
STRATEGIC MEDICAL WORKFORCE PLANNING				
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 link with any structures established by HSE-MET in the context of the MWP model being developed by the MWP Project.	Department of Health  Other Government Departments  HSE  HEA	Proposals for structure developed by Department of Health in consultation with other relevant parties	Q4 2014
			Structure established	Q1 2015
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.	HSE	Resource needs identified and action taken	Q3 2014

3	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.	HSE-MET	Proposals developed in consultation with other relevant parties	Q4 2014
			Proposals implemented	Q2 2015
4	<p>The Working Group recognises that, currently, there are in the region of 900 doctors in service posts in the acute hospital sector and 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:</p> <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>	HSE	Proposals developed	Q4 2014
			Proposals implemented	Q2 2015
<b>PUBLIC HEALTH MEDICINE</b>				
5	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	Department of Health HSE Faculty of Public Health	Working Group established	Q3 2014

	<p>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>	Medicine	Report finalised and submitted to Minister	Q2 2015
<b>GENERAL PRACTICE</b>				
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>Department of Health HSE Staff associations</p>	<p>Agreement on introduction of flexible GMS GP contracts</p>	Q4 2014
		<p>Department of Health HSE Staff associations</p>	<p>Relevant parties to consider in context of discussions on new GMSGP contract</p>	To commence by Q4 2014
		HSE	Secure email facility in place	Q4 2014

			to support secure communication between GPs and hospital clinicians	
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.	Department of Health HSE Staff associations	Introduction of new GP contract to provide for introduction of universal primary care	Q4 2014 (for under 6s)
<b>PSYCHIATRY</b>				
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.	HSE	Proposals developed and implemented	Q2 2015
<b>CAREER PLANNING AND MENTORING SUPPORTS</b>				
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.	HSE Medical Council Training bodies	Process developed and agreed	Q3 2015
10	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 was established to address the recommendations of the December report. This work should also take cognisance of the HRB Review.	HSE Training Bodies	Strategy and plan developed	Q1 2015

### **7.3 Progress in Implementing the Recommendations of Previous Reports**

In order to support progress in implementing the recommendations of the previous Strategic Review reports, published in December 2013 and April 2014 respectively, the Working Group sought an update from the relevant parties on developments during the January-June 2014 period. These are set out in detail in Appendix One.

With regard to the interim report (December 2013), the recommendations are being taken forward through the HSE System Reform Group. In relation to the report on career structures and pathways on completion of specialist training (April 2014), the recommendations are being progressed through a number of structures/processes, as appropriate.

### **7.4 Monitoring Implementation and Assessing the Impact**

The Working Group acknowledges 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.

The Group warmly welcomes the progress that has been made to date in advancing the recommendations of previous reports and recognises 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.

In this context, the Group recommends that:

- As a matter of priority, the Department of Health and HSE jointly agree and put in place appropriate multi-stakeholder arrangements to oversee continued implementation of the recommendations of the Review;
- NCHD and Consultant retention rates in the public health system are reported on a quarterly basis through the *Health Service Performance Assurance Report*;
- Six monthly implementation reports are submitted to the Minister for Health, and subsequently published.

It further considers it important that the impact of the measures proposed is regularly assessed. To do this, both lead and lag indicators will be required. The Working Group notes that a number of valuable data sources and research instruments exist within the system which would assist in this regard, including the following:

- HSE-MET'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;
- Annual surveys undertaken by the training bodies.

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## APPENDIX ONE: PROGRESS UPDATE ON IMPLEMENTATION OF PREVIOUS REPORTS

INTERIM REPORT (DECEMBER 2013)				
RECOMMENDATION	KEY DELIVERABLES	TARGET DATE	PROGRESS UPDATE	
1	With regard to the <i>quality of the training experience</i> , 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.	Measures to protect training time identified	Q2 2014	<p>Health service management, the IMO and the Forum of Postgraduate Training Bodies are agreed on the need to ensure NCHD access to protected time for education and training activities as appropriate to their participation in a specialist training or professional competence scheme. It has been agreed that NCHDs will receive rostered protected training time for:</p> <ul style="list-style-type: none"> <li>• On site regular weekly/fortnightly scheduled educational and training activities including conferences, grand rounds, morbidity and mortality conferences</li> <li>• Time to allow trainees to observe and subject to Consultant approval, participation under supervision in certain planned clinical procedures</li> </ul> <p>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 per annum.</p> <p><u>Timelines:</u></p> <ul style="list-style-type: none"> <li>• Development of recording system – June 2014</li> <li>• Implementation – July 2014</li> <li>• Review – December 2014</li> </ul>
		Measures implemented	Q4 2014	
2	In relation to <i>non-core task allocation</i> , 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	National implementation plan developed	Q1 2014	<p>The Nursing and Midwifery Services Director has confirmed that an officer is commencing work on leading this project with effect from 23<sup>rd</sup> June 2013. A number of hospitals that have made significant progress in this matter and the project plan will be developed taking</p>

	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.	Plan fully implemented	Q3 2014	account of this work.
3	With regard to <i>duration of training</i> , 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.	Reviews completed	Q2 2014	The Forum of Irish Postgraduate Medical Training Bodies carried out a review of the duration of Irish training programmes comparing the length of these programmes against the Australian and United Kingdom model.
		Measures implemented (as appropriate)	Q2 2015	<p>Of the 41 comparable training programmes reviewed, 36 (88%) were of equal or less duration as the United Kingdom. Of the 40 comparable training programmes, 20 (50%) were the same duration to Australia.</p> <p>Of the 43 Irish training programmes reviewed, 10 (23%) operate streamlined training programmes. Streamlined training is defined as trainees who enter the programme following Intern year and reach the end point of training within the expected duration once all the required competencies are reached.</p> <p>33 (77%) of the training programmes have two stages of training – BST and HST. In 17 (51%) of these specialties trainees can reasonably expect to progress from BST to HST directly following completion of the BST programme.</p> <p>In 16 (49%) of these training programmes trainees generally work 1-2 years in a non-training registrar post. This “gap” causes extended duration of training for these specialties. The reasons for this “gap” between BST and HST vary.</p> <p>Streamlined training may not be appropriate for all specialties.</p> <p>NCHDs often accept a non-training registrar post in order to gain further experience in the specialty which can increase their competitiveness for an HST programme. Although in some specialties candidates do apply to the</p>

			<p>training programme with BST plus 1-2 years registrar experience currently this is variable across the specialties and changes annually based on intake numbers.</p> <p>It should also be noted that NCHDs also choose to take the extra Registrar year before applying for HST to use the time to decide the specialty path they wish to pursue. A full review of the reasons for the pursuing a gap year and the average number of candidate applying to HST with registrar experience has not been undertaken.</p> <p>Progress to date includes:</p> <ul style="list-style-type: none"> <li>• 94% of the training programmes with an identified expected “gap year” are currently undergoing a formal review of the training programmes with duration included within this review</li> <li>• Three out of the five training programmes whose duration of training programme have been identified as longer than the UK training programmes are formally reviewing the duration of the training programme</li> <li>• The postgraduate training bodies are currently agreeing a policy on recognition of training credit for time spent in other training programmes. The process for applying for recognition of training credit will be made clear as part of the training programme application process. Adoption of a policy of reciprocity will allow trainees who decide to move into different specialties to have credit for previous training time recognised thereby ensuring the training period is not extended unnecessarily</li> <li>• HSE-MET will continue to engage with individual training bodies regarding seamless training and abolition of gap years under the 2014-2015 SLA process</li> </ul> <p><u>Timeline</u></p> <ul style="list-style-type: none"> <li>• Map, by specialty, the average</li> </ul>
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				<p>number of years to complete specialty training. Identifying outliers against international norms. Identify structural issues which extend training : May 2014 - Complete</p> <ul style="list-style-type: none"> <li>• Review of structural issues which extend training : October 2014</li> <li>• Implement changes as appropriate: July 2015</li> </ul>
4	<p>The Working Group considers that <i>greater predictability at the outset of training schemes</i> regarding locations of rotation would be beneficial for trainees and their 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>	<p>Measures implemented on a specialty-by-specialty basis</p>	<p>Q2 2014</p>	<p>The Forum of Irish Postgraduate Medical Training Bodies carried out an audit of the number of pre-defined rotations within the Irish training programmes.</p> <p>There are 7 BST programmes and 4 (57%) of these programmes offer pre-defined rotations. Of the BST training programmes who do not offer pre-defined rotation 100% intend to introduce set rotations in 2015.</p> <p>There are 33 HST programmes and 10 (30%) offer pre-defined rotations of at least 2 years in duration. Of the HST training programmes who do not offer pre-defined rotations 91% intend to introduce set rotations in July 2015.</p> <p>Of the 10 streamlined training programmes reviewed 3 (30%) offer pre-defined rotations of at least 2 year in duration. Of the streamlined training programmes who do not offer pre-defined rotations 100% intend to introduce set rotations in July 2015.</p> <p>HSE-MET will continue to engage with individual training bodies regarding pre-defined rotations under the 2014-2015 SLA process.</p> <p><u>Timeline</u></p> <ul style="list-style-type: none"> <li>• Map, by training programme, the current practice identifying specialties that do not offer pre-defined rotations : May 2014 - Complete</li> <li>• Specialties that do not offer pre-defined rotations design rotation: October 2014</li> <li>• Implement pre-defined rotations : July 2015</li> </ul>

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 <i>more flexible and differentiated approaches and options during training</i> 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	Q2 2014	Currently in place is the HSE National Flexible Training Scheme for Higher Specialist Trainees which is a national scheme managed and funded by HSE-MET. The scheme provides for 24 supernumerary places to facilitate doctors at higher specialist training level to continue their training in a flexible manner for a set period of time. It is recognised that this scheme is limited and increasing the number of available places is not viable. The Forum and the HSE are working together to explore other options to provide flexible training. Work in progress includes: <ul style="list-style-type: none"> <li>• Defining and considering the categories of flexible training that could be offered (half time, week on/week off, 3 day week etc)</li> <li>• Quantifying the demand by trainees for flexible training</li> <li>• Considering the training implications, service impact and contractual issues</li> </ul> The goal for the 2015 intake is to include an option for training flexibly.
		Couple-matching initiative implemented	Q2 2015	
6	In relation to <i>training supports</i> , 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	Q2 2014	Currently there are two schemes in operation which provide financial support to NCHDs. These are: <ul style="list-style-type: none"> <li>• Clinical Course &amp; Examination Refund Scheme for NCHDs - this scheme is open to all NCHDs. There is an approved list of clinical courses &amp; examinations qualifying for this refund scheme. A maximum contribution of €450 is payable to NCHDs for each course or exam on this list.</li> <li>• Specialist Training Fund for Higher Specialist Trainees - This scheme is open to Higher specialist trainees and 3rd/4th year GP trainees only. The funding available to each trainee is €500 per year of training and the fund rolls over if not claimed in a particular year.</li> </ul> HSE-MET recognises that the costs associated with training may vary depending on the specialty. HSE-MET will work with the Forum of Postgraduate Training Bodies to review the above schemes in order to ensure that the supports available are targeted more

				appropriately to reflect the needs/requirements of the trainee and specialty. Another aim of the review is to promote the schemes to ensure awareness amongst trainees, and to streamline the process for trainees in accessing these funds.
7	With regard to the <i>paperwork burden associated with rotations</i> , the Working Group recommends that the HSE and employers should jointly explore how processes can be streamlined. Addressing 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	Q2 2014	The HSE and employers appreciate the volume of paperwork associated with NCHDs rotating between hospitals/employers and understand the need to streamline processes in order to minimise the paperwork burden.
		Measures implemented	Q4 2014	<p>It is felt that an electronic solution is required in order to eliminate hard copy documents/forms being completed/submitted as part of each rotation. A proposal document is currently being prepared by the HSE. It is proposed to use a web based system to control and manage NCHD documentation. All data/documents will be stored via the use of cloud computing and will be accessible to NCHDs and their respective employers.</p> <p><u>Timeline</u></p> <ul style="list-style-type: none"> <li>• Establish working group with relevant key stakeholders: June 2014</li> <li>• Review current procedures/processes associated with NCHDs rotating: September 2014</li> <li>• Agree on standardised hospital/employer requirements: October 2014</li> <li>• Design system: December 2014</li> <li>• Test/Pilot/Roll Out Nationally: March – June 2015</li> </ul>
8	With regard to <i>improving communication</i> , 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	Q1 2014	A lead NCHD model, mapped to the clinical directorate structure, has been piloted for the acute hospital system. This model was designed to provide a specific and structured interface between the clinical directorate structure and hospital management and the NCHDs through the conduit of a Lead NCHD.
		Measures to improve communication identified and implemented	Q3 2014	The role of the lead NCHD is to provide a formal link at management level between the relevant NCHD cohort and the clinical directorate / hospital management structure, thereby enabling a structured, continuous two way flow of engagement and communication between

				<p>management and NCHDs. This initiative was supported by the Joint HSE/Forum of Irish Postgraduate Medical Training Bodies Clinical Director/Clinical Programme Steering Group and Forum Trainee Subcommittee.</p> <p>The recruitment for the pilot began in January 2014 with Lead NCHDs appointed in 8 clinical sites. Each Lead NCHD was given a level of protected time on those sites and the funding available to the sites to enable and facilitate such was provided.</p> <p>A review of the pilot programme is currently being undertaken by HSE-MET and the Clinical Director Programme.</p> <p>A questionnaire has been sent to the clinical director and the CEO/Hospital Manager of the relevant sites seeking views on the pilot.</p> <p>Each Lead NCHD has or will meet with the National Lead for the Clinical Director Programme and/or National Lead for Medical Education and Training to review the pilot. The review is expected to be completed by July 2014.</p> <p>Following this review the HSE will determine if the programme will be rolled out nationally.</p>
9	<p>With a view to <i>supporting career planning</i>, 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>Q1 2014</p>	<p>As reported in Chapter 6, the HSE has launched 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 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>

**REPORT ON CAREER STRUCTURES AND PATHWAYS FOLLOWING  
COMPLETION OF SPECIALIST TRAINING (APRIL 2014)**

RECOMMENDATION		KEY DELIVERABLES	TARGET DATE	PROGRESS UPDATE
1	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 <i>variation in rates of remuneration between new entrant Consultants and their established peers</i> that have emerged since 2012. It further recommends that the relevant parties explore options, within existing contractual arrangements, to advance a <i>more differentiated Consultant career structure</i> as outlined in Section 5.3 (i.e. clinical service provision, clinical leadership and management, clinical research, academic, quality improvement and other roles).	Agreement on a more differentiated Consultant career structure and associated rates of remuneration	July 2014	This process has commenced and active engagement is underway.
2	With regard to <i>developing opportunities for flexibility within the Consultant's work commitment</i> , 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	Q4 2014	This recommendation has been allocated, along with recommendation 4 below, to the HSE System Reform Group for implementation.

3	With regard to <i>family-friendly flexible working</i> , 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	Q3 2014	This recommendation has been allocated to HSE National HR for implementation.
4	In relation to <i>improving supports for newly appointed Consultants</i> , 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. 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.	See Recommendation 2 above	Q4 2014	This recommendation has been allocated, along with recommendation 2 above, to the HSE System Reform Group for implementation.
5	The Working Group recommends that the reconfiguration of hospital services should be used as an opportunity to address the barrier of the <i>unattractiveness of the working environment in some Level 2 and Level 3 hospitals</i> . 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.	Hospital Group strategic plans incorporate proposals for rationalisation of services with unscheduled care rosters	Within 1 year of establishment of Hospital Group	This recommendation has been submitted to the Strategic Advisory Group on the Implementation of Hospital Groups, and will be incorporated into the criteria used to evaluate the strategic plans of Hospital Groups as they evolve.

6	<p>With regard to <i>improving clarity around availability of Consultant posts by specialty and location</i>, 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. 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.</p>	<p>Medical workforce planning model developed and implemented</p>	<p>Q2 2015</p>	<p>In progress as reported in Chapter Two of this report.</p>
		<p>Proposals for development of post-CSCST fellowship capacity</p>	<p>Q4 2014</p>	<p>This recommendation has been allocated to HSE-MET for implementation.</p>