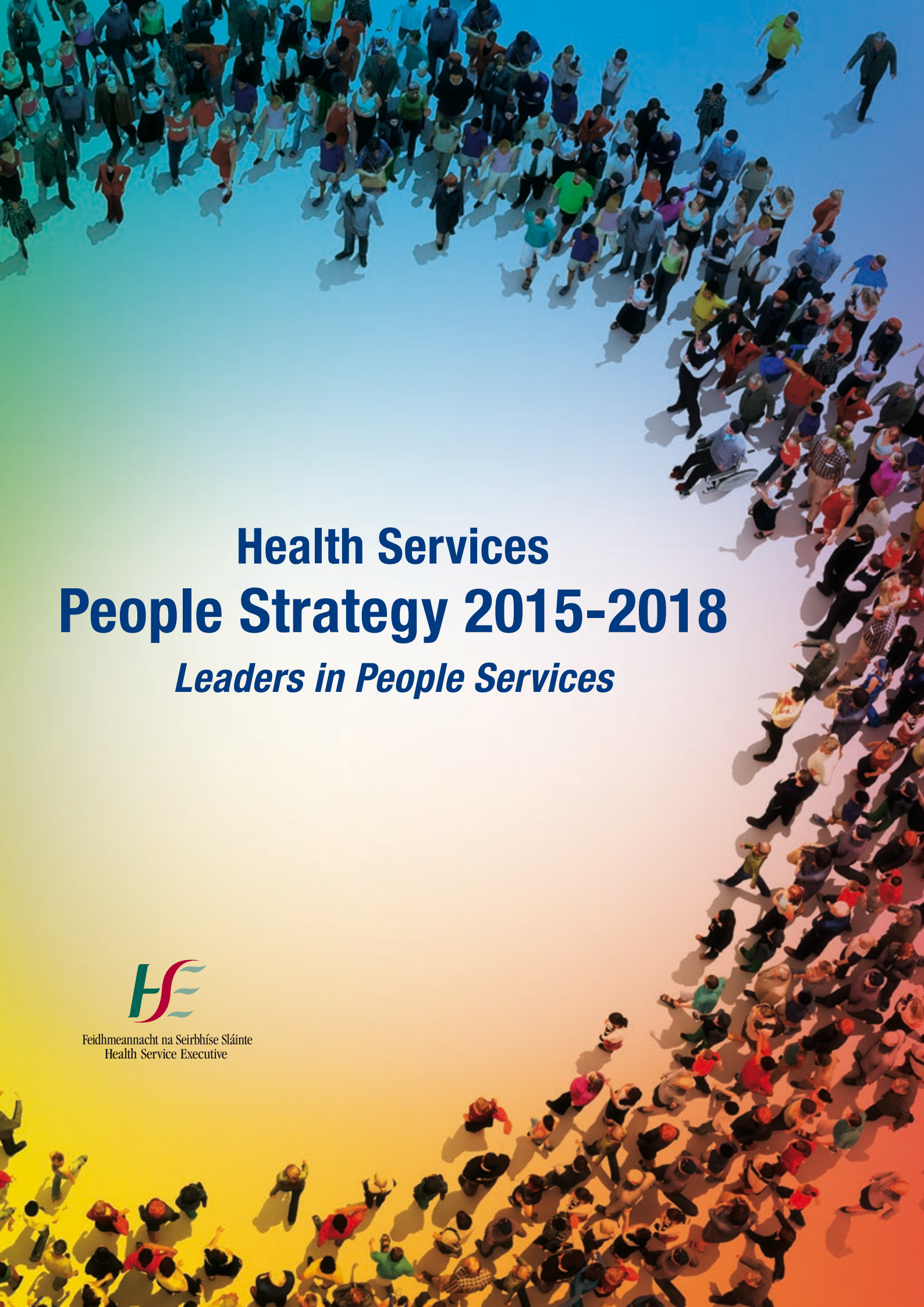

# Health Services
# People Strategy 2015-2018
## *Leaders in People Services*

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

## Supporting Documentation

All supporting documentation which was generated in the development phase of the *People Strategy,* including the theoretical background, is available from nationalhr@hse.ie

Work Plans with assigned responsibility, deliverables and time frames have been developed to support the implementation of the *People Strategy* - these are also available from nationalhr@hse.ie

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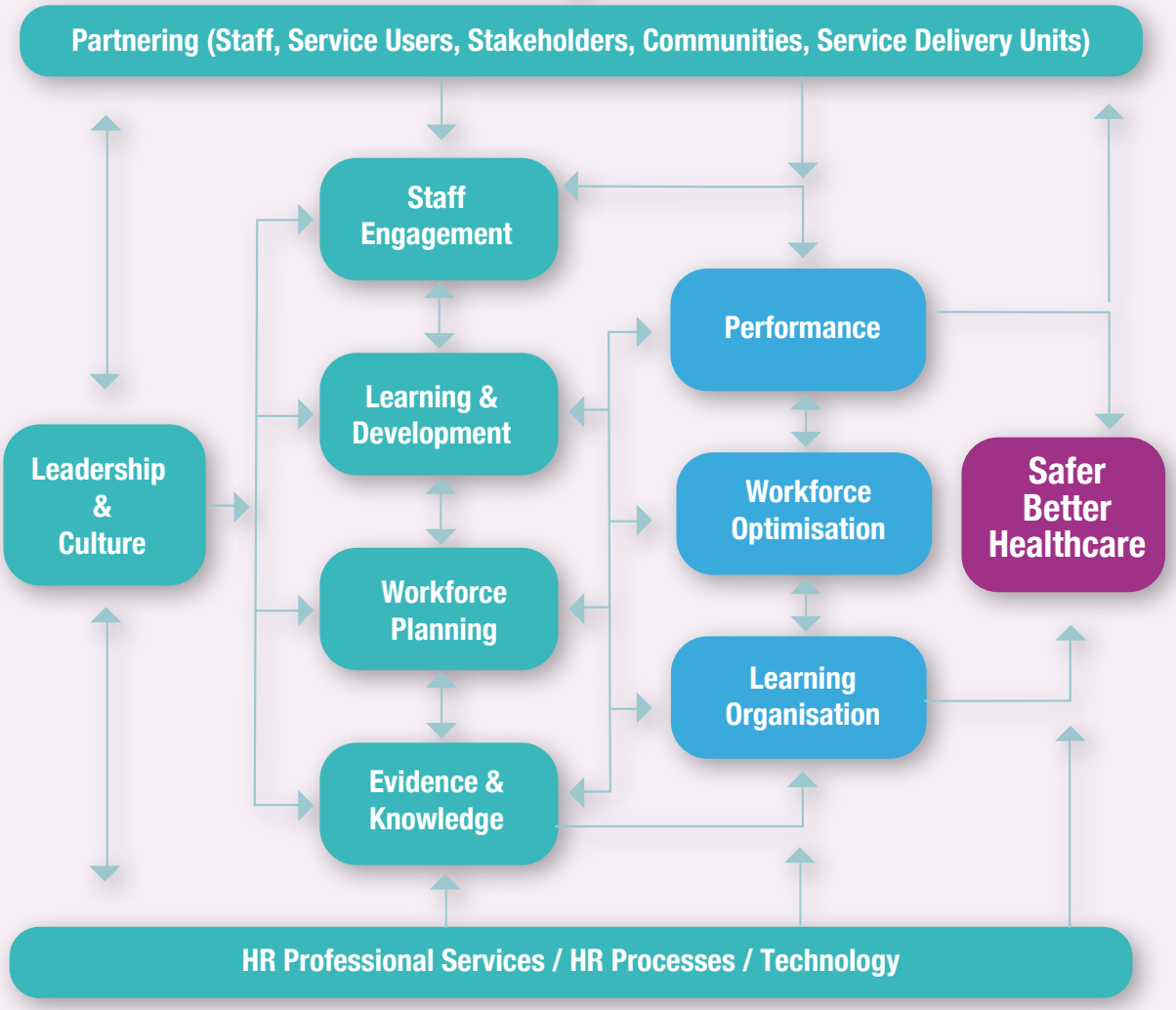
# Acknowledgement

The development of the *People Strategy* involved a significant level of dedicated preparation, planning, analysis and support during 2015. I would like to acknowledge all those who were involved in the development phase and wish in particular to thank those of you who actively participated in the engagement and consultation workshops. I also wish to acknowledge all those who provided valuable feedback on the *Strategy* during its development. Thank you also to those who provided administrative support in the gathering of data and completing documentation to support the *Strategy* development process. I am confident that with the support of senior leaders and HR colleagues at national and service delivery levels throughout the country we can make real progress in realising our ambition to become leaders in people services.

**Rosarii Mannion,**
**National Director of Human Resources**

# *People Strategy* Framework 2015-2018

## Leaders in People Services




Legend: Enablers | Results | Goal

Our Values

Care Compassion Trust Learning

# Foreword

Our vision for healthcare as set out in the *Corporate Plan, 2015 - 2017* is to put people at the heart of everything we do - we are committed to delivering high quality safe healthcare to our service users, communities and the wider population. This *People Strategy* has been developed in recognition of the vital role of staff at all levels in addressing the many challenges in delivering health services across and within all settings in communities, hospitals and healthcare facilities. Our clear commitment is to engage, develop and value our workforce to deliver the best possible care and services to the people who depend on them. We also know from evidence that staff who are valued, supported in their development and treated well improve patient care and overall performance.

This *People Strategy* underpins the wider health reform and is focused on people services for the whole of the health system - improved people management is the responsibility of all leaders, managers and staff. The role of our colleagues in Human Resources (HR) is to lead, facilitate and support many of the activities described in the *Strategy* and to do so by working in partnership with colleagues throughout the system. Many of the important actions outlined will only be delivered by working across and between services at all levels and in particular by engaging with frontline staff who are our connection with those who use our services. By working together on the implementation of the *Corporate Plan* and *People Strategy* we will reform our services and have pride and confidence in our ability to deliver excellence to the people living in our communities. I look forward to working with colleagues across the health services to harness the talent and expertise of our staff at every level and drive the implementation of the *People Strategy*.

**Tony O'Brien,**
*Director General*

# Leaders in People Services

Across the health system a talented, committed workforce through their collective knowledge, skills and hard work provide excellent health services to those who need care and to the wider community. This *People Strategy* is focused on providing a cohesive framework to lead, manage and develop the contribution of all staff in an environment that is conducive to learning and wellbeing. It is also focused on the future needs of the service to meet the workforce demands to attract and retain high calibre staff. It is supported by detailed Work Plans that have named responsibility to deliver the outcomes required under the direction of the HR Leadership Team.

This *People Strategy* identifies the following people management priorities that will be targeted for action recognising the need for leadership and support at every level to implement improvements:

- Leadership and Culture
- Staff Engagement
- Learning and Development
- Workforce Planning
- Evidence and Knowledge
- Performance
- Partnering

It is intended that by addressing these important areas as detailed in the *People Strategy* and associated Work Plan we will improve our performance, optimise our workforce and develop further as a learning organisation.

The *People Strategy* in particular provides the system with a challenge to start doing things differently in people management. I am particularly committed to developing a professional HR Service that is technically competent and responsive to the needs of the organisation. In partnership with you, your representative organisations, professional bodies, Trade Unions and academic partners, I believe we can transform how people management is delivered throughout the system.

As a HR Service, we need to continue to listen to staff, act on your feedback and advocate on your behalf to improve the work environment and enhance services. The outcome of the first *Employee Survey, 2014* has informed our thinking and there are plans underway to conduct another staff survey in 2016. I am looking forward to working with you to implement this *People Strategy* and hope that together we can create a modern, inclusive, caring, and high performing HR Service that will support the delivery of safer better healthcare to those have placed their trust in us to do so.

**Rosarii Mannion,**
*National Director of Human Resources*

# National Context

The development of the *People Strategy* has been shaped by a number of relevant national strategies and frameworks including the following:

- ***Health Service Executive Corporate Plan 2015 - 2017:*** sets out the overall direction for health and social care services and what needs to be achieved over the next three years. The core purpose of this *People Strategy,* is to support the implementation of the *Corporate Plan,* taking into account the significant other contextual frameworks in the system. It provides leadership in relation to the human resource aspects in terms of adding value, enhancing the people capability and being organised in a way that delivers on national requirements.
- ***Performance Accountability Framework for the Health Services 2015:*** sets out the means by which the HSE, and in particular the National Divisions, Hospital Groups and Community Healthcare Organisations (CHOs), will be held to account for their performance in relation to **Access** to services, the **Quality and Safety** of those services, doing this with the **Financial** resources available and by effectively harnessing the efforts of its overall Workforce.
- ***Future Health - A Strategic Framework for Reform of the Health Service 2012 - 2015:*** sets out the commitment for the Department of Health and HSE to work together to implement an approach to workforce planning and development with the objectives of:

  - Recruiting and retaining the right mix of staff
  - Training and up-skilling the workforce
  - Providing for professional and career development
  - Creating supportive and healthy workplaces
  - Investing in leadership, management development and succession planning

- ***Department of Health - Statement of Strategy 2015 - 2017:*** commits to playing its part in nurturing a health system where high performance is achieved and the knowledge and skills of health service staff are enhanced and developed. An underlying objective is to have a stable and sustainable workforce to achieve national priorities and clinical and operational improvement.
- ***National Standards for Safer Better Healthcare 2012:*** describes a vision for high quality, safe healthcare and prioritises standards related to Leadership, Governance, Management and the Workforce. In particular it acknowledges that people working in the service are recruited, organised, developed and supported so that they have the skills, competencies and knowledge to enable the delivery of high quality, safe and reliable care.
- ***Healthy Ireland 2013 - 2025 and Healthy Ireland in the Health Services - National Implementation Plan 2015 - 2017:*** an effective health system is a prerequisite for improved health and wellbeing and a competent skilled and multi-disciplinary workforce is the most important resource for delivering health and wellbeing services.
- ***Public Service Agreement 2010 - 2014*** *(Croke Park Agreement)****; Public Service Stability Agreement 2013 - 2018*** *(Haddington Road and Lansdowne Road Agreements)*
- ***HSE Framework for Improving Quality in our Health Services 2015:*** developed to ensure that the thinking, planning and delivery of care in our services is orientated firmly towards quality and improved patient and service user experiences and outcomes.
- ***Human Resource Management in the Public Health Sector - HR Proposition 2013:*** this proposition outlined how HR needed to change within the context of the overall reform of the Public Health Sector, taking up a critical leadership role in supporting the change.
- ***Health Services Employee Survey:*** undertaken in 2014, the findings reinforced a number of significant organisational messages including the need to reconnect with leadership, enhance communications, demonstrate staff value, recognise diversity and maximise staff potential.

# Background to the *People Strategy*

The *People Strategy* sets out our ambition for people management across the health services. It is grounded in an ethos of valuing the collective capabilities, knowledge, skills, life experiences and motivation of our workforce - **our human capital.** The *Strategy* was developed through many engagement sessions with staff and stakeholders from all parts of the health system. Included in this process were engagement workshops where the analysis of the issues, potential solutions and approaches were developed. The *Strategy* was also informed by relevant contextual and theoretical references and research[1]. The evidence clearly indicates how HR policies interconnect with line management practices to create employee satisfaction, motivation and commitment leading to high performance. The research also indicated that we could reduce mortality, decrease morbidity and improve the quality of life of our patients and service users through better quality people management. The latter part of the strategy development process focused on distilling important people management practices that would enhance organisational performance underpinned by the following concepts:

- Leading with vision, inspiration and integrity
- Adding value for service users, communities and staff
- Creating a sustainable future
- Developing organisational capability
- Harnessing creativity and innovation
- Managing with agility
- Succeeding through the talent of people
- Sustaining service excellence

[1]Detailed data from consultation sessions and supporting documentation available from: nationalhr@hse.ie

# Implementation of the *People Strategy*

This document provides the *People Strategy* Framework, intended outcomes and what we will do to deliver on the priority areas identified. The *Strategy* is supported by **Work Plans** that set out the detailed actions and deliverables for each of the interrelated priorities. Members of the HR National Leadership Team will take lead responsibility to drive and support implementation. The implementation of the *Strategy* will also be supported by a formal programme management approach to ensure that work is undertaken in a planned and systematic manner. This is line with the broader system reform programme work that is currently underway. Implementation of the *People Strategy* will be led, facilitated and supported by the HR Division. The approach to implementation will be based on partnering with managers and staff throughout the system to ensure ongoing relevance, taking a joined up approach to the delivery of the strategic priorities.

# Future Role and Purpose of Human Resources

In order for HR to effectively deliver on the *People Strategy* and serve the system to achieve its corporate goals, reform of HR Services is needed. The *People Strategy* in particular sets out the organisational commitment to enable the HR Service to move to a more facilitative, supportive, developmental and enabling approach that fully understands its role to serve healthcare business and clinical priorities. In order to achieve this there is a need for a change in the capacity and capability of the HR profession and in the approach that it brings. HR is committed to taking up a business partnering role at strategic levels within the organisation. Line managers throughout the system are key to the delivery of excellent people services - the HR Service is committed to working in partnership with line managers to add value and enhance people capability. From a technical HR perspective, being able to respond in a timely and efficient manner and provide guidance on relevant HR Frameworks and Policy will be central to our success. The HR delivery system will be re-organised in a way that is positioned to deliver on the HSE Corporate Goals and to support CHOs, Hospital Groups and the National Ambulance Service (NAS). This will require a revision of the HR Delivery Model and associated structures.

# *People Strategy* - Vision, Mission and Values

**VISION**

**A Healthier Ireland with a high quality health service valued by all.**

**Source**: *Building a high quality health service for a healthier Ireland, Health Service Executive Corporate Plan 2015 - 2017*

**MISSION**

**People in Ireland are supported by health and social care services to achieve their full potential.**

**People in Ireland can access safe, compassionate and quality care when they need it.**

**People in Ireland can be confident that we will deliver the best health outcomes and value through optimising our resources.**

**PEOPLE VISION**

**Enabling all staff to perform to the best of their ability delivering service excellence.**

**PEOPLE MISSION**

**Provide professional HR Services to transform the organisation's capability to deliver safer better healthcare by creating an environment that supports and values staff.**

# Values

## Care

- We will provide care that is of the highest quality
- We will deliver evidence based best practice
- We will listen to the views and opinions of our patients and service users and consider them in how we plan and deliver our services

## Compassion

- We will show respect, kindness, consideration and empathy in our communication and interaction with people
- We will be courteous and open in our communication with people and recognise their fundamental worth
- We will provide services with dignity and demonstrate professionalism at all times

## Trust

- We will provide services in which people have trust and confidence
- We will be open and transparent in how we provide services
- We will show honesty, integrity, consistency and accountability in decisions and actions

## Learning

- We will foster learning, innovation and creativity
- We will support and encourage our workforce to achieve their full potential
- We will acknowledge when something is wrong, apologise for it, take corrective action and learn from it

We will try to live our values every day and will continue to develop them over the course of this plan

### Health Service Executive Corporate Plan 2015 - 2017

The *Corporate Plan* clearly sets out our values of ***Care, Compassion, Trust and Learning.***
Embedding these values into everything we do will help make our vision a reality. In practice, we need to:

- Demonstrate value in the way we work and treat each other
- Use our values to guide the decisions we take
- Identify and deal with behaviours that don't live up to our expectations
- Be responsible for the way we work and not just the work we do

# *People Strategy* delivering on the *Corporate Plan*

## People Ambition

We want to deliver the best possible care to our patients and service users.
We will continue to invest in and develop a workforce that is dedicated to excellence, welcomes change and innovation, embraces leadership and teamwork and maintains continuous professional development and learning.

**Source:** *Building a high quality health service for a healthier Ireland, Health Service Executive Corporate Plan 2015 - 2017*

# Our Plan

This *Corporate Plan* sets out our 5 goals, the actions required to deliver them and how we will measure success

**Goal 1**
- Promote health and wellbeing as part of everything we do so that people will be healthier

**Goal 2**
- Provide fair, equitable and timely access to quality, safe health services that people need

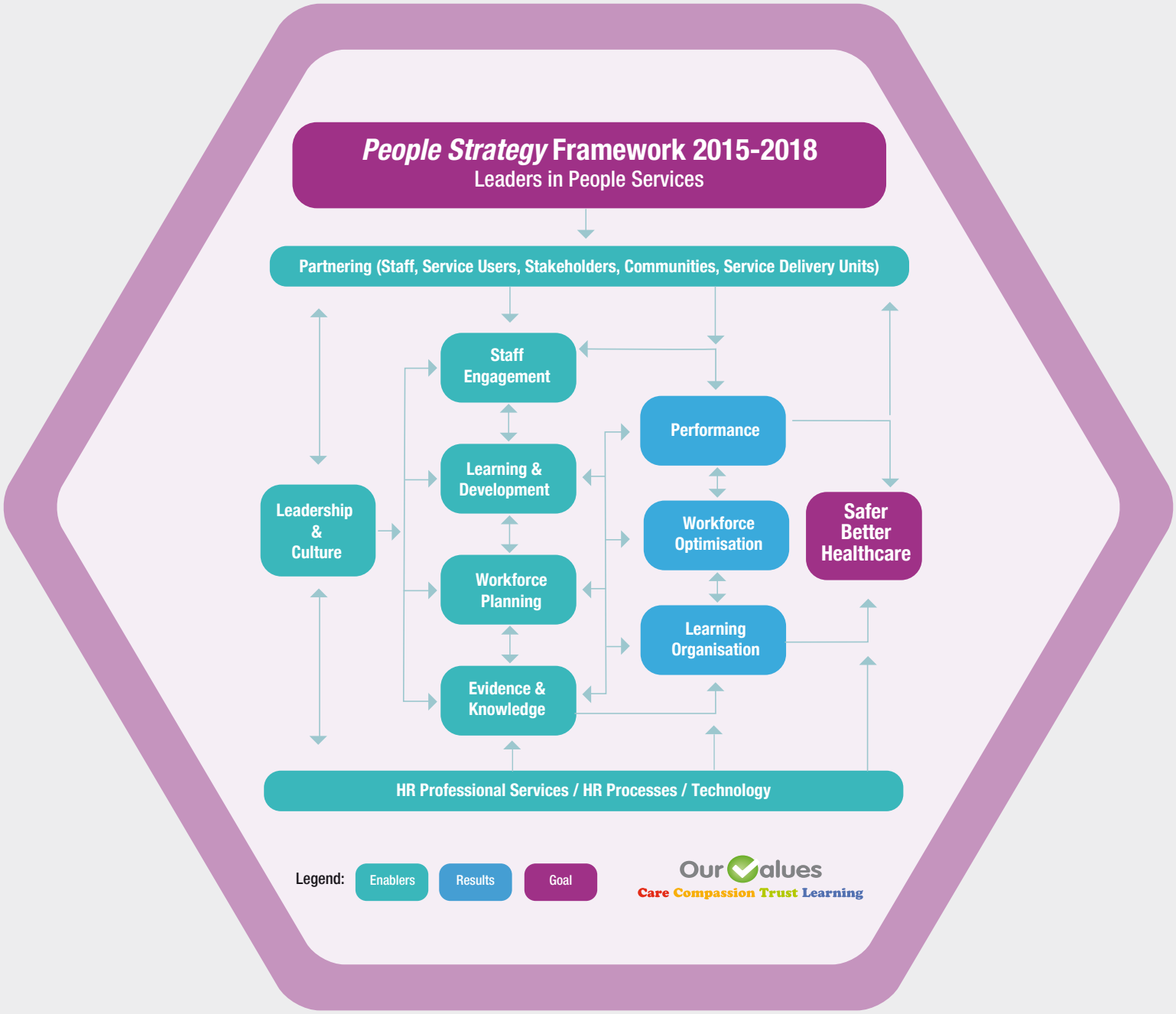
**Goal 3**
- Foster a culture that is honest, compassionate, transparent and accountable

**Goal 4**
- **Engage, develop and value our workforce to deliver the best possible care and services to the people who depend on them**

**Goal 5**
- Manage resources in a way that delivers best health outcomes, improves people's experience of using the service and demonstrates value for money

# *People Strategy* Framework

The Framework used to outline the strategic priorities in the *People Strategy* is based on an applied version of the Excellence Model (European Foundation for Quality Management - EFQM). The key premise of the Framework is that achieving our ultimate goal of ***Safer Better Healthcare*** is achieved through leadership driving cultural change enabled by staff engagement, workforce planning and adopting a partnering approach. This is further supported by learning and development, use of evidence and knowledge, HR transactional processes and performance management. The Framework also presents core people management results i.e. becoming a learning organisation, workforce optimisation and improved performance throughout the delivery system. The main value in presenting this Framework is that it gathers the interrelated and interdependent elements of the *People Strategy* which can then be applied at different levels across the system and adapted to local contexts. The key elements are outlined below:



# *People Strategy* Outcomes


The *People Strategy* planned outcomes are the statements that describe what will be achieved and what can be reliably demonstrated or measured at the end of the *Strategy* implementation process. Adopting this approach supports our ambition and challenges the whole system to deliver on a common agenda. The combined outcomes from each of the priority areas in the *People Strategy* will result in improved performance, workforce optimisation and a learning organisation delivering the overall goal of Safer Better Healthcare.

### Priority 1 Leadership and Culture

Effective leadership at all levels, working collectively towards a common purpose, creating a caring and compassionate culture and inspiring innovation, creativity and excellence throughout the organisation.

### Priority 2 Staff Engagement

Staff have strong sense of connection to the service, take personal responsibility for achieving better outcomes and support team colleagues to deliver results.

### Priority 3 Learning and Development

A learning culture that prioritises development to ensure staff are equipped to confidently deliver, problem solve and innovate safer better healthcare.

### Priority 4 Workforce Planning

Comprehensive workforce plan in place based on current and predicted service needs, evidence informed clinical care pathways and staff deployment.

### Priority 5 Evidence and Knowledge

Work practices and client pathways are evidence informed and decision making is based on real time and reliable data.

### Priority 6 Performance

Staff and teams are clear about roles, relationships, reporting and professional responsibilities so that they can channel their energy and maximise performance to meet organisational targets.

### Priority 7 Partnering

Partnership with staff, service managers and stakeholders effectively developed and managed to add value and support the delivery of safer, better healthcare for local communities driving change and improving the client experience.

### Priority 8 Human Resource Professional Services

HR Services designed to create value, enhance people capacity and positioned to deliver organisational priorities.

# PRIORITY 1
# LEADERSHIP & CULTURE

Outcome: Effective leadership at all levels, working collectively towards a common purpose, creating a caring and compassionate culture and inspiring innovation, creativity and excellence throughout the organisation.

## What We Will Do

### Leadership Strategy

1.1 Launch and communicate the *People Strategy* to set out the direction for people services across the system.

1.2 Develop models of shared and distributed leadership, nurturing a strong culture of engagement and team working, inspiring staff at all levels to deliver high quality, safe services.

1.3 Create a national *Leadership Academy* comprising the best thought and practice based leaders from across the system to lead, influence and develop leadership standards, practice and succession management.

1.4 Work in collaboration with stakeholders to develop a single purposeful *Leadership and Management Development Strategy*.

1.5 Place particular emphasis on engaging clinicians and supporting them in leading change and quality improvements at all levels.

1.6 Refresh and validate leadership competency framework to recruit, develop and retain staff of the highest calibre across all staff groupings.

### Leadership Presence

1.7 Develop and support leaders to provide direction and purpose, and connect with all staff and teams through open and transparent communication, demonstrating evidence based decision making as core leadership practices.

1.8 Develop leaders' capacity to engage effectively with service users, work with other relevant health service divisions and connect with local communities to enhance the quality of patient pathways and patient experiences.

1.9 Increase visibility and connection between leaders and staff listening to feedback, focusing on person centred quality improvements and delivering timely solution-focused responses.

### Leadership Culture

1.10 Work with the Quality Improvement Division to develop a leadership culture that is firmly focused on quality and improved patient and service user experiences and outcomes.

1.11 Strengthen leadership capacity to lead and manage transformational change and reform with a particular focus on a coaching facilitative style of management.

1.12 Work with the Communications Division to support a leadership culture that can deliver excellence in healthcare communications.

1.13 Demonstrate leadership behaviours that support front line staff to contribute to and drive improvements in the care they provide through a continuous learning culture.

1.14 Create a team culture of respect for each other's knowledge, skills and viewpoints and change behaviours that negatively impact on patient safety or colleagues' effectiveness.

### Leadership Accountability

1.15 Develop accountability arrangements so that each staff member and team is clear regarding role, decision-making authority and fit within the organisation in line with the *Performance Accountability Framework* for the Health Services.

1.16 Ensure that health outcomes for service users and communities are central to leadership accountability and measurement frameworks.

1.17 Put in place performance and accountability review systems at individual, team and service levels.

# PRIORITY 2
# STAFF ENGAGEMENT

Outcome: Staff have a strong sense of connection to the service, take personal responsibility for achieving better outcomes and support team colleagues to deliver results.

## What We Will Do

### Staff Voice

2.1 Embed an engagement culture as a hallmark of leadership by taking a whole system approach to developing a *Staff Engagement Strategy* working with all Divisions building on the experiences and contributions of staff.

2.2 Conduct an annual *Staff Survey* and work with the delivery system to take actions based on findings.

2.3 Prioritise effective two-way communication as a core enabler of meaningful staff engagement.

2.4 Value the unique position of front line workers by systematically listening to their feedback, responding appropriately and initiating service improvements.

2.5 Establish HR User Groups to ensure greater connectivity with the service delivery units and partners across the system.

### Staff Commitment

2.6 Enable staff to have meaningful roles, performance feedback and recognition, appropriate decision-making autonomy and development opportunities.

2.7 Support staff to act as advocates for service users and enable their participation in decision making regarding care planning and solution focused approaches.

2.8 Support collaborative practice through investment in team working, team leadership and service user engagement to deliver integrated quality care.

2.9 Promote Diversity, Inclusion and Equality across the system valuing different perspectives, depth of experience and the strengths and potential of individuals and teams.

### Staff Health and Wellbeing

2.10 Develop *Staff Health and Wellbeing Strategy* to support staff in managing their own health and wellbeing.

2.11 Ensure policies and procedures are designed to enable staff to maximise their work contributions and work life balance.

### Staff Working Environment

2.12 Strengthen occupational safety and health support and advice across the system to support managers in developing working environments that are conducive to the delivery of safer better healthcare.

2.13 Build on *Positive Workplace Initiatives* that recognise our social and collective responsibilities to create sustainable and nurturing environments that recognise staff and value resilience and innovation.

2.14 Put in place protocols to empower staff to raise concerns and take action if they perceive risks to service users, colleagues or themselves and support them in relation to adverse events.

PRIORITY 3

# LEARNING & DEVELOPMENT

Outcome: A learning culture that prioritises development to ensure staff are equipped to confidently deliver, problem solve and innovate safer better healthcare.

## What We Will Do

### Learning and Development Plan

3.1 Develop a *Learning and Development (L&D) Plan* with an agreed funding stream that builds individual and organisation capacity and knowledge to meet current and strategic requirements.

3.2 Communicate what staff can expect by way of supports to progress learning and development in a fair and transparent manner.

3.3 Develop processes for learning needs analysis and learning transfer to support current and anticipated future service delivery standards.

3.4 Assess and develop the capability and capacity of current leaders against future service requirements, anticipated challenges and agreed leadership competencies.

3.5 Ensure all L&D interventions delivered internally or contracted through academic or other partners are aligned to organisational priorities and the requirements of Community Healthcare Organisations (CHOs), Hospital Groups and the National Ambulance Service (NAS).

3.6 Increase the focus on multi-disciplinary development to enhance the patient experience, support team working/collaborative practice and bring about evidence based service improvements.

### Learning and Development Delivery

3.7 Integrate all aspects of L&D into a single consolidated delivery service.

3.8 Invest in internal HR and L&D professionals to support them in the optimum delivery of innovative thought-leading leadership and development programmes and interventions.

3.9 Prioritise delivery of mandatory and statutory training and commission new training provision related to prioritised need.

3.10 Collaborate internally and externally to lead innovative design of critical learning interventions and programmes across the organisation.

### Learning and Development Approach

3.11 Put in place *Personal Development Plans* and enable staff exercise personal and professional responsibility for the quality and safety of services provided.

3.12 Ensure personal development planning and staff supervision are core management practices focusing on the competencies, knowledge and behaviours of staff.

3.13 Work with leadership colleagues to embed systematic processes to identify talent and support leadership and career development.

3.14 Develop coaching and mentoring as a key leadership and line management support in facilitating improved performance and service developments.

3.15 Work with professional bodies and staff representative associations to develop Continuous Professional Development responses that support improved performance.

3.16 Support staff to achieve professional registration and credentialing.

3.17 Prioritise 'on the job' experiential learning through job rotation and shadowing and consider augmenting existing capability through partnerships, secondments and interchanges.

### Learning and Development Evaluation

3.18 Review effectiveness of current learning delivery and support systems and embrace new methodologies including further development of e-learning approaches (e.g. www.hseland.ie)

3.19 Quantify the L&D spend, evaluate and measure learning and development outcomes to ensure organisational relevance and return on investment.

# PRIORITY 4
# WORKFORCE PLANNING

Outcome: Comprehensive workforce plan in place based on current and predicted service needs, evidence informed clinical care pathways and staff deployment.

## What We Will Do

### Workforce Planning Framework

4.1 Develop an integrated multi-disciplinary *Workforce Planning Framework* based on best practice to add value, attract and retain talent and deliver on organisational goals.

4.2 Develop the knowledge and skills to undertake high quality workforce planning including future scanning to respond to changing needs in healthcare.

4.3 Provide HR support to strengthen capacity to engage in business case development to ensure compatibility between service planning, workforce planning and workforce resourcing.

4.4 Work with service managers and the Higher Education Institutions in taking a strategic approach to graduate supply, education and practice placements and ensure robust governance arrangements are in place in line with health service requirements.

### Workforce and Service Design

4.5 Build capacity to redesign/reconfigure services and the workforce in line with best practice, evidence based models of care and anticipated future needs including the Clinical Care Programmes.

4.6 Support individuals and teams to adopt new ways of working and practice changes informed by evidence and research.

4.7 Evaluate vacancies as they arise so that every vacancy is seen as an opportunity to change and reform how services are delivered in line with evidence.

4.8 Support the reform of CHOs, Hospital Groups and the NAS through practice based interventions at individual and team levels.

### Workforce Talent Management

4.9 Develop a talent management framework that takes account of the employee life cycle and supports staff along the entire career journey maximising their contribution to the organisation.

4.10 Identify and nurture talent, including staff mobility to facilitate and support improved performance and career development.

4.11 Work with Health Business Services (HBS) to restructure recruitment to achieve optimum delivery of workforce plans.

4.12 Prioritise approaches to attract and retain talent including flexible working arrangements that meet service and staff needs.

4.13 Prioritise succession planning and progression opportunities for staff at all levels.

### Workforce 'Organisation'

4.14 Prioritise staff deployment that responds and is adaptable to changing health and social care needs across the organisation.

4.15 Conduct targeted skills audit across priority areas, targeting skills that underpin existing and future health service needs.

4.16 Develop solutions to close gaps highlighted in the skills audit, paying particular attention to skill mix within teams and services.

4.17 Build capacity to support effective staff deployment through e-rostering and use of 'staff banks'.

PRIORITY 5

# EVIDENCE & KNOWLEDGE

Outcome: Work practices and client pathways are evidence informed and decision making is based on real time and reliable data.

## What We Will Do

### Data Gathering and Reporting

5.1 Develop streamlined data gathering and reporting processes and systems to meet requirements of the *Performance Accountability Framework* - including the *HR Early Warning System*, learning from investigations, HIQA reports, reviews etc.

5.2 Develop information systems that efficiently capture, store and retrieve HR data to assist decision making, support Balanced Scorecard approach and reporting to the National Performance Oversight Group.

5.3 Develop workforce metrics reporting (including dashboards) at all levels in a format that is user friendly and avoids duplication.

5.4 Integrate HR and Finance systems to ensure single source data and aspire to capture data through existing processes rather than additional input.

5.5 Work with Health Business Services (HBS) and the Office of the Chief Information Officer (CIO) to drive and capture the benefits of an e-HRM System.

### Data Analysis

5.6 Develop capacity to create intelligence from HR data and to predict trends, spot anomalies and highlight early warnings.

5.7 Build and develop workforce metrics, analytics and planning capability within HR and across line management by working with the Business Intelligence Unit, ICT, HBS Enterprise Resource Planning Service (ERPS) and external support as required.

### Knowledge Management

5.8 Provide managers with the required HR and Workforce Metrics and Business Intelligence (BI) in a timely manner to enable accurate decision making.

5.9 Encourage utilisation of data and knowledge to support the sharing of good practice and shared learning.

5.10 Work with colleagues in Health and Wellbeing and other relevant Divisions to ensure that the library service can effectively support services in evidence informed practice.

5.11 Ensure compliance with Freedom of Information and Data Protection Legislation and Regulation.

### Application of Evidence

5.12 Measure improvements in HR performance through the provision and use of high quality HR information and metrics.

5.13 Use HR data to assist in service redesign and support service modernisation in line with revised clinical care pathways, shared care arrangements, practice changes and models of service.

PRIORITY 6

# PERFORMANCE

Outcome: Staff and teams are clear about roles, relationships, reporting and professional responsibilities so that they can channel their energy and maximise performance to meet organisational targets.

## What We Will Do

### Performance Governance

6.1 Provide clarity for each staff member and team regarding role, professional responsibilities, reporting relationship and fit within the organisation in line with the *Performance Accountability Framework*.

6.2 Work with leaders and staff at all levels to achieve compliance with professional, regulatory and quality standards and be accountable for service targets.

6.3 Implement the planned *HR Early Warning System* to ensure HR moves to a more proactive approach to prevent and mitigate risk to service users and staff.

### Performance Management

6.4 Implement and roll-out a revised, redesigned performance management system that is supportive and developmentally based.

6.5 Continue to position employee relations to offer a proactive, timely service to line managers, promote best practice, intervene early to reduce tension and conflict in the system and ensure compliance with legislative frameworks.

6.6 Establish a unified National Investigation Unit that provides a timely and efficient response and uses learning outcomes to continuously improve performance.

6.7 Develop systems to celebrate success, recognise good performance and the provision of regular feedback to staff on their work contributions.

### Performance Capacity

6.8 Support managers in recognising good and poor performance and provide them with the skills to give feedback in real time/on the job on a consistent basis at individual and team levels.

6.9 Develop competence to manage poor performance in a timely and respectful manner ensuring that clear process guidance is available.

6.10 Implement approaches (including performance management and education/training) to assist leaders, managers and staff to recognise behaviour or conduct that has or is likely to have a negative impact on patient safety and/or on team colleagues and develop skills to intervene in a constructive way.

PRIORITY 7
# PARTNERING

Outcome: Partnership with staff, service managers and stakeholders effectively developed and managed to add value and support the delivery of safer better healthcare for local communities driving change and improving the client experience.

## What We Will Do

### Partnering with Staff, Service Users and Local Communities

7.1 Position person centred care and continuous quality improvements as a priority for all staff and teams enabled by leadership and learning and development supports.

7.2 Ensure leaders and staff have the skills to engage with service users as equal partners and local communities in the co-design, development and evaluation of services taking a joined up approach.

7.3 Support staff to utilise service user experience and feedback to enable cultural change and drive innovation and quality improvements.

7.4 Recognise our corporate social responsibility and public service ethos through initiatives that support staff as citizens and add value to local communities.

### Partnering with Stakeholders

7.5 Develop HR as a respected and equal business partner at strategic and service delivery unit level throughout the system.

7.6 Agree a collaborative approach with staff and their representative associations to support the delivery of this *Strategy*.

7.7 Develop relationships with key external stakeholders including professional and accreditation bodies to progress organisational goals.

7.8 Continue to improve working relationships with Trade Union partners to create a workplace culture and environment based on best practice and compliance with negotiated agreements.

7.9 Increase our interaction with key stakeholders at national level including key health and social care agencies, the Department of Health, the Department of Expenditure & Reform and the Oireachtas on matters of policy alignment, shared learning, budget planning and management, and information reporting.

### Partnering with Service Providers

7.10 Ensure our governing and commissioning standards and processes are explicit and designed to ensure best possible outcomes for service users and customers and are subject to ongoing review and evaluation.

7.11 Improve organisational capacity to commission effectively, utilising system and specialist knowledge, enhancing our partnerships with service providers.

7.12 Build on relationships with academic and other external providers to continually improve HR standards and practice in line with new developments and research.

# PRIORITY 8
# HUMAN RESOURCE PROFESSIONAL SERVICES

Outcome: HR Services designed to create value, enhance people capacity and positioned to deliver organisational priorities.

## What We Will Do

### HR Delivery Model and Structure

8.1 Define the role and develop the HR Delivery Model to support service and business needs and provide professional HR Services that are technically competent and strive for excellence.

8.2 Build and develop the HR Structure to support service and business needs, and prioritise frontline HR Services by creating a senior HR business partner role in each Hospital Group, Community Healthcare Organisation (CHO) and in the National Ambulance Service (NAS).

8.3 Define and communicate the corporate HR offering to the system to meet organisational goals and front line service requirements aligned to performance accountability arrangements.

8.4 Ensure HR is anticipating service needs and helping to shape service delivery at all levels as well as responding to the operational needs of the business in a timely, supportive manner.

8.5 Develop a strong customer service focus within HR to respond in a consistent and efficient manner to the needs of service managers and staff.

8.6 Clarify the HR elements of the shared services operating model, processes and customer relationship between Health Business Services (HBS) and HR to optimise outcomes.

8.7 Quantify the direct HR spend and ensure it is targeted to maximise return on investment.

### HR Processes

8.8 Review HR Policies, Procedures, Protocols and Guidelines (PPPGs) to ensure that they reflect best practice in line with legislative/regulatory requirements, professional standards, compliance with staff/national agreements and European Directives, and monitor consistent implementation.

8.9 Ensure optimum transactional efficiency is achieved by working with the HBS to improve current outcomes in support of the delivery system.

8.10 Work with HBS to specifically address the responsiveness of the recruitment process to add pace to the timeline between approval and appointment including the establishment of 'transfer' panels.

8.11 Utilise Lean Process Mapping to ensure all HBS systems that are aligned to HR are robust, effective, cost efficient and demonstrate value for money.

### HR Profession

8.12 Achieve *Excellence Through People Accreditation* for the HR Service.

8.13 Progress the achievement of professional registration for existing HR staff (CIPD membership) and seek registration as a recruitment criteria for new staff.

8.14 Commence leadership development with the Senior HR Leadership Team and develop professional learning and development opportunities for all HR staff using a range of methodologies.

8.15 Up-skill HR professionals with the skills they need to act as business partners and technical experts to support line managers particularly in relation to employee relations, manpower planning, change management etc.

## e-Human Resource Management (e-HRM) & Technology

8.16 Develop an **e-HRM Strategy** to harness ICT and technology to improve administration, transactions and process performance in the context of the *People Strategy*.

8.17 Use technology to be a key enabler to delivering HR services and allow HR professionals to be more strategic.

8.18 **Operational e-HRM:** Develop and harness e-HRM to maximise the contribution of automation in the management of personnel and pension records, payroll, training and development administration, and recruitment administration, e.g.,

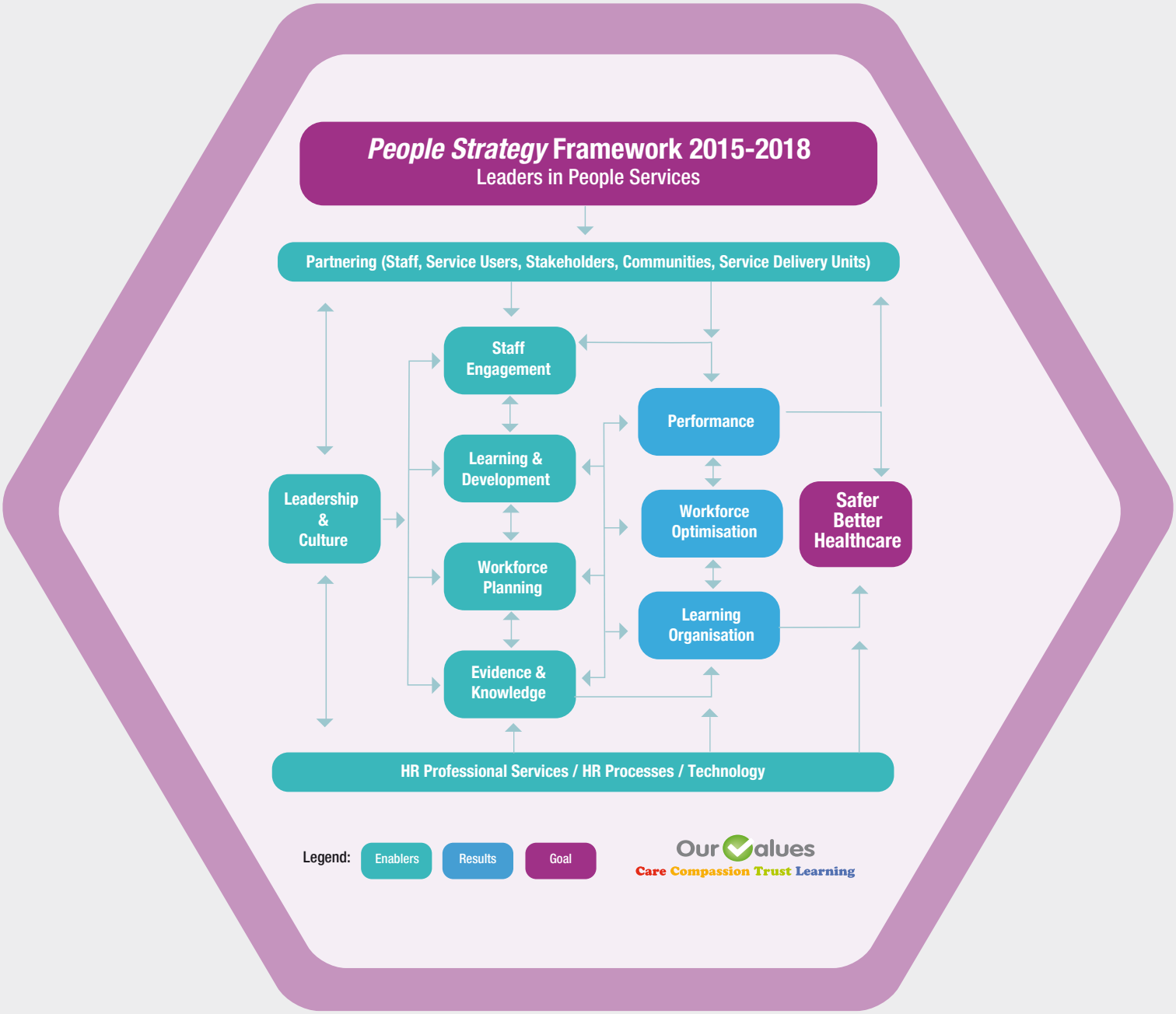
- HR, HBS and the Office of the Chief Information Officer (CIO) will develop a plan to have an e-Personnel Record
- Develop and support plans to have an e-recruitment portal for all health jobs
- Develop and support plans to have a learning and development system to manage and record all learning activities through HSELanD.ie ensuring integration with a wider e-HRM Platform including SAP and other HR Management Information Systems
- Enable and support the further roll-out of e-Time and Attendance and e-rostering

8.19 **Relational e-HRM:** Develop and harness e-HRM to support service delivery units and processes in talent management, staff banks, change management, training, performance management, e.g.,

- Change-Hub to support change management (see www.hseland.ie)
- e-learning and shared learning
- e-recruitment
- employee and management self-service
- Support the creation of HR dashboards in organisational and workforce monitoring, planning and performance

8.20 **Transformational e-HRM:** Develop and harness e-HRM to support strategic HR activities in knowledge management, strategic change management and communications.

8.21 Work with the Communications Division to develop an evidence based and end user-focused approach to the development of transformational e-HRM that is integrated and aligned with the organisation's *Digital Communications Strategy.*


People Strategy Framework 2015-2018
Leaders in People Services
Partnering (Staff, Service Users, Stakeholders, Communities, Service Delivery Units)
Staff Engagement
Learning & Development
Workforce Planning
Evidence & Knowledge
Leadership & Culture
Performance
Workforce Optimisation
Learning Organisation
Safer Better Healthcare
HR Professional Services / HR Processes / Technology
Legend:
Enablers
Results
Goal
Our Values
Care Compassion Trust Learning

# List of Abbreviations

| | |
|---|---|
| BI | Business Intelligence |
| CHO | Community Healthcare Organisation |
| CIO | Chief Information Officer |
| CIPD | Chartered Institute of Personnel and Development |
| e- | electronic |
| e-HRM | e-Human Resource Management |
| EFQM | European Foundation for Quality Management |
| ERPS | Enterprise Resource Planning Service |
| HBS | Health Business Services |
| HIQA | Health Information and Quality Authority |
| HR | Human Resources |
| HSE | Health Service Executive |
| HSELanD | Health Services e-Learning and Development Service |
| ICT | Information and Communication Technology |
| L&D | Learning and Development |
| NAS | National Ambulance Service |
| PPPGs | Policies, Procedures, Protocols and Guidelines |
| SAP | Systems Applications and Products |

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**For further information please contact:**

Office of the National Director of Human Resources,
Health Service Executive,
Dr. Steevens' Hospital,
Steevens' Lane,
Dublin 8.

**Phone:** +353 (0)1 635 2319
**Email:** nationalhr@hse.ie
**URL:** www.hse.ie

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Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

# MEDICAL WORKFORCE PLANNING

## Future Demand for General Practitioners

## 2015-2025

National Doctor Training and Planning, HR Directorate, Health Service Executive,
Dr. Steevens' Hospital, Dublin 8, Ireland

*"Investing in the career development of doctors"*

September 2015

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# *Foreword*

This report on the future medical workforce required for General Practice in the Irish health service is the result of the first in-depth specialty-based exercise carried out by the National Doctors Training and Planning Unit in the HSE. Future reports will address the manpower needs of all medical specialties, and work is already underway in Paediatrics/Neonatology and Emergency Medicine.

The approach we have taken is based on the genesis of various scenarios for the delivery of care, each projected over a 10-year period. It reflects the outcome of the deliberations of an expert panel, combined with extensive background research.

The scenarios incorporate factors such as population growth predictions generated by the Central Statistics Office, current estimated GP visitation rates, potential impact of policy decisions such as extension of GP visit card eligibility, as well as data related to part-time working and trainee numbers.

Workforce planning attempts to predict the future, and is fraught with difficulty. The recommendations contained in this report must be considered carefully in the context of the limitations associated with the methodology of workforce planning. However, there are some certainties that we can accept. There is a current undersupply of GPs in Ireland, we are faced with a recruitment and retention challenge in the specialty, many of the doctors delivering primary care are not on the specialist register, our population is growing, and extension of GP visit card eligibility on an incremental basis is Government policy.

The key findings and recommendations contained in this report will inform policy-makers in terms of projections for GP workforce numbers and also regarding important additional priorities such as promoting the specialty as an attractive career choice and the need for policies to maximise recruitment and retention within the profession.

I would like to express my thanks to the expert panel for their wise input, and particularly to Roisin Morris in NDTP, for her major contribution to this work.

**Eilis McGovern**
**Director, HSE National Doctors Training and Planning**

**September 2015**

## Report Authors

Professor Eilis McGovern, Director, HSE National Doctors Training and Planning
Dr Roisin Morris, Project Manager, HSE National Doctors Training and Planning

## Members of Expert Panel

We would like to acknowledge the valuable contribution of the Expert Panel on General Practice Workforce Planning in the development of this GP workforce planning report.

| | |
|---|---|
| Brian Murphy | HSE Primary Care Division |
| Teresa Cody | Department of Health, Primary Care |
| Dr Gerard Mansfield | Irish College of General Practitioners |
| Dr Claire Collins | Irish College of General Practitioners |
| Dr Joe Clarke | HSE Clinical Programme, Primary Care |
| Pat O'Dowd | HSE National Contracts Office |
| Elaine O'Connell | HSE Director of Public Health Nursing |
| Kathy Taaffe | HSE Practice Nurse Development Coordinator |
| Dr Antoinette Gregan | General Practitioner |
| Ruth Morrow | Advanced Nurse Practitioner, Primary Care |

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# *Executive Summary*

General Practice in Ireland is currently going through a process of change, related in particular to the introduction of free GP care to the under 6s and the over 70s in the first instance, with planned extension of free GP care to the population as a whole.

Increasing demands on the health system as a direct result of the extension of free GP care, combined with an ageing population, will have a major impact on the future need for GPs. In order to plan for this changing demand, a workforce planning exercise was carried out within the National Doctors Training and Planning Unit of the HSE. The following points summarise the observations, outputs and recommendations arising from this exercise.

1. There is evidence of a significant undersupply of GPs in Ireland at present.
2. By 2025, the predicted shortage of GPs in Ireland will range from **493** to **1,380** depending on increased levels of access to free GP care.
3. If the shortfall is to be addressed by training the required GP workforce here in Ireland (as opposed to inward migration of trained GPs to Ireland from other countries) there will be a need to significantly increase the annual intake into GP postgraduate specialist training.
4. More than a third of doctors working as GPs are not on the Medical Council's specialist register of general practitioners.
5. There is evidence of increased feminisation of the profession as well as increased part-time working.
6. In addition to the need to train more GPs, there is a requirement for innovative recruitment and retention strategies.
7. A national register of GPs should be introduced to improve the availability and quality of data on the GP workforce.
8. Data collection regarding various important aspects of GP care needs to be improved (for example data related to GP visitation rates).
9. Further research into areas such as nurse-led care and the impact of IT on general practice should be carried out.

It is the intention of NDTP that a follow-up review of workforce planning for general practice will be carried out over the next two years, and that the findings of this report will be updated at that time.

# Section 1: Medical Workforce Planning in the HSE

## 1.1 HSE National Doctors Training and Planning

In 2007, the Medical Education and Training Unit (MET) was established in response to the role outlined for the HSE in the Health Act 2004 and, in particular, the Medical Practitioners Act 2007. In 2013, MET established a Medical Workforce Planning Unit to undertake a review of current medical staffing in Ireland and to make recommendations regarding projected requirements in future years. More recently, in 2014, the Consultants Appointment Unit was incorporated into MET.

The co-location of these 3 functions in a single department provides a unique opportunity to integrate strategy for workforce planning across the entire medical career journey, from medical school graduation to appointment as a specialist/consultant.

In late 2014, the name of the unit was changed to National Doctors Training and Planning (NDTP) in order to more fully reflect these changes. NDTP is a unit within the HSE National Directorate for Human Resources.

In terms of medical workforce planning, the work of the NDTP forms part of the integrated workforce planning approach being developed within HSE's Workforce Planning, Analysis and Informatics unit. Further to this NDTP engages with the Department of Health workforce planning function.

## 1.2 Medical Workforce Planning

*'Worldwide demand for cars will never exceed one million, primarily because of a limitation in the number of available chauffeurs'* Research prediction, Mercedes-Benz, 1900.

*'I think there is a world market for about five computers.'* Thomas Watson, Chairman, IBM, 1943.

Planning is required to avoid greatly miscalculating the future direction of any service, organisation or industry, and future planning has now become a core business function.

Part of the work of the National Doctors Training and Planning unit of the HSE is to estimate and plan for the number of medical specialists required to support health service delivery over the next 10 plus years, so that medical trainee numbers can be appropriately matched to expected specialist requirements.

Estimating the number of specialists required to meet service delivery needs is not a straightforward task. The approach used by NDTP is to consider a number of different potential scenarios relating to how the health service might function in 10, 15 or 20 years; comparable estimates of the demand for future specialists can then be made based on these future scenarios. Following estimation, decision-makers will typically be presented with data relating to required workforce and trainee numbers as per each future health service scenario. These estimates can then be used to guide decisions relating to the future specialist workforce and parallel training requirements.

## *1.3 Principles Underpinning Medical Workforce Planning*

Certain key principles underpin the NDTP approach to medical workforce planning (MWP). These include the following:

***1.3.1*** MWP should be consistent with the recommendations of the Report on Medical Education in Ireland: A New Direction. Report of the Working Group on Undergraduate Medical Education and Training[1] (the Fottrell Report) and the report on Preparing Ireland's Doctors to meet the Health Needs of the 21st Century[2] (Buttimer Report) i.e.

I. More patient care should be consultant-delivered

II. More patient care should take place in the community

III. The Irish health service should be self-sufficient in the production of medical graduates, with reduced dependency on International Medical Graduates (IMGs - doctors who graduate from medical schools outside Ireland)

IV. There should be a gradual reversal in the ratio of non-consultant doctors to consultants (currently approximately 1.7:1)

***1.3.2*** MWP recommendations should be consistent with the WHO Global Code on the International Recruitment of Healthcare Personnel. Ireland is a signatory of the code, which states that not only should countries be self-sufficient (and this has been addressed in Ireland with the increase in EEA medical school intake from 305 to 725 as a result of the Fottrell Report) but that they should not poach doctors from low and middle income countries, particularly those with acute healthcare personnel shortages.

***1.3.3*** MWP recommendations should encompass medical workforce requirements for the entire population to include both the public and private healthcare systems.

***1.3.4*** 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.

***1.3.5*** MWP recommendations should incorporate the implications of existing, and where known, future healthcare policy (for example the Report of the National Task Force on Medical Staffing[3] (the "Hanly Report"); the National Clinical Programmes; the new Hospital Groups; the Small Hospitals Framework; the National Cancer Control Programme; Universal Health Insurance).

***1.3.6*** Trainee numbers for each specialty should be based on MWP projections for that specialty.

***1.3.7*** 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.

***1.3.8*** Where appropriate, innovative models of care should be explored, for example new team structures, new medical roles and skills transfer.

## *1.4 The Workforce Planning Methodology*

A core focus of the NDTP unit over the past two years has been the development and implementation of a methodology to support planning the specialist medical workforce in to the future. This methodology has now been developed through a number of key phases of research, stakeholder consultation and data modelling as follows:

1. A review of international workforce planning methodologies was carried out with particular focus on those models and methodologies deemed most appropriate and relevant to the Irish context. A more in-depth review of the following models was subsequently carried out:
   i. Ireland: A Quantitative Tool for Workforce Planning in Healthcare[4]
   ii. Ireland: Department of Health, General Practice Workforce Planning Model[5]
   iii. Australia: Health Workforce Australia: Health Workforce 2025 - Medical Specialties – Volume 3[6]
   iv. Canada: The Ontario Population Needs-Based Physician Simulation Model[7]
   v. The Netherlands: Model developed by The Advisory Committee on Medical Manpower Planning[8]
   vi. England: Centre for Workforce Intelligence: a Strategic Review of the Health Workforce. Informing the Medical and Dental Student Intake[9-11]

   Upon completion of the review process, we focused on the workforce planning systems in place in England and the Netherlands as we considered them progressive in design, implementation and evaluation and they were accessible in terms of availability of information and expertise.
2. Following the workforce planning methodologies review, consultation with national and international experts in the development and implementation of models and methodologies related to workforce planning for health care took place. This involved consultation with colleagues from the Netherlands, England, Trinity College Dublin and Solas as well as participation in an EU level workforce planning for health initiative.
3. A request for submissions on medical workforce planning was sent to all medical specialty training bodies as well as to relevant National Clinical Programme Leads. These stakeholders were asked to submit their recommendations on the number of specialists required to staff their specialty area in the medium term. Stakeholders were also asked for their views on the major policy drivers that could shape or influence the future of their specialty workforce as well as their general views on how the specialty might be developed to fit with future changes in health service delivery. Relevant documentation and references were requested. Completed submissions were analysed according to recommended numbers and ratios of specialists as well as the major drivers expected to influence the future of the specialty workforce.

4. A current state analysis of the specialist workforce was carried out using the FÁS (now Solas) and Expert Group on Future Skills Need's Quantitative Tool for Workforce Planning in Health Care as a template for data collection[4]. Data were gathered from multiple sources including (for GPs) the Medical Council, the Central Statistics Office, the Irish College of General Practitioners, Primary Care Reimbursement Service and the Centre for Health Policy and Management, Trinity College Dublin. This research resulted in a breakdown of the approximate number of specialists and non-specialists in the current employment stock; the ratio of specialists and non-specialists per head of population and the number of entrants and exits from the employment stock as well as, for GPs, the number of annual GP consultations estimated across age groups and level of access to free GP care.

5. A review of Irish and international benchmarks and ratios used in medical workforce planning was completed. Current ratios of specialists per head of population in Ireland were estimated and compared with those ratios recommended by specialty stakeholders in their responses to our request for submissions on medical workforce planning. Further comparisons were made across current ratios of specialists to the population in Ireland, those recommended in the Hanly Report 3 as well as those in place in comparable healthcare jurisdictions namely Australia, the UK and New Zealand (New Zealand for surgery only). This review was deemed important to give context to commonly cited ratios in medical workforce planning in Ireland by comparing them internationally.

6. A one day workshop with a wider stakeholder group to include medicine, nursing, Government, the Health Service Executive, epidemiology, health technology, economics, patients, academia and allied health was convened to further understand the major drivers of change to the future of the health service over the next 10 to 20 years. The results of this workshop process were (and will continue to be) used to give context to the future of health care in Ireland and to support thinking around the major areas requiring further consideration in the planning process. These areas included population change, epidemiological change, service reconfiguration and integrated care, technological developments, economic growth/stagnation and professional task reallocation within the multidisciplinary team.

7. An expert panel consisting of the major stakeholders in workforce planning for General Practice was set up with a view to establishing consensus on the recommended number of specialists required for the specialty over the next 10 years. A total of three panel meetings were convened for this purpose. Meetings also served to provide information and clarifications where required as well as to guide decision making in relation to data to be used in the statistical modelling phase of the methodology.

8. Statistical modelling of all workforce data, including current and future recommended supply and demand variables, was carried out across a number of different stakeholder informed scenarios representing the possible future of the health service over the next 10 years.

# Section 2: Overview of the General Practice Workforce in Ireland

## 2.1 The Context of General Practice in the Irish Health Service

In Ireland, General Practitioners play a central role in the delivery of primary care services. The majority of GPs in Ireland are self-employed private practitioners providing services to the general population. A large proportion of general practitioners (but not all) provide free GP care to approximately 2 million people in the population through state contract arrangements, including free GP care to the under 6's. The remainder of the population of Ireland will generally pay their GP on a per consultation basis.

Individual patients who are eligible for free GP care are covered by the state run General Medical Services (GMS) programme and hold either a Medical Card or a GP Visit Card. Medical Card holders are eligible for free GP care, a range of medications and other products free of charge. Medical Card holders must be below a certain income in order to qualify. Medical Cards may also be granted on a discretionary basis. Certain people in Ireland who do not qualify for a medical card may apply to the Health Service Executive for a GP Visit Card. GP Visit Cards allow individuals and families who qualify, to visit their General Practitioner free of charge. The majority of those over 70 years of age will hold a Medical Card, subject to means testing. The HSE has also recently decided to provide a medical card to all children under 18 years of age with a diagnosis of cancer.

Persons who have contracted hepatitis C directly or indirectly from the use of Human Immunoglobulin-Anti-D or the receipt within the State of another blood product or a blood transfusion, as well as women covered by the redress for Women Resident in Certain Institutions Act, 2015 have access to, inter alia, free GP care. From July 2015, children under the age of 6 have access to free GP care. From August 2015 all persons aged over 70 years have access to free GP care. All others in the population pay for GP care through out-of-pocket expenditure.

Under the terms of the Health Provision of General Practitioner Services Act 2012, it became mandatory for a GP to be on the specialist register of the Medical Council in order to obtain a GMS contract. Despite this, there remain a number of GMS contract holders who are not on the specialist register who would have obtained their GMS contract prior to the legislation being enacted. Specialist registration was introduced by the Medical Council in 2007.

Within the current Government Health Reform Programme, 'Future Health'[12], priority is given to the introduction of free GP care for the entire population of Ireland on a phased basis. The first phase of policy implementation involved the introduction of free GP care to children under the age of 6. This was extended to the over 70s in August 2015. Proposals exist to extend free GP care to the under 12's and the under 18's, with gradual extension of free GP care to the population of Ireland.

While a significant proportion of GPs are likely to sign up to free GP care contractual arrangements, this will not be the case for all GPs. Some GPs are expected to choose to deliver a fully private service to their patients.

## 2.2 Total Number of Doctors Working in General Practice

The population of doctors working in general practice in Ireland is heterogeneous and is made up of several cohorts including the following:

i. Career GPs who are based in Ireland, and who work permanently in the health service, either full or part-time. They may or may not be on the specialist register.

ii. Non-career doctors who are based in Ireland and contribute to general practice provision; for example

   a. NCHDs (non-consultant hospital doctors) providing short-term GP cover for out-of-hours services and holiday relief. These doctors are most likely to be on the general register of the Medical Council.

   b. Doctors whose main area of practice is in another specialty, for example occupational medicine, but who work part-time in general practice. These doctors are unlikely to be on the general practice specialist register, but may be on the general or an alternative specialist register.

iii. Doctors not normally resident in Ireland who travel to Ireland regularly (usually for a number of weeks at a time) to provide short-term cover for out-of-hours services/relief for annual or other leave. These doctors may or not be on the specialist register. They are most commonly recruited through Irish medical employment agencies.

For this reason, it is difficult to be definitive about the exact number of doctors who contribute to the general practice workforce.

There is no central register of GPs working in Ireland. However, a number of different data sources exist to support the workforce planning process. The most useful sources of information are the Medical Council, the Irish College of General Practitioners and the Primary Care Reimbursement Service.

### 2.2.1 The Medical Council Register of Medical Practitioners

The Medical Council collects and analyses data from the trainee, general and specialist registers to produce valuable data on the GP workforce. Medical Council data includes the number of GPs on all registers as well as the country of basic medical qualification, age, gender and part-time working patterns.

According to data from the Medical Council, as of January 2015, a total of 4,685 registered doctors who had worked in the previous 12 months (i.e. not inactive or retired) stated general practice to be their primary area of practice. Of these, 2608 (56%) were on the specialist register, 38% were on the general register and 6% were on the trainee register. Less than 1% were on the specialist register but not registered as GPs. This latter group would comprise doctors who are on a different specialist register (for example Occupational Medicine) but who work primarily in general practice. See Table 1 below.

*Table 1 Doctors who worked in 2014 and Identified Themselves as Working in General Practice*

| Division registered | N | Percent |
|---|---|---|
| Specialist registration (in GP) | 2,608 | 56% |
| Specialist registration (not in GP) | 21 | <1% |
| General registration | 1,763 | 38% |
| Trainee Specialist registration | 293 | 6 % |
| **Total** | **4,685** | **100%** |

*Data as of January 2015*

Doctors registering with the Medical Council are asked to state if they have worked in Ireland in the preceding 12 months. If we exclude doctors who worked outside Ireland only (81 on the GP specialist register and 388 on the general register) and those who were on the trainee specialist register, then we can say that approximately 3,923 doctors worked in general practice in Ireland in 2014. See Table 2 below.

*Table 2 Estimated Number of Doctors Working General Practice in Ireland in 2014*

| Division registered | N | Percent |
|---|---|---|
| Specialist registration (in GP) | 2,527 | 64% |
| Specialist registration (not in GP) | 21 | <1% |
| General registration | 1,375 | 35% |
| **Total** | **3,923** | **100%** |

*Data as of January 2015*

*For the purpose of this report, we refer to all doctors providing GP services (whether on the specialist register of the Medical Council or not) as GPs. It should be noted that it is an aspiration of the Department of Health and the HSE that all doctors working in general practice should be on the specialist register. (At the time that specialist registration was introduced by the Medical Council in 2007, not all eligible GPs availed of the opportunity to register; these GPs are registered in the general division However, 35% of doctors who work as GPs are not specialist trained).*

This figure of 3,923 is, however, an underestimate. The Medical Council records are based on the registering doctor identifying the specialty in which they practice for most of their professional time. Therefore, doctors described in Section 2.2 ii (a) and (b) above are not captured. It is not possible to accurately identify this underestimate.

In the absence of a comprehensive register of GPs, we consider the data from the Medical Council's workforce intelligence reports for 2012 and 2013 registrations as well as more recent registration information, to be the best available data on the current configuration of the GP workforce in Ireland (Medical Council, 2013; 2014)[13-14].

### *2.2.2 The Irish College of General Practitioners Membership Register*

The Irish College of General Practitioners (ICGP) collects and analyses data on the GP workforce, including the number of doctors registered for professional competence and those holding membership of the ICGP.

Currently 3,799 doctors are registered on the ICGP-run professional competence scheme. Of these, 2,772 are also ICGP members. While it is a legal requirement that all doctors on the Medical Council register maintain professional competence, it is not mandatory for a doctor practicing in primary care to be a member of the ICGP. In order to be eligible for membership of the ICGP, a GP must have completed recognised GP specialist training or have successfully completed the ICGPs 'alternative' route to college membership.

### *2.2.3 The HSE Primary Care Reimbursement Service Database*

The HSE Primary Care Reimbursement Service (PCRS) collects data on the number of GMS contract-holders and those GPs delivering state-funded primary care services such as Cervical Check, Heartwatch and a range of childhood immunisations.

Since 2012, in order to obtain a General Medical Services (GMS) contract, a doctor must be on the GP specialist register. The number of GMS contract holders as of April 2015 was **2,418**. While the GP principal within a practice will hold the GMS contract, other doctors employed within that practice may deliver care to GMS patients. It is not currently a requirement that these doctors be on the specialist register.

An additional **462** GPs who do not hold GMS contracts are registered to provide services under alternative programmes, such as the Primary Childhood Immunisation Scheme, Heartwatch, the Methadone Treatment Scheme and National Cancer Screening Services. It is not necessary to be on the specialist register in order to obtain or deliver care related to one of these subsidiary contracts.

The total number of GPs on the PCRS database is 2,880, which is significantly less than the total number of GPs registered with the Medical Council. We estimate that the remaining 1,000 (approximately) doctors who practice in primary care, do not hold any type of state contract. As very few doctors practice exclusively in the private sector, we have made an assumption that these doctors work as part of teams in general practices where the principal holds a GMS or other state contract. These doctors may be GP assistants.

The PCRS does not hold data on the Medical Council registration of GPs holding state contracts. Therefore, we do not know how many of these 2,880 GPs hold specialist registration.

## 2.3 Gender Breakdown, Working Patterns and the Feminisation of the GP Workforce

Medical Council data records that 47% of doctors on the GP specialist register were female, while 46% of all doctors participating in general practice were female.

Approximately 22% of all GPs stated that they worked on a part-time basis while 76% stated that they worked full-time (the remaining 2% indicated 'other').

Breaking these figures down, 13% of males and 34% of females work part-time, while 85% of males and 64% of females work full-time.

In consultation with the ICGP we have estimated a full-time whole time equivalent (WTE) rate of 1, to include administrative work associated with the GPs clinical workload, and a part-time WTE rate of 0.5. Overall, we estimate the WTE rate across full and part-time males and females to be approximately 0.88.

If we consider the gender breakdown of the current GP workforce along with the projected gender breakdown of those leaving and entering the workforce post-specialisation (from the Irish postgraduate medical education system only), we estimate that there will be a 6% increase in the proportion of female GPs in the workforce, as shown in table 3 below. This is because the proportion of trainees who are female has increased significantly in recent years, and will have implications for the future WTE rate among GPs. It is very possible that increased demand for flexibility at work will lead to an increase in the number of GPs working part-time. It is important to note also that recent research conducted by the ICGP showed that increasing numbers of males also have intentions to work part-time in the future (Collins et al, 2014)[15].

*Table 3 Workforce Feminisation Estimates*

| Feminisation Estimates | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Stock of females in employment | 1,805 | 1,838 | 1,864 | 1,887 | 1,906 | 1,924 | 1,941 | 1,958 | 1,973 | 1,988 | 2,002 |
| Exits other than retirement | 36 | 37 | 38 | 39 | 40 | 40 | 41 | 42 | 43 | 44 | 45 |
| Exits due to retirement | 46 | 46 | 46 | 46 | 46 | 46 | 46 | 46 | 46 | 46 | 46 |
| Irish CCST graduates | 115 | 110 | 107 | 104 | 104 | 104 | 104 | 104 | 104 | 104 | 104 |
| Total number of females | 1,838 | 1,864 | 1,887 | 1,906 | 1,924 | 1,941 | 1,958 | 1,973 | 1,988 | 2,002 | 2,015 |
| Stock of males in employment | 2,118 | 2,086 | 2,058 | 2,033 | 2,011 | 1,990 | 1,968 | 1,947 | 1,925 | 1,904 | 1,882 |
| Exits other than retirement | 21 | 21 | 21 | 21 | 21 | 21 | 21 | 21 | 21 | 21 | 21 |
| Exits due to retirement | 54 | 54 | 54 | 54 | 54 | 54 | 54 | 54 | 54 | 54 | 54 |
| Irish CCST* graduates | 42 | 47 | 50 | 53 | 53 | 53 | 53 | 53 | 53 | 53 | 53 |
| Total number of males | 2,086 | 2,058 | 2,033 | 2,011 | 1,990 | 1,968 | 1,947 | 1,925 | 1,904 | 1,882 | 1,861 |
| Female share in the stock | 46% | 47% | 48% | 48% | 49% | 49% | 50% | 50% | 51% | 51% | 52% |

**CCST refers to Certificate of Completion of Specialist Training*

***Note it is difficult to get a clear picture of gender breakdown across years of trainees due to deferrals etc. The trainee gender breakdown in the table above is derived through consultation with the ICGP*

## 2.4 Age Profile of GPs

The average age of GPs in Ireland, as per the Medical Council data for 2013, was found to be 49 years, with a particularly high proportion over the age of 55 (36%) compared to other specialties. For this reason, proportionately more retirements are expected in the next 10 years. Table 4 below outlines the age categories of doctors registered on the specialist and general divisions as general practitioners who were actively working in Ireland in 2013.

*Table 4 Total Age Breakdown of Doctors Delivering GP Services in Ireland in 2013*

| Age Group | N | % |
|---|---|---|
| 25-34 | 511 | 13 |
| 35-44 | 1,087 | 28 |
| 45-54 | 934 | 24 |
| 55-64 | 962 | 25 |
| 65 + | 427 | 11 |
| **Total** | **3,921** | **100** |

*Rounding will impact the addition of the above to exactly 100%. Trainees are excluded from these estimates. Source, Medical Council – unpublished.*

## 2.5 Exits from the GP Workforce

In 2013 57 GPs exited the specialist register. It is estimated that 157 of specialist and non-specialist registered GPs exited the workforce in 2013. This estimate is based on:

i. A derived estimate of 1% of males and 2% of females exiting the workforce for reasons other than retirement i.e. for family reasons, change of career etc. This equates to around 57 GPs in 2014 and

ii. A derived estimate of 100 GPs retiring per year. This is based on GP age profile and an expected average retirement age of 68 years to account for the fact that GPs holding contracts related to the GMS Scheme, Mother and Infant Care Scheme and/or the Primary Childhood Immunisation Programme are now eligible to work to the age of 72 years.

We accept that these estimates are open to challenge.

## 2.6 Entrants into the GP Workforce

General practice training is four years in duration. The first two years of training are spent primarily in hospital settings, with the third and fourth years spent in supervised general practice. Prior to 2010, the annual intake into GP training was 120; this was increased to 157 due to a projected increase in demand for GPs.

Currently approximately 73% of GP trainees are female. It is anticipated that this figure will be approximately 66% in 2025.

In 2013, 170 GPs entered the specialist division of the register, of whom 112 had completed training in Ireland and 58 had trained abroad. Of these new entrants 42 were over the age of 40, and 59% were female. There was a 4% increase in the number of GP specialists on the register between 2012 and 2013.

## 2.7 GP Emigration

There is little data available on those who graduate from Higher Specialist Training in Ireland going abroad to take up posts. A recent survey of 649 current GP trainees and 445 GP graduates from 2010 to 2013, carried out by the Irish College of General Practitioners, details emigration patterns of graduates since 2010, emigration expectations of current trainee GPs, as well as a range of manpower issues facing the profession (Collins et al, 2014[15]). Key findings from the report include the following:

1. Most graduates (60%) would prefer to remain in Ireland, however uncertainty around security in their professional roles, defined career progression opportunities and the role of GPs in the Irish healthcare system are the main factors driving the decision amongst current trainees and recent graduates to consider emigration.
2. Among trainees, 12.3% of current trainees are definitely planning to emigrate and 25% are undecided with only one quarter planning to definitely stay in Ireland.
3. Among graduate respondents, 16.9% are currently working overseas. Of this group only 17.1% are planning to return to Ireland to work.

## 2.8 Estimation of Current Undersupply of GPs

There is strong evidence of a significant undersupply of GPs in Ireland. This is reflected in the following:

- The heavy reliance on overseas doctors to provide locum and short-term cover in general practice, particularly for out-of-hours services and holiday relief. There are several out-of-hours co-ops which are heavily dependent on these doctors, most of whom are based in South Africa. It is likely that this represents a group of doctors who are resident and work overseas, but who visit Ireland to do short-term locum work.

- The best indication of the numbers of doctors involved in this activity comes from the Medical Council. In the Medical Intelligence Report (Medical Council, 201313), the Council recorded that 4.5% of GPs had practiced both in and outside Ireland in the previous year. This would equate to 217 doctors. Of these, 142 were GPs on the specialist register who had graduated from a medical school outside of Ireland. However, the total number is unknown.
- Other doctors contributing to the locum/temporary/short-term GP workforce include non-consultant hospital doctors (NCHDs) not in training, who choose to work as locum GPs when they are not working in the acute hospital sector. Again, we have no accurate estimate of this number.
- There are approximately 21 GMS vacancies around Ireland currently (split almost evenly between urban and rural practices). Locum arrangements are put in place for all of these vacancies to ensure continuity of services to the relevant communities.
- GPs who have reached retirement age who, although they would like to retire, continue to work due to the inability to identify an appropriate replacement GP for their practice also represent an unmet demand for GPs.
- Finally, doctors who work full-time but would rather work on a part-time basis represent an unmet demand within the primary care system.

While it is not possible to get accurate figures to attach to this part of the general practice workforce, we have estimated that it is the equivalent of 500 headcount for the purposes of scenario generation in the following sections.

## *2.9 Data Availability*

One of the main challenges in workforce planning for general practice relates to the lack of data on the configuration of the workforce. While the Medical Council has made an invaluable contribution to the availability of data across different medical specialties, there remain difficulties in accessing data on the GP workforce including that relating to part time working rates and workload.

There is a serious lack of evidence related to the provision of locum and out-of-hours care. A significant number of doctors providing GP services in Ireland are coming from overseas, are not registered specialists and are working either in Ireland only or inside and outside Ireland in the same year. As already mentioned many of these doctors are likely to be delivering locum services and represent an unmet need in the provision of GP services across Ireland. We do not know enough about who is delivering locum and out-of-hours GP care in Ireland.

## 2.10 Summary of Current Configuration of GP Workforce 2013/2014

The availability of accurate and reliable data on the GP workforce is limited. In order to support workforce planning for general practice, we have summarised the best available data in Table 5 below.

*Table 5 Current Configuration of the GP Workforce 2013/2014*

**GENERAL PRACTICE**

| Assumption | Value | Source |
|---|---|---|
| Number of GPs on the specialist register | 2,548 | Medical Council Specialist Register as of January 2015, analysis of GPs and 21 other specialists providing GP services who are on the specialist register and working in Ireland |
| Number of GPs on the general register | 1,375 | Medical Council analysis of doctors working in general practice who are on the general register and working in Ireland |
| Number of GPs (specialist and general registered) | 3,923 | Medical Council analysis of doctors working in general practice who are on the specialist and general register and working in Ireland |
| Number of GPs who obtained their basic medical qualification overseas and are on the specialist register | 221 | Medical Council analysis of doctors working in general practice who are on the specialist register and working in Ireland |
| Number of GPs who obtained their basic medical qualification overseas and are on the general register | 409 | Medical Council analysis of doctors working in general practice who are on the general register and working in Ireland |
| Total number of international medical graduates delivering GP services in Ireland | 630 | Medical Council analysis of doctors working in general practice who are on the specialist and general register and working in Ireland |
| Proportion of international medical graduates delivering GP services in Ireland | 16% | Derived using Medical Council analysis of doctors working in general practice who are on the specialist and general register and working in Ireland |
| Estimated number of GPs representing unmet need | 500 | Derived from Medical Council data related to overseas doctors on the general register and those doctors working beyond the age of 70 as well as hospital based NCHDs working in general practice as locums and those working full rather than part-time |
| Females in employment | 47% specialists<br>46% all doctors | Medical Council, 2014 – analysis of the general and specialist registers for 2013 |
| Males in employment | 53% specialists<br>54% all doctors | Medical Council, 2014 – analysis of the general and specialist registers for 2013 |
| Part-time working all | 22% | Medical Council, 2014. Numbers represent 'all' doctors in general practice |
| Part-time: full-time working females | 34%:64% | Medical Council, 2013. Numbers represent 'all' doctors in general practice |
| Part-time: full-time working males | 13%:85% | Medical Council, 2013.Numbers represent 'all' doctors in general practice |
| Part time WTE adjustment rate | 0.50 | Based on information from the ICGP |
| Full time WTE adjustment rate | 1 | Based on information from the ICGP |
| Age profile of the GP stock | Table 4 | Medical Council Register 2013 analysis of GPs per age group (specialist and general register) |
| Annual retirement from stock per annum | 100 per year | Medical Council Register 2013 analysis of GPs per age group (specialist and general register). Estimate and derived from age related data |
| Attrition from employment stock (not due to retirement) | Males: 1%<br>Females: 2% | Informed by Medical Council 2014 / derived for gender |
| Steady state annual intake into national GP training programme | 157 | HSE/ICGP |
| Cumulative annual attrition from GP training | Almost zero | HSE/ICGP |
| Annual graduates – national GP training programme | 157 approximately | HSE/ICGP. Note - approximately 34% of new entrants on the specialist register (2013) completed their training overseas |

# Section 3: Demand for GP Services

## 3.1 Estimating the Future Demand for GP Services in Ireland

There are multiple factors that impact on the demand for GP services. For the purposes of this exercise, we are focussing on 3 major variables including:

i. Population change

ii. Utilisation based on consultation/visitation rates

iii. Proportion of the population eligible for free GP care, as a reflection of Government policy

In order to estimate this demand for GPs over the next 10 years, we used a number of potential future scenarios upon which to make different supply and demand focused workforce projections. The scenarios are stakeholder-informed and based on recommendations from the ICGP and the Clinical Programme for Primary Care, as well as on Government policy. The recommendations are based on submissions received in Q4 2013 as per the workforce planning methodology outlined in Section 1 of this report. See Appendix A for more information.

The scenarios used in GP workforce planning include the following:

- Scenario 1: Maintaining the estimated ratio of GP consultations to the population, weighted for age and visitation levels, prior to the introduction of free GP care to the under 6s.
- Scenario 2: Maintaining the estimated ratio of GP consultations to the population as per Scenario 1 while accounting for estimated unmet demand for GPs within the system as defined in Section 2.7 above
- Scenario 3: Extending free GP care to all those under the age of 6, while also accounting for estimated unmet demand within the system
- Scenario 4: Extending free GP care to all those under the age of 6 and over the age of 70, again accounting for estimated unmet demand within the system

Workforce planning estimates related to the extension of free GP care to the under 6s and over 70s are explored within the main body of this report. Workforce planning estimates related to the extension of free GP care those under the age of 12 and 18 respectively and over the age of 70, as well as the extension of free GP care to 'all' is included in Appendix B.

While extension of free GP care to those with a chronic disease was also suggested for inclusion in workforce planning, this scenario is excluded from the current planning exercise and will be revisited upon the availability of better data. Extension of free GP care to those with a chronic disease is addressed in part in the discussion section of this document.

Service utilisation is estimated in order to gauge the demand for GP services today. The GP consultation rates used herein are derived from estimates made by researchers at the Centre for Health Policy and Management, Trinity College Dublin and the most recent data on the number of people in Ireland who currently have free access to GP care. It is our understanding that these rates are based on best available data. Estimates of the number of visits an individual with and without free access to GP will make per year are, in the main, based on retrospective data from the following sources:

- Central Statistics Office, National Quarterly Household Survey, 2010[16]
- The Irish Longitudinal Study on Ageing – a national representative study on people in Ireland over the age of 50[17]
- Growing Up in Ireland – a national longitudinal study on the progress and development of approximately 20,000 children in Ireland[18]
- Central Statistics Office, Survey on Income and Living Conditions[19]
- Health Service Executive, Primary Care Reimbursement Service

In the consultation rates estimation process, the researchers gave consideration to the number of people with and without General Medical Service (GMS) and general practice Visit (GPV) cards. In estimating the change in consultation rates should free GP care be introduced, adjustments were made to account for the association between deprivation and poorer health outcomes, among other factors. Table 6 below outlines the estimates derived from the above data sources as well as relevant population statistics (CSO, 2011)[20].

We base our estimates on the assumption that all eligible patients will avail of free GP care i.e. rather than choosing to pay a GP who does not participate in free GP care schemes.

In the absence of 'actual' and representative GP consultation rates related data, the consultation rates data presented in Table 6 are derived from best available information. Averages are used where the breakdown of age groups and consultation rates in the original data set does not tally with that used for the purpose of GP workforce planning projections herein. Table 6 also gives an overview of the change in consultation rates related to projected population growth. For example, there is a projected fall in the population of under 6s over the coming years, while the over 70s age group is projected to increase substantially. Further research on 'actual' consultation rates should be explored.

*Table 6 GP Consultation Rates Estimated as per Best Available Data*

| | Age | 2015 | 2025 |
|---|---|---|---|
| Total population | 0-5 | 440,963 | 347,595 |
| Covered prior to free GP care | | 132,289 | 104,279 |
| Uncovered prior to free GP care | | 308,674 | 243,317 |
| Average visits pp covered | | 3.2 | 3.2 |
| Average visits pp uncovered | | 3 | 3 |
| Average visits pp uncovered if free | | 3.1 | 3.1 |
| Total visits if covered | | 423,324 | 333,691 |
| Total visits if not covered | | 926,022 | 729,950 |
| Total visits if not covered but now free | | 956,890 | 754,281 |
| Total visits prior to free GP care | | 1,349,347 | 1,063641 |
| Total visits with free GP care to all under 6 | | 1,380,214 | 1,087972 |
| Total population | 6 to 11 | 408,012 | 420,547 |
| Covered | | 171,365 | 176,630 |
| Uncovered | | 236,647 | 243,917 |
| Average visits pp covered | | 2.6 | 2.6 |
| Average visits pp uncovered | | 0.8 | 0.8 |
| Average visits pp uncovered if free | | 1.5 | 1.5 |
| Total visits if covered | | 445,549 | 459,237 |
| Total visits if not covered | | 189,318 | 195,134 |
| Total visits if not covered but free | | 354,970 | 365,876 |
| Total visits per status quo | | 634,867 | 654,371 |
| Total visits if free | | 800,520 | 825,113 |
| Total population | 12 - 17 | 369,746 | 454,230 |
| Covered | | 147,898 | 181,692 |
| Uncovered | | 221,848 | 272,538 |
| Average visits pp covered | | 2.8 | 2.8 |
| Average visits pp not covered | | 1.5 | 1.5 |
| Average visits pp uncovered if free | | 2.7 | 2.7 |
| Total visits if covered | | 414,116 | 508,738 |
| Total visits if not covered | | 332,771 | 408,807 |
| Total visits if not covered but free | | 598,989 | 735,853 |
| Total visits as per status quo | | 746,887 | 917,545 |
| Total visits if free | | 1,013,104 | 1,244,590 |

*Table 6 GP Consultation Rates Estimated as per Best Available Data*

| | Age | 2015 | 2025 |
|---|---|---|---|
| Total population | 18-44 | 1,722,770 | 1,643,976 |
| Covered | | 551,286 | 526,072 |
| Uncovered | | 1,171,484 | 1,117,904 |
| Average visits pp covered | | 4.8 | 4.8 |
| Average visits pp not covered | | 2.1 | 2.1 |
| Average visits pp uncovered if free | | 3.4 | 3.4 |
| Total visits if covered | | 2,646,175 | 2,525,147 |
| Total visits if not covered | | 2,460,116 | 2,347,598 |
| Total visits if not covered but free | | 3,983,044 | 3,800,873 |
| Total visits as per status quo | | 5,106,290 | 4,872,745 |
| Total visits if free | | 6,629,219 | 6,326,020 |
| Total population | 45-64 | 1,107,838 | 1,317,230 |
| Covered | | 343,430 | 408,341 |
| Uncovered | | 764,408 | 908,889 |
| Average visits pp covered | | 5.8 | 5.8 |
| Average visits pp uncovered | | 2.1 | 2.1 |
| Average visits pp uncovered if free | | 3.4 | 3.4 |
| Total visits if covered | | 1,991,893 | 2,368,380 |
| Total visits if not covered | | 1,605,257 | 1,908,666 |
| Total visits if not covered but free | | 2,598,988 | 3,090,222 |
| Total visits as per status quo | | 3,597,150 | 4,277,046 |
| Total visits if free | | 4,590,881 | 5,458,601 |
| Total population | 65-69 | 202,341 | 244,734 |
| Covered | | 95,100 | 115,025 |
| Uncovered | | 107,241 | 129,709 |
| Average visits pp covered | | 5.2 | 5.2 |
| Average visits pp uncovered | | 2.6 | 2.6 |
| Average visits pp uncovered if free | | 4.7 | 4.7 |
| Total visits if covered | | 494,521 | 598,130 |
| Total visits if not covered | | 278,826 | 337,243 |
| Total visits if not covered but free | | 504,031 | 609,632 |
| Total visits if status quo | | 773,347 | 935,373 |
| Total visits if free | | 998,553 | 1,207,762 |

*Table 6 GP Consultation Rates Estimated as per Best Available Data*

| | Age | 2015 | 2025 |
|---|---|---|---|
| Total population | 70+ | 403,828 | 583,741 |
| Covered prior to free GP care | | 327,101 | 472,830 |
| Uncovered prior to free GP care | | 76,727 | 110,911 |
| Average visits pp covered | | 5.6 | 5.6 |
| Average visits pp uncovered | | 4.1 | 4.1 |
| Average visits pp uncovered if free | | 6.2 | 6.2 |
| Total visits if covered | | 1,831,764 | 2,647,849 |
| Total visits if not covered | | 314,582 | 454,734 |
| Total visits if not covered but now free | | 475,709 | 687,647 |
| Total visits prior to free GP care for all over 70 | | 2,146,346 | 3,102,583 |
| Total visits with free GP care to all over 70 | | 2,307,473 | 3,335,496 |

*Covered: Those holding a GPV or Medical Card*
*Uncovered: Those not holding a GPV or Medical Card*

While the focus of this report is on population change, utilisation of services and consultation rates, both health technology and nurse-led care can impact on the demand for general practitioners. These areas are discussed in more detail in Section 6 below.

# Section 4: Estimating the Gap between Supply and Demand for GPs in Ireland

## 4.1 Projecting the Supply and Demand for GPs in Ireland

In order to project the supply and demand for GPs over the next 10 years, we adapted and extended a statistical forecasting model developed by the Expert Group on Future Skills Needs and Solas (Behan, 2009)[4]. Variables used to estimate the **supply** of GPs include the number of doctors delivering GP services that are registered with the Medical Council, in headcount and WTE equivalents; the part-time and full-time working adjustment rates as well as the gender breakdown of doctors.

The number of doctors retiring and the assumed proportion of those exiting the workforce for reasons other than retirement are also estimated along with the number of doctors entering the workforce post specialist training. As mentioned above, it is an aspiration of the Department of Health and the HSE that all doctors delivering GP services in Ireland be specialist qualified. Within the statistical forecasting model, the inflow of overseas GPs is set to zero in order to isolate the domestic supply of GPs and assess the extent to which the national education and training system can meet estimated future demand. In this way, entrants in to the GP workforce are based on the number of doctors who complete postgraduate GP training and enter on to specialist register of the Medical Council. Exits, on the other hand are based on all GPs leaving the health system, regardless of whether they hold general or specialist registration. A number of emigration trends are explored within the model also.

**Demand** projections are based on both population changes and service utilisation patterns across the relevant age groups and the future scenarios for GP care in Ireland. Population projections from the CSO (2011)[20] are used to estimate the number of consultations across age groups that might be expected to 2025.

## 4.2 Future General Practice Demand and Supply Scenarios

As already mentioned above, workforce planning for GPs is based on a number of different stakeholder-informed future scenarios for the profession. These include:

**Scenario 1:** The level of access to GP care remains at the level prior to the introduction free GP care to the under 6s, as do service utilisation rates. The change in demand for GPs is based solely on projected population change over the next 10 years.

**Scenario 2:** The baseline assumption in Scenario 1 is unchanged, i.e. demand as defined by access to free GP care and service utilisation rates remain the same as 2015 (prior to the introduction of free GP care to the under 6s) and adjusted for projected population change. However, an adjustment is made for the unmet demand for GPs identified in 2015, and carried forward throughout the 10 year projection period.

**Scenario 3:** Free GP care for the under 6s is superimposed onto Scenario 2, and the consequent impact on service utilisation/demand for GP care is estimated over 10 years. Again, an adjustment is made for unmet demand as per Scenario 2.

**Scenario 4:** Free GP care for the over 70s is superimposed onto Scenario 3, and the consequent impact on service utilisation/demand for GP care is estimated over 10 years. An adjustment is made for unmet demand as per Scenarios 2 and 3.

Important assumptions related to the GP workforce planning methodology include the following:

- There is no inward migration of GPs.
- There is no emigration among GPs.
- The training intake remains at 157 per year.
- There is almost no attrition from GP training (0.3% attrition annually as per information from the ICGP).
- All graduates of GP training enter the workforce, with a WTE ratio of approximately 0.88.
- All cohorts to which free GP care is extended will choose to avail of free GP care rather than paying for it.

It is important to note that, in this workforce planning model, there is no outward or inward migration of GPs accounted for so that graduates of Irish GP specialist training represent the only supply stream of doctors entering the workforce. A 10-year projection period is used across each scenario presented.

## *4.3 Scenario Results*

The workforce planning projections are outlined in Tables 7 to 11 below. Figure 1 contains a guide to interpretation of these tables.

**Figure 1**

**Interpretation of the Gap Analysis Projection Tables**

- **Employment** represents the number of GPs required to maintain the current ratio of GPs per 1,000 estimated patient consultations for 2015. That ratio is .24 WTE (.27 headcount) GPs per 1,000 consultations. Consultation levels differ based on the extension of free GP care to different cohorts of the population which impacts the required number of GPs per 1,000 consultations.
- **Expansion** demand represents the number of additional specialists required to keep the current ratio of GPs to consultations constant year on year e.g. employment requirements 2016 minus employment 2015 = expansion demand.
- **Replacement** demand represents the number of specialists exiting the workforce and is based on projected retirements and 'other' leavers.
- **Recruitment** requirement represents the number of specialists required as per expansion demand and replacement demand.
- **Graduate** supply represents those specialists completing specialist training and entering the workforce.
- **Gap to specialist supply** represents the difference between the recruitment requirement and the specialist supply.

*A minus sign indicates an oversupply of GPs as per the gap between supply and demand over the 10 year period*

### 4.3.1 Scenario 1 Results

Within Scenario 1, change in the demand for GP services is based on the level of GP consultations per age group prior to the introduction of free GP care to the under 6s, projected forward as per population change only. The analysis, which is outlined in Table 7 below, suggests that by 2025 there will be a shortage of approximately 493 GPs (430 WTEs) if the annual trainee intake remains at 2014 levels, i.e. 157.

*Table 7 Gap Analysis, Scenario 1*

| | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | Totals to 2025 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Employment | 3923 | 3957 | 3994 | 4033 | 4072 | 4113 | 4155 | 4197 | 4240 | 4281 | 4324 | |
| Expansion demand | 34 | 37 | 39 | 39 | 41 | 42 | 42 | 42 | 42 | 43 | 44 | 445 |
| Replacement demand | 157 | 158 | 159 | 160 | 161 | 161 | 162 | 163 | 164 | 165 | 166 | 166 |
| Recruitment requirement | 191 | 195 | 198 | 199 | 202 | 204 | 204 | 205 | 206 | 208 | 209 | 2220 |
| Graduate supply | 157 | 157 | 157 | 157 | 157 | 157 | 157 | 157 | 157 | 157 | 157 | 1727 |
| Gap to specialist supply | 34 | 38 | 41 | 42 | 45 | 47 | 47 | 48 | 49 | 51 | 52 | 493 |

*Some numbers may not add up due to rounding*

### 4.3.2 Scenario 2 Results:

Scenario 2 explores the gap between the supply and demand for GPs should the ratio of specialists to consultations in Scenario 1 remain unchanged and should all unmet demand (as defined in Section 2) be considered in estimating the recruitment requirement.

The results of the gap analysis for Scenario 2 indicate a shortage of 1049 GPs (920 WTEs) should doctors representing unmet demand be replaced by doctors coming out of GP specialist training programmes. Here the 500 GPs estimated to be contributing to the workforce and representing unmet demand are added to the recruitment requirement. The changing population is accounted for in these estimates and results in the unmet demand increasing from 500 to approximately 556 over the next 10 years. See Table 8 below.

*Table 8 Gap Analysis, Scenario 2*

| GAP ANALYSIS | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | Totals to 2025 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Employment | 3923 | 3957 | 3994 | 4033 | 4072 | 4113 | 4155 | 4197 | 4240 | 4281 | 4324 | |
| Expansion demand | 34 | 37 | 39 | 39 | 41 | 42 | 42 | 42 | 42 | 43 | 44 | 445 |
| Replacement demand | 157 | 158 | 159 | 160 | 161 | 161 | 162 | 163 | 164 | 165 | 166 | 1775 |
| Requirements to meet unmet need by 2025 | 51 | 51 | 51 | 51 | 51 | 51 | 51 | 51 | 51 | 51 | 51 | 556 |
| Recruitment requirement | 242 | 245 | 249 | 249 | 252 | 254 | 255 | 256 | 256 | 258 | 260 | 2776 |
| Graduate supply | 157 | 157 | 157 | 157 | 157 | 157 | 157 | 157 | 157 | 157 | 157 | 1727 |
| Gap to graduate supply | 85 | 88 | 92 | 92 | 95 | 97 | 98 | 99 | 99 | 101 | 103 | 1049 |

**The estimated 556 locums representing overseas doctors and those over 70s fulfilling a service need are spread over the 10 year projection period. This increases to 556 by 2025 as per population change. Some numbers may not add up due to rounding*

### *4.3.3 Scenario 3 Results:*

Scenario 3 explores the gap between the supply and demand for GPs by 2025 as free access to GP care is extended to the under 6s. Within this scenario, unmet demand is also accounted for in the recruitment requirement estimates. The analysis of this scenario infers a requirement of 1056 extra GPs (925 WTEs) in order to meet demands related to increased visitations arising from the extension of free GP to the under 6s and in order to meet unmet demand already in the system. See Table 9 below.

*Table 9 Gap Analysis, Scenario 3*

| GAP ANALYSIS | 2015 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | Totals to 2025 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Employment | 3923 | 3931 | 3965 | 4002 | 4041 | 4080 | 4120 | 4163 | 4204 | 4247 | 4288 | 4331 | |
| Expansion demand | | 42 | 36 | 39 | 39 | 41 | 42 | 42 | 42 | 42 | 43 | 44 | 452 |
| Replacement demand | | 157 | 158 | 159 | 160 | 161 | 161 | 162 | 163 | 164 | 165 | 166 | 1775 |
| Requirements to meet unmet need by 2025 | | 51 | 51 | 51 | 51 | 51 | 51 | 51 | 51 | 51 | 51 | 51 | 556 |
| Recruitment requirement | | 250 | 245 | 248 | 249 | 252 | 254 | 255 | 256 | 256 | 258 | 260 | 2783 |
| Graduate supply | | 157 | 157 | 157 | 157 | 157 | 157 | 157 | 157 | 157 | 157 | 157 | 1727 |
| Gap to graduate supply | | 93 | 88 | 91 | 92 | 95 | 97 | 98 | 99 | 99 | 101 | 103 | 1056 |

*Some numbers may not add up due to rounding*

### *4.3.4 Scenario 4 Results:*

The results of the gap analysis for Scenario 4 indicates a shortage of 1121 GPs (983 WTEs) as free access to GP care is extended to the under 6s and the over 70s by 2025 and accounting for current levels of unmet demand within the system. See Table 10.

*Table 10 Gap Analysis, Scenario 4*

| GAP ANALYSIS | 2015 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | Totals to 2025 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Employment | 3923 | 3975 | 4011 | 4049 | 4090 | 4131 | 4174 | 4218 | 4262 | 4306 | 4350 | 4395 | |
| Expansion demand | | 88 | 38 | 41 | 41 | 43 | 44 | 44 | 44 | 44 | 45 | 46 | 518 |
| Replacement demand | | 157 | 158 | 159 | 160 | 161 | 161 | 162 | 163 | 164 | 165 | 166 | 1775 |
| Requirements to meet unmet need by 2025 | | 51 | 51 | 51 | 51 | 51 | 51 | 51 | 51 | 51 | 51 | 51 | 556 |
| Recruitment requirement | | 296 | 247 | 250 | 251 | 254 | 256 | 257 | 258 | 258 | 260 | 262 | 2848 |
| Graduate supply | | 157 | 157 | 157 | 157 | 157 | 157 | 157 | 157 | 157 | 157 | 157 | 1727 |
| Gap to graduate supply | | 139 | 90 | 93 | 94 | 97 | 99 | 100 | 101 | 101 | 103 | 105 | 1121 |

# Section 5: Discussion and Recommendations

## 5.1 Discussion of the General Findings

Planning for the General Practitioner workforce in Ireland is important in the current health care environment given the recent and planned extension of free GP care, the aging population and increasing pressure on the acute hospital system, among other factors.

The workforce projections outlined in Section 4, Tables 7 to 10 address the estimated gap between the supply and the expected demand for GPs in the primary health care system over the next 10 years.

Of importance to note here is that the estimated inflow of GPs into the workforce is made up of newly trained specialists only. This is done in order to gauge the number of extra specialist doctors required to ensure that the GP workforce is increasingly made up of specialist trained doctors, thereby making the primary care system decreasingly reliant on non-specialist qualified doctors. Also of note is that in the main set of projections outlined above, we have set emigration to zero. This is done in order to assess the ability of the training system to produce enough specialists to meet demand. In this way we assume all doctors who graduate from specialist training, enter the GP workforce.

### Scenario 1

The first set of projections, outlined in Table 7, outlines the estimated shortage of GPs based on GP numbers and utilisation patterns prior to the introduction of free GP care to the under 6s, corrected for population change on an annual basis until 2025. It assumes that there will be no change in Medical Card and GP Visit Card eligibility. The annual shortage ranges from 34-52, cumulatively adding up to 493 headcount (430 WTE) at the end of the 10 year period.

In the projection estimates we have addressed the impact of the ageing population on the utilisation of GP services should access to those services remain unchanged, at levels prior to the introduction of free GP care to the under 6s. The number of people in Ireland over the age of 70 is projected to increase from around 402,871 to 583,169. With this ageing population will come increased demands for GP services, regardless of levels of free access to GP care.

### Scenario 2

Table 8, incorporates a correction for current unmet demand for GP services, extrapolated over a 10 year period. In the absence of hard evidence, we have estimated this at 500 headcount, and rather than apply the correction in year 1, we have spread it over the years 2015-2025. The unmet demand is superimposed on the baseline figures of Scenario 1, i.e. Scenario 2 represents a cumulative situation. The annual shortages range from 85 to 103, cumulatively adding up to 1,049 headcount at the end of the 10 year period.

The background to our estimation of unmet demand is described in Section 2. At the present time, Ireland is dependent on doctors from overseas, hospital NCHDs, and a cohort of its own GPs who would prefer to retire or work part-time; these doctors are filling gaps that our permanent, career-GPs cannot address due to inadequate numbers. They are providing an essential service. Furthermore, the WHO Global Code of Practice on the International Recruitment of Health Personnel recommends that countries should have a sustainable medical workforce.

## Scenario 3

Scenario 3 addresses the projected requirement for GPs as free access to GP care is extended to the under 6s. Again, the figures in Table 9 represent a composite of the 3 scenarios, with Scenario 3 being superimposed on Scenario 2. The annual shortages range from 93 to 103, cumulatively adding up to 1,056 headcount (925 WTE).

The small increase in the gap which we see on comparing Scenarios 2 and 3 may be explained by the falling birth rate in Ireland. The CSO population projections show a reduction in the population of under 6s from 440,963 in 2015 to 347,595 in 2025. We are using the CSO M2F2 population projections as part of our workforce planning methodology for all specialties. M2F2 forecasts are on the conservative side. However, when the actual annual birth rates since 2011 are compared with the projected birth rates as per the CSO M2F2 it can be seen that the number of registered births was in fact lower than those predicted. See Table 11 below.

*Table 11 Number of Births to 2013. Estimated Actual and Projected*

| | **Births CSO Actual Estimate (Registrations)** | **M2F2** |
|---|---|---|
| 2011 | 74,650 | 72,452 |
| 2012 | 72,225 | 74,235 |
| 2013 | 68,930 | 75,160 |
| 2014 | | 73,004 |

## Scenario 4

The final set of projections superimpose the effects of extending free GP care to the over 70s to the previous scenarios. The results of the gap analysis indicate a shortage of 1,121 GPs (983 WTEs) over the 10 year projection period, with an annual range of 105 to 139.

Tables have been prepared for 3 further scenarios including:

- Extension of free GP care to under 12s
- Extension of free GP care to under 18s
- Extension of free GP care to all

These tables can be found in Appendix B.

## 5.2 The Impact of Emigration/Migration on the Demand for GPs

The methodology used herein incorporates certain assumptions including the assumption that all graduates of GP training enter the workforce and that there is no emigration among GPs. It is important to address these assumptions, as well as other variables which might influence the modelling, and outputs of the scenario analyses.

Accurate emigration and migration figures are not available. However, an ICGP survey of GPs suggests that recently qualified specialists are finding the costs of setting up in independent practice prohibitive. This, combined with cumulative cuts in GMS payments, is cited to be leading to the emigration of young GPs. GMS along with other public service financial cut-backs were introduced during a time of economic crisis in Ireland. There is however a commitment from Government to gradually reverse these cuts, which may go some way to reducing the number of young GPs leaving the country.

In order to better understand the potential impact of emigration on the future supply of GPs, a number of alternative emigration trends were explored within the workforce planning model. This was done through manipulation of the 0% emigration assumption within the model as follows:

- 5% rate of emigration
- 10% rate of emigration
- 15% rate of emigration

Table 12 shows the resulting adjustment in the 10 year shortfall for each of the 4 scenarios. As can be seen, even modest emigration rates have a major impact on the gap between the supply and demand for GPs.

*Table 12 Impact of emigration rates on scenarios/gap analysis*

| Emigration Rate | WTE/ Headcount | Scenario 1 | Scenario 2 | Scenario 3 | Scenario 4 |
|---|---|---|---|---|---|
| 0% | Headcount | 493 | 1,049 | 1,056 | 1,121 |
| | WTEs | 430 | 920 | 925 | 983 |
| 5% | Headcount | 580 | 1,135 | 1,142 | 1,208 |
| | WTEs | 504 | 994 | 1,000 | 1,057 |
| 10% | Headcount | 666 | 1,222 | 1,228 | 1,294 |
| | WTEs | 579 | 1,068 | 1,074 | 1,131 |
| 15% | Headcount | 752 | 1,308 | 1,315 | 1,380 |
| | WTEs | 653 | 1,142 | 1,148 | 1,205 |

### 5.3 Flexible Working Arrangements

The analysis carried out within the workforce planning modelling indicated that over the next 10 years the percentage of female GPs in the workforce is likely to increase from around 46% to 52%.

As female GPs are more likely to work part-time, feminisation of the GP workforce will drive the demand for increased numbers of GPs to meet patient demand. Today, a GMS contract holder can apply for flexible working as long as there is no resultant reduction in the whole time equivalent number of GMS contract holders in a specific locality. This flexible working allowance for GMS contract holders should help reduce the headcount demand for GPs over the next 10 years.

Flexible working arrangements can be configured in such a way as to allow for part time work at, for example, 60% to 75% of the working week rather than the current estimated rate of 50%. Such arrangements represent a trend emerging internationally and across professional groupings in response to escalating employment and training costs, reducing birth rates, shortages in the employment stock and the need to encourage women in to the workplace. Increasingly male employees are also seeking flexible working arrangements.

### 5.4 Nurse-Led Care and Chronic Disease Management in General Practice

#### 5.4.1 Nurse-led Care in General Practice

The development of nurse-led care can help reduce GP workload, lead to financial savings and alleviate the escalating demand for GPs in the future. In countries such as the UK, New Zealand and Australia nurse-led care is delivered for chronic conditions, immunisations and general care for older people in the population. This means that GPs can concentrate on the more complex patient cases, leaving nurses to carry out some routine procedures.

Consideration should be given to the need for increased nursing to GP ratios and to specialist training (up to Advanced Nurse Practitioner level) for practice nurses so that they may become a primary care team or network resource to support the management of long term conditions in the community. In this way, more generalist practice nurses could deliver routine care.

In the UK it is notable that financial incentives for general practice successful in achieving positive patient outcomes was the main driver behind the expansion of nurse-led care (Hoare et al, 2012)[21].

#### 5.4.2 Chronic Disease Management

As already noted, within our workforce planning we have not addressed the extension of free GP care to those people with a chronic disease. Future considerations in the workforce planning process must include the impact of progress towards chronic disease and other care being delivered in the community setting. We acknowledge the importance of considering the potential of for example, the increased delivery of chronic disease

management and older age care by nurses in the community, on the demand for GP services in the future. Another important area that must be considered is the potential impact of increased access to homecare packages and the role the GP will play in overseeing care in the home. It is envisaged that the proposed new contract between the HSE and general practitioners, relating to the delivery of GP care through the GMS scheme, will recognise the potential for combined nurse, GP care activity. New models of care for chronic disease management in the community infer combined GP and nurse-led initiatives for certain major illness e.g. diabetes.

In building a picture of what planning for chronic disease management in the community will entail, we note the following:

There are three main levels of patient complexity relating to chronic disease presentation and management as follows:

Level 1: Individuals who have a chronic illness which can be well controlled by the patients themselves with primary care support. This equates to approximately 80% of patients.

Level 2: Individuals with more complex illness who may have one or more chronic illness of varying severity, but are not at high risk of hospitalisation, if they are well managed in the community. This equates to approximately 15% of patients.

Level 3: Individuals with complex conditions, often with complications, who require specialist care, intensive intervention and are at high risk of hospitalisation. This equates to approximately 5% of patients (HSE, 2008 p. 4).[22]

Using these statistics, we can assume that approximately 95% of all chronic disease patients could be treated in the community setting, by either a GP or an appropriately qualified nurse. In order to benchmark this against current primary care based treatment of chronic illness patients, we need better data.

According to the HSE there are currently around 800,000 people in Ireland who have one or more of the major chronic diseases COPD/asthma, diabetes and heart failure and atrial fibrillation. Around one third of these have more than one of these chronic diseases. The HSE are recommending that these patients be cared for in the community by both GPs and practice nurses. Taking the complexity of illness in to consideration, it can be estimated that around 95% of the 800,000 patients referred to above i.e. 760,000 patients, could be treated for their chronic illness in the community. The HSE currently advocates that these patients could receive structured chronic disease care in the community seeing a GP approximately once per year and a practice nurse around twice per year. In this way, the introduction of chronic disease management in the community would increase GP consultation rates, over and above those for free GP care for the under 6s and the over 70s, by around 760,000 per year. Here, we are assuming that the current level of consultations for the over 70s in particular will not be impacted by chronic disease management in the community setting being introduced free of charge.

If advanced nurse practitioners and practice nurses were to be resourced to manage chronic illness in the community, in the place of GPs, this could decrease the requirements for GPs in managing the care of these patients. It is safe to assume that a significant level of chronic disease management in the community setting could be nurse delivered if the appropriate training and primary care resources were made available.

## 5.5 The Impact of Health Technology on the Demand for GPs

General practice in Ireland has been relatively progressive at adopting technology to assist in case and practice management. Optimum use of IT systems in GP practices however can assist the practice to coordinate, measure, track, and share health related data to monitor and improve clinical workflow processes. This in turn can lead to increased efficiencies, reduced costs and improved patient health outcomes. Health technology is increasingly facilitating improved workflows across both the primary and acute care settings. The introduction of the electronic patient record has the potential to greatly increase efficiencies within and across primary and acute care settings.

Benefits of health technology optimisation within the practice setting include the following:

- Facilitation of the transfer of information related to laboratory, scans and test results, medications, immunisations and other information about patient care. This serves to greatly enhance care coordination.
- The standardisation of data collection at practice, community and national level. This in turn facilitates monitoring and review of practice processes as well as practice and population level analysis.
- The development of data registers and datasets to inform chronic disease incidence and related workload, GP and practice nurse consultations among other things. Such registers and datasets provide evidence to support the development of policy and practice and can be invaluable in supporting primary care strategic planning in relation to, for example, more practice nurse-led care. This in turn can lead to increased efficiencies and reduced costs.

While the implementation of health technologies can serve to increase GP workload in the short term i.e. through the need for learning, data inputting etc. the impact on GP workload ultimately can be reduced. For example, in the Netherlands the impact of technology on the demand for GPs was found to lead to an overall decrease in demand of 1%, taking both increased workload and increased efficiencies into consideration (Van Greuningen et al, 2012)[8].

The impact of health technology on primary care is an area that needs further examination.

## 5.6 Resources to Support Practice Development

Expansion of the GP workforce can only take place if supported by infrastructural and human resources. The planned reversal of financial cuts and the provision of other support requirements will be important in ensuring adequate general practice resourcing.

## 5.7 Actions Required to Address Current and Future GP Shortages

### 5.7.1 Trainee Intake

The main finding of the GP workforce planning exercise outlined in this report is that a current and future shortfall of GPs has been identified and clarified. In order to ensure that Irish patients continue to have ready access to GP services, these results should be reviewed with a view to formulating a policy aimed at addressing the projected deficit.

If we use the "gap to graduate supply" figures from the 4 scenarios (i.e. the figures in red in the last line of tables 7 to 10) as a proxy for the projected shortfall in trainee intake, this would suggest that an annual increase of between 50 (scenario 1) and 110 (scenario 4) GP training places is required to prepare for the future GP demand. In this regard, the following points are noted:

i. **Scenario 1** Should an increase in the number of GPs in training to meet future demand based on population ageing alone, without provision for the extension of free GP care to the under 6s, then an increase of around **50** GPs per year would be required. These estimates assume all trainees are available to enter the workforce upon specialist qualification.

ii. **Scenario 2** In order to meet the current unmet demand for GPs (represented by current GMS panel vacancies; doctors flying into Ireland from overseas for short periods of time to fill locum GP demand, including red-eye co-op shifts; NCHDs from the acute sector working as locum GPs; GPs working beyond retirement but not by choice; GPs working full-time when they would otherwise choose to work part-time) it is estimated that an annual increase of approximately **100** training places will be required

iii. **Scenarios 3 and 4** If both unmet demand for GPs in the system today and requirements to meet demand based on the roll-out of free GP care to the under 6s and the over 70s over the coming 10 years are to be considered, then the training intake allocation should increase by approximately **110** places per year.

iv. If we factor emigration among newly qualified GPs into training related estimates, then the requirement for increased training places, over and above the current 157, could be up to between 75 per year and 138 per year (based on a 15% emigration rate among new specialists)

v. The headcount projections above could be impacted by variations in the incidence of part-time working/WTE rate of doctors working in the system over the next 10 years. For example, a greater proportion of GPs (both male and female) may choose to work shorter hours. In this way, attention should be paid to part-time working/WTE rates when reviewing trainee intake requirements.

vi. In order to ensure that, in the future, newly qualified medical graduates choose to apply for GP training, it is important that general practice is promoted as a positive career choice among undergraduate and second level students. In addition, innovative approaches to training such as accelerated training for doctors who have completed recognised training in other specialties should be considered.

### 5.7.2 Innovation in the Recruitment and Retention of GPs

Reliance solely on the training system to meet the future demand for GPs in Ireland is not appropriate. A number of parallel recruitment and retention strategies should be considered in order to meet the future demand for GPs, which could thereby reduce the trainee requirements. These include the following:

i. A return to work programme to encourage early leavers from general practice back into the profession. These early leavers are most likely to include GPs who left the workforce for family reasons.

ii. Ongoing support for flexible working to ensure that more GPs are retained in the workforce rather than opting out in order to meet family and other commitments. This applies to both GMS contract holders and non-GMS contract holders. This has been recommended in the Strategic Review of Medical Training and Career Structure (DoH, 2014[23]).

iii. Examining mechanisms to support rural practice.

iv. Incentivising all GPs to work closer to the age of 70, in order to maximise the contribution of the current GP workforce. A flexible working scheme for those approaching retirement could be implemented. We acknowledge that GMS contract holders can currently work up to the age of 72.

v. A retention strategy for trainees and newly qualified specialists, as we know that there is currently a trend towards increasing intention to emigrate amongst recent graduates. Flexible working arrangements, structured career pathways and support and assistance in practice development could be considered.

### 5.7.3 Research and Data-Related Recommendations

The following research and data-related recommendations are proposed:

i. The introduction of a HSE register of all GPs working in Ireland is recommended in order to get an accurate profile of the GP workforce. This should include data collection on parameters such as numbers and registration of GPs, WTE rates, gender and age.

ii. Further research by the HSE and the ICGP into GP consultation rates is recommended in order to capture representative data on the actual utilisation of GP services across age groups, gender, deprivation, illness presentation and geography.

iii. An analysis of the future impact of moving chronic disease management from the acute hospital setting into primary care, on general practice, should be carried out. This should be done in tandem with an analysis of the potential for more nurse-led care in the general practice setting

iv. Further analysis on the potential impact of increasing nurse-led care in the general practice setting for conditions other than chronic disease management should also be considered.

v. A stakeholder consultation exercise on the potential future impact of advances in technology on general practice is recommended. This should include consultation on the implications of advances in technology for GP workforce requirements due to possible efficiencies which might result e.g.

   a. Patient data sharing across the acute and community setting

   b. Online access to diagnostics, lab results, radiology etc.

## 5.8 Conclusion

Over the coming 10 years, it is estimated that the demand for GP services will increase substantially. The number of people in Ireland over the age of 70 will increase from around 403,000 to 583,000. With this ageing population will come increasing chronic illness rates and increasing demand for GP services. This will have a major impact on health service planning and will require an appropriate response from Government, the acute hospital system, social care and primary care services.

The increase in access to free GP care to different cohorts of the population will also have an impact on the demand for GP services, as those who previously did not have access to a GP free of charge are likely to visit the GP more frequently. Feminisation of the workforce and trends in doctor emigration also threaten the availability of doctors to deliver much needed GP services.

All indicators point to an urgent requirement to plan for an expanded GP workforce. This will require increasing the training intake in to GP training programmes in the immediate term, along with the implementation of strategies to maximise recruitment and retention potential.

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# Appendix A

Table A1 outlines the current number and ratio of general practitioners per 100,000 of the population in Ireland (as of 2014 when this exercise was carried out). Included in this table are the projected numbers of specialists per 100,000 of the population in 2024, should the current ratio remain static at the 2014 level. Table A1 also includes the research informed range of specialists per head of population as per expert stakeholder perspectives and the ratios in place, projected and/or recommended in comparable healthcare jurisdictions.

*Table A1 General Practice Specialist Posts 2014-2024*

| 2014 | | 2024* | | Research informed range of specialists per head of population to 2024 ** | |
|---|---|---|---|---|---|
| **N** | **Ratio per 100,000 pop** | **N** | **Ratio per 100,000 pop** | **N** | **Ratio per 100,000 pop** |
| 2,880 (2,464 WTE) | 62 | 3,086 (2,715 WTE) | 62 | 3,086 - 4,978 (2,715 - 4,380 WTE) | 62 - 100 |

* *Accounting for population growth and an unchanged ratio of specialists*
** *The recommendation is based on information in Table 7 and represents a range from the lowest to the highest ratio considered*

The benchmarking data in Table A1 was informed by submissions from expert stakeholders i.e. the HSE Clinical Programme for Primary Care and the ICGP as well as research on population based ratios of GPs in the UK and Australia. See Table A2 for more information.

*Table A2 Benchmarking Research: Including Submissions Overviews and International Ratio Information*

| | |
|---|---|
| **National Clinical Programme for Primary Care** | Medical Council statistics indicate that there are over 4,000 doctors who class themselves as General Practitioners (GPs). The Irish College of General Practitioners (ICGP) and Health Service Executive (HSE) data would indicate somewhere around 2,600 GPs currently active in Ireland. At present there are 157 GP training places annually across 15 GP training programmes – this has increased from 120 training places in 2009. GP training has also moved to a four year cycle – increased from 3 years in the period 2005 – 2008. In addition an unspecified number of GPs train in the United Kingdom, some of whom return to Ireland but numbers are anecdotal. |

The male female ratio is around 3:1 females. This has implications in terms of full time equivalent GPs as both female and male GPs elect in increasing numbers to work part time due to family commitments. A recent ICGP survey noted that 93% of GP trainees see themselves working in general practice in 10 years time, indicating that retention of trained GPs is positive. However in this survey 44% of GPs saw themselves working in a part time capacity. The 2009 FAS report into healthcare workforce planning predicted that there would be a shortfall of 265 GPs annually by 2020. Another confounding factor is the age profile of Irish GPs – the median age being in the late 50's. The FAS report in 2009 envisaged up to 240 GPs retiring between 2011 and 2015 although the HSE has increased the retirement age to 70 and economic circumstances may reduce the potential number of retirees. The Primary Care Strategy 2001 and subsequent government policy has envisaged a move from secondary care to more activity in the primary care sector. Central to this change is the development of primary care teams with GPs as key leaders in the governance of such teams. Added to this are the ageing demographics of Irish society and the consequent increase in workload in primary care.

The current model of GP training is basically two years in hospital rotations followed by two years in general practice as a registrar. The ICGP criteria list the types of hospital rotations that are appropriate to GP training such as paediatrics/ obstetrics and gynaecology, medicine etc. There is a limited number of training places particularly in paediatrics which is deemed an essential rotation. As a result any plan to increase GP training places needs to take into account the problem in placing GP trainees in an ever decreasing number of hospital SHO rotations in such specialities. GP training schemes anecdotally report that they would struggle to house extra training places given the current model of training which is based on small group learning and day release.

GPs have traditionally worked as single handed practitioners or in small groups. With the increasing complexity of care and workload demands there is a move to multi-disciplinary teams where GPs share workload and delegate tasks such as chronic illness management to practice nurses and other primary care team members. In this context it is important to take workforce planning across the primary care sector rather than considering GP

training in isolation. A model of care is emerging from both the clinical programmes in the HSE and on the ground in primary care where GPs supervise illness management while practice nurses work according to models of care and protocols. An example of this is diabetes care which is predominantly carried out by practice nurses with the aid of clinical nurse specialists. The role of the public health nurse also needs to be explored and re-defined in this changing environment. There is a need for a census of the current GP workforce given the wide variation in Medical Council numbers and those registered with the HSE and ICGP as GPs. The suggestion is to build on the work of Health Atlas. This could be done in collaboration with the ICGP and HSE. In addition, the HSE needs to look at primary care workforce planning in particular with reference to practice nurses who although not all HSE employees, are supported by a grant system to GPs. In the meantime there is no doubt that a limited increase in GP training places could be considered in the short term. The suggestion is made given the above constraints, that a modest increase of 20 GP training places would be appropriate and achievable.

**The Irish College of General Practitioners**

The determination of an appropriate ratio of General Practitioners (GPs) per head of population must be considered in a scenario specific format. Currently there is health policy suggesting that Irish general practice is expected to change significantly. A number of scenarios could be considered:

*Scenario 1:* A single change, being the provision of care to all children under 6 years via the General Medical Services (GMS) contract
*Scenario 2:* as above plus provision of care to all those patients with chronic disease, without expectation of payment at point of care
*Scenario 3:* Universal Health Insurance and how it will change Irish general practice
*Scenario 4:* Government employment of some/all general practitioners

Ireland's allocation of General Practitioners per head of population was in line with the Organisation for Economic Co-operation and Development average (OECD, 2009) at 52 per 100,000 population in 2009. However the distribution of physicians as a percentage of total physicians shows that Ireland (12%) has a lower ratio of GPs compared

with the OECD (20%) average. Recent research in 2013 by Teljeur et al. suggests the number of GPs per head of population may be higher than the 2009 OECD figures at 64.4 per 100,000 population and an absolute number of 2,954. Government policy in recent years has the expectation of general practice to perform at a level of much higher ranked healthcare systems, such as France and Canada. In both of these countries, the ratio is over 100 per 100,000 population and comprises some 50% of their total registered physicians. In terms of the number of additional GPs deemed appropriate by ICGP over the next 5 to 10 years, best estimates of numbers are in respect to particular scenarios. Some of the relevant issues for consideration within each scenario are as follows:

General Practice has 22% of its workforce working part-time, according to the Irish Medical Council Workforce Intelligence Report (2013). There is an age related increase in the percentage of all doctors working part-time. Under 35 years, 4% of males and 7% of females work part-time. This figure increases in the 35-44 age bracket to 4.4% and 23% respectively and continues to rise such that in the 55-64 age bracket it has become 9% and 36% respectively. In 2012, 59% of new specialist entrants to the general practice division of the specialist register were female. This corresponds to the total number of female medical graduates from Irish medical schools. Currently female doctors are twice as likely to work part-time as their male counterparts.

There is little Irish data accurately detailing the volume of work per full time GP. We know that some GPs consult with four patients per hour and some 6 per hour. The number of presenting complaints (issues) per consultation is rarely less than two and commonly four. More data on these parameters in Irish general practice is needed to truly conceptualise the workload currently being met. Only then can we start to extrapolate the increase in workload that will inevitably follow the introduction of any of the current government's plans. All government plans involve removing cost at point of care to the patient and we know this will double or triple the frequency of consultation by those people currently outside the General Medical Services Scheme. Some general practitioners have started to produce this data and the high level of computerisation will allow widespread collection of data. Potentially the rapidly expanding network of practices involved in the Irish

| | |
|---|---|
| | Primary Clinical Research Network (IPCRN), could gather accurate data as census data does not reflect the experience of practitioners on the ground.<br><br>2013 ICGP membership data showed 258 GPs to be in the 65-69 year age group. With state contracts all ending at 70 years, it is reasonable to assume that the majority of these GPs will retire at 70 years of age. In 2010, the number of available training places in general practice increased from 129 to 157. Training duration is four years and so the first year of graduation since expansion occurred is 2014. |
| **United Kingdom Ratios** | General Practice is the largest medical specialty within the United Kingdom where GPs see more patients daily than any other specialist in the National Health Service (NHS). The short-term focus of recommended ratios is to increase specialist training numbers to reach the government's recruitment target which is 3,250 GP training places per year to be reached in England by 2015. In 2011 there were 67.8 GPs per 100,000 of the population in England. The Centre for Workforce Intelligence project this ratio to improve to around 83-84 per 100,000 by 2030, estimating that if the 3,250 GP trainee places target is achieved by 2015 and maintained thereafter, it will increase baseline supply projections by around 43% or 15,300 GPs by 2030 (on a headcount basis). |
| **Australia Ratios** | The Royal Australian College of General Practitioners state that while there is no universally agreed acceptable GP to patient ratio, the Department of Health and Ageing (DoHA) defines a District of Workforce Shortage (DWS) as a geographical area in which the population's need for medical services has not been fully met. The Department of Health and Ageing has determined this by comparing the supply of GPs with the national average supply, and considers the ratio of 71 per 100,000 population as the standard doctor-to-patient ratio. Recent studies show that 42% of the current general practitioner workforce is aged 55 years or older. Whilst there has been a significant increase in training numbers since 2007 i.e. from 600 per year to 1,200 per year by 2014, increased training numbers will not fully offset the retiring workforce in the medium-to-long term. This is due to training numbers falling short of the estimated 1,500 places per year required to meet demand by 2016. |

***Notes:***

- According to data for 2013, 2,809 doctors were registered in the Medical Council Specialist Division as General Practitioners. Teljeur et al. (2013) estimated that there were approximately 2,954 GPs working in Ireland in 2012/13. This equates to 64.4 GPs per 100,000 population in terms of headcount, and 61.3 GPs per 100,000 in terms of whole-time equivalent (WTE) and assuming that 91% of GPs work full-time. A combination of data from GMS, ICGP, Cervical Check and IMD databases were used to arrive at the estimate. For the purpose of making training intake recommendations, the estimated GP workforce for 2014 is 2,880 based on estimates outlined above.
- The WTE rate used herein is .88. This rate is estimated for 2013 based on the Medical Council rate of 75% working full-time; 23% working part-time and 2 % 'other' approximately. As per the ICGP survey results cited in the submission outlined above, in 10 years time there is potential for approximately 44% of the GP workforce to be working part time. This represents a doubling of the part time working numbers estimated by the Medical Council in 2012.
- Population 2014 is projected to be 4,626,423 using the M2F2 scenario CSO (2011)
- Population 2024 is projected to be 4,979,921 using the M2F2 scenario CSO (2011)
- Information in Table A2 does not necessarily represent the views of HSE-NDTP

# Appendix B

## Scenario Analysis: Further Extension of Free GP Care

### Scenario 5: Extension of Free GP Care to the Under 12s and Over 70s

The results of the gap analysis for Scenario 5 indicates a shortage of 1165 GPs (1029 WTEs) should free access to GP care by extended to the under 12's and the over 70s by 2025. These estimates build in the extra GP requirements to account for unmet need within the primary care system i.e. doctors flying in from overseas to fill locum requirements, GPs working beyond retirement where they cannot find a replacement GP for their clinic and doctors from the acute hospital sector working in a locum GP capacity in their free time. See Table B1 for the results of this analysis.

*Table B1*

**Scenario 5 - Free GP care to Under 12s and Over 70s**

| GAP ANALYSIS | 2015 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | Totals to 2025 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Employment | 3,923 | 4,021 | 4,057 | 4,097 | 4,139 | 4,181 | 4,224 | 4,268 | 4,311 | 4,355 | 43,98 | 4,441 | |
| Expansion demand | | 134 | 39 | 42 | 42 | 43 | 44 | 44 | 44 | 43 | 44 | 43 | 561 |
| Replacement demand | | 157 | 158 | 159 | 160 | 161 | 161 | 162 | 163 | 164 | 165 | 166 | 1,775 |
| Requirements to meet unmet need by 2025 | | 51 | 51 | 51 | 51 | 51 | 51 | 51 | 51 | 51 | 51 | 51 | 556 |
| Recruitment requirement | | 342 | 248 | 252 | 252 | 254 | 256 | 256 | 257 | 257 | 259 | 259 | 2,892 |
| Graduate supply | | 157 | 157 | 157 | 157 | 157 | 157 | 157 | 157 | 157 | 157 | 157 | 1,727 |
| Gap to graduate supply | | 185 | 91 | 95 | 95 | 97 | 99 | 99 | 100 | 100 | 102 | 102 | 1,165 |

### Scenario 6: Extension of Free GP Care to the Under 18s and Over 70s

The results of the gap analysis for Scenario 6 indicates a shortage of 1256 GPs (1101 WTEs) should free access to GP care by extended to the under 18's and the over 70s by 2025. This scenario accounts for unmet need within the system also. See Table B2.

*Table B2*

**Scenario 6: Extension of Free GP Care to the Under 18s and Over 70s**

| GAP ANALYSIS | 2015 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | Totals to 2025 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Employment | 3,923 | 4,094 | 4,131 | 4,172 | 4,215 | 4,258 | 4,303 | 4,349 | 4,395 | 4,440 | 4,485 | 4,531 | |
| Expansion demand | | 208 | 40 | 43 | 43 | 45 | 46 | 46 | 46 | 45 | 46 | 44 | 652 |
| Replacement demand | | 157 | 158 | 159 | 160 | 161 | 161 | 162 | 163 | 164 | 165 | 166 | 1,775 |
| Requirements to meet unmet need by 2025 | | 51 | 51 | 51 | 51 | 51 | 51 | 51 | 51 | 51 | 51 | 51 | 556 |
| Recruitment requirement | | 416 | 249 | 253 | 253 | 256 | 258 | 258 | 259 | 259 | 261 | 260 | 2,983 |
| Graduate supply | | 157 | 157 | 157 | 157 | 157 | 157 | 157 | 157 | 157 | 157 | 157 | 1,727 |
| Gap to graduate supply | | 259 | 92 | 96 | 96 | 99 | 101 | 101 | 102 | 102 | 104 | 103 | 1,256 |

## *Scenario 7: Extension of Free GP Care to All*

The results of the gap analysis for Scenario 7 indicate a shortage of around 2055 GPs (1,801 WTEs) should free access to GP care by extended to the entire population of Ireland by 2025. Again, this scenario accounts for unmet need within the system currently. See Table B3 for the results of this analysis.

*Table B3*

**Scenario 7: Extension of Free GP Care to All**

| GAP ANALYSIS | 2015 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | Totals to 2025 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Employment | 3,923 | 4,843 | 4,882 | 4,925 | 4,972 | 5,019 | 5,069 | 5,121 | 5,172 | 5,223 | 5,274 | 5,325 | |
| Expansion demand | | 959 | 43 | 47 | 47 | 50 | 52 | 51 | 51 | 51 | 51 | 49 | 1,451 |
| Replacement demand | | 157 | 158 | 159 | 160 | 161 | 161 | 162 | 163 | 164 | 165 | 166 | 1,775 |
| Requirements to meet unmet need by 2025 | | 51 | 51 | 51 | 51 | 51 | 51 | 51 | 51 | 51 | 51 | 51 | 556 |
| Recruitment requirement | | 1167 | 251 | 256 | 258 | 261 | 264 | 264 | 265 | 265 | 267 | 265 | 3,782 |
| Graduate supply | | 157 | 157 | 157 | 157 | 157 | 157 | 157 | 157 | 157 | 157 | 157 | 1,727 |
| Gap to graduate supply | | 1,010 | 94 | 99 | 101 | 104 | 107 | 107 | 108 | 108 | 110 | 108 | 2,055 |

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Health Service Executive

# NDTP

National Doctors Training & Planning

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Health Service Executive
Dr. Steevens' Hospital
Dublin 8
Ireland

t +353 1 635 2237
f +353 1 635 2898
e doctors@hse.ie
w www.hse.ie/doctors

# FOREWORD

The functions of medical education and training, medical workforce planning and the consultant post approval process are now centralized in the National Doctors Training & Planning (NDTP) department of the HSE. The department was re-named in November 2014 to reflect this enhanced role.

This second annual report documents the major activities carried out in 2015, and highlights the areas we wish to target in 2016.

Additional intern, specialist training and post-CSCST Fellowship posts were approved in 2015 in order to create further training capacity for the increasing graduate numbers from Irish medical schools. The annual careers day had its largest attendance yet and the new medical careers website was launched. The process for refunding NCHDs for allowable training expenses was simplified and agreement was reached with training bodies to cap the application fee payable by Doctors applying for basic specialist training.

The first of a planned series of specialty-specific workforce planning reports (for general practice) was published, and work on a paediatrics/neonatology report was progressed. Work commenced on streamlining and simplifying the consultant application process, and a new on-line portal was introduced to reduce the paperwork burden for NCHDs as they rotate from site to site.

NDTP works closely with many partners both within and without the HSE, and we are very grateful for their cooperation and support in achieving our mutual goals.

I would like to record my thanks to the NDTP team who continue to support me in my role since I joined the unit in 2012.

Prof. Eilis McGovern
Director
National Doctors Training & Planning
HSE

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# 1. MEDICAL EDUCATION AND TRAINING

## 1.1 Annual Assessment of NCHD Posts

Part 10 of the Medical Practitioners Act 2007 (MPA 2007) defines the legislative responsibilities of the Health Service Executive in relation to Medical and Dental Education and Training. A key responsibility defined for the HSE is the requirement to assess on an annual basis, the number of intern posts and the number and type of specialist medical training posts required by the health service. Furthermore, the HSE is required to assess, on an annual basis, the need for and appropriateness of NCHD posts which are not utilised or required for the purposes of medical training. The HSE is required to publish the results of each of its annual assessments.

During the course of the training year 2015/2016, HSE-NDTP has published its sixth annual assessment of NCHD posts. The principles utilised by HSE-NDTP to underpin the number and type of specialist training posts required by the health service for the period July 2015 to June 2016, have remained consistent with previous years, namely:

- The requirements of the Medical Practitioners Act 2007, the Health Act 2004 and the findings of Preparing Ireland's Doctors to meet the Health Needs of the 21st Century, Report of the Postgraduate Medical Education and Training Group (Buttimer 2006) and Medical Education in Ireland – A New Direction, Report of the Working Group on Undergraduate Medical Education and Training (Fottrell Report 2006)
- The purpose of training within the Irish health care service is to facilitate entry to the relevant specialist division(s) of the Register of Medical Practitioners maintained by the Medical Council
- Strategic planning of medical trainee numbers to ensure that both current specialist workforce requirements and future projected needs are met
- Each post determined by the HSE as being required for training meeting the following criteria:
  - Each post must be incorporated into a formal training structure under the auspices of one of the Intern Training Networks or recognised postgraduate training bodies
  - Each post must be part of a programme approved by the Medical Council for the purposes of intern or specialist medical training
  - Each post must have their, pre-defined, progression-based learning objectives which the trainee must acquire during the time spent in post
  - Each post must have a designated educational trainer who is on the appropriate specialist register
  - The progress of the trainee in the post against the pre-defined learning objectives must be assessed by the designated educational trainer and must be subject to external validation

The sixth annual assessment of NCHD posts by the HSE-NDTP is available at:
http://www.hse.ie/eng/staff/Leadership_Education_Development/MET/ed/rep/

## 1.2 Funding of Intern and Postgraduate Specialist Training in Ireland

Section 86(6) of the MPA 2007 requires the HSE to manage medical education and training services as 'health and personal social services' for the purposes of sections 38 and 39 of the Health Act 2004. The effect of this primary legislation is to require the establishment of formal, highly structured contractual arrangements between the HSE and any agent providing medical education and training services. These requirements were first implemented in annual Service Level Agreements signed in 2010 between the HSE and a range of providers.

HSE-NDTP completed SLAs worth over €15m with Postgraduate Training Bodies and Intern Training Networks for the provision of specified training services to doctors in internship, specialist medical training and CPD programmes during 2015. This figure does not include funding provided by the HSE for general practice training – the HSE and ICGP are working towards the introduction of a similar funding model to that used in other disciplines with a view to commencement in July 2016.

The training funding model represents new investment by the state in medical education and training agencies and provides a comprehensive framework for structured, accountable and robust development of the relationships between the parties. In 2015 NDTP and the training bodies agreed to link a number of key priorities or outcomes with specific funding to crystallize the connection between funding and deliverables.

***Service Level Arrangements for Medical Education and Training Programmes***

| | Specialist Medical Training | Continuous Professional Development Support Scheme | Internship Training |
|---|---|---|---|
| Irish Surgical Postgraduate Training Committee | Yes | Yes | |
| Faculty of Radiologists | Yes | Yes | |
| Irish Committee on Higher Medical Training | Yes | Yes | |
| Faculty of Paediatrics | Yes | Yes | |
| Faculty of Pathology | Yes | Yes | |
| Institute of Obstetricians & Gynaecologists | Yes | Yes | |
| Faculty of Public Health Medicine | Yes | | |
| Faculty of Occupational Medicine | Yes | | |
| College of Psychiatrists of Ireland | Yes | Yes | |
| College of Anaesthetists | Yes | Yes | |
| Irish College of Ophthalmologists | Yes | Yes | |
| Irish College of General Practitioners | Yes | | |
| Intern Training Network Dublin Mid-Leinster (UCD) | | | Yes |
| Intern Training Network South (UCC) | | | Yes |
| Intern Training Network West / Northwest (NUIG) | | | Yes |
| Intern Training Network Mid-West (UL) | | | Yes |
| Intern Training Network Dublin Northeast (RCSI) | | | Yes |
| Intern Training Network Dublin Southeast (TCD) | | | Yes |

### 1.3 Intern Training

It is a requirement of the Medical Practitioners Act 2007 that graduates of medical schools in Ireland must complete a twelve month internship in order to practice medicine in Ireland. During this time a trainee doctor is registered as an Intern on the Medical Council Trainee Specialist Division (TSD).

Intern training is delivered by six Intern Training Networks which are designated and funded by the HSE, and specifically recognised and accredited for this purpose by the Medical Council. Intern training is currently provided in acute hospitals (37), independent hospitals (2) and general practice settings (6).

The intern year is the first opportunity for medical graduates to experience the reality of working as a doctor and to apply their skills and knowledge to the care of patients. On successful completion of internship, the designated Intern Training Network, through its partner university/medical school, recommends an intern to the Medical Council for the award of Certificate of Experience. This certificate entitles the holder to apply to the Medical Council for registration on the trainee specialist division or general division of the Register of Medical Practitioners maintained by the Medical Council.

Following the implementation of the recommendations contained in the Fottrell Report (Medical Education in Ireland: A New Direction, 2006), there has been an incremental annual increase in the number of exchequer-funded graduates from Irish medical schools. In order to ensure that each of these graduates is facilitated to obtain an internship, NDTP has collaborated with clinical sites and intern networks to increase the number of intern posts on an annual basis. Now that the numbers of graduates has plateaued, it is not anticipated that there will be any further increase in numbers.

The table below outlines the number of funded intern posts for the past 6 years and shows an increase of 42% during this period.

***Intern Training Posts 2010 - 2015***

| Year | Number of Funded Intern Posts |
|---|---|
| 2010 | 512 |
| 2011 | 557 |
| 2012 | 570 |
| 2013 | 640 |
| 2014 | 684 |
| 2015 | 727 |

**Changes to the Intern Match Process**

There were insufficient places in the first round of the 2015 intern match for all exchequer-funded/HEA graduates who entered Irish medical schools via the CAO.

In October 2015, a decision was made by the Department of Health to prioritise these graduates in the first round of the 2016 intern matching process as a reflection of Government policy with regard to the future projected medical workforce requirements for the Irish health service.

The new process involves a first round of offers to exchequer-funded/HEA graduates (including graduate entry) ranked by centile. The remaining places will be offered in the first instance to other EEA and work-permit exempt applicants. Finally, any remaining places will be offered to Non-EEA applicants. This approach recognises and protects the state's existing investment in undergraduate/graduate entry medical education.

NDTP-HSE has engaged with Medical Schools, Intern Networks, the HEA, the CAO and the NRS, with a view to introducing the required changes to the process which will impact on the intern intake in July 2016.

### 1.4 Postgraduate Specialist Training

There have been significant changes in the delivery of postgraduate specialist training in Ireland in recent years. Traditionally all training was delivered in a two stage process, involving initial or basic training followed by higher specialist training. In recent times however, specialist training programmes in Ireland are transitioning towards a model of streamlined training. In 2015 streamlined training was introduced into Ophthalmology (for both Medical and Surgical Ophthalmology training) and Psychiatry; this was in addition to its introduction to the specialties of Anaesthesia, Surgery and Emergency Medicine in prior years.

The objective of streamlining is to shorten the training pathway in Ireland primarily by means of eliminating the traditional requirement of "gap years". The prolonged duration of the training journey in Ireland was highlighted by trainees as a contributory factor to the challenge of recruitment/ retention of our young doctors; for this reason, the Strategic Review of Medical Training and Career Structure 2014 (MacCraith Report) recommended that training bodies should urgently review their programmes in line with international norms.

Trainees who consistently meet their required educational milestones will be enabled to progress along the continuum of their training pathway from initial entry point to the final exit point as a certified specialist.

Streamlined training is very attractive to young graduates as it brings clarity and certainty regarding the training journey, particularly with regard to the duration of training. This is particularly relevant for graduate-entry medical school graduates, who wish to complete specialist training as quickly as possible.

Postgraduate medical training in Ireland is provided under the educational auspices of one of the medical postgraduate training bodies accredited for this purpose by the Medical Council of Ireland. The range and type of these programmes and their provider is listed in the table below. The duration of programmes is specialty specific, with programmes ranging from four to eight years in duration.

| Medical Discipline | Medical Specialty | Medical Council Accredited Postgraduate Training Body |
|---|---|---|
| Anaesthesia | Anaesthesia | College of Anaesthetists of Ireland |
| Emergency Medicine | Emergency Medicine | Irish Surgical Postgraduate Training Committee, RCSI |
| General Practice | General Practice | Irish College of General Practitioners |
| Medicine | Cardiology | Irish Committee on Higher Medical Training, RCPI |
| | Clinical Genetics | |
| | Clinical Pharmacology | |
| | Dermatology | |
| | Endocrinology & Diabetes Mellitus | |
| | Gastroenterology | |
| | General Internal Medicine | |
| | Genito-Urinary Medicine | |
| | Geriatric Medicine | |
| | Infectious Diseases | |
| | Medical Oncology | |
| | Nephrology | |
| | Neurology | |
| | Palliative Medicine | |
| | Rehabilitation Medicine | |
| | Respiratory Medicine | |
| | Rheumatology | |
| Obstetrics & Gynaecology | Obstetrics & Gynaecology | Institute of Obstetrics & Gynaecology, RCPI |
| Occupational Medicine | Occupational Medicine | Faculty of Occupational Medicine, RCPI |
| Ophthalmology | Medical Ophthalmology | Irish College of Ophthalmologists |
| Paediatrics | Paediatrics | Faculty of Paediatrics, RCPI |
| Pathology | Chemical Pathology | Faculty of Pathology, RCPI |
| | Haematology | |
| | Histopathology | |
| | Immunology | |
| | Microbiology | |
| Psychiatry | Child & Adolescent | College of Psychiatrists of Ireland |
| | General Adult | |
| Public Health Medicine | Public Health Medicine | Faculty of Public Health Medicine, RCPI |
| Radiology | Radiology | Faculty of Radiologists, RCSI |
| | Radiation Oncology | |
| Surgery | Cardiothoracic Surgery | Royal College of Surgeons in Ireland |
| | General Surgery | |
| | Neurosurgery | |
| | Ophthalmic Surgery | |
| | Otolaryngology | |
| | Paediatric Surgery | |
| | Plastic Surgery | |
| | Trauma & Orthopaedic Surgery | |
| | Urology | |

The application and selection processes for training slots on postgraduate medical training programmes are managed at national level directly by the relevant postgraduate medical training bodies with the agreement of the HSE.

In July 2015, there were a total of 680 Year 1 training slots available in the Irish system at a time when there were 684 interns completing their intern year.

On successful completion of specialist training (as assessed and validated by the relevant training body), a Certificate of Satisfactory Completion of Specialist Training (CSCST) is issued to the individual trainee. Attainment of such certification is a pre-requisite for application by the trainee to be formally registered as a specialist on the relevant specialist division(s) with the Medical Council of Ireland. Such specialist registration is a requirement for appointment to a consultant post in the Irish public health service.

### 1.5 New Training Initiatives

**GP Training**

In contrast to all other training bodies, GP training is funded through the Primary Care Directorate rather than through NDTP. Work is ongoing between the HSE and the ICGP to prepare for the delivery of GP training via the ICGP through a service level agreement with NDTP, to bring it into line with all other postgraduate specialist medical training bodies and programmes.

**Pilot Radiology Pre-HST Training Year**

There is no bespoke Radiology BST programme, and trainees therefore enter Radiology HST from a range of training backgrounds. With the agreement of NDTP, the Faculty of Radiologists in collaboration with their surgical and emergency medicine training partners, have commenced a pilot programme, the goal of which is to provide prospective radiology trainees with an alternative training pathway. This is a one year training programme at SHO level consisting of six months emergency medicine and six months surgery and during this year trainees are facilitated to spend a half day per week in radiology. During their surgery rotation trainees attend surgical boot camp. The pilot will be reviewed at the end of two years.

**Increased Specialist Registrar Posts**

As further outlined in the Medical Workforce Planning section, there has been a further increase in the intake into Higher Specialist Training – a policy which commenced in 2014 - based on projections for consultant/GP numbers in the future. In 2015, there were significant increases in Public Health Medicine, Psychiatry and several surgical specialties, as well as smaller increases in many other areas.

**Post-CSCST Fellowships**

The introduction of Post-CSCST Fellowships began in 2014 and was a recommendation contained in the Strategic Review of Medical Training and Career Structure (MacCraith Report). The rationale is that trainees, on completion of specialist training and on being awarded specialist registration, may train in Ireland in certain subspecialties without the need to travel abroad to do so. The skills, experience and qualifications gained during this time will enhance a doctor's suitability and competitiveness for a consultant post in the Irish health service.

The training bodies are continuing to identify and propose suitable Post-CSCST Fellowship opportunities within Ireland and a number have been approved and commenced in July 2015:

- Pain Management (Anaesthetics) x 2
- Intensive Care Medicine
- Paediatric Intensive Care Medicine
- Cardiac Anaesthesia

It is intended to have up to 20 Post-CSCST Fellowships approved by July 2016.

**Oral and Maxillo-Facial Surgery (OMFS) Training**

In October 2014 NDTP and RCSI agreed to re-introduce a higher specialist training programme in OMFS in July 2015. The previous programme was discontinued in 2001, and it is a HSE priority to re-establish the programme in order to ensure that there are suitably qualified specialists available to work in the Irish health system. Unfortunately, RCSI was not in a position to commence the programme in 2015, and work is ongoing to ensure that there is a trainee intake in 2016.

## 1.6 Career Guidance for Medical Students and Trainees

### Annual Careers Day

Minister for Health, Dr Leo Varadkar, opened the 2015 Medical Careers Day in Dublin Castle on the 19th September 2015 and launched a new medical careers website www.medicalcareers.ie designed to help medical students and interns make informed decisions about their career choices to achieve their professional ambitions. This was the 3rd year that the Medical Careers Day has taken place and the positive feedback has grown each year in tandem with the attendance figures.

Professor Eilis McGovern at Careers Day 2015

The Medical Careers Day has been developed to provide expert career advice and guidance with information on postgraduate training and the opportunity to explore a wide range of career opportunities for trainee doctors and information on the next steps for a successful medical career. As well as final year medical students and interns, students in their penultimate year in college were invited to the event in 2015, as we are aware that many students make career choices at a very early stage.

Dr Gina Sheppard, GP Bray, Dr Peter Corry, Intern UHL at Careers Day 2015

The free event, a joint initiative between the HSE, Forum of Irish Postgraduate Medical Training Bodies and the Medical Council, offered a full programme of career advice in the different medical specialties, the importance of the learning environment for trainee doctors and guidance on how to pursue a successful and long-lasting medical career. Each training body was invited to host an individual stand with representatives on hand to provide advice and guidance to attendees, and others such as the Irish Medical Council also hosted stands.

A date has been confirmed for the 2016 careers day, and planning for the event will commence shortly.

### Medical Careers Website

The development of a medical careers website was a key recommendation contained in the Strategic Review of Doctors Training and Career Structure (MacCraith Report).

The purpose of the website is to help plan a medical career in Ireland. This resource is a comprehensive, informative tool to provide medical career choice options to define a personal path from university through to post graduate training. The site provides information on:

- Medical Schools in Ireland
- The Intern Year and how to apply for an internship
- Postgraduate Training and how to become a specialist in Ireland

The specialty specific pages provide further detail on training in those specialties. Information on training across all specialty areas is given. The site provides direct links to each of the relevant training bodies and information on how to submit an application.

The medical careers website was officially launched by the Minster for Health, Dr. Leo Varadkar T.D. at the annual Medical Careers Day in September 2015. It is planned to further develop the website in 2016 and into the future, to make it an even more valuable resource for NCHDs.

The medical careers website may be accessed at:
www.medicalcareers.ie

Daniel MacManus, RCSI, Wendy Paine RCSI, Czara Kennedy UL, Tatiana Nuzum, RCSI, Minister for Health Dr Leo Varadkar, Conor Doorley, UL, Prof Eilis McGovern, Director, National Doctors Training & Planning, Jane O'Connor, RCSI, Alanna Keena, RCSI

## 1.7 National Doctors Training & Planning Website

Since the launch of the National Doctors Training & Planning micro site in 2014 www.hse.ie/doctors we have continued to develop each section of the website: Education and Training, Workforce Planning and Consultant Applications.

The NDTP Team

The Education and Training section provides information on the various NDTP-funded programmes. These programmes include scholarships, fellowships, bursaries, financial support for exams and flexible training opportunities

There is also information for current and future interns. A 'Post-CSCST Fellowship' tab was added recently which provides general information on the scheme as well as the process involved in applying for a Fellowship

Available in the Consultant Applications section are relevant forms and guidance documents, committee information (including dates), consultant reports and listing of necessary consultant qualifications for appointment.

During 2015 a new tab was created specifically relating to the Medical Practitioners System (MPS). This section includes a link to user manuals, FAQs, system updates and access forms. Since the rollout of NER nationally in 2015 this has become an invaluable resource to system users.

The Workforce Planning section provides an overview of the workforce planning project; details of key deliverables and interim reports are included.

The website also provides contact details of NDTP team members plus a 'Diary Dates 'and a 'Feedback' section.

## 1.8 Clinical Courses and Examination Refund Scheme

The HSE NDTP Clinical Course and Exam Refund Scheme continues to be a central and pragmatic support for the educational and professional development of NCHDs in the HSE. A broad range of exams and courses are refunded under the auspices of this scheme, reflecting the diversity, range and level of expertise that exists within the NCHD cohort in Ireland.

Every year the list of eligible exams and courses is updated, reflecting changes in employment, skill and safety criteria as well as academic requirements for specialist certification.

In 2015, the financial structure of the scheme was streamlined to ensure trainees received refunds in a more timely fashion. This was a recommendation of the MacCraith Report. Clinical sites are now funded prospectively by NDTP at the start of the year, thereby facilitating immediate payment of refunds locally. NDTP also increased the refundable amount for UK exams from €450 to €650 to compensate for some of the additional costs associated with UK courses. The details of payments are collated centrally in the NDTP office.

A total of 4,226 exams and courses were refunded (see table below) in 2015 costing €1,909,647. This is a 45% increase when compared with the amount refunded in 2014 which was €1,319,380. It is possible that the introduction of a faster, less cumbersome process has contributed to the increase in the cost of the scheme, together with the increase in the number of NCHDs nationally and the increase provided for UK exams.

***Table of Exam and Course Refunds in 2015***

| Approved Clinical Courses | |
|---|---|
| ACLS | 1,241 |
| ALERT | 0 |
| APLS | 137 |
| ATLS | 145 |
| Basic Life Support | 16 |
| CCrISP | 17 |
| MedicALs | 3 |
| EPLS | 1 |
| ICCC | 82 |
| ICCT | 76 |
| ICCP | 16 |
| NRP | 21 |
| PALS | 73 |
| PLS | 31 |

| Ophthalmology Examinations | |
|---|---|
| MRCSIO1 | 19 |
| MRCSIO2Clin | 13 |
| MRCSIO2Writ | 17 |
| EBOD | 5 |
| FRCSIO | 4 |
| **Emergency Medicine** | |
| MCEMUK A | 50 |
| MCEMUK B | 25 |
| MCEMUK C | 24 |
| FCEMUK | 25 |
| **General Medicine Examinations** | |
| MRCPI1GM | 306 |
| MRCPII2GMWrit | 239 |
| MRCPIGM2Clin | 170 |
| **Paediatric Examinations** | |
| MRCPI1Child | 65 |
| MRCPI2ChildClin | 24 |
| MRCPI2ChildWrit | 29 |
| **Pathology Examinations** | |
| FRCPathUK1 | 16 |
| FRCPathUK2 | 18 |
| MRCPCH | 1 |
| **Radiology Examinations** | |
| FFR Prim | 22 |
| FFR Final | 19 |
| **Psychiatry Examinations** | |
| MRCPsychUK1 | 71 |
| MRCPsychUK2 | 49 |
| MRCPsychUK3 | 7 |
| MRCPsychUKCASC | 28 |
| CPsychI BCE | 2 |
| **General Practice Examinations** | |
| MICGPAKT | 15 |
| MICGPCKT | 165 |
| MICGPMEQ | 161 |
| MICGPCCT1 | 120 |
| MICGPCCT2 | 116 |
| **Anaesthesia** | |
| MCAI- MCQ | 65 |
| MCAI OSCE/VIVA | 51 |
| FCA-Final | 42 |
| JFICMI | 7 |
| **Obstetrics and Gynaecology** | |
| MRCOG1 | 30 |
| MRCP12OG Writ | 36 |
| MRCP12OG Clin | 29 |
| **Surgery** | |
| IEGS1 (General Surgery) | 11 |
| IEGS2 (General Surgery) | 4 |
| Inter Col. Cardiothoracic 1 | 3 |
| Inter Col. Cardiothoracic 2 | 2 |
| IEN1(Neurosurgery) | 6 |
| IEN2 (Neurosurgery) | 1 |
| Inter Col. Otolaryngology 1 | 6 |
| Inter Col. Otolaryngology 2 | 6 |
| Inter col.Paediatrics 1 | 3 |

| Ophthalmology Examinations | |
|---|---|
| Inter col.Paediatrics 2 | 1 |
| IEPLASS1 (Plastics) | 3 |
| IEPLASS2 (Plastics) | 2 |
| IETOS1(Trauma and Orthopaedic) | 5 |
| IETOS2(Trauma and Orthopaedic) | 4 |
| IEU1(Urology) | 3 |
| IEU2 (Urology) | 4 |
| | |
| Membership of RCSI MCQ | 151 |
| Membership of RCSI OSCE | 64 |
| **Public Health Medicine** | |
| MFPHMI1 | 0 |
| MRPHMI2 | 3 |
| **Occupational Medicine** | |
| MFOMI | 1 |
| **Total** | **4,226** |

### 1.9 Higher Specialist Training Fund

To complement the suite of educational and training supports implemented on foot of the introduction of the NCHD Contract 2010, the HSE created in 2011 a fund for Higher Specialist Trainees i.e. Specialist and Senior Registrars enrolled in approved Higher Training Programmes (HST/ST3-8) and GP trainees in their third and fourth years of training. It is also available to those SpRs/SRs on the HSE-supported Dr. Richard Steevens Scholarship and HSE-HRB supported National SpR/SR Academic Fellowship Programme.

This fund can be used to support participation in relevant educational and training events (which are additional to those mandatory elements of training provided by the individual training bodies) that have been approved by the relevant postgraduate training body. This may include, where deemed appropriate by the postgraduate body, a proportion of the travel and subsistence costs associated with the educational and training event. This fund can also be used to support the purchase by trainees of specialist medical equipment specifically required as part of their training programme, for example, magnifying glasses for use in microsurgery.

Since October 2014 the scheme was revised to introduce a more streamlined process to ensure reimbursements were issued without unnecessary delays for claimants. Applications for reimbursement are now administered directly by the individual Postgraduate Training Bodies. The funding available to each HST/ST3-8 and 3rd/4th year GP trainee is equivalent to €500 per year of training. While each trainee can carry over €500 per year for the number of years that their specialist training period consists of; a trainee cannot claim such funding in advance.

Since the implementation of this scheme, the HSE made approximately €600,000 available each year to higher specialist trainees through this fund via the agreements in place between the HSE and the Postgraduate Training Bodies.

### 1.10 National Flexible Training Scheme

The medical workforce is changing and, over recent years, numerous reports including the MacCraith report have pointed to the importance of providing flexible working arrangements for doctors.

The HSE National Flexible Training Scheme for Higher Specialist Trainees is a national scheme managed and funded by NDTP, and funds the equivalent of 12 WTE fully funded supernumerary posts, i.e. up to 24 participants working a 50% commitment at any one time. These posts are funded separately by NDTP and are therefore additional-to-complement. As the vacant fulltime training post can be backfilled there is no negative effect on service delivery, in fact the scheme provides an additional 50% resource.

The scheme facilitates doctors at higher specialist training level to continue their training in a flexible manner for a set period of time.

Trainees must be enrolled in a Higher Specialist Training Programme under the auspices of one of the postgraduate medical training bodies recognised by the Medical Council in Ireland.

The HSE National Flexible Training Scheme Guide sets out details of the National Flexible Training Scheme and provides information for trainees, training bodies and employers about the programme.
http://www.hse.ie/eng/staff/leadership_education_development/met/ed/flex/hse_national_flexible_training_scheme_.pdf

*Breakdown of Flexible Trainees by Specialty from 2002 to Date*

| Specialty | 2002 /2003 | 2003 /2004 | 2004 /2005 | 2005 /2006 | 2006 /2007 | 2007 /2008 | 2008 /2009 | 2009 /2010 | 2010 /2011 | 2011 /2012 | 2012 /2013 | 2013 /2014 | 2014 /2015 | 2015 /2016 | Total by Speciality |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Anaesthetics | | 2 | 2 | 3 | 3 | 2 | 4 | 3 | 2 | 2 | | 1 | 3 | 3 | **30** |
| Clinical Microbiology | | | | | | | | | | | 1 | 1 | 1 | 1 | **4** |
| Dermatology | | 1 | | | 1 | | 1 | 1 | 1 | 2 | 4 | 3 | 2 | 2 | **18** |
| Emergency Med | | | | | | | 2 | 1 | 1 | 1 | 1 | 1 | 1 | 2 | **10** |
| Gastroenterology | | 1 | 1 | 1 | 1 | 1 | 1 | | | | 1 | | 1 | | **8** |
| General Practice | | | | | 2 | 1 | 1 | 1 | | | | | | | **5** |
| General Surgery | | | | | | | | | | | | | 1 | 1 | **2** |
| Geriatric Medicine | | | | | | | | | | 1 | 1 | | 1 | | **3** |
| Haematology | 1 | 1 | | | | | | | | | 1 | 1 | 1 | | **5** |
| Histopathology | | 1 | 1 | 2 | 2 | 2 | 2 | 6 | 6 | 3 | 3 | 2 | 1 | 1 | **32** |
| Infectious Diseases | | | | | | | | 1 | 1 | 1 | | 1 | 1 | | **5** |
| Microbiology | 1 | 1 | 1 | 1 | 1 | | 3 | 3 | 1 | 1 | 1 | 1 | | 1 | **16** |
| Neurology | | | | | 1 | | | | | 1 | | | 1 | | **3** |
| Obs & Gynae | 3 | 2 | 2 | 2 | 2 | 1 | 3 | 2 | 1 | | 1 | 1 | 1 | 2 | **23** |
| Occupational Med | 2 | 2 | 2 | 2 | 2 | 1 | 1 | 1 | | | | | | | **13** |
| Ophthalmic Surgery | | | | | | | | | | | | | 1 | 1 | **2** |
| Paediatrics | 2 | 3 | 3 | 3 | 3 | 1 | | | 1 | 3 | 2 | 1 | 1 | | **23** |
| Palliative Care | | | | | | | 1 | 2 | 2 | 1 | | 1 | 1 | 1 | **9** |
| Plastic Surgery | | | | | 1 | 1 | 1 | | | | | | | 1 | **4** |
| Psychiatry | | 1 | 1 | 1 | 2 | 1 | | | | | | | | | **6** |
| C&A Psy | 1 | 1 | 1 | 1 | 1 | 1 | 1 | | | 1 | 1 | 2 | 3 | 5 | **19** |
| Radiology | | | | | | | | 1 | | | | 1 | 1 | | **3** |
| Rehabilitation Medicine | | | | | | | | | | | 1 | 1 | | | **2** |
| Respiratory Med | | | | | 2 | | | | | | | | | 1 | **3** |
| Rheumatology/GIM | | | | | | | | | | 1 | 1 | 1 | 1 | | **4** |
| Trauma & Orthopaedics | | | | | | | | | 1 | 1 | 1 | 1 | 1 | 2 | **7** |
| **Total p.a.** | **10** | **16** | **14** | **16** | **24** | **12** | **21** | **22** | **17** | **19** | **20** | **20** | **24** | **24** | **259** |

As the Strategic Review of Medical Training and Career Structure (MacCraith Report) has recommended an extension of the availability of flexible options for training to all trainees, NDTP and the Forum of Postgraduate Training Bodies began a dialogue in late 2014 to explore the alternative possibilities for example job-sharing and flexible training. The Postgraduate Training Bodies introduced a policy for flexible options for trainees from July 2015.

### 1.11 Scholarships/Fellowships

**Dr Richard Steevens' Scholarships**

Four scholarships are awarded annually, with funding provided for the equivalent of four SpR salaries. In the event that there is funding remaining (for example, if a successful candidate already has partial funding in place) the remaining funds are used to award a small number of bursaries to suitable candidates.

The purpose of the scholarships is to support doctors to spend time in clinical training in centres of excellence abroad in areas of medicine and patient care where the particular subspecialty, or the required training, is limited or unavailable in Ireland. The ultimate aim is to bring the skills and experience gained back to the Irish health service for the benefit of our patients. This is a competitive process, and the candidates must demonstrate a high level of achievement in their careers to date, and strong potential for the future.

The scholarship was developed and established by the HSE in 2007, following a recommendation in the Buttimer Report (2006). To date, 34 doctors have been awarded scholarships and a further twelve have been awarded bursaries under the programme. A number of past recipients have since been appointed to consultant posts in Ireland.

Four scholarships and three bursaries were awarded in 2015 under the Dr Steevens' Scholarships Programme. The scholarships were awarded to the following outstanding candidates (in alphabetical order):

**Dr Daniel Cagney**, SpR, Radiation Oncology, to undertake a CNS Fellowship focusing on Intracranial and Extra Cranial Stereotactic Body Radiotherapy in Brigham & Women's Hospital in Boston.

**Dr Anne Collins**, SpR, Plastic and Reconstructive Surgery, to undertake a fellowship in Plastic, Reconstructive and Microsurgery in St Vincent's Hospital, Sydney.

**Dr Sean Hynes**, SpR, Histopathology to undertake a Fellowship in Molecular Pathology in Queens University and City Hospital, Belfast.

**Dr Sean O'Dowd**, SpR, Neurology, to undertake a fellowship in Parkinson's disease and Related Neurodegenerative Disorders in Newcastle-upon-Tyne Hospitals NHS Foundation Trust Academic Neuroscience Directorate.

In addition to the prestigious and much sought after Dr Richard Steevens' Scholarships HSE-NDTP also awarded three bursaries in 2015. Out of the rich pool of talent the following three HSE doctors (in alphabetical order) were awarded a bursary:

**Dr Aisling Barry**, SpR, Radiation Oncology, to undertake a fellowship in Extra-Cranial Stereotactic Body Radiotherapy in Princess Margaret Hospital, Toronto.

**Dr Elaine Neary**, SpR, Paediatrics, to undertake a Clinical fellowship on the integrated training programme in Neonatal-Prenatal Medicine at the Hospital for Sick Children, Toronto.

**Dr Ciara O'Rafferty**, SpR, Paediatric Haematology, to undertake a fellowship in Malignant Paediatric Haematology and Haematopoietic Stem Cell Transplantation in Birmingham Children's Hospital.

**Review of the Scholarship Programme**

A review of the Dr Steevens' Scholarship was undertaken in August 2015. The review involved undertaking a survey of the 30 doctors who were awarded either a scholarship or bursary from the scheme since its commencement in 2007.

One of the key findings of the survey was that 24 of the 30 doctors had returned from their placement abroad to work in the Irish Health Service. Of the 6 doctors who had not returned at the time of survey, 5 indicated that they still intend coming back to Ireland to work (subject to a consultant post being available or other conditions). The results from the survey also highlighted the high value doctors placed on the opportunity the Dr Steevens' Scholarship offered trainees and the significant impact undertaking the scholarship had on their career. In addition, the survey indicated that the scholarship allowed doctors to train, and later work, in areas that have been underserviced or under-resourced in Irish hospitals.

Following the review it was agreed to continue with the scheme for 2015-16. NDTP will also consider if there are opportunities to develop or expand the scheme to meet current and future needs of the Irish healthcare system.
The next round of scholarships was advertised in November 2015, with successful applicants due to commence training in the year commencing July 2016.

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**Comments from Some Previous Recipients of the Dr Richard Steevens' Scholarship**

**Dr Fionnuala Breathnach**
*"The Richard Steevens' Scholarship programme allowed me to pursue my interest in the subspecialist field of maternal fetal medicine and harness my specialist training to the point of provision of a service in a way that would not otherwise have been possible for me. I consider myself incredibly fortunate in owing a debt of gratitude to such a wide group of people that made this programme possible."*

**Dr Aoife Lowry**
*"This programme was a significant help to me to take up an excellent Fellowship position in a high volume European Centre. As Fellowships in Europe are rarely funded by the host institution, without the support of programmes such as the Richard Steevens' Scholarship I believe that Irish trainees will be less likely to take up these positions which would certainly be a missed opportunity, particularly for subspecialties such as endocrine surgery which are considerably more developed in Europe."*

**Dr Venita Broderick**
*"The Richard Steevens' programme was invaluable to me in facilitating my Fellowship at the Royal Children's hospital Melbourne. Many fellow jobs at well renowned institutions are poorly or not at all remunerated. Without the funding from the programme my Fellowship may not have been possible. I hope the programme will continue to support Irish trainees in acquiring expertise overseas which ultimately benefits Irish patients."*

**National SpR/SR Academic Fellowship Programme**

The National SpR/SR Academic Fellowship Programme (NSAFP) was jointly established in 2009 by the HSE and the Health Research Board in response to a recommendation in the Buttimer Report (2006). The development of career pathways for health professionals, involving research, was a key action identified in the Department of Health & Children's 2009 Action Plan for Health Research.

The programme supported Specialist/Senior Registrars to enter an integrated training and research pathway which leads to both a CSCST in the appropriate specialty, and a PhD. Previously, medical trainees have had to pause their clinical training in order to undertake research.

As part of a strategic review, the HRB opted to discontinue its involvement in the programme, and there was therefore no intake into the joint programme in 2015.

### 1.12 Academic GP Fellowships

The National General Practice Academic Clinical Fellowship Programme was established in 1999. A formal review was commissioned by NDTP in 2010, and a new guidance document issued in 2011.

The goal of the Fellowship Programme is to support the professional development of future leaders of academic general practice in the Irish health service. It does so by offering a structured three year programme of 1) research, 2) education and training, and 3) clinical practice, all overseen by an academic department of general practice. All three components of the Fellowship Programme are considered integral and in this regard the Fellowship has been designed with a view to attributing equal importance to the engagement of successful candidates in each.

The awarding bodies for the National General Practice Academic Clinical Fellowship are the HSE, the ICGP and the AUDGPI (Association of University Departments of General Practice in Ireland). The programme is funded by the HSE.

There are currently 2 fellows on the scheme, one each appointed in 2014 and 2015.

The Fellowships were awarded for an initial period of 12 months. A formal review will be conducted by the three awarding bodies following this 12 month period, and subject to satisfactory progress of the candidate, the Fellowship will be extended for a further 12 month period. A similar process will occur at the end of the second year also. There will be no extensions beyond the third year.

# 2 MEDICAL WORKFORCE PLANNING

## 2.1 Medical Workforce Planning Mission

NDTP incorporated medical workforce planning (MWP) into its remit in May of 2013, with a view to bringing the number of doctors in postgraduate medical training programmes in line with expert informed estimates of the future demand for specialists in the health service.

Medical workforce planning addresses future projections for the appropriate staffing of the medical workforce in Ireland. Projections are for the Irish population in its entirety, to include both public and private sector requirements. This involves analysis of the supply into the medical workforce today and analysis of whether or not that supply is appropriately matched to patient need. It also involves the analysis of how supply should be planned for in light of future population, societal and health service change.

An international benchmarking exercise, related to the ratio of specialists per head of population, was completed in early 2014, followed by the development of a medical workforce planning methodology based on appropriate international and national health workforce planning systems.

In September 2015, a report on the future medical workforce required for General Practice was published. The report detailed the first in-depth specialty-based planning exercise carried out by NDTP in projecting specialist demand over a 10 year timeframe. The workforce planning approach involved the development of various scenarios for the delivery of GP care, each projected over a 10-year period and based on the outcome of the deliberations of an expert panel, combined with extensive background research. The scenarios included population projections, current estimated GP visitation rates, the potential impact of policy decisions such as extension of GP visit card eligibility, as well as data related to part-time working, feminisation and trainee numbers. A summary of the report findings include the following:

1. There is evidence of a significant undersupply of GPs in Ireland at present
2. By 2025, the predicted shortage of GPs in Ireland will range from 493 to 1,380 depending on increased levels of access to free GP care
3. If the shortfall is to be addressed by training the required GP workforce here in Ireland (as opposed to inward migration of trained GPs to Ireland from other countries) there will be a need to significantly increase the annual intake into GP postgraduate specialist training
4. More than a third of doctors working as GPs are not on the Medical Council's specialist register of general practitioners
5. There is evidence of increased feminisation of the profession as well as increased part-time working
6. In addition to the need to train more GPs, there is a requirement for innovative recruitment and retention strategies
7. A national register of GPs should be introduced to improve the availability and quality of data on the GP workforce
8. Data collection regarding various important aspects of GP care needs to be improved (for example data related to GP visitation rates)
9. Further research into areas such as nurse-led care and the impact of IT on general practice should be carried out

A draft workforce planning report has been prepared for the specialty of Paediatrics/Neonatology to include future demand based on a new model of care for the specialty and the requirements of the new children's hospital. This report is due for completion in early 2016. NDTP is also currently working on projecting the demand for specialists in Emergency Medicine and also expect to have this workforce planning exercise completed in early 2016.

## 2.2 Project Objective

The core objective of the Medical Workforce Planning project is the development of a workforce planning instrument which will provide the HSE with a system to produce reliable medical workforce projections based on a methodology designed to be responsive and adaptive to predicted future changes in the Irish healthcare environment.

## 2.3 Key Project Principles

Certain key principles underpin the NDTP approach to MWP. These include the following:

1. MWP should be consistent with the recommendations of the "Report on Medical Education in Ireland: A New Direction. Report of the Working Group on Undergraduate Medical Education and Training" (Fottrell 2006)

2. Project recommendations should be consistent with the WHO Global Code on the International Recruitment of Healthcare Personnel. Ireland is a signatory of the code, which states that

    - countries should aim for self-sufficiency with regard to healthcare workers (this has been addressed in Ireland with the increase in EEA medical school intake from 340 to 725 as a result of implementation of the Fottrell Report), and

    - countries should not poach doctors from low and middle income countries, particularly those with acute healthcare personnel shortages

3. MWP recommendations should encompass medical workforce requirements for the entire population to include both the public and private healthcare systems

4. MWP recommendations should incorporate future health need. This will require the incorporation of projections relating to, for example, demographic changes; alterations indisease incidence and prevalence; medical and therapeutic innovations; policy initiatives and technological advances

5. MWP recommendations should incorporate the implications of existing and, where known, future healthcare policy, for example the "Report of the National Task Force on Medical Staffing" (Hanly 2003), the National Clinical Programmes, the proposed new Hospital Groups, the Small Hospitals Framework, the National Cancer Control Programme and Universal Health Insurance

6. 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

7. 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

8. Where appropriate, innovative models of care should be explored, for example new team structures, new medical roles and skills transfer

# 3 CONSULTANTS DIVISION

## 3.1 Applications for Consultant Posts

The Consultants Appointments Unit is now known as the Consultants Division of NDTP. The Division is responsible for the regulation of the number and type of consultant posts within the public health system, including the HSE, voluntary hospitals and other agencies.

The Division processes all applications for additional or replacement consultant posts for consideration by the Consultant Applications Advisory Committee (CAAC) at their monthly meetings. Membership of the CAAC includes senior HSE officials, medical consultants, representatives from patient advocacy groups and representatives from the Irish Hospital Consultants Association and the Irish Medical Organisation.

The role of the CAAC is to provide independent and objective advice to the HSE on applications and qualifications required for consultant posts. The recommendations of the CAAC are then submitted to the National Director of Human Resources and, if a post is approved, the Consultants Division issues the Letter of Approval. This letter details the approved post title, the location and structure of the consultant's work commitments, and the professional qualifications required for the post.

The work of the Consultants Division increased during 2015 with the number of applications for consultant posts continuing to rise each month. As of 31st December 2015 the Consultants Division received and processed 182 applications for new additional consultant posts and 106 applications for replacement posts, totalling 288 applications processed in 2015. These 288 applications were reviewed by the Consultant Applications Advisory Committee and 231 were recommended for approval.

## 3.2 Applications for Type C Contracts

Applications by consultants for a Type C contract, to enable private practice in addition to their public commitment, are also processed within the Consultants Division. These applications are in the first instance submitted for review to the Acute Hospitals Directorate and, if applicable, are referred to the Type C Committee for consideration at their monthly meetings. Upon recommendation for approval by the Type C Committee these applications are then directed to the HSE Director General for consideration.

The Consultants Division maintains a record of all Type C contracts processed and approved. A total of 54 applications for change to a Type C contract were received in 2015. A Benefits Realisation reporting system, whereby applicants awarded a Type C contract in conjunction with their employer must report on the benefits accrued to the public healthcare system as a result of the new contract commenced in 2014 and has been expanded during 2015.

## 3.3 Statutory Register of Approved Consultant Posts & Qualifications for Consultant Posts

The Consultants Division maintains the statutory register of approved consultant posts. The Division is also responsible for specifying the qualifications for consultant appointments. This is done with input from the postgraduate medical training bodies and the CAAC. In 2015 there were two submissions made for two new qualifications to be included, both of which were approved by the CAAC.

## 3.4 Summary of Activities and Trends

Activity within the Consultants Division has increased considerably in recent years. The table below shows that between 2014 and 2015 activity levels increased by almost 22%; in the period, 2011 to 2015 activity has increased by almost 90%.

**Consultants Division Activity 2011 - 2015**

| Year | Additional | Replacement | Restructure | Contract | Title | Quals | Type C | Total |
|---|---|---|---|---|---|---|---|---|
| 2015 | 182 | 106 | 5 | 2 | 3 | 2 | 54 | **354** |
| 2014 | 98 | 95 | 15 | 8 | 10 | 5 | 49 | **280** |
| 2013 | 101 | 93 | 6 | 8 | 1 | 1 | 10 | **220** |
| 2012 | 54 | 111 | 13 | 4 | 4 | 1 | 8 | **195** |
| 2011 | 77 | 62 | 8 | 32 | 1 | 0 | 1 | **181** |

At the end of 2015 there were 2,891 approved permanent consultant posts in the public health service. This was up from 2,747 at the end of 2014 and represents an increase of 944 since the end of 2004. The trend in approved consultant establishment by specialty in selected years between 1984 to 2015 is below.

**Trend in Consultant Establishment Selected Years 1984 - 2015**

| | 1984 | 1994 | 2004 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|---|---|---|---|
| Anaesthesia | 153 | 184 | 287 | 336 | 336 | 338 | 347 | 348 | 361 |
| Emergency Medicine | 1 | 13 | 52 | 63 | 78 | 78 | 79 | 80 | 88 |
| Intensive Care | - | - | - | 6 | 8 | 9 | 14 | 18 | 20 |
| Medicine | 177 | 201 | 378 | 512 | 558 | 600 | 621 | 641 | 686 |
| Obstetrics/Gynaecology | 89 | 83 | 104 | 125 | 125 | 126 | 127 | 133 | 142 |
| Paediatrics | 48 | 62 | 108 | 141 | 143 | 149 | 153 | 159 | 173 |
| Pathology | 83 | 95 | 176 | 227 | 228 | 230 | 238 | 248 | 255 |
| Psychiatry | 196 | 194 | 295 | 369 | 376 | 378 | 392 | 406 | 425 |
| Radiology | 93 | 99 | 168 | 222 | 224 | 229 | 232 | 235 | 248 |
| Radiation Oncology | - | - | 15 | 26 | 26 | 26 | 26 | 26 | 26 |
| Surgery | 245 | 255 | 364 | 419 | 425 | 430 | 441 | 453 | 476 |
| **Total** | **1,085** | **1,186** | **1,947** | **2,446** | **2,527** | **2,593** | **2,670** | **2,747** | **2,891** |

The approved consultant establishment increased by 144 posts between the 31st December 2014 and the 31st December 2015. The changes by specialty are shown below.

**Change in Approved Consultant Establishment by Specialty 2014-2015**

| | 2014 | 2015 | Increase |
|---|---|---|---|
| Anaesthesia | 348 | 361 | 13 |
| Emergency Medicine | 80 | 88 | 8 |
| Intensive Care | 18 | 20 | 2 |
| Medicine | 641 | 686 | 45 |
| Obstetrics/Gynaecology | 133 | 142 | 9 |
| Paediatrics | 159 | 173 | 14 |
| Pathology | 248 | 255 | 7 |
| Psychiatry | 406 | 425 | 19 |
| Radiology | 235 | 248 | 13 |
| Radiation Oncology | 26 | 26 | 0 |
| Surgery | 453 | 476 | 14 |
| **Total** | **2,747** | **2,891** | **144** |

## 3.5 New Developments

The Consultants Division is involved in a number of new developments including devising a set of key performance indicators for the processing of consultant applications. It is planned that these will go live in 2016 and that reports will be published and available to view on the NDTP website. In addition, the introduction of a simplified and more streamlined consultant post application process and also the further development of the Consultants Module of NDTP's medical practitioner system for rollout to clinical sites commenced in 2015. This will facilitate the matching of individual consultants with consultant posts providing an enhanced picture of consultant employment in the health service.

## 3.6 Consultants Continuing Medical Education (CME)

The document 'Consultants Implementing the Public Service Agreement' agreed by Health Service Employers (HSE), Department of Health and Department of Public Expenditure & Reform, the Irish Medical Organisation (IMO) and the Irish Hospitals Consultants Association (IHCA) notes that:

"The Medical Practitioners Act 2007 and the Consultant Contract 2008 oblige health service employers to facilitate the professional competence of consultants in their employment. The Management position is that public funding targeted at continuing medical education for consultants must be utilised and managed in a manner that is aligned with legislative requirements, is transparent, measurable, ensures value for money and is provided through appropriate structures."

Taking this into account and following substantial consultation with the Forum of Postgraduate Training Bodies, NDTP produced a guidance document for consultants, employers and training bodies on Continuing Medical Education supports for consultants. The document provided a standard application form to be used nationally along with guidance on items covered within the CME fund. This was the first time such a document had been introduced nationally and it helps to ensure consistent application of the fund to all consultants irrespective of which hospital they are employed.

## 3.7 Incremental Credit for New Entrant Consultants in the Irish Public Health Service

The Consultants Incremental Credit Committee (CICC) was established following the outcome of the LRC Negotiations on Consultants Pay / Career Structure (7th January 2015). As per the recommendations agreed in the LRC, the committee was "tasked with setting a framework for the application of incremental credit which takes account of relevant and appropriate service" and the Director of NDTP was appointed as Chair of the committee.

The CICC developed a framework to incorporate the LRC recommendations and outline how incremental credit, up to the 6th point of the new consultant salary scales, may be awarded to doctors for relevant service post-CSCST and/or for completing relevant qualifications both pre and post CSCST. The framework is available on the HSE website at: https://www.hse.ie/eng/staff/Resources/HR_Circulars/frameworkinccredit.pdf

An FAQ document was also developed in September 2015 by the CICC to provide additional guidance and examples for Doctors and Medical Manpower Managers seeking finer detail on how the framework is applied as well as allowing for updates to be captured on an ongoing basis. The FAQs are available at:
https://www.hse.ie/eng/staff/Resources/HR_Circulars/FAQs.pdf

The CICC continues to meet on a quarterly basis and its function includes the following:

- To review the policy document on a regular basis
- To respond to employers' requests for a decision regarding an exceptional case
- To respond to employers' requests for clarification on the policy
- To consider and respond to appeals from employees / applicants referred via the employer at local level (as part of this process, the employee / applicant's letter of appeal is automatically sent to the CICC)

# 4 ADDITIONAL AREAS OF NDTP ACTIVITY

## 4.1 Continuous Professional Development Support Scheme (CPD-SS)

NCHDs working in the public health service who are registered on the General Division or Supervised Division and who are not actively enrolled and participating in a specialist training programme, are required by law to actively maintain their professional competence in line with the Medical Council's requirements. To meet these legal requirements, such NCHDs must enrol on a Professional Competence Scheme (PCS) with the relevant training body.

The CPD-SS is funded by NDTP to facilitate NCHDs who are not in training posts to continue to maintain and enhance their clinical knowledge and skills and also to maintain their professional competence in line with Medical Council requirements. NCHDs are required to achieve a minimum of 20 externally validated educational credits per annum.

The CPD-SS was introduced in July 2015 and replaces the previous Professional Development Programme (PDP) which had been in existence for a period of four years. The new CPD-SS was based on valuable feedback received from NCHDs, through an on-line survey and a number of focus groups undertaken by NDTP. Eligible NCHDs are now permitted to undertake training and educational activities with any Irish training body. They are no longer restricted to courses provided by the training body with whom they register. For example an NCHD who is registered with the Royal College of Surgeons for the CPD-SS may attend a course provided by the College of Anaesthetists. This change provides NCHDs with access to a much wider range of courses and educational opportunities than previously available. An electronic payment system is in place between NDTP and the training bodies thus meaning that individual NCHDs are not required to pay in advance for courses and await a refund. The new CPD-SS scheme will be subject to ongoing review by NDTP to ensure it is delivering the opportunities required by the relevant NCHD cohort to meet the requirement of PCS and ensure value for money.

## 4.2 Lead NCHD Initiative

NCHDs, individually and as a group, form an essential component of the healthcare system. They represent a valuable resource in the management and leadership structures of hospitals. The Lead NCHD initiative is one of a range of initiatives taken at national level to improve NCHD recruitment and retention in the Irish public health system. The idea behind the Lead NCHD initiative is that Lead NCHDs provide a formal link at management level between the NCHD cohort and the management structure on their site. The role is a recommendation from the MacCraith Report, and, while still developing, is critical to two way communication between NCHDs and the management structures in hospitals around the country, which benefits NCHDs and patients.

During 2015 NDTP continued to collaborate with the National Clinical Director Programme and the Quality Improvement Division (QID) on this developing initiative. In the current year (July 2015 to July 2016) there are 40 Lead NCHDs appointed across the 31 hospitals involved. Supports provided to Lead NCHDs in 2015 include; two Lead NCHD workshops, one in March 2015 and one in August 2015 which was attended by 24 of the Lead NCHDs appointed for 2015/16. A further workshop is planned for February 2016.

Participants at the Lead NCHD Workshop August 2015

Director General Addressing Lead NCHDs March 2015

In addition, as part of developing linkages with the Clinical Directors the Lead NCHDs have been invited to attend Clinical Director Workshops in November 2015 and December 2015 and will likely be invited to future Clinical Director Workshops in 2016.

In 2015 as a further progression of the Lead NCHD initiative a proposal was developed for a National Lead NCHD/NDTP Fellowship to commence in July 2016. The purpose of the Fellowship is three-fold. Firstly, to continue the development of the Lead NCHD Initiative in collaboration with the Clinical Director (CD) Programme and QID. Secondly, to provide input to other NDTP initiatives and contribute to the wider NDTP agenda. Thirdly, to undertake a research study or project connected with the Lead NCHD Initiative/NDTP related initiative as part of a post graduate/masters programme. The Fellowship presents an exciting opportunity for an NCHD to develop their leadership and managerial skills and is a full-time commitment for a one year period, encompassing both working in NDTP and also undertaking a research study or project, as part of a post graduate/masters programme. Applications were invited from NCHDs who have experience as a Lead NCHD and the successful applicant has been appointed as the first National Lead NCHD/NDTP Fellow commencing in July 2016.

### 4.3 International Medical Graduate Training Initiative (IMGTI)

The IMG Training Initiative was launched in June 2013 and is overseen and governed by the Health Service Executive (HSE) and the postgraduate medical training bodies in Ireland on a collaborative basis through the Forum of Irish Postgraduate Medical Training Bodies. The initiative continues to go from strength to strength with numbers increasing year on year.

The purpose of the IMG Training Initiative is to enable overseas trainees to gain access to clinical experiences and training that they cannot get in their own country, with a view to enhancing and improving the individual's medical training and learning and in the medium to long term, the health services in their own countries.

This initiative facilitates participants to access a structured period of training and experience as developed by an Irish postgraduate medical training body to specifically meet the clinical needs of participants as defined by their home country's health service. The period of clinical training that will be provided under the IMG Training Initiative is ordinarily 24 months, after which the overseas doctors will be expected to return to their country of origin. The initiative is aimed primarily at doctors from countries with less developed health sectors and is not intended to lead to settlement in Ireland.

A pilot IMG Training Initiative commenced in 2013/2014, involving 28 trainees coming to Ireland from Pakistan in partnership with the College of Physicians and Surgeons Pakistan (CPSP). The initial pilot project included trainees in specialties of Anaesthetics, Emergency Medicine and Surgery. In 2014/2015 the initiative with the CPSP was expanded to include specialties of General Medicine, Paediatrics, Obstetrics & Gynaecology and Psychiatry. Over this period the IMG Training Initiative also expanded to include a small number of fully sponsored trainees from Kuwait, Saudi Arabia, UAE and Oman. In 2015/2016 the number of IMG trainees enrolled in a structured IMG programme and working in the public health service expanded further and is now just over 200 (See Table Below).

| Year | CPSP | Fully Sponsored | Total IMGs |
|---|---|---|---|
| 2013/2014 | 28 | 0 | **28** |
| 2014/2015 | 81 | 5 | **86** |
| 2015/2016 | 73 | 43 | **116** |

## 4.4 Developmental Funding for Intern/Specialist Training

Since 2010 significant funding has been provided to postgraduate medical training bodies in support of initiatives which have made important contributions to the development of postgraduate medical training.

During 2015, funding applications were invited from postgraduate training bodies and intern training networks which have SLAs in place with NDTP. Project proposals fell within the following broad themes such as:

- Training in clinical practice
- Integrating evidence into training
- Funding for specialised training related equipment or software
- Seed funding for development projects with a view to subsequent implementation

Proposals for developmental funding are required to identify measurable outcomes which will benefit postgraduate training in Ireland and the Irish health service.

A high number of proposals were received from postgraduate training bodies and intern training networks. NDTP agreed to support 19 projects and approved developmental funding of €597,000 for the 2015-16 period.

A summary of the projects that received developmental funding for the 2015-16 period will be posted on the HSE website at: www.hse.ie/doctors.

## 4.5 Application Fee for BST

During the Service Level Agreement discussions in 2015, NDTP secured agreement from each of the training bodies to either reduce the application fee to a maximum of €50 or abolish the fee entirely. The application fee is used by training bodies to cover administration costs associated with high volumes of applications however NDTP were concerned at the impact that the higher application fees may have had on applicants.

## 4.6 Medical Practitioners System – Current Status and Developments Plans

In 2015 further developments to NDTP's Medical Practitioners System (MPS) took place. The MPS is a web based database containing the following elements:

- Non-Consultant Hospital Doctors (NCHD) Database
- National Employment Record (NER)
- Consultants Module

### Non-Consultant Hospital Doctor (NCHD) Database

The NCHD Database was developed in 2011 and enables users to generate reports on pre-defined parameters including location, grade and specialty. The NCHD Module has been rolled out to all employers of NCHDs, who use it to create a post for each NCHD and to match an NCHD to that post. The postgraduate medical training bodies also access the NCHD Module and enter the relevant training attributes. The MPS utilises the employment attributes entered by the employer and the training attributes entered by a training body, to identify whether the NCHD post for that period of employment is activated as a specialist training post and is therefore valid for training. The MPS takes a direct feed from the Irish Medical Council Register which allows the medical practitioner's full Medical Council registration details to be viewed. The system runs an automatic check on the registration status of all medical practitioners, thereby enabling users to determine whether specific NCHDs hold the appropriate registration for employment purposes. Employers accessing the MPS NCHD Module have access to 13 specific reports on the national system. These reports range from very detailed, post specific and NCHD specific reports, to high level tabulated summaries and pie charts regarding the status and position of various criteria on their site.

### National Employment Record (NER)

2015 saw the addition of a new module to the MPS. It was in response to one of the recommendations of the 'Strategic Review of Medical Training and Career structures' (MacCraith Report) to reduce the paperwork burden for NCHDs, associated with rotating between clinical sites.

NDTP developed the NER which was launched on 8th June 2015 and eliminates the requirement for duplication of paperwork. Each NCHD must register a secure NER portal account which provides a central location to upload documentation associated with changing employer such as Garda Vetting, Occupational Health/EPP, Hire Form,

mandatory training certificates, CV etc. NER was piloted with the July 2015 Intern cohort, and due to the success of the pilot was subsequently rolled out to all NCHDs nationally in October 2015. By the end of 2015 almost 2,600 NCHDs have opened their NER account.

A further development planned for 2016 is the introduction of automated e-mails to NCHDs to remind them when particular documents are nearing expiry, for example Work Permit, ACLS etc. These reminders can be configured to be copied to the employer also if required.

**Reporting Functionality of NER**

The NER provides a range of reports for hospital sites, including:

- Hospital sites can view an NCHD's NER account and ascertain the status of all documentation requirements
- Hospital sites can produce status reports on NER account documents for all NCHDs
- Reports indicate which documents are required/not required, in date, nearing expiry, expired or missing
- Compliance reports show the percentage compliance at hospital level with each document type e.g. hand hygiene, BLS, ACLS, Fire Training etc
- NDTP can view reports at a national level showing compliance with all documents types
- All reports are exportable to Excel
- NER produces a contact details report for all NCHDs. Once all NCHDs have opened NER accounts NDTP will be able to communicate with all NCHDs in the state, which has not been possible up to this point

**Consultants Module**

During 2015 work also began to further develop the Consultants Module of the MPS. This module contains details of all approved consultant posts and is maintained by the Consultants Division in NDTP. In addition to recording the details of the consultant post, the module contains the functionality to match individual consultants to the consultant post in which they are employed. While some work has been done on this matching process, it is not complete as it is actually the hospital sites/CHOs that are best positioned to complete this matching process. Part of the project to further develop the Consultants Module includes devolving the Consultants Module to clinical sites on a phased basis during 2016. There will also be enhanced reporting functionality available for NDTP and at clinical site level.

## 4.7 Additional Priorities for 2016

**Lead NCHD Awards**

The introduction of Lead NCHD Awards is a new development planned for 2016. The Lead NCHD Awards are designed to acknowledge the work undertaken by Lead NCHDs during the course of their tenure on their clinical site. Entries are in the form of a poster along with an accompanying abstract that explains the initiative. Award categories include; enhanced communication between NCHDs and other colleagues, local NCHD education/training, policy/process development, quality improvement initiative, or a patient centred initiative.

**Further Increases in Flexible Training Numbers**

The Minister for Health has recently requested that NDTP funded Flexible Training scheme be extended on a phased basis over a three year period to result in a doubling of the number of places available. With effect from the next NCHD rotation in July 2016, NDTP is funding an increase of an additional 8 flexible training places. In addition NDTP is now extending the scheme to junior trainees from year 2 BST training onwards.

**NDTP Key Performance Indicators**

The Consultants Division Key Performance Indicators were developed during 2015 with data collection to commence in January 2016. The primary aim of the KPI's is to reflect the timeline between receipt of an application for a new or replacement Consultant post right through to the post being approved and the letter of approval for the post issued. A key priority for NDTP in 2016 will be recording and analysing the data captured using the Consultant Applications KPI's in order to identify any barriers within the current Consultant Applications system to the timely progression of Consultant posts. In addition, it is planned that publication of the KPI reports will take place on a quarterly basis and that this will enhance public awareness and perception of the current process.

**Process Review and Redesign within the Consultants Division**

Work has begun in 2015 to review and redesign a number of the processes within the Consultant's Division including; the development of the Consultants Module of the Medical Practitioners System (MPS), the simplification and streamlining of the CAAC application process and the development of an online application process for CAAC applications. 2016 will see these projects continue and gain momentum. Development of the Consultants Module of the MPS will allow this module to be rolled out to clinical sites and for individual consultants to be matched to the consultant post in which they are employed. Work on a simplified and streamlined application form for applications to the CAAC has begun and will be completed and launched in 2016. This will be followed by the development of an online application process for these applications to be piloted in 2016.

**Training Lead Role**

As noted in the 2014 Annual Report NDTP intends to introduce the role of Training Lead at consultant level in hospital groups. This post will have a key role in the coordination of generic training issues at clinical site level and will be the central point of contact for the Medical Council standards for clinical sites. At the end of 2015 plans to introduce the role were at advanced stage with an expected implementation date of July 2016.

**Strategic Plan 2016 – 2020**

Towards the end of 2015 NDTP began work on a strategic plan for the period 2016 to 2020. Developing the strategy included a consultation exercise with a range of NDTP's stakeholders. The plan to be launched in 2016 will set out a number of strategic priorities to guide NDTP's activities over the period of the strategy.

National Doctors Training & Planning

National Doctors Training & Planning
Health Service Executive
Dr. Steevens' Hospital
Dublin 8
Ireland

Oiliúint agus Pleanáil Náisiúnta na nDochtúirí
Feidhmeannacht na Seirbhíse Sláinte
Ospidéal Dr. Steevens'
Baile Atha Cliath 8
Éire

t +353 1 635 2237
f +353 1 635 2898
e doctors@hse.ie
w www.hse.ie/doctors

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# NDTP

National Doctors Training & Planning

# STRATEGIC PLAN 2016–2020

*"Investing in the career development of doctors"*

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National Doctors Training & Planning
Health Service Executive
Dr. Steevens' Hospital
Dublin 8
Ireland

t +353 1 635 2237
f +353 1 635 2898
e doctors@hse.ie
w www.hse.ie/doctors

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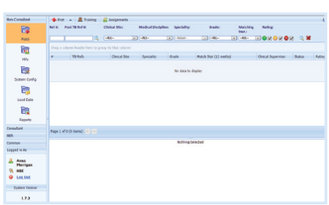
# NDTP Key Milestones

## 2010 – 2016

**2010**
Introduction of Higher Specialist Fund

**2010**
Centralised Recruitments of Interns

**2011**
Launch of NCHD Database



**2011**
Academic GP Fellowship

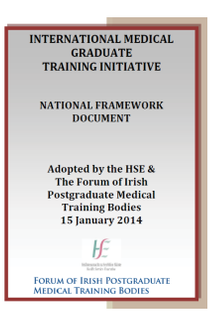

**2012**
Introduction of First Streamlined Training (College of Anaesthetists)

**2013**
First Annual Careers Day

MEDICAL CAREERS DAY
BUILDING YOUR FUTURE

**2013**
Establishment of Medical Workforce Planning Function

**2013**
Introduction of IMGTI

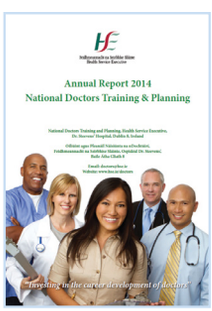



**2014**
Workforce Planning Benchmarking Report

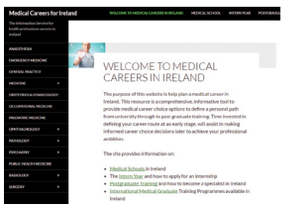
**2014**
MET renamed NDTP to reflect the incorporation of CAU and Medical Workforce Planning

**2014**
NDTP Website Launched

**2014**
First NDTP Annual Report



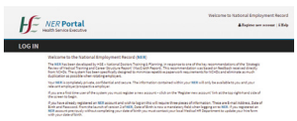

**2015**
Launch of Medical Careers Website




**2015**
Launch of Post CSCST Fellowships

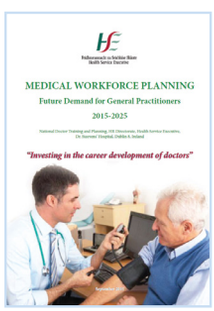
**2015**
Introduction of CPD-SS


**2015**
Launch of the National Employment Record (NER)



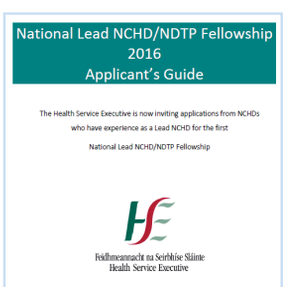

**2015**
National Roll-out of Lead NCHD Initiative

**2015**
Publication of the GP Workforce Planning Report




**2016**
Increased Flexible Training Positions

**2016**
Appointment of First National Lead NCHD/NDTP Fellow



# FOREWORD FROM THE NATIONAL DIRECTOR HUMAN RESOURCES

I welcome the publication of HSE - National Doctors Training & Planning's Strategic Plan 2016 -2020. This plan supports the HSE's commitment in our Corporate Plan to delivering high quality, safe healthcare to our patients, communities and the wider population. A key component of this commitment is having an aligned and appropriately skilled medical workforce, in the right locations, providing care to our service users. The NDTP strategy sets out the priorities and actions required over the next four years in order to develop a medical workforce that meets the evolving needs of the Irish healthcare system.

This strategy is also aligned with the Health Services People Strategy 2015 – 2018 and promotes reform of the health system, ensuring that there is a continuing focus on appropriate, relevant, high quality training for doctors, which, when combined with highly-developed workforce planning methodology, will result in major benefits for the health service and patients.

The NDTP objectives outlined in this report cannot be achieved in isolation, but require engagement and co-operation from the many stakeholders with which NDTP collaborates in carrying out its three functions of Medical Education and Training, Medical Workforce Planning and the Consultant Post Approval Process.

The HSE fully supports NDTP in implementing this strategic plan and I look forward to the achievement of its objectives and the positive impact that will result.

Rosarii Mannion
National Director Human Resources
HSE

# FOREWORD FROM THE NATIONAL CLINICAL ADVISOR AND GROUP LEAD ACUTE HOSPITALS

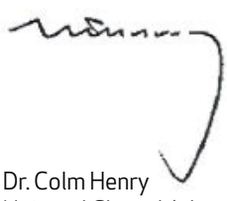
Ireland has a long and honourable tradition in training doctors. Medical students in other countries will have learnt of some of the fabled characters of Dublin medicine, such as William Stokes, who developed and refined the art of bedside teaching that underpins much of medical training to this day.

Training doctors for the next generation demands that we adapt at different speeds: rapidly to react to new treatments and technologies and more deliberately to respond to the changing profile and needs of our population. In recent years, reports such as that from the MacCraith group, recognise the importance of aligning medical training with the current and future healthcare needs of our citizens. The development of more integrated models of healthcare demands that doctors, even in small specialties, take a broader perspective on the needs of their patients to include disease prevention and health promotion.

The distribution of our population continues to change and presents new challenges as we try to meet the expectations of patients who live further from urban centres. As some treatments become more complex, there is a realisation that specialised services, as well as the training they provide, cannot be available in every hospital and county and need to be consolidated in a smaller number of centres where we can secure the best outcomes and provide specialty training of greater quality. The greater proportion of healthcare, however, will always take place in the community and in more general hospital settings and we must not lose sight of the need to train and condition doctors for these environments.

The NDTP, led by Eilis McGovern, has produced a strategy document which addresses all these challenges as we look to the years ahead. This document lays out a vision for medical training which services the needs of our whole community while preserving the legacy of Stokes and generations of trainers to whom we are indebted.

I look forward to working in collaboration with NDTP over the lifetime of this strategy and beyond to deliver the planned outcomes.



Dr. Colm Henry
National Clinical Advisor and Group Lead Acute Hospitals
HSE

# INTRODUCTION FROM THE DIRECTOR NATIONAL DOCTORS TRAINING & PLANNING

I am pleased to introduce HSE-National Doctors Training & Planning's Strategic Plan for 2016 to 2020. This is the first strategic plan for the department since the three functions of medical education and training, medical workforce planning and the consultant post approval process were centralised in NDTP in November 2014. At that time, the department was re-named National Doctors Training & Planning in order to more accurately reflect its activities, having formerly been known as Medical Education and Training (MET). This four year strategy aims to build on what has been achieved since the foundation of MET in 2007, including the continued delivery of NDTP's statutory responsibilities. The strategy is guided by a vision and mission that reflects the role of the department in an evolving health service.

This policy contains six strategic objectives, each with associated outcomes, which, when achieved, will result in significant benefit to patients and service users. Operational plans will be developed on an annual basis to guide the implementation of the strategy, and progress will be reviewed regularly.

I would like to thank all those who participated in the development of this strategic plan, and in particular, the individuals and organisations who shared their views and insight as part of a stakeholder consultation process. Successful implementation will require the active involvement, engagement and support of our many partners, both within and outside the HSE, and the NDTP team looks forward to working with them in order to realise our vision.

Prof. Eilis McGovern
Director
National Doctors Training & Planning
HSE

# EXECUTIVE SUMMARY

National Doctors Training & Planning (NDTP) incorporating Medical Education and Training, Medical Workforce Planning and the Consultant Post Approval Process, was established in November 2014. It has a statutory remit that is outlined in the Health Act 2004 and the Medical Practitioners Act 2007.

The combined objective of the three core functions of NDTP is to ensure that, at all times, the Irish health service is provided with the appropriate number of specialists, who possess the required skills and competencies to deliver high quality and safe care, and whose training is matched to the model of healthcare delivery in Ireland, regardless of location.

The drivers and influencers of NDTP policy and decision-making are diverse and include national health policy, national clinical programmes, demographic changes, evolving health service structures, retention of doctors, the 'MacCraith Report' (Strategic Review of Medical Training and Career Structure 2014), HSE strategies and frameworks, and key stakeholder engagements regarding training for doctors.

The NDTP vision is that patient care and patient outcomes are maximised as a result of an aligned and appropriately skilled medical workforce. In order to facilitate the development of such a medical workforce, NDTP must excel in all three of its core domains, namely medical education and training, medical workforce planning and the consultant post approval process.

This involves projecting and proposing on an annual basis the number of medical trainees required for each specialty; commissioning and funding the training required to meet these needs; ensuring that the training content and delivery is responsive to the changing needs of the Irish healthcare system; supporting the retention of these doctors upon completion of their training; identifying the future medical workforce requirements in each specialty, and managing the consultant post approval process in a timely and efficient manner.

This NDTP plan contains six strategic objectives which, when delivered over the lifetime of the strategy, will result in a series of outcomes that will benefit patients. The six strategic objectives are as follows:

1. Develop a shared vision amongst all stakeholders of the future of doctor training and consultant post requirements in Ireland
2. The role, responsibilities and added value of NDTP is understood by all key stakeholders
3. Trainee and specialist/consultant numbers, specialty and skill-set are aligned with current and future service requirements
4. NDTP objectives and operations are supported by, and aligned with, key HSE divisions
5. Productive engagement mechanisms and relationships exist with stakeholders
6. NDTP is fit for purpose and capable of delivering on its objectives

It is anticipated that the following outcomes will materialise and become embedded as progress is made in the delivery of the strategic objectives outlined above:

- A shared approach to future doctor training and consultant post requirements for the Irish health service exists and is understood, leading to a combined and focused effort by all stakeholders
- The training provided to doctors is appropriate, adaptive and capable of responding to the changing needs of the patient and the health service
- Ireland's medical workforce is increasingly aligned with the needs of the Irish health system
- Doctors' experience of both training and work is consistently positive regardless of location
- Morale amongst all doctors – NCHDs, trainees, GPs, specialists and consultants - has improved, resulting in better outcomes for patients
- Doctors trained in Ireland remain and work in Ireland in the long term
- Medical training in Ireland is increasingly highly regarded internationally
- NDTP investment in doctors' training is delivering value for money
- An established workforce plan / framework is shaping appropriate medical education and training and the employment of all doctors in the health service
- Consultant posts are filled in a timely manner resulting in a reduced reliance on locums, which in turn is providing better training and patient experiences throughout the Irish health service
- There is equity of access to quality services and better outcomes for patients, regardless of where they live
- High quality data is enabling and informing decision-making and career planning for the medical workforce

NDTP has developed a high level implementation plan to guide the delivery of the strategy. Priority actions include the continued development of a robust workforce planning methodology; the development of processes and databases for capturing data that can then be harnessed and used to guide further decision making; and communication of this strategy and the NDTP statutory role and responsibilities to its stakeholders. This high level implementation plan will be supplemented with annual operational plans that identify the key actions to be taken by NDTP each year.

# 1. THE CONTEXT IN WHICH NDTP OPERATES

National Doctors Training & Planning (NDTP) was established in September 2014 on the re-naming of the Medical Education and Training unit (MET). The new title for the department was chosen in order to better reflect its three core functions - Medical Education and Training, Medical Workforce Planning and the Consultant Post Approval Process. It is positioned within the HSE National Directorate for Human Resources.

The work stream originally assigned to MET in 2007 related exclusively to medical education and training. Medical workforce planning (MWP) was added to its remit in May of 2013, with a view to bringing the number of doctors in postgraduate medical training programmes in line with expert informed estimates of the future demand for specialists in the health service.

In early 2014, the Consultants Appointments Unit (CAU) also came under the remit of MET. The CAU was established in 2008 to carry out certain statutory functions outlined in the Health Act 2004 which transferred to the HSE on the dissolution of Comhairle na nOspidéal. These functions are to regulate the number and type of appointments of consultant medical staff and other such staff as may be prescribed in hospitals, and to specify the qualifications for consultant appointments. The Consultants Contract 2008 also provided that the CAU would become the secretariat to both the Consultant Applications Advisory Committee (CAAC) and the Type C Committee. The CAU is now known as the Consultants Division of NDTP and continues to manage the consultant post approval process.

The combined objective of the three core functions of NDTP - medical education and training, medical workforce planning and consultant post approval process - is to ensure that, at all times, the Irish health service is provided with the appropriate number of specialists, who possess the required skills and competencies to deliver high quality and safe care, and whose training is matched to the model of healthcare delivery in Ireland, regardless of the location of the particular service.

The role of NDTP is underpinned by the fact that the HSE is, de facto, the biggest employer in the state of doctors trained by the postgraduate medical specialist training bodies and is the provider of clinical placements for this training.

The intelligence-gathering and outputs from medical workforce planning and projections directly influence decision-making in NDTP's training arena. NDTP focuses on two main areas of training:

- The numbers of trainees required in each specialty to provide the future medical workforce
- The content of training, which must be adaptive and responsive to changes in health service delivery in order that our future specialists have the right skills and competencies for patient and service needs

The consultant post approval process is the final point in this pathway, linking the output from training with the recommendations from workforce planning.

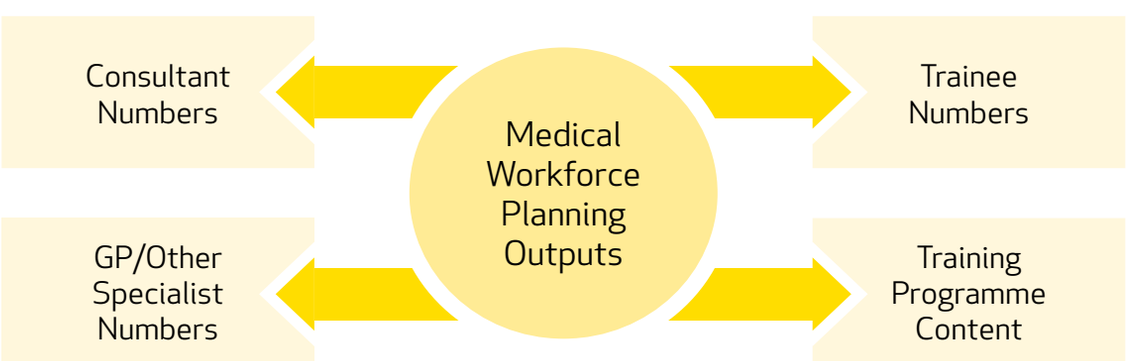



**Figure 1 Role of Medical Workforce Planning Outputs**

In the past, the key stakeholders with which NDTP engaged on a regular basis were the postgraduate training bodies. This reflected the main activity of the department, which was the annual renewal of the service agreements with each training body, and agreement on the annual trainee intake.

However, with a new focus on medical workforce planning, there is an opportunity to match postgraduate specialist medical training (both trainee intake and training content) to future workforce projections. This requires NDTP to liaise closely with the service delivery departments of the HSE, particularly the National Directorates for Acute Hospitals, Mental Health and Primary Care. Another important source of information regarding the future design of service delivery is the National Clinical Programme initiative. NDTP is in a pivotal position to link the vision for the future delivery of healthcare with the training bodies who train our future general practitioners, specialists and consultants.

The role of trainees as major stakeholders is also acknowledged. In this time of unprecedented recruitment and retention challenges in the Irish healthcare system, the views of our trainees are relevant and important, and must be taken into consideration.

### 1.1 Legislative Framework and Statutory Role

The Medical Education, Training and Research unit (METR) was inaugurated in the HSE in 2007 in response to recommendations contained in the Fottrell (Medical Education in Ireland – A New Direction) and Buttimer (Preparing Doctors to meet the Health Needs of the 21st Century) Reports published in 2006. When the Medical Practitioners Act 2007 was implemented, the Postgraduate Medical and Dental Board was dissolved and the relevant postgraduate specialist training functions for which it was responsible transferred to METR. The research function was transferred to the Directorate of Strategy and Clinical Programmes in 2011, and henceforth the unit was referred to as MET (Medical Education and Training).

The statutory role of the HSE, executed by the METR unit, was outlined in both the Health Act 2004 and the Medical Practitioners Act 2007, and NDTP continues to fulfil these responsibilities.

Section 7 of the Health Act 2004 assigned specific accountability and responsibility to the HSE to facilitate the education and training of its employees, including medical practitioners.

The Medical Practitioners Act 2007 introduced a comprehensive system for the regulation of all medical practitioners, with a view to ensuring that they are appropriately qualified and competent to practise medicine and deliver health services safely to the public. Part 10 of the Act requires the HSE:

- To facilitate the education of students training to be registered medical practitioners
- To promote the development of specialist medical and dental education and training and to co-ordinate such developments in co-operation with the Medical Council, the Dental Council and the medical and dental training bodies
- In co-operation with the medical and dental training bodies and after consultation with the Higher Education Authority, to undertake appropriate workforce planning with a view to meeting the staffing and training needs of the health services on an ongoing basis
- To assess on an annual basis the number and type of intern and training posts required by the health service and to put these proposals to the Medical Council
- To advise the Minister on medical and dental education after consultation with medical and dental training bodies and other appropriate bodies

In addition, NDTP is also responsible for ensuring that:

- 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

## 1.2 Policy Framework

NDTP is cognisant of the national context in which it operates and the development of this strategy has been informed by a number of relevant national strategies and frameworks.

### 1.2.1 HSE People Strategy 2015 - 2018

The HSE policy for its staff is contained in the People Strategy 2015 – 2018. This supports the implementation of the HSE Corporate Plan through a focus on eight priorities, all combining to deliver the overall goal of safer better healthcare. The NDTP strategic plan is fully aligned with the People Strategy, and in particular with the priorities identified in workforce planning, learning and development, and evidence and knowledge.

### 1.2.2 Future Health – A Strategic Framework for Reform of the Health Service 2012-2015

This outlines the joint commitment of the Department of Health and the HSE to work together to implement an approach to workforce planning and development with the objective of

- Recruiting and retaining the right mix of staff
- Training and upskilling the workforce
- Providing for professional and career development
- Creating supportive and healthy workplaces
- Investing in leadership, management development and succession planning

### 1.2.3 Department of Health – Statement of Strategy 2015-2017

This commits the Department to building on the previous strategy and to playing its part in nurturing a health system where high performance is achieved, and the knowledge and skills of health service staff are enhanced and developed. An underlying objective is to have a stable and sustainable workforce to achieve national priorities, as well as clinical and operational improvement.

### 1.2.4 Strategic Review of Medical Training and Career Structure (MacCraith Reports 2013 - 2014)

The retention of doctors who graduate in Ireland and undergo specialist training within the Irish health system is a major challenge. With the implementation of the Fottrell Report (Medical Education in Ireland - A New Direction, 2006), Ireland is producing more medical graduates than ever before. However, the emigration of doctors has resulted in challenges in recruitment and retention of doctors in the health service. In a move to address this challenge, the Strategic Review of Medical Training and Career Structure was established in 2013 by the Minister for Health and chaired by Professor Brian MacCraith. Following the publication of the MacCraith Report, many of the recommendations have now been implemented. Several training bodies have responded to the need for better clarity of the training journey by introducing streamlined training. In some specialties this has also resulted in a reduction in the duration of specialist training. Other initiatives have included reducing the paperwork burden associated with rotations through the introduction by NDTP of the National Employment Record (NER), and the introduction of the Lead NCHD role to provide a formal link at management level between the NCHD cohort and the management structure on hospital sites.

### 1.2.5 HIQA National Standards for Safer Better Healthcare 2012

The Health Information and Quality Authority has a national statutory role to set and monitor compliance with standards for the quality and safety of health and social care services in Ireland. This report includes a recommendation that people working in the service are recruited, organised, developed and supported so that they have the skills, competencies and knowledge to enable the delivery of high quality, safe and reliable care.

### 1.2.6 National Clinical Programmes

The National Clinical Programmes (NCPs) represent a strategic initiative between the HSE and the Irish postgraduate training bodies. The aim of the NCPs is the development of standardised models of care across medical specialties and healthcare disciplines, and they share three core objectives:

- To improve the quality of patient care
- To improve access to services
- To improve cost effectiveness

NCP models of care act as strategic plans underpinning clinical service delivery, and incorporate evidence-based recommendations which have been shown to be associated with improved patient outcomes.

NDTP analyses the medical staffing required (with regard to number, specialty and skill-set/competencies) to implement models of care so that the objectives of the Clinical Programmes can be met. The Clinical Programme models of care, therefore, have a major influence on the work of NDTP in terms of medical workforce planning and associated training requirements.

### 1.3 Other Factors Influencing NDTP Policy

#### 1.3.1 The Requirement for Strategic Medical Workforce Planning

The MacCraith Report emphasised the central role of strategic medical workforce planning and welcomed the newly constituted NDTP, recognising the opportunity it provides to facilitate a more efficient and integrated approach to medical education and training, medical workforce planning and the consultant post approval process for the public health system. NDTP has produced several high-level reports since 2013, and in September 2015 published the first specialty-specific report, addressing the projected demand for GPs in Ireland over the next 10 years. As part of the methodology, consideration was given to demographic change, service utilisation patterns, the extension of free GP care to different population groupings, feminisation of the workforce and doctor emigration.

NDTP intends to produce specialty-specific reports for all major medical specialties, with medical workforce planning reports for Paediatrics/Neonatology and Emergency Medicine due for publication shortly. Given the number of specialties in the medical workforce, NDTP will need further resourcing to increase the capacity of the unit in order to complete this first cycle of reports in a timely manner.

#### 1.3.2 Demographic Changes

The demographic changes taking place in Ireland are another key consideration for NDTP in developing this strategy. The population of Ireland is growing and people are living longer, often with chronic and more complex medical conditions. This increases the demand for doctors and requires a focus from all stakeholders involved in the planning for, and training of, doctors to ensure that Ireland is creating a pipeline of trainees, who will be our future consultants/specialists/GPs.

Population distribution is also becoming more condensed as people (typically younger people) leave rural Ireland in search of employment in our cities. However, people who live in rural settings are entitled to the same high standard of medical care. It is becoming increasingly difficult to attract doctors (both consultants/specialists, NCHDs and GPs) to locations outside of our major cities, where hospitals typically operate at a lower level of complexity. NDTP will work to address this challenge in co-operation with partners both within and outside the HSE in order to create an environment where doctors regard these work opportunities as viable and attractive career choices, and to ensure that their training provides them with the appropriate skills.

#### 1.3.3 Evolving Health Service Structures

The recent introduction of Hospital Groups (HGs) and Community Healthcare Organisations (CHOs) has major implications for the work of NDTP. As these new structures mature and refine their respective models for the delivery of services, opportunities will arise for many consultant posts to have joint linkages with both a major centre and a more peripheral location within the same hospital group. NDTP, through its Consultants Division, and informed by medical workforce planning, is ideally placed to coordinate the evaluation of applications for consultant posts to ensure that the needs of all patients are met.

#### 1.3.4 International Doctors

Despite Ireland producing more medical graduates than ever before, there is still a disproportionate reliance on International Medical Graduates (IMGs) and the use of short-term locum doctors. This has particular implications for national compliance with the European Working Time Directive and the provision of medical services to rural communities. In addition, the Medical Council has highlighted the implications for patient safety of an over-reliance on IMGs and locums.

In June 2013, the International Medical Graduate Training Initiative (IMGTI) was launched to provide a route for overseas doctors wishing to undergo structured postgraduate medical training within the public health service in Ireland. The initiative is overseen and governed by the HSE and the postgraduate medical training bodies in Ireland on a collaborative basis through the Forum of Irish Postgraduate Medical Training Bodies. The overseas trainees are enabled to gain access to clinical experiences and training, with a view to enhancing and improving the individual's medical training and learning, and in the medium to long term, the health services in the trainees' own countries when they return home. The operation of this training initiative enables Ireland to deliver on its commitments contained in the World Health Organisation Global Code of Practice on the International Recruitment of Health Personnel.

### 1.3.5 Stakeholder Engagement

As outlined earlier in this section, stakeholder engagement is routine to the work of NDTP. Another key partner is the Forum of Irish Postgraduate Medical Training Bodies. The Forum, which is funded by NDTP, was established in 2007 to promote common strategies and enhance universal efficiencies amongst the postgraduate medical training bodies. It provides a co-ordinated mechanism for the postgraduate medical training bodies to engage with the HSE, the Medical Council and the Department of Health, on issues relating to the provision of postgraduate medical education. Frequent interaction takes place between NDTP and the training bodies, both individually and collectively via the Forum.

Intern training is delivered by six Intern Networks, and NDTP funds the cost of training delivered by the networks through annual service agreements.

NDTP works closely with the Medical Council, which has a statutory role in the regulation of intern and postgraduate medical training. In 2013, the Medical Council and NDTP signed a Memorandum of Understanding to work co-operatively to:

- Facilitate the training of medical students, interns and specialist trainees via Medical Council accredited clinical placements at HSE/ HSE-funded clinical training sites in order that these students and NCHDs may become eligible for entry in the Specialist Division of the Register of Medical Practitioners
- Further develop and enhance the standard of medical education and training for the benefit of patients
- Ensure the type and quantity of posts match current and future training and service needs
- Ensure NCHDs who are not in formal specialist training programmes are facilitated to maintain their professional competence
- Communicate as appropriate on all matters of strategic mutual and high level operational interest in areas including, but not limited to, workforce planning, structural reform and registration of medical practitioners

| Patients and the Public | |
|---|---|
| Doctors | NCHDs \| Consultants \| Other Specialists |
| Medical Training | Postgraduate Medical Training Bodies \| Intern Network<br>University Medical Schools |
| Health Service & Health System | HSE Internal \| Acute Hospitals \| Mental Health \| Primary Care \| QID \| NRS<br>National Clinical Programmes \| Hospital Groups \| Medical Manpower Managers<br>Community Healthcare Organisations |
| Regulation | Medical Council |
| Government Departments & Agencies | Department of Health \| Department of Jobs, Enterprise & Innovation<br>Department of Justice & Equality \| Department of Education<br>Higher Education Authority |

**Figure 2 NDTP Stakeholders**

# 2. VISION & MISSION

## VISION

*Patient care and patient outcomes are maximised as a result of an aligned and appropriately skilled medical workforce.*

***Our vision explained:***

NDTP recognises that patients are the ultimate beneficiaries of our vision. Developing a medical workforce that is aligned and appropriately skilled allows patient care and patient outcomes to be maximised through the combination of the following factors:

- The correct number of doctors are training or trained in each medical specialty to meet both the current and future health needs of the population
- The training received by doctors equips them for the role in which they are working within the health service
- The correct balance between generalist and specialist doctors exists to cater for the population needs
- Doctors are located throughout the country in the places where they are needed
- Consultant–delivered care and extended consultant presence becomes more widespread, leading to a reduced dependence on NCHDs and a gradual decrease in the NCHD:consultant ratio. More trainees will be required to provide the future consultant workforce and there will be a reduction in non-training NCHD posts
- Recruitment and retention of doctors trained in Ireland is maximised due to their positive experience of training and working in the health service
- Medical training in Ireland maintains its position of international repute
- Posts, whether GP, specialist or consultant, are filled in a timely manner
- There is equitable access to GPs, specialists and consultants for patients regardless of whether they live in an urban or rural location and regardless of whether they live near a Model 2, 3 or 4 hospital

In order to facilitate development of a medical workforce that is both aligned and appropriately skilled NDTP must excel in all three of its core domains, namely medical education and training, medical workforce planning and the consultant post approval process. NDTP must ensure that medical training in Ireland maintains its position of international repute.

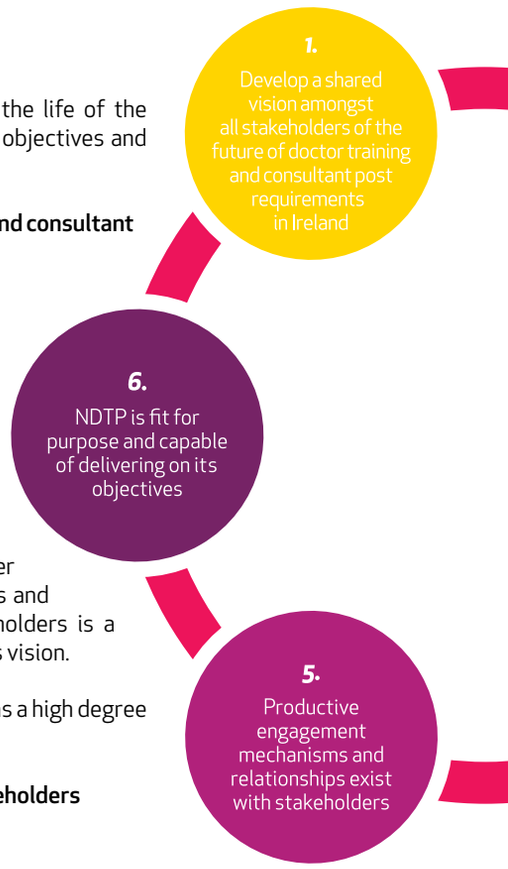
## MISSION

*NDTP, through its role in medical education and training, medical workforce planning and the consultant post approval process, contributes to the best possible outcomes for patients in the Irish health service.*

***Our mission explained:***

The role of NDTP is to project and propose on an annual basis the numbers, type and skill-set of medical trainees required in each specialty to meet the current and future needs of the Irish healthcare system; to commission and fund the training required to meet these needs; to support the retention of these doctors upon completion of their training; to identify the future workforce requirements for each medical specialty; and to manage the consultant post approval process in an efficient and timely manner in order to ensure that consultant posts are aligned to the needs of the health service.

# 3. STRATEGIC OBJECTIVES & OUTCOMES




The NDTP strategy contains six strategic objectives which, when achieved over the life of the strategy, will deliver a series of outcomes that will benefit patients. The strategic objectives and outcomes are described below.

**1: Develop a shared vision amongst all stakeholders of the future of doctor training and consultant post requirements in Ireland**

Key Actions

1. Initiate and drive discussion and debate around the future of doctor training and consultant post requirements. The creation of a shared vision necessitates engagement with stakeholders, both within and outside the HSE, to discuss and develop a shared perspective on meeting Ireland's future health service requirements.

2. Develop a plan to engage with key decision-makers to consider the future of doctor training and workforce planning for NCHDs and consultants. Regular and meaningful engagement with stakeholders is a central tenet of how NDTP wishes to develop and implement this vision.

3. Seek to measure the levels of involvement by key stakeholders, as a high degree of engagement is key to the realisation of this shared vision.

**2: The role, responsibilities and added value of NDTP is understood by all key stakeholders**

Key Actions

1. Clearly communicate the statutory role and key responsibilities of NDTP. Recent stakeholder engagements carried out as part of the development of this strategy indicate that there is a lack of awareness and understanding of the role and responsibilities of NDTP. This perception is partly the result of the relatively recent establishment of NDTP in its current form (as a combination of MET, medical workforce planning and the Consultants Appointments Unit), and indicates the requirement for NDTP to undertake a communications exercise to inform stakeholders of its expanded remit.

2. Periodically check the effectiveness of the communications exercise in increasing awareness of NDTP's role and responsibilities amongst key stakeholders.

**3: Trainee and specialist/consultant numbers, specialty and skill-set are aligned with current and future service requirements**

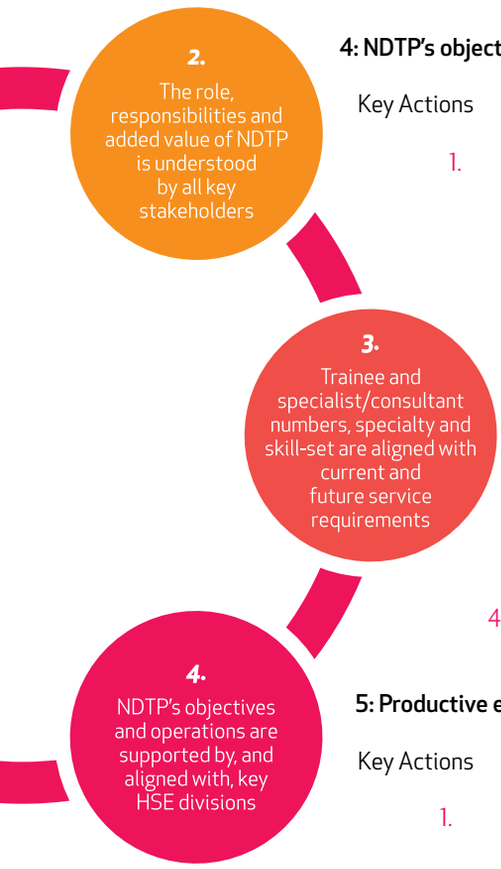
Key Actions

1. Continue to make improvements to the methodology for determining trainee and consultant numbers to meet predicted service requirements. This methodology is crucial, as effective medical workforce planning is fundamental to the delivery of NDTP's vision. In further developing this methodology, NDTP will consider the most appropriate data sources to be developed across the health services as well as within NDTP itself. In the interim, the projections for trainee and consultant numbers will be based on the best available data.

2. NDTP will work with the Department of Health and the HSE to incorporate its workforce planning function into the service-wide integrated workforce planning system, which is at the early stages of development.

3. Develop a fit for purpose consultant post approval process that can be incorporated seamlessly within the overall consultant recruitment practice. Enhance the user-friendliness of the consultant post approval process by developing and implementing an online solution.

4. Further develop the process to track registrations, recruitment and retention levels, including geographical location, for NCHDs, consultant post approvals and consultant appointments. Accurate information on doctors entering and leaving the health service is essential for accurate workforce planning.




**4: NDTP's objectives and operations are supported by, and aligned with, key HSE divisions**

Key Actions

1. NDTP collates useful data and information about doctors working in Ireland and is currently enhancing its capabilities in this area through the development and roll-out of databases and online information resources. NDTP will more actively share this data and information both within the HSE and externally to inform and guide decision making.

2. Develop more structured mechanisms for engagement, collaboration, information sharing and input between NDTP and other HSE departments e.g. Clinical Programmes, Acute Hospitals Directorate, Primary Care Directorate, to ensure that relevant activities and decision-making processes are enhanced.

3. In turn NDTP's ability to perform its duties will be strengthened through these engagements and deepened relationships.

4. Drive the implementation of wider HSE policies through our engagement with other stakeholders.

**5: Productive engagement mechanisms and relationships exist with stakeholders**

Key Actions

1. The training bodies determine the curriculum, duration and location of postgraduate medical training in Ireland. NDTP will continue to work closely with the training bodies to ensure that the Irish health service is provided with the appropriate number of specialists, who possess the required skills and competencies to deliver high quality and safe care, and whose training is matched to the model of healthcare delivery in Ireland regardless of location.

2. The Medical Council, in seeking to create a supportive learning environment to enable good professional practice, captures data about the levels of satisfaction amongst trainees through its annual national trainee survey, Your Training Counts. NDTP acknowledges the importance of this data and the need to utilise it to improve the training experience and environment for NCHDs. NDTP will work collaboratively with its stakeholders to drive changes and improvements in this area.

3. Establish a mechanism for direct engagement with interns and trainees in order to gain a better understanding of their issues, with the ultimate aim of improving the trainee experience and increasing trainee retention.

4. Build on the existing process for engagement with training bodies and intern networks to identify SLA outcomes and deliverables that will ensure that intern and postgraduate specialist training is continually evolving and adapting to current and future health service requirements.

**6: NDTP is fit for purpose and capable of delivering on its objectives**

Key Actions

1. Examine how the use of IT might be enhanced to improve NDTP's efficiency and effectiveness. A large part of NDTP activity, particularly in the area of workforce planning, requires the capture, and analysis, of data. Many functions could be enhanced/ streamlined with greater utilisation of IT. As an example, the recent introduction of the National Employment Record (NER) has already delivered an improved experience for NCHDs through the reduction of paperwork required as they rotate from hospital to hospital, whilst simultaneously providing NDTP with a national picture of NCHD employment.

2. Review and define the operational requirements to implement the strategy. We will quantify the necessary human and infrastructural resources required to deliver the strategy. Key resources will include staff with appropriate skillsets.

3. Operate with efficiency to achieve the maximum outputs from staff and internal processes in order to deliver the strategy. Role clarity and clear accountability for all staff are central to this, as are development opportunities, and initiatives to facilitate succession planning and retention of key staff.

4. Given NDTP's investment in doctors' training, financial prudency is essential. NDTP must ensure that value for money is returned for taxpayers. Effective budget management/ financial management is essential to ensure accurate tracking of expenditure and monitoring of performance against agreed targets.

5. Adequate resourcing is essential for NDTP to successfully implement its strategy. In addition to the costs of successfully discharging the functions of NDTP, there will be increased costs in future years related to the increasing numbers of interns and trainees.

As NDTP achieves its strategic objectives then the outcomes envisaged below will be achieved.


### 3.2 Outcomes

It is anticipated that the following outcomes will materialise and become embedded as progress is made in the delivery of the strategic objectives outlined above:

- A shared approach to future doctor training and consultant post requirements for the Irish health service exists and is understood, leading to a combined and focused effort by all stakeholders
- The training provided to doctors is appropriate, adaptive and capable of responding to the changing needs of the patient and the health service
- Ireland's medical workforce is increasingly aligned with the needs of the Irish health system
- Doctors' experience of both training and work is consistently positive regardless of location
- Morale amongst all doctors – NCHDs, trainees, GPs, specialists and consultants - has improved, resulting in better outcomes for patients
- Doctors trained in Ireland remain and work in Ireland in the long term
- Medical training in Ireland is increasingly highly regarded internationally
- NDTP investment in doctors' training is delivering value for money
- An established workforce plan / framework is shaping appropriate training, and the employment of all doctors in the health service
- Consultant posts are filled in a timely manner resulting in a reduced reliance on locums, which in turn is providing better training and patient experiences throughout the Irish health service
- There is equity of access to quality services and better outcomes for patients, regardless of where they live
- High quality data is enabling and informing decision-making and career planning for the medical workforce

# 4. IMPLEMENTING THE STRATEGY

NDTP has developed a high level implementation plan to guide the roll-out of the strategy, and within this plan, the sequencing of actions is an important consideration. Priority actions include continuous improvement of the workforce planning methodology, the development of processes and IT solutions for capturing data that can then be harnessed and used to guide further decision making, and communication of this strategy, as well as NDTP's statutory role and responsibilities, to its stakeholders.

The high level implementation plan will be supplemented with annual operational plans that identify the key actions to be taken by NDTP each year. The use of annual operational plans enables NDTP to tailor its actions in line with its resources and funding position each year, and will give flexibility to respond to any changing circumstances that may arise. NDTP will regularly review its progress in implementing this strategy and will publish in its Annual Report information on the delivery of its strategic objectives and the achievement of the associated outcomes.

While outlining and communicating this strategy, NDTP acknowledges the potential impact of external factors - such as changes in economic conditions, government health policy, the annual HSE service plan and funding constraints – on its ability to implement the plan. NDTP will remain alert to any changes in these factors, and will adjust its plans accordingly.

A number of implementation considerations and key success factors for the successful implementation of this strategy have been identified.

### 4.1 Implementation Considerations

The following implementation considerations will be addressed in the short term to ensure the effective delivery of this strategy:

**Organisation structure that is fit for purpose**

An organisational review of NDTP will be undertaken in the first year of the strategy to ensure the appropriate workforce, skill-mix and resources are in place to implement the strategic plan. This will include ensuring that professional development opportunities are in place.

**A shared vision across all stakeholders**

A shared vision is essential between all stakeholders in order to ensure that, at all times, the Irish health service is provided with the appropriate number of specialists, who possess the required skills and competencies to deliver high quality and safe care, and whose training is matched to the model of healthcare delivery in Ireland regardless of location.

**Internal and external communication of the strategy**

At an early stage in the implementation of the strategic plan, it will be important to ensure that the strategy is communicated effectively, both internally and externally. Internally, within the HSE, this communication will be important to achieve buy-in, while external communication of the strategy will be the first step towards a unified or shared vision for doctors' training and consultant post requirements in Ireland.

**Integration of NDTP's three core functions**

For NDTP to successfully implement its strategy each of its core functions must feed into the other two. For example, medical workforce planning should act as a guide to doctors' training and the number and type of consultant post application approvals.

### 4.2 Critical Success Factors

Successful implementation of this strategy will be contingent on building positive momentum in engagement with stakeholders, in addition to ensuring that the appropriate systems, resources and supports are developed and in place. Some of the critical success factors that need to be considered to support the successful implementation of NDTP's strategy are outlined below.

| | |
|---|---|
| 1. | **Putting the plan on a project management footing** |
| | There is a need to support the achievement of this strategy with the development of annual operational plans. This planning process will be grounded in a project management approach. The resulting plans will break down the outcomes at an operational level and will be reviewed and monitored regularly. |
| 2. | **Strong leadership** |
| | Securing buy-in from senior management and developing a strong leadership team with a clear mandate to oversee the delivery of the outcomes will be critical to the future success of NDTP. |
| 3. | **Appropriate structures and reporting mechanisms** |
| | In order to most effectively implement this strategy it is important that NDTP ensures its structures are fit for purpose and aligned within the HSE. |
| 4. | **Support from key external stakeholders** |
| | NDTP will seek opportunities to engage and work collaboratively with key external stakeholders to deliver on its mission and vision. |
| 5. | **Obtaining the necessary resources** |
| | Obtaining the necessary funding to achieve the strategic objectives of this plan, in the current economic environment, may provide a challenge for NDTP. Building a strong case for additional resources will be critical. |

# APPENDIX 1: PROCESS FOR THE DEVELOPMENT OF THE NDTP STRATEGY

The NDTP strategy development process was informed by government policy, HSE planning and strategy documentation, and environmental factors thought likely to have an impact over the life of this strategy.

A consultation exercise was conducted with a range of NDTP stakeholders so that their views could inform the strategy development process.

Representatives from the following stakeholders participated in the consultations:

- Clinical Director Programme, Quality Improvement Division, HSE
- College of Anaesthetists of Ireland
- College of Psychiatrists of Ireland
- Consultant Applications Advisory Committee
- Council of Deans of Irish Medical Schools
- Department of Health
- Forum of Irish Postgraduate Medical Training Bodies
- Health Service Executive – Acute Hospitals Division
- Health Service Executive – Human Resources Division
- Intern Network Coordinators
- Irish College of General Practitioners
- Irish Medical Organisation
- Lead NCHD Group
- Medical Manpower Manager Group
- Medical Council of Ireland
- National Clinical Programmes
- Trainee subcommittee – Forum of Irish Postgraduate Medical Training Bodies
- Royal College of Physicians of Ireland
- Royal College of Surgeons in Ireland

# NOTES:

National Doctors Training & Planning

National Doctors Training & Planning
Health Service Executive
Dr. Steevens' Hospital
Dublin 8
Ireland

Oiliúint agus Pleanáil Náisiúnta na nDochtúirí
Feidhmeannacht na Seirbhíse Sláinte
Ospidéal Dr. Steevens'
Baile Atha Cliath 8
Éire

t +353 1 635 2237
f +353 1 635 2898
e doctors@hse.ie
w www.hse.ie/doctors

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# Recruitment of NCHDs to non-training posts

## Guidance

*16th June 2016*

## Purpose of document

This document sets out guidance on and the standards to apply to the recruitment of Non-Consultant Hospital Doctors (NCHDs) to non-training or service posts in HSE and HSE-funded Hospitals and Mental Health services or agencies.

Queries may be made by email to andrew.condon@hse.ie

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## A. Performance indicators

The indicators below are to be used within each hospital / agency to assess compliance with the required standard regarding NCHD recruitment and will be used by the HSE at national level when evaluating hospital / agency performance. They represent a summary of the guidance in Section B of this document.

| Performance indicators | | |
|---|---|---|
| **Theme** | **Area** | **Performance indicator** |
| **The HSE's legal obligations** | Codes of Practice | Codes of Practice are available to NCHDs applying for posts |
| | Employer obligations | There is evidence that the Employer has regard to the Codes of Practice and relevant legislation when recruiting NCHDs |
| **The recruitment process** | Advertising and marketing of posts | All NCHD posts, including those filled via agencies, must be advertised |
| | What NCHDs can expect | NCHDs must receive a confidential and professional service as set out a Section 6 of this document |
| | Information to be issued to NCHDs applying for posts | NCHDs must be issued each of the documents listed at Section 7 |
| | Information to be sought from NCHDs before assessment | NCHDs must provide a CV, evidence of registration and at least two references before assessment |
| | Assessment | Each NCHD applying or referred by an agency must be formally assessed and that assessment documented |
| | Information to be sought from NCHDs following assessment | NCHDs must provide Certificates / qualifications, material for Garda Clearance and attend as required at Occupational Health / complete the relevant Occupational Health Form if they are to proceed to appointment |
| | Checklist of required documentation | The employer must be able to confirm they or the NER hold(s) the required documentation in respect of each NCHD |
| | Documentation required from agency NCHDs | The employer must maintain core documentation regarding agency NCHDs |
| **Ensuring a safe recruitment process** | Records of the recruitment process | The employer must maintain fully documented records which clearly support each stage of the process, including notes of interviews. |
| | Use of the Medical Practitioners System and National Employee Record (NER) Module | The employer must match all NCHDs to a post on the MPS database irrespective of duration of post and must use and be able to demonstrate that they have used the NER in respect of each eligible NCHD. |
| | Minimising risk | • The employer must resolve key issues before any NCHD starts work, including<br>• Registration<br>• Employment record<br>• Gaps in employment<br>• Confirmation from previous employers regarding investigations / sanctions |
| | Notification of need of risk assessment | The employer has notified the required parties regarding any NCHD whose details are not recorded on the NER and who requires risk assessment prior to further employment |

## B – The HSE's legal obligations regarding recruitment of NCHDs

### 1. Commission for Public Service Appointments

The Commission for Public Service Appointments (CPSA) is responsible for regulating recruitment and appointment processes in the HSE and HSE-funded agencies, including those relating to NCHDs in non-training or service posts.

The Commission was established by the Public Service Management (Recruitment and Appointments) Act 2004 and is bound by law to ensure that recruitment and selection is carried out by fair, open and merit-based means.

The key responsibilities of the Commission are:

- Setting standards for recruitment and selection and publishing these standards as Codes of Practice,
- Safeguarding these standards by monitoring and auditing appointment processes,
- Publishing procedures for persons to make a complaint about an appointment process,
- Examining complaints alleging breaches of the Code of Practice,
- Granting licences to public bodies to carry out recruitment,
- Maintaining order in the public service recruitment market

Further information regarding the CPSA is available at www.cpsa.ie

### 2. The Public Service Management (Recruitment and Appointments Act) 2004

Appointment processes to all positions within the remit of the Public Services Management (Recruitment and Appointment) Act 2004 – including NCHDs – are subject to Codes of Practice published by the CPSA.

The Codes set out the regulatory framework for appointment processes and centre on five recruitment principles:

- Probity,
- Appointments made on merit,
- An appointments process in line with best practice,
- A fair appointments process applied with consistency,
- Appointments made in an open, accountable and transparent manner.

These ensure that all appointments are made in an open, transparent and accountable manner. Through its audit function, the CPSA safeguards the standards established in the Codes of Practice and ensures compliance by the HSE with these standards.

### 3. Codes of Practice governing appointments to posts in HSE

Since 1st April 2005 recruitment to non-training or service NCHD posts in the HSE has been subject to the provisions of the Public Services Management (Recruitment and Appointment) Act 2004. Appointments must be made in accordance with the standards applying to the circumstances of the appointment. Three particular codes apply:

i. Code of Practice for Appointment to Positions in the Civil Service and Public Service – this sets out principles to be observed when appointing an NCHD in a non-training or service post;
ii. Code of Practice for Emergency Short-term Appointments to Positions in the Health Service Executive – this sets out the principles to be observed in recruitment and

selection procedures and recruitment practices where a HSE Hospital / Agency wishes to appoint a NCHD to a non-training / service post on an emergency short-term basis to meet critical needs e.g. an agency appointment;

iii. Code of Practice for Atypical Appointments to Positions in the Civil Service and Certain Public Bodies – this sets out the principles to apply where it is necessary to assign a NCHD in a non-training or service post to higher duties (acting up) on a temporary basis.

Each Code has particular requirements which inform the guidance and standards specified in this document. The Codes are available here: http://www.cpsa.ie/en/Codes-of-Practice/

## 4. Employer Obligations

When recruiting NCHDs to non-training or service posts, each employer is required to have regard to the following

- The relevant Code of Practice issued by the CPSA,
- The terms and conditions of the HSE's recruitment licence – issued to it by the CPSA,
- The need for maintain confidentiality during the recruitment process subject to the provisions of the Freedom of Information Acts 1997 and 2003 and any other provisions that have been clearly identified in the published documentation,
- Relevant legislation, including the Public Service Management (Recruitment and Appointments) Act 2004, Employment Equality Acts 1998 and 2004, Disability Act 2005, Official Languages Act 2003, Data Protection Acts 1988 and 2003 and Freedom of Information Acts 1997 and 2003.

These mirror the requirements applying to the appointment of other healthcare professionals by the HSE and have informed the guidance below.

## C – The recruitment process

### 5. Advertising and marketing of posts

All NCHD appointment processes should be supported by clear marketing / advertisement designed to target an appropriate field of suitable NCHDs. For example, hospitals / agencies will be aware of particular publications, media or websites which are relevant to NCHDs. In addition, NCHD posts can be advertised via the HSE website at http://hse.ie/eng/staff/Jobs or on the Public Appointments Service website at www.publicjobs.ie Advertisements may be for a specific post but encourage NCHDs in a range of specialties to apply at any time should they be interested. All applications for posts should be directed through a single process and NCHDs applying or interested in applying advised that all applications are treated in a standardised manner.

In this regard, where the hospital / agencies has received unsolicited Curriculum Vitaes or job applications it should not make any appointment till after the position has been advertised to a wider group of potential candidates. Similarly, where the hospital / agency has decided to source NCHDs from an agency, the agency must have taken steps to advertise the positions to be filled. In no circumstances should NCHDs referred by an agency be accepted for employment where the agency has not advertised opportunities.

### 6. What the NCHD applying for a post should expect

NCHDs applying for posts in HSE Hospitals / Agencies should receive a confidential service that is professional, courteous and considerate, friendly and helpful.

NCHDs should receive:

- Detailed information on vacancies and the recruitment and selection process,
- Timely acknowledgement and response to queries,
- Reasonable notice for all appointments,
- Clear, specific and meaningful feedback provided when requested by candidates,
- Provision of specific requirements for candidates with disabilities.

NCHDs should be informed that applications will be treated in strict confidence, subject to the provisions of the Freedom of Information Acts, 1997, the Data Protection Act 1988 & 2003, the Public Services Management (Recruitment & Appointments) Act 2004 and other provisions that have been identified in published documentation.

### 7. Information to be issued to NCHDs applying for posts

Each NCHD applying for a post should have access to:

- A job specification describing the key duties and functions of the post (e.g. standard duties);
- A copy of NCHD Contract 2010,
- Information on the conduct of the recruitment process, including:
  - the approach that will be adopted to determine the order of merit,
  - the criteria on which selection decisions will be made,
  - review procedures.
- Information on the specific criteria the NCHD must fulfil to be appointed, including the requirement that they:
  - have the knowledge and ability to discharge the duties of the post concerned,
  - are suitable on the grounds of character,
  - are suitable in all other relevant respects for appointment to the post concerned.

- The NCHD should be informed that if successful at interview, they will not be appointed to the post unless they:
    - are fully competent and available to undertake, and fully capable of undertaking, the duties attached to the position,
    - agree to undertake the duties attached to the post and accept the conditions under which the duties are, or may be required to be, performed, including the offer of NCHD Contract 2010.

## 8. Information to be sought from NCHDs applying for posts before assessment

Each NCHD applying for a post or, in the case of a medical recruitment agency, the agency, should submit at least the following before any consideration is given to the NCHD's assessment:

- Evidence of registration / application for registration with the Medical Council of Ireland,
- Residency (e.g. Garda National Immigration Bureau Card) / Work Permit status,
- Satisfactory Garda Vetting
- An up to date CV,
- An application form (if used by the hospital / agency),

and, noting issues associated the volume of applications

- at least two references, one of which must be from the most recent supervising Consultant / employer.

## 9. Assessment of NCHDs

Each NCHD applying for a post must be formally assessed and that assessment formally recorded.

In the case of NCHDs who are not currently employed by the relevant hospital / agency – including NCHDs who were employed previously and left to work elsewhere and NCHDs referred by recruitment agencies for periods of a week or more - assessment should be by interview.

Interview boards must have at least two members and include a Consultant in the relevant specialty. During the interview process, the NCHD should provide evidence of:

- evidence of identification
- their registration / application for registration with the Medical Council of Ireland,
- their work permit status.

Interviews should be conducted in person and in exceptional circumstances via SKYPE or similar video conferencing facilities.

At the final stage, NCHDs who meet the required standard for the post should be placed in order of merit subject to work permit status and other regulatory requirements and considered for appointment in that order.

In the case of NCHDs who are currently employed by the relevant hospital / agency, assessment should be by way of a review with the relevant Consultant / Clinical Director and a relevant manager. The appraisal form at Appendix I of this guidance could be used to inform any offer of further employment.

In no circumstances should NCHDs who have not been assessed take up employment or be presented to the public as a doctor appropriate to take clinical decisions.

Decisions taken throughout the assessment process should be based on the qualifications, attributes and skills necessary to undertake the duties and fulfil the responsibilities of the post to the required standard.

## 10. Assessment of NCHDs referred via agencies for short term posts

In the case of NCHD referred by medical recruitment agencies for short-term appointments of less than 1 week the requirement is that the hospital / agency obtain from the recruitment agency a formal, written assurance that the NCHD has the appropriate skills, experience and documentation to fulfil the duties required before the NCHD can commence work.

## 11. Information to be sought from NCHDs following assessment

Once the NCHD has been assessed and a decision taken to proceed, the NCHD should be matched to a post on the Medical Practitioners System, this will allow the relevant Medical HR department to view the NCHD's NER account. Medical HR must ensure satisfactory Garda Vetting and satisfactory Occupational Health clearance, including Exposure Prone Procedure (EPP) clearance (if required) is in place. If this is not available from the NER account then the Doctor will be required to complete these documents.

## 12. Documentation required to support NCHD appointment

Employers should use a checklist to track receipt of appropriate documentation and should place the checklist on the relevant NCHD's file. A typical checklist could include confirmation of receipt of the following:

- Application documentation,
- CV,
- Registration documentation,
- Work permit (if applicable),
- Evidence of Residency (e.g. Garda National Immigration Bureau Card) (if applicable),
- Qualifications / certificates,
- Interview result / Assessment result,
- References – at least two and one of which must be from the most recent supervising Consultant / Employer,
- Offer letter – signed and dated,
- NCHD Contract 2010 acceptance page – signed and dated,
- NER NCHD Hire Form,
- Satisfactory Garda Vetting,
- Evidence of maintenance of Medical Council Continuing Professional Development requirements,
- Staff Census Form (if appropriate) – signed and dated,
- Pre-employment Health Assessment Form / Occupational Health Form – signed and dated,
- Verification of Service form / Appraisal Form completed by previous employer(s),
- Valid IELTS Certificate to standard required by HSE,
- Evidence of compliance with Standard Precautions (including Hand Hygiene) training requirements,
- Evidence of compliance with Manual Handling training requirements,
- Advanced Cardiac Life Support / Advanced Paediatric Life Support Certification (if appropriate).

## 13. Documentation required for NCHDs provided by an agency

Where the NCHD is not directly employed by hospital / agency and is instead employed by a medical recruitment agency on behalf of the HSE, subject to the National Agency Agreement the following documentation must be sourced and reviewed before the NCHD commences work:

- CV,
- Registration documentation,
- Work permit (if applicable),
- Evidence of Residency (e.g. Garda National Immigration Bureau Card),
- Qualifications / certificates,
- Interview result / Assessment result,
- References – at least two at least one of which must be from the most recent supervising Consultant / employer who engaged the NCHD,
- Garda Vetting Clearance,
- Evidence of maintenance of Medical Council Continuing Professional Development requirements,
- Pre-employment Health Assessment Form / Occupational Health Form – signed and dated,
- Verification of Service form / Appraisal Form completed by previous employer(s),
- Valid IELTS Certificate to standard required by HSE,
- Evidence of compliance with Standard Precautions (including Hand Hygiene) training requirements,
- Evidence of compliance with Manual Handling training requirements,
- Advanced Cardiac Life Support / Advanced Paediatric Life Support Certification (if appropriate).

## D – Ensuring a safe recruitment process

### 14. Records of the recruitment process

Each hospital / agency must maintain fully documented records which clearly support each stage of the process, including notes of interviews in line with requirements regarding retention of personnel records.

Hospitals / agencies must ensure that any documentation relating to the assessment of NCHDs clearly relates to the selection criteria for the post.

Documentation and information on its use may be audited at any time by the CPSA.

### 15. Use of the Medical Practitioners System and the NCHD Employee Record (NER)

The use of the Medical Practitioners System and the NER module are mandatory requirements for all employers of NCHDs.

A National NCHD Database (Medical Practitioners System) was developed by the HSE and rolled out in July 2011. The primary function of the database at that time was to enable the registration, training and employment details of NCHDs and the training and employment details of NCHD posts to be collated and shared on a single national system. All NCHDs appointed to a post in the public health system (training, non-training, CPSP, Interns) must be matched to a post on the MPS system. This is the only way to accurately track all publically funded posts an NCHD has held in Ireland.

Since June 2015 HSE and HSE-funded hospitals / agencies and certain groups of NCHDs have had access to a new module - the National Employment Record (NER) which allows NCHDs and employers to upload and maintains NCHD employment documentation, personal details, training certificates and other documentation. Documentation includes but is not confined to:

- Hire Form,
- CV,
- Evidence of medical work experience outside Ireland,
- Garda Vetting documentation,
- Occupational Health Certification status,
- Exposure Prone Procedure Certification status,
- Work Permit,
- Scanned Passport,
- Birth Certificate,
- Garda National Immigration Bureau documentation,
- International English Language Testing System (ILETS) Certification,
- Basic Life Support / Advanced Cardiac Life Support / Advanced Paediatric Life Support Certification,
- Evidence of compliance with Standard Precautions (including Hand Hygiene) training requirements,
- Evidence of compliance with Manual Handling training requirements,
- Fire Training Certification,
- Radiation Protection Certification,
- Haemovigilance Training Certification.

In the course of 2016 NER has been extended to cover all NCHDs. In this context, NER will provide a means of assessing the qualifications and experience of NCHDs who have previously worked in the Irish public health system into the future.

Obligations of Medical HR

- Each employer must create a post on the Medical Practitioners System to reflect every funded NCHD post on their site,
- Each NCHD employment who holds the 2010 NCHD Contract should be matched to a post,
- Each employer is responsible for uploading Garda Vetting, Occupational Health and if required EPP and Work Permit for every NCHD employed,
- Each employer must view the ID uploaded by the NCHD to verify their identity and activate their portal account,
- Each employer must view and verify/reject all documents uploaded by their NCHDs,
- Ensure each NCHD employed on your site who holds the 2010 NCHD Contract opens an NER Account prior to the July 2016 changeover.

Obligations of NCHD

- Each NCHD who holds the 2010 NCHD contract is required to open a NER Portal account
- Every NCHDs should complete all sections of the NER National Hire Form (which replaces the HR101 for the recruitment of NCHDs)
- Each NCHD should upload the relevant training certificates (e.g. BLS/Standard Precautions (including Hand Hygiene)/Fire Training/Patient Handling etc.), and pre-employment documentation (e.g. passport, birth cert and if applicable GNIB)

## 16. Minimising the risk associated with appointment of NCHDs

Noting the above, there remains a risk to the delivery of safe, high quality patient care arising from the appointment of NCHDs who have not previously worked in the Irish public health system or who have gaps in their employment record.

Taking this into account, hospitals / agencies must, as a minimum, meet the documentary requirements set out at Sections 12 and 13 above and resolve the following issues before any NCHD commences employment:

- Date of registration with the Medical Council of Ireland,
- Written evidence of all previous employment settings within the past ___ years, including public sector, private sector, agency and work as an agency doctor (independent contractor),
- Coherent explanations at interview (and to be documented as part of the interview) for gaps in employment in excess of 1 week,
- Confirmation by way of references, forms completed by previous employers and declaration / contract form completed by the NCHD that (s)he has not been subject to investigation or sanction of any kind relating to performance as a doctor.

## 17. Notification of need for risk assessment for NCHDs not recorded on NER

Where HSE hospitals / agencies identify that an individual NCHD whose details are not recorded on the NER requires risk assessment prior to further employment or during the course of employment they should notify relevant staff nationally to ensure that the HSE adopts a coherent approach to the employment of and services to be requested from the NCHD.

Emails should be sent to andrew.condon@hse.ie and copied to the relevant Head of Human Resources for the relevant Hospital Group or Community Health Organisation. They should be headed 'Confidential: NCHD risk assessment required'

The risk assessment should be guided by the appraisal process detailed at Appendix I.

The body of the email should record the NCHD's name and Medical Council Registration number, location of interview (if relevant), employment location (if relevant), specialty, sub-specialty and grade (if known) and provide contact details for the notifying HSE hospital / agency.

* * *

# Appendix I – Appraisal Guidelines

Please note that these appraisal guidelines are those used by the Royal College of Physicians of Ireland and are reproduced here to assist with the process of risk assessment

| Section One - General Information | |
|---|---|
| Name of candidate: | Medical Council Number: |
| This person worked under my supervision from: | To: |
| Clinical Site: | Country: |
| Specialty: | Grade (e.g. Intern, SHO): |
| Are you in anyway related to the applicant? Yes ____ No ____ | |
| Relationship: | |

Please complete the following sections based on the following marking system:
1 = poor 2 = inadequate 3 = satisfactory 4 = above average 5 = excellent

It is expected that most candidates will score "3". Only exceptional candidates should score "4" or "5".

| Section Two - Professional Attitude | Please tick one number per line | | | | |
|---|---|---|---|---|---|
| Professionalism | 1 | 2 | 3 | 4 | 5 |
| Diagnostic skills | 1 | 2 | 3 | 4 | 5 |
| Diligence in record taking | 1 | 2 | 3 | 4 | 5 |
| Emergency management | 1 | 2 | 3 | 4 | 5 |
| Clinical judgement | 1 | 2 | 3 | 4 | 5 |
| Punctuality | 1 | 2 | 3 | 4 | 5 |
| Relationship with other medical colleagues | 1 | 2 | 3 | 4 | 5 |
| Relationship with nursing, paramedical & allied health staff | 1 | 2 | 3 | 4 | 5 |
| Relationship with patients and relatives | 1 | 2 | 3 | 4 | 5 |

| Section Three - Personal Attributes | Please tick one number per line | | | | |
|---|---|---|---|---|---|
| Time management | 1 | 2 | 3 | 4 | 5 |
| Management of stress & workload | 1 | 2 | 3 | 4 | 5 |
| Commitment & motivation | 1 | 2 | 3 | 4 | 5 |
| Communication skills | 1 | 2 | 3 | 4 | 5 |
| Disposition & appearance | 1 | 2 | 3 | 4 | 5 |
| Reliability | 1 | 2 | 3 | 4 | 5 |
| Teamwork | 1 | 2 | 3 | 4 | 5 |
| Attendance & performance at conferences | 1 | 2 | 3 | 4 | 5 |

| Section Four - Additional Questions | |
|---|---|
| Did this doctor perform well in this post? | ☐ Very well ☐ Acceptable ☐ Not Acceptable |
| Would you be happy to work again with this doctor? | ☐ Yes ☐ No |
| To your knowledge has this candidate ever been the subject of a complaints process/ investigation relating to a patient incident? If yes, please provide more details under the comment section. | ☐ Yes ☐ No |
| Do you think this doctor is suitable for a career in [specialty] _____? | ☐ Yes ☐ Unsure ☐ No |
| Has this doctor any outstanding characteristics? | |
| If you have any further comments/concerns regarding the candidate that have not been covered above, please use the space below or attach further correspondence. | |

Your Full Name _____

Job Title _____

Telephone Number _____

Signed _____ Date _____

This form will not be accepted without a Hospital Stamp

- In determining how to score a candidate i.e. 1 – 5, the following directions should be used for guidance purposes:
  - A rating of "1" indicates the candidate is below average when compared to other doctors at this level and there are significant weak areas or uneven aspects to performance for this job level.
  - A rating of "3" indicates the candidate is average when compared to other doctors at this level and achieves a sufficiently high standard for this job level.
  - A rating of "5" indicates the candidate is above average when compared to other doctors at this level and displays distinctive strengths for this job level.
- The following guidelines should be used be used when assessing the candidate's performance in each category.

| PROFESSIONAL ATTITUDE | Poor / Inadequate (1/2) | Satisfactory (3) | Above Average / Excellent (4/5) |
|---|---|---|---|
| **Professionalism** | Displays poor levels of commitment, integrity, professional reflection, accountability and honesty. | Sound levels of communication, clinical reasoning, integrity, accountability and honestly. Demonstrates ability to engage in professional reflection and awareness of ethical issues. | Displays exceptional levels of altruism, accountability, awareness of ethical issues, professional reflection, integrity and honesty in daily practice for the benefit of the patient. |
| **Diagnostic Skills** | Fails to interpret and synthesise symptoms, signs and investigations | Competent clinician. Good knowledge with an orderly logical approach to differential diagnosis. | Outstanding diagnostician. Excellent clinical memory. |
| **Diligence in record keeping** | Incomplete, inaccurate, poorly recorded. | Usually complete, orderly and systematic | Precise, perceptive, 'can spot the rarity' |
| **Emergency Management** | Falls apart at times of crises. Unable to deal satisfactorily with emergencies. | Remains calm and organised at time of crises. | Handles crises situations very well. Calm demeanour. Inspires other team members. |
| **Clinical Judgement** | Deficient assessments of patient status. Does not recognise own limitations. Does not call for help. | Sound patient assessments. Recognises the sick patient. | Outstanding clinician who is aware of his / her limits. Always knows when to call for help. |
| **Punctuality** | Consistently late in completing required tasks or duties. | Competent in completing a task/obligation at a previously designated time. | Consistently excellent ability to complete a required task or fulfil an obligation before or at a previously designated time. |
| **Relationship with medical colleagues** | Fails to get on with seniors, contemporaries or juniors. May even undermine them. Refuses to help them out | Good rapport with colleagues. Usually willing to help in a crisis. Trusted, easy to work with. | Always willing to help even if personally inconvenient. Able to diffuse problems in the team. Would be regarded as "an excellent colleague". |
| **Relationship with nursing, paramedical & allied health staff** | Treats them with disdain. Generates as opposed to solving problems. Rude | Sound and professional yet approachable. Treats others with respect and is respected in return | Inspires enthusiasm. Exceptional communication skills. |
| **Relationship with patients and relatives** | Increases patient's and relatives anxieties. Rude. Patients do not want him / her as their doctor. Bad listener & communicator | Sound caring attitude. Can allay fears of patients and relatives. Takes time. Listens well. Explains well. Trusted by the patients and relatives. | Inspires confidence. Establishes excellent rapport. Excellent communicator. Patients delighted to be looked after by him / her |

| PERSONAL ATTRIBUTES | Poor / Inadequate (1/2) | Satisfactory (3) | Above Average / Excellent (4/5) |
|---|---|---|---|
| **Time management** | Poor ability to manage time, set goals or identify priorities. | Manages time well – demonstrates consistent ability to plan and allocate their time and identify and manage priorities. | Outstanding at planning and allocating time, scheduling activities and prioritising and setting goals. |
| **Management of stress & workload** | Constantly disorganised. Does not identify priorities. Always behind in workload. | Manages priorities well in face of excessive workloads. | Very good handling of stress and workload. Prioritises appropriately. Delegates or seeks help when necessary. |
| **Commitment & motivation** | No inclination to organise work. Needs to be 'pushed' constantly | Able to organise working routine without supervision. Looks for opportunities to learn. | Constantly pro-active, always prepared to accept additional opportunities to advance. |
| **Communication skills** | Does not communicate satisfactorily with patients, relatives or other team members. | Good communicator. | Pays great attention to importance of good communications skills. Regularly seeks feedback that his / her message has been understood. |
| **Disposition & appearance** | Sloppy in appearance and work manner. Does not inspire confidence in others. | Good overall attitude. Presents himself / herself well. | Highly motivated individual with excellent attitude. Inspires confidence in colleagues and patients, and consistently presents himself/herself very well. |
| **Reliability** | Unreliable, scatterbrained. Forgets to do things to the possible detriment of patients | Dependable. Does not need reminding. Conscientious in patient care | Highly conscientious. Anticipates problems. |
| **Teamwork** | Poor team player. Works alone. Does not contribute to team performance. | Good team player. Understands importance of teamwork. | Good understanding of team roles of his / her role on team. Works harmoniously with all other team members. |
| **Attendance & performance at conferences** | No interest in giving papers or making presentations within the hospital or at clinical meetings. | Keen to give presentations which are well illustrated and well delivered. | Fully researched original ideas. Enthusiastic presenter. Answers questions lucidly. |

## Appendix II – Interview Guidelines for NCHD posts

**Please note that these interview guidelines reproduce those developed by the South South West Hospital Group and represent minimum requirements for the interview of NCHDs**

The Employment Equality Acts 1998 and 2004

**The employment equality Acts 1998 and 2004 outlaws discrimination in employment, vocational training, advertising, collective agreements, the provision of goods and services and other opportunities to which the public generally have access on nine grounds. These are:**

- **Gender**
- **Marital Status –not permitted under Act to ask a candidate for example "are you married/single/divorced etc"**
- **Family Status - not permitted under Act to ask a candidate for example "do you have any children"**
- **Age – not permitted under Act to ask a candidate" what age are you"**
- **Disability**
- **Race**
- **Sexual orientation**
- **Religions belief**
- **Membership of the Traveller Community**

**Format and Timing of the Interview**

| Skill Area | Time (minutes) |
|---|---|
| Introduction | 2 |
| Motivation for understanding and applying for the post | 10 |
| Clinical, Medical and Diagnostic Skills (inc Caseload /Work Management) | 10 |
| Communication, Interpersonal & Team Skills | Observable from interview |
| Wrap Up & Close | 3 |
| **Total** | **25** |

Mobile phones to be turned off or put in silent mode during interviews

**Introduction of Candidate to Board Members:**

Medical Manpower/HR Rep commence the interview by introducing board members to the candidate and provides the candidate with an over view of the format of the interview. The emphasis is to put the candidate at ease.

The candidate will be informed of the importance of putting forward his / her own personal contribution at all stages and informed of the opportunity to add information at the end of the interview.

The candidate will be informed that they may ask for clarity on questions posed at any point during the interview

### Questions to ask on Motivation and applying for role

*This part of the interview is dedicated to ascertaining the candidate's genuine motivation for the post. It is time to question the candidate on his / her perceived strengths and weaknesses and how he / she feel that this opportunity will benefit him / her in terms of career aspirations.*

- Tell me about your career history and highlights to date?
- Tell me about your professional development achievements that you are particularly proud of?
- Why are you applying for the role here in this hospital?
- What aspects of your previous experience do you think will be most helpful to you in this role?
- What influenced your decision to pursue a career in Medicine / Surgery (relevant specialty)?
- What are your long term career aspirations?
- What do you fee would be the most challenging aspect of the role for them?
- What do you aim to learn from the role?
- What do you consider to be your biggest strengths?
- What do you consider to be your biggest weakness / areas for development?

### Questions to ask on Clinical, Medical and Diagnostic Skills (including Caseload / Work Management)

*The key objective is to gain as rounded a picture of the candidate as possible by seeking evidence from his / her past experience / knowledge that will demonstrate his/her ability to meet the challenges of this NCHD role. In questioning, you may also wish to determine the candidates ability to plan and organise their workload and caseload:*

| | |
|---|---|
| **Clinical / Medical/Diagnostic Situation or Event** | Pose Clinical Scenario(s) to the candidate and ask them how they would manage same **or**<br>Ask the candidate to describe a specific clinical / medical/diagnostic event or situation that they were involved in. (The candidate must describe a specific event), not a generalised description of what they have done in the past. |
| **Action taken** | Ask the candidate to describe the action s/he took – keep focus on candidates own contribution – what candidate did<br>What happened? Who was involved?<br>What assessments did you make? What interventions? What evaluations?<br>Describe the rationale behind the decisions taken?<br>How did you plan / organise your caseload / meet objectives within an appropriate timescale?<br>What aspects did you face in dealing with the situation. |
| **Result achieved** | What was the outcome? What did you accomplish? What did you learn? |

- Give me a specific example of a situation when you had to deal with a particularly challenging case?
- Give me a specific example of a situation when you had difficulty in managing a patient?
- Give me a specific example of an experience you had in dealing with a difficult colleague?

**Note taking & Summary Comments:**

Notes need to be taken during the interview, capturing a key word from the questions asked by the Board Member(s) and as much of what the candidate says as possible.

These notes are an objective record of the interview and may be used as evidence and justification for any decisions made, should the decision of the board be open to appeal.

Board members are also required to provide a summary comment for each candidate at the end of the evaluation. This comment will be provided as feedback to candidates and is particularly important in situations where the individual has been unsuccessful at interview.

# Towards Successful Consultant Recruitment, Appointment and Retention

# *Recommendations of a Committee appointed by the HSE regarding reform of the processes for creation, approval recruitment and appointment to Consultant posts*

***December 2016***

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## Glossary

The following acronyms and terms are used in this report:

CAAC – Consultant Applications Advisory Committee
CAU – Consultant Appointments Unit
CHO – Community Healthcare Organisation
CPSA – Commission for Public Service Appointments
DoH – Department of Health
DEPR – Department of Public Expenditure and Reform
Hanly Report – Report of the National Taskforce on Medical Staffing (DoH, 2003)
HSE – Health Service Executive
HR – Human Resources
Imrie Report - 'Training 21st Century Clinical Leaders, A review of the Royal College of Physicians of Ireland training programmes' RCPI 2015
MacCraith Reports - Reports of the Strategic Review of Medical Training and Career Structures (DoH 2013-14)
NDTP – National Doctors Training & Planning
NCHD – Non-Consultant Hospital Doctor
NRS – National Recruitment Service
PAS – Public Appointments Service
RCSI – Royal College of Surgeons in Ireland
RCPI – Royal College of Physicians of Ireland

## Executive Summary

### i) Purpose of report

This report analyses the current operational and administrative barriers to efficient creation, and approval of and recruitment to Consultant posts. It examines the factors influencing applications for such posts and related workforce and service planning, delays in the application and approval process, the implementation of the Health Service Executive's regulatory functions, the interaction between the range of agencies involved in Consultant recruitment and how successful candidates are supported in the early stages of appointment. The report proposes actions to address each of these issues.

The report reflects the considered view of a range of stakeholders, including health service employers, senior Consultants and Clinical Leads in a range of specialties, Hospital Groups, HSE Human Resources, National Doctors Training & Planning, Forum of Postgraduate Medical Training Bodies, the HSE National Recruitment Service, Acute Hospitals Division, Mental Health Division, the Public Appointments Service and Department of Health.

Notwithstanding the Terms of Reference set out by the Director-General (see below) the Committee felt that it was important to point out at the outset that simply correcting and providing rigour to the recruitment and appointment process was not of itself enough to address the present Consultant recruitment crisis but that other factors also needed to be addressed. These include shortfalls in Consultant numbers and the availability of Consultants, working conditions and, most particularly, concerns regarding remuneration.

### ii) A health system facing unprecedented challenges and difficulties recruiting Consultants

The report concludes that the HSE is facing unprecedented challenges meeting increasing demands while delivering significant efficiency savings and managing changing health delivery systems - all within a new Hospital Group and CHO configuration. In this context, Consultants, working as part of coordinated Consultant and multi-disciplinary teams are fundamental to the delivery of safe, high quality medical care.

This requires that Consultants and managers work together collaboratively and innovatively. Consultant planning and appointment is an important mechanism for organising resources effectively to support patient care and ensure healthcare delivery organisations, Consultants and patients benefit.

National policy remains the development of a Consultant-provided service as per the Report of the National Task Force on Medical Staffing (Hanly Report) and the Reports of the Strategic Review of Medical Training and Career Structures (MacCraith Reports 2013-14).

A significant driver of Consultant vacancies is a Consultant recruitment and retention crisis. PAS, for example, has confirmed that of the 149 Consultant posts it advertised in 2015, 20 (13%) received no applicants. A further 28 (19%) had only one applicant. No information was available on the standard of applicants.

A range of factors contribute to this situation, many of them unrelated to the work of the Committee. Nevertheless, relevant contributing factors included:

- that the health service had not linked the creation of additional Consultant posts to the availability of potential candidates – many of whom were doctors in publicly-funded training or who had recently completed training.
- potential candidates for Consultant posts could not easily access information on forthcoming opportunities.
- employers took lengthy periods to progress applications for approval of replacement posts.
- inadequate job planning and allocation of resources.
- once posts were approved there were further delays before posts were advertised.
- such delays often required appointment of non-permanent Consultants to meet service needs pending the permanent appointment.
- lack of clarity regarding opportunities for flexible working.
- once posts were offered candidates often delayed taking up appointment.
- when starting, new Consultants experienced inconsistent induction processes and were often faced with limited resources and a struggle to access same.
- poorly utilised probation and appraisal processes.
- remuneration – while base salary and on-call payments have increased with effect from 1st September 2014 the difference between new and older salary scales at final point of the scale is a source of concern to candidates as well as a potential source of intra-departmental disharmony and a disruptive influence on the need for good team-working.

Research by the RCSI Doctor Migration Project provides useful context for the above. As part of its work, the Project has researched the outward migration or emigration of doctors from the Irish health system. Although Ireland now trains sufficient doctors to meet the needs of the Irish health system, increasing numbers are emigrating. High levels of doctor migration (inward and outward) distort the composition and skills mix of the health workforce and undermines attempts to match supply to need. These research findings are being used to support the work of HSE HR, NDTP and the Medical Council in developing feasible strategies to retain and attract back doctors.

Key findings from the RCSI research to date include that respondents stated that their emigration from Ireland had been driven by professional rather than personal reasons. Of the top five reasons for emigration given by respondents, all but one related to the workplace (in order of preference: working conditions, training, career progression, financial reasons, personal reasons). Doctors stated that the working conditions experienced in Ireland left them with *'no option but to leave'* and gave concrete examples of the working conditions they had experienced in the Irish health system, particularly in relation to long working hours.

Respondents stated that health employers' did not respect the health professionals in their employ, that poor working conditions were evidence of that disrespect and that significantly improved working conditions in the Irish health system would be necessary prior to their return.

Although the reforms identified by respondents are wide-reaching, the underlying goal, as articulated by respondents, was for a safe practice environment in which health professionals could perform to the best of their abilities and *'to feel pride at the end of a shift well done instead of dismay at feeling that slap-dash substandard care has been provided'*.

These findings are echoed in the Imrie Report ('Training 21st Century Clinical Leaders, A review of the Royal College of Physicians of Ireland training programmes' RCPI 2015), which noted that remaining in Ireland has become less attractive for doctors, specifically those undertaking postgraduate specialist training. Leading factors in the increased difficulties in the recruitment and retention of senior trainees include a 30% reduction in salary for new Consultants during Ireland's

financial crisis and an increased pressure on clinicians in all disciplines to maintain a high level of service with reducing resources.

**iii) Flaws of governance and administration**

The Committee noted that there is scope for significant improvement in governance and administration prior to and during the application and approval process for Consultant posts and subsequently in the recruitment and appointment process. Changes were required to ensure the health service could rapidly and efficiently create and fill Consultant posts.

The Committee identified a number of stages within which these process improvements could be categorised and addressed. These are described below:

- governance and administration
- prior to submission of applications for permanent posts
- during the application process
- during the recruitment process
- during the appointment process
- relating to the review and continuing support processes

Separately, a key concern for many potential candidates for Consultant posts in recent years has been salary. Starting salary, progression through points on the salary scale and how new appointees compare to colleagues appointed in earlier years are all reported as influencing decisions by potential candidates to apply or to accept an offer of a post.

**iv) Findings and actions for implementation**

The Committee identified a number of recent developments which have or have the potential to facilitate successful Consultant recruitment and retention prior to setting out 33 findings and related actions for implementation. These include:

- the creation and publication of a 'Proposed / Approved Consultant Appointment' document as part of a single pack of documentation which informs each stage of post application, approval and recruitment,
- the introduction of significantly shorter timescales for key aspects of the process,
- revised advertisement and interview arrangements,
- enhanced engagement and communication with potential candidates at an early career stage and throughout the process, recognising that appointments will always be made on merit following an open and transparent selection process,
- measures to accelerate the candidate clearance process, contract offer and identification of start dates,
- use of proleptic appointments (taking account of the CPSA Codes of Practice) and standardised approaches to induction and probation,
- use of Job Plans, provision of appropriate resources and ongoing appraisal and feedback,
- creation of a single point of information covering each stage of the process for candidates and health service employers,
- integration of the Committee's actions for implementation into the HSE's national performance and accountability processes.

Set out below is a summary of the position prior to and following the implementation of the actions as set out above.

| Application, Approval and Recruitment process before implementation | Application, Approval and Recruitment process after implementation |
| --- | --- |
| Disconnect between posts approved and training programmes, limited engagement with trainees / potential candidates on opportunities | Greater links between posts approved, workforce planning and training programmes, engagement with candidates and use of proleptic appointments |
| Hospitals / agencies submit applications to CAAC, once application approved, HSE hospitals / agencies submit further documentation to NRS | All documentation is now part of a single pack, submitted at the start of the process - reducing timescale |
| CAAC and NRS documentation is lengthy, complex and not available to candidates | Documentation has been significantly revised, shortened and the Letter of Approval and Approved Consultant Appointment document are made available to candidates |
| Documentation often omitted strategic plan, job description or resources necessary to perform duties of post | Documentation includes strategic plan for service, job description and work practice plan and identifies resources needed to perform duties |
| No set timescale for advertising posts | PAS / HSE-funded hospitals and agencies should advertise within 2 weeks of approval |
| PAS may wait weeks before receiving details of Interview Boards | Interview Board nominees required before advertisement |
| Inconsistent or absent induction, probation, appraisal processes | Standardised and formal induction, probation, appraisal processes in place |
| Limited, out of date guidance on process for approval of and recruitment to Consultant post | Comprehensive guidance on each aspect of the process available to employers, applicants and appointees |

## 1. Introduction

In December 2015 the Director General of the Health Service Executive (HSE) requested Prof. Frank Keane, National Clinical Lead Surgery, to lead a process to address a range of issues associated with the creation and approval of Consultant posts and successful recruitment to such posts.

This document comprises Prof. Keane's report to the Director General via the National Director Human Resources. Once approved by the Director General, this report becomes formal HSE policy. Attached to this report at Appendix V is guidance which it is proposed to issue to health service employers and other relevant parties regarding the creation and approval of Consultant posts and recruitment to Consultant posts.

## 2. Terms of reference and membership

The Director General emphasised that successful Consultant recruitment and retention was key to the delivery and development of services and reduction of agency costs. Noting that the Labour Relations Commission proposals of 7th January 2015 relating to a new Career and Pay Structure for Consultants were being implemented and that there was limited potential for further movement on Consultant salaries, he identified the need to address the operational and administrative barriers to successful Consultant recruitment and retention by addressing the following:

- Ensuring applications for Consultant posts are comprehensive, compliant with relevant national policies and submitted in a timely manner (particularly for replacement posts);
- Processing of applications for Consultant posts by HSE National Doctors Training & Planning;
- Delays in progressing Consultant posts to advertisement once approved;
- The need to explore the possibility of developing a framework for assessing candidate availability for Consultant posts;
- Developing a protocol setting out the required supports to be available to newly-appointed Consultants;
- An assessment of existing, advertised vacant Consultant posts with a particular focus on mechanisms to access and attract graduates of Irish training schemes and standard-setting for the Consultant post application process.

The Director General indicated that Prof. Keane would undertake his work supported by an executive group drawn from a larger committee which would include:

- National Director Human Resources (HR)
- Medical Workforce Lead
- Director of National Doctors Training & Planning (NDTP)
- Acute Hospital Division representative
- Mental Health Division representative
- HSE National Recruitment Service (NRS) representative
- National Clinical Advisor & Group Lead Acute Hospitals Division
- National Clinical Advisor & Group Lead Mental Health Division

- Medical Manpower Manager with significant national experience
- Clinical Leads Paediatrics, Emergency Medicine, Medicine, Surgery, Older persons.

The Director General further requested that a report be prepared for him via the National Director HR within a short period regarding the measures identified for action in the Acute Hospital and Mental Health settings and the extent to which they have implemented.

Taking the above into account a Committee was formed comprising the following:

- Prof. Frank Keane, Clinical Lead Surgery and Chair,
- Rosarii Mannion, National Director HSE HR
- Andrew Condon, Medical Workforce Lead, HSE HR
- Prof. Eilis McGovern, Director of NDTP
- Yvette Keating, HR Manager, Staff Health & Wellbeing, HSE HR
- Mary Doran, National Recruitment Manager, HSE NRS
- Margaret McCabe, Head of Recruitment and Selection, Public Appointments Service (PAS)
- Lara Hynes, Principal Officer, National Human Resources, Department of Health (DoH)
- Prof. Garry Courtney, Clinical Lead Medicine,
- Prof. John Crowe, Chair, Forum of Postgraduate Medical Training Bodies
- Adrienne Doherty, Workforce Planner, HSE Mental Health Division
- Angela Fitzgerald, Deputy National Director, HSE Acute Hospitals Division
- Dr Colm Henry, National Clinical Advisor & Group Lead Acute Hospitals
- Barry Holmes, Director of Human Resources, Royal College of Surgeons in Ireland (RCSI)
- James Keane, General Manager, Portiuncula Hospital Ballinasloe
- Dr Siobhan Kennelly, Clinical Lead Older Persons
- Dr Gerard McCarthy, Clinical Lead Emergency Medicine,
- Catriona McConnellogue, Communications Lead, HSE HR
- Dr John Murphy, Clinical Lead Neonatology,
- Mr Kevin O'Malley, Group Clinical Director, Ireland East Hospital Group
- Yvonne O'Neill, Assistant National Director, HSE Mental Health Division
- Prof. Alf Nicholson, Clinical Lead Paediatrics,
- Dr Margo Wrigley, National Clinical Advisor & Group Lead Mental Health

and an Executive Group established, including:

- Prof. Frank Keane, Clinical Lead Surgery and Chair,
- Rosarii Mannion, National Director HR
- Andrew Condon, Medical Workforce Lead, HSE HR
- Dr Colm Henry, National Clinical Advisor & Group Lead Acute Hospitals
- Barry Holmes, Director of Human Resources, RCSI
- Yvette Keating, HR Manager, Office of National Director of HR
- Catriona McConnellogue, Communications Lead, HSE HR
- Prof. Eilis McGovern, Director of National Doctors Training & Planning
- Mr Kevin O'Malley, Group Clinical Director, Ireland East Hospital Group
- Dr Margo Wrigley, National Clinical Advisor & Group Lead Mental Health

The Committee met on 26th January, 23rd February, 5th April, 23rd May and 13th June 2016. The Executive Group on 19th January, 16th February and 22nd March 2016.

Andrew Condon and Yvette Keating of HSE HR provided a secretariat and drafting resource to the Committee.

## 3. Background to the establishment of the Committee

### i) The current Consultant workforce

As of end May 2016 there are 2,933 approved permanent Consultant posts. An increase of 197 since January 2015 and of 986 since January 2005.

Data provided to the Committee indicates that approximately 200 of these permanent Consultant posts are vacant. There are approximately 300 non-permanent Consultant posts, most of which appear to be associated with vacant permanent posts. This means that service is maintained – to a certain degree – in the absence of a permanent appointee.

Each year approximately 55% of the Consultant posts approved by the HSE are additional, while 45% are replacement. In this context, in the decade since it assumed the functions of Comhairle na nOspidéal, the HSE has processed applications for and approved 1,415 posts, each of which represents a recruitment opportunity.

Based on the data above, at the current time the number of vacant Consultant posts is gradually reducing, albeit at a very slow rate. While this emphasises the challenge associated with filling particular Consultant posts, it illustrates the extent of growth in Consultant posts - for every vacant post which is being recruited/advertised and filled, another new post is being approved.

### ii) Barriers to successful Consultant recruitment and retention

As noted above, the Director General identified the need to address operational and administrative barriers to successful Consultant recruitment and retention.

This followed an evaluation of the processing, approval and recruitment of Consultant posts undertaken by HSE HR in conjunction with the HSE NRS and the PAS following agreement on a new pay and career structure for Consultant posts in January 2015.

This evaluation identified a range of issues associated with Consultant vacancies, including:

- the extent to which Consultant posts – both new and replacement – are progressed without reference to potential candidate availability. At the current time, there is no relationship between the post being approved and whether there are sufficient candidates available in Ireland or abroad (e.g. number of trainees in Irish training schemes in that specialty / sub-specialty over recent years);
- the large number of Consultant Applications Advisory Committee (CAAC) approved posts for which NRS are awaiting Job Descriptions from the relevant acute hospital or mental health service before they can progress the post to the PAS. The effect of this is to maintain a vacancy with no permanent recruitment process initiated;
- that Hospitals and Mental Health Services often wait till a Consultant has retired before initiating the application to secure a replacement / reconfigured post. This has the effect of creating vacancies even where the impending potential vacancy was known years in advance.
- that Consultant vacancies are not uniform in terms of specialty or location. In this context, particular specialties including Psychiatry, Surgery, Emergency Medicine and Paediatrics are experiencing challenges irrespective of location while sites such as Waterford, Letterkenny, Naas and Portiuncula struggle to recruit Consultants in any specialty.

The review noted that further factors influencing Consultant decisions to apply for or accept an offer of a post are:

- remuneration – while base salary and on-call payments have increased with effect from 1st September 2014 there remains a concern expressed by medical representative organisations and others that remuneration is not high enough, that Consultant Contract salary rates agreed in 2008 have not been paid and that specialist remuneration has not kept pace with other countries (e.g. United States, Australia) since 2008 - further reducing Ireland's competitiveness. The difference between new and older salary scales at final point of the scale is another source of concern to candidates as well as a potential source of intra-departmental disharmony and a disruptive influence on the need for good team-working.
- the perception held previously by staff in a number of hospitals / agencies that Consultant remuneration can be determined locally or be determined by the HSE itself rather than in line with Department of Health sanctioned salary rates has resulted in a number of successful candidates for Consultant posts holding a decision to accept an offer pending 'negotiation' with their prospective manager to secure rates of pay that are either not sanctioned or breach public pay policy requirements;
- lack of clarity with regard to access to facilities / resources – in a number of cases Consultants have commenced post in the absence of / with severely limited access to key resources or facilities to deliver services. Additionally, Consultants have commenced without administrative support, access to office space or appropriate clinical supports;
- what appears, in some cases, to be local "last in gets least resources" effect and an absence of collective responsibility within disciplines / specialties and hospitals to plan for and embrace new arrivals and share, in a balanced way, facilities and responsibilities;
- poor or variable 'welcoming' processes including induction and appraisal.

The review concluded that – in light of the above - vacancy figures for various specialties and locations often did not relate to the availability of qualified candidates but instead to poor processes, unnecessary delays and the lack of clarity as to the procedures needed for the creation, approval and filling of posts.

## 4. Methodology

As noted, the Committee met on five occasions, the Executive Group on three occasions. The Committee considered a range of background documentation and received presentations from key stakeholders describing particular aspects of existing processes and plans for reform. The Committee also discussed the approach adopted to particular issues and identified areas where change was required.

The Executive Group identified key issues for examination and discussion by the wider Committee, facilitated detailed analysis of particular areas and undertook preliminary review of documentation and proposals before consideration by the wider Committee.

Separately, Prof. Keane and the Secretariat engaged with key stakeholders, including NDTP, NRS and PAS to progress issues identified by the Committee / Executive Group and ensure there was agreement on the approach proposed.

The Committee decided that in order to meet its terms of reference, it would be necessary to:

- identify or develop a solution(s) to each "issue" and assign same to the appropriate agency for implementation,
- address specific Acute Hospital and Mental Health issues which influenced the efficient processing of applications,
- draft revised guidance to replace the 2009 "Procedures for the Regulation of Consultant Applications, Recruitment and Appointments" setting out the required standard of performance on each issue,
- facilitate the development of a new Consultant Appointment / Job Plan Template,
- engage following initial drafting with stakeholders not directly represented on the Committee, including Clinical Directors, the Irish Medical Organisation, Irish Hospital Consultants Association and the Forum of Postgraduate Medical Training Bodies.
- Structure actions for implementation as a report to the Director General of the HSE to be adopted as policy.

It was agreed that issues relating to variation in rates of Consultant remuneration and Consultant role substitution were not within the terms of reference and would not be addressed.

## 5. Process for creation and filling of a Consultant post

Prior to examination of the specific issues the Committee reviewed the current processes for creation and filling of Consultant posts. The key stages in the creation of a Consultant post are:

i) planning / identification of an existing or new service need for a Consultant post,
ii) funding and progression of applications,
iii) the approval process for posts in line with the HSE's regulatory functions and contractual obligations,
iv) recruitment.

These stages and the processes associated with same are described below.

### i) Planning / identification of existing or new service need for a Consultant post

The decision that a Consultant post is required in a particular specialty, sub-specialty or location may be taken in response to either national plans for the development of services or specialties, plans initiated at Hospital Group or Community Health Organisation (CHO) level or arising from identification of a need within a particular hospital or agency.

Between 1971 and 2005 Comhairle na nOspidéal (see section 5 iii) a) below) published detailed plans for the development of Consultant services in a range of specialties as part of a statutory function to advise the Minister for Health on the organisation of hospital services. Comhairle's regulatory role regarding the approval of Consultant posts ensured that applications for posts were assessed against this planning framework.

Since 2005, Consultant posts are progressed with regard to:

- the HSE Service Plan approved by the Minister for Health,
- the Group, hospital or Mental Health Service specific plans,
- the views of HSE Clinical Strategy and Programmes Division.

Three additional planning frameworks inform the overall development of Consultant services – the Report of the National Task Force on Medical Staffing (Hanly Report) published by the Department of Health in 2003 which set out how many Consultant posts were required in each specialty, sub-specialty and in line with population needs to provide a Consultant-provided service and support implementation of the European Working Time Directive; the HSE National Doctors Training & Planning Medical Workforce Benchmarking Report 2014, which – inter alia – evaluated the ratio of specialists to population in Ireland compared to other states; and the specialty specific medical workforce planning reports as they are published by NDTP (General Practice published in 2015 and Emergency Medicine set to be published in 2016) which set out projected Consultant requirements and associated trainee numbers. The NDTP reports do not address the configuration of services or the appropriate location for particular posts.

Noting the above, a large number of Consultant posts are progressed as a result of local Hospital / Mental Health Service / Agency / Mental Health Service initiatives to replace existing posts arising from retirement or resignation or additional posts outside the scope of national, Group or CHO planning. There appears to be a lack of integration at national, specialty or Hospital Group and CHO level between plans regarding the number, type or proposed location of Consultant posts

## ii) Funding of Consultant posts and progression of applications

Consultant posts regulated by the HSE are, with the exception of Academic Consultant posts, almost entirely funded by the HSE.[1] Academic Consultant posts are jointly funded by the HSE, the Higher Education Authority via the relevant university[2] and other sources.

HSE-funded hospitals / agencies[3] / Mental Health Services utilise HSE funding to progress 1. replacement posts – where funding has been in place for a number of years, 2. additional posts - where funding is provided in the relevant annual HSE Service Plan approved by the Department of Health and, 3. additional posts - where funding which is not anticipated in the HSE Service Plan is identified within the Hospital / Mental Health Service / Agency / Mental Health Service, at a Hospital Group or CHO level or at national level. The majority of Mental Health Service are funded through the CHO structure. It should be noted that there is often significant local discretion in terms of how funding for service developments is used in terms of staff recruitment. There is often no specific requirement in the approved service plan or Divisional Operational Plans to hire specific grades or numbers of staff. Even where numbers are specified, location is sometimes left unclear.

In this context, Consultant posts can be progressed by hospitals / agencies in line with existing funding (replacement posts), service planning or outside the national service planning framework. The decision to progress a particular replacement or additional post is made at Hospital Group / CHO level and is subject to:

- Budgetary pressures – the extent to which funding is available within the relevant hospital, mental health service or agency budget;
- Hospital / Mental Health Service / Agency level, Mental Health Service / CHO and/or national prioritisation in terms of development or ongoing provision of clinical services;
- The HSE Pay and Numbers framework approved by the Department of Health (DoH) and the Department of Public Expenditure and Reform (DPER) which provides for creation and replacement of posts subject to availability of the required pay resource.

While the need for a Consultant post can be identified within a Hospital / Mental Health Service / Agency / Mental Health Service or at national level, the key determinant of whether an application is submitted for national approval is a decision by the relevant Hospital Group / CHO. Once that decision is made, the relevant Hospital Group / CHO progresses an application to the CAAC via NDTP. The Hospital Group / CHO formally confirms funding availability as part of the application.

A concern relating to replacement posts is that the process above can delay the submission of an application for a replacement post past the point where a Consultant has retired on age grounds, or having given notice, has resigned.

In general terms, replacement posts are already encompassed within the Hospital Group / CHO annual funding allocation. However, the position regarding funding for additional posts is not as clear. Taking that into account, as of June 2016, all applications for Consultant posts must be submitted in line with the Hospital Group / CHO Funded Workplan. This means that the Hospital Group CEO / CHO Chief Officer must certify that funding for the post is available.

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[1] There are a very small number of Consultant posts supported by research or other third party funding.
[2] The term 'university' includes the Royal College of Surgeons in Ireland (RCSI)
[3] Hospitals / Agencies funded under Section 38 or Section 39 of the Health Act 2004 – Section 38 hospitals include voluntary hospitals and St James's and Beaumont which are statutory agencies established by Ministerial Order

## iii) Approval of Consultant posts in line with regulatory and contractual obligations

### a) prior to establishment of HSE

Consultant posts in publicly-funded hospitals, Mental Health Services and health agencies are regulated under law. Between 1971 and 2004 posts were regulated under the Health Act 1970 by Comhairle na nOspidéal. Comhairle was an independent statutory body under the Department of Health which alongside regulation of Consultant posts, provided reports advising the Minister for Health on the future development of acute hospital and mental health services and related Consultant staffing. From 1st January 2005 Section 57 of the Health Act, 2004 transferred the regulation of the number and type of appointments of Consultant medical staff from Comhairle na nOspidéal to the HSE. The advisory function ceased at that point.

### b) Regulation of Consultant posts by the HSE

The HSE's regulatory function covers all Consultant appointments in the public health service in Ireland including the HSE hospitals, voluntary hospitals, Mental Health Services and other agencies whether additional, replacement, temporary or locum and irrespective of the extent of the commitment involved or source of funding of the appointment. It includes:

- new and replacement permanent Consultant posts;
- locum and temporary (non-permanent) Consultant posts;
- structuring / restructuring of Consultant posts;
- determination of the Type of Contract / Category of Contract to apply to Consultant posts and various functions relating to changes in Type of Contract / Category of Contract;
- determination of the qualifications to apply to Consultant posts;
- determination of the title of Consultant posts.

Taking account of the regulatory functions of the HSE, health service employers are required to seek the prior approval of the HSE before making a Consultant appointment (whether permanent or non-permanent) and comply with the HSE Letter of Approval in making the appointment. Where an application for an permanent, temporary or locum Consultant post is refused or deferred, it would be illegal for an employer to proceed with the appointment and any employer proceeding to create a post which has not been approved by the HSE leaves itself open to legal risks arising from claims involving holders of unregulated posts.

In addition to the delivery of Consultant services by persons who may not be appropriately qualified or competent, a key issue associated with unregulated Consultant appointments is that they may block or delay the submission of applications for HSE-approved posts and can contribute to the ad hoc development of services which may not be in line with local or national policy. The Protection of Employees (Fixed Term Work) Act, 2003 has particular implications for health employers offering repeated fixed-term (temporary and locum) appointments to individual candidates as repeated appointments can result in employees acquiring contracts of indefinite duration.

In summary, the purpose of regulation is to ensure that persons employed as Consultants in the public health service are appropriately qualified and competent to provide services as Consultants. Breaches by an employer of the HSE's regulatory requirements have significant implications for the organised and safe delivery of Consultant services. Individuals represented to the public as Consultants in the public health system must be appropriately qualified and competent to perform the duties and functions of a Consultant. Such individuals must be employed in regulated posts –

where the HSE has assessed the viability of and need for the post with regard to the safe delivery of Consultant services.

**c) Assignment of regulatory functions within HSE**

The HSE's regulatory functions regarding Consultants parallel those relating to Non-Consultant Hospital Doctor (NCHD) posts. Under the Health Act 2004 the HSE regulates the number and type of appointments and qualifications for appointment of Specialist Registrars and Senior Registrars. Under the Medical Practitioners' Act 2007 the HSE regulates the number and type of intern posts, of other medical training posts and is obliged to publish reports regarding same. The HSE also has statutory functions regarding the number of non-training NCHD posts. Since 2007 the HSE's statutory functions relating to NCHDs have been delivered by the National Doctors Training & Planning Unit (NDTP), part of the HSE Human Resources Division.

The work of NDTP comprises regulation of NCHD posts as described above, workforce planning including current state analysis of the medical workforce, international benchmarking, specialty workforce reports and design and implementation of the medical workforce planning system as part of overall health workforce planning; development and funding of medical education and training and continuous professional development; and the maintenance of information and publication of reports on same.

Between 2005 and 2014 the HSE's regulatory functions regarding Consultant posts were delivered by Consultants Appointment Unit (CAU) as part of the wider HSE Human Resources Division. In 2014 the Consultant Appointments Unit was incorporated into NDTP. In that regard NDTP supports the CAAC and Consultant post application process, maintains a statutory register of approved Consultant and NCHD (training) posts and sets qualifications for Consultant appointments - with input from the postgraduate medical training bodies, Clinical Programmes and the CAAC. NDTP also engages in regular review and streamlining of CAAC processes and is progressing development of an online process for applications to CAAC.

In general terms, applications submitted to NDTP are processed and presented to CAAC within six weeks of submission. This follows review by NDTP staff, revision or completion of the application as necessary by the Hospital Group / CHO and review by the relevant Clinical Lead on behalf of the Clinical Programme or by the National Clinical Advisor and Group Lead or other nominee of the CAAC.

**d) Consultant Contract 2008**

The Consultant Contract 2008 as agreed by the HSE, medical unions, Department of Health & Children and Department of Finance provided for two committees – the Consultant Applications Advisory Committee (CAAC) and Type C Committee - to advise the HSE on the regulation of Consultant posts (Appendix X of Consultant Contract 2008) and includes a series of provisions relating to individual Consultants changing contract type or restructuring their post. These provisions closely follow those set out in Consultant Contract 1997 – which had provided for similar functions to be delivered by Comhairle na nOspidéal.

In summary, Section 22 c) of the Contract provides for Consultants to have their Contract Type reviewed by the CAAC / Type C Committee where significant changes occur in a particular area in the delivery of acute hospital / Mental Health Service care. The Contract notes that a decision on applications for change will be considered by the CAAC together with the views of the Employer. Section 22 d) states that a decision on such application will be made following the advice of the

CAAC. Section 22 e) outlines the role of the Type C Committee in considering requests for designation of posts as Type C and indicates that a decision on such application will be made by the HSE following the advice of the Type C Committee. Section 9 d) relates to the restructuring of Consultant posts and states that applications for restructuring are made through the Employer to the HSE for advice by CAAC.

**e) Consultant Applications Advisory Committee and Type C Committee**

As noted above, the purpose of the CAAC and Type C Committees is to advise the HSE on the regulation of Consultant posts. The purpose of the CAAC is to provide independent and objective advice to the HSE on applications to create medical Consultant posts and the qualifications for Consultant posts. The agreement establishing the CAAC notes that it provides a significant opportunity for Consultants to contribute their expertise and professional knowledge to the decision-making process for the development of Consultant services throughout the country. The CAAC adds expert insight to the work undertaken as part of National Service Plans and HSE Divisional Operational Plans. The Committees also provide an agreed contractual mechanism for delivery of the HSE's statutory functions and decision-making regarding change of contract type, change of structure of post, change of title and related appeals. Both Committees include representation from a range of medical specialties, hospital and health management nominees, the Department of Health, Postgraduate Training Bodies, patient advocates and representatives of the Irish Medical Organisation and Irish Hospital Consultants Association. NDTP provides administrative support to the Committees, which meet monthly.

Applications for approval of permanent Consultant posts, change in contract type or restructuring of a Consultant post are submitted to the CAAC via NDTP and are considered by the CAAC. With the sole exception of applications for a change of contract type to Type C – which are sent to the Type C Committee and follow a similar process there – the CAAC considers the matter and either:

- makes a recommendation to the HSE,

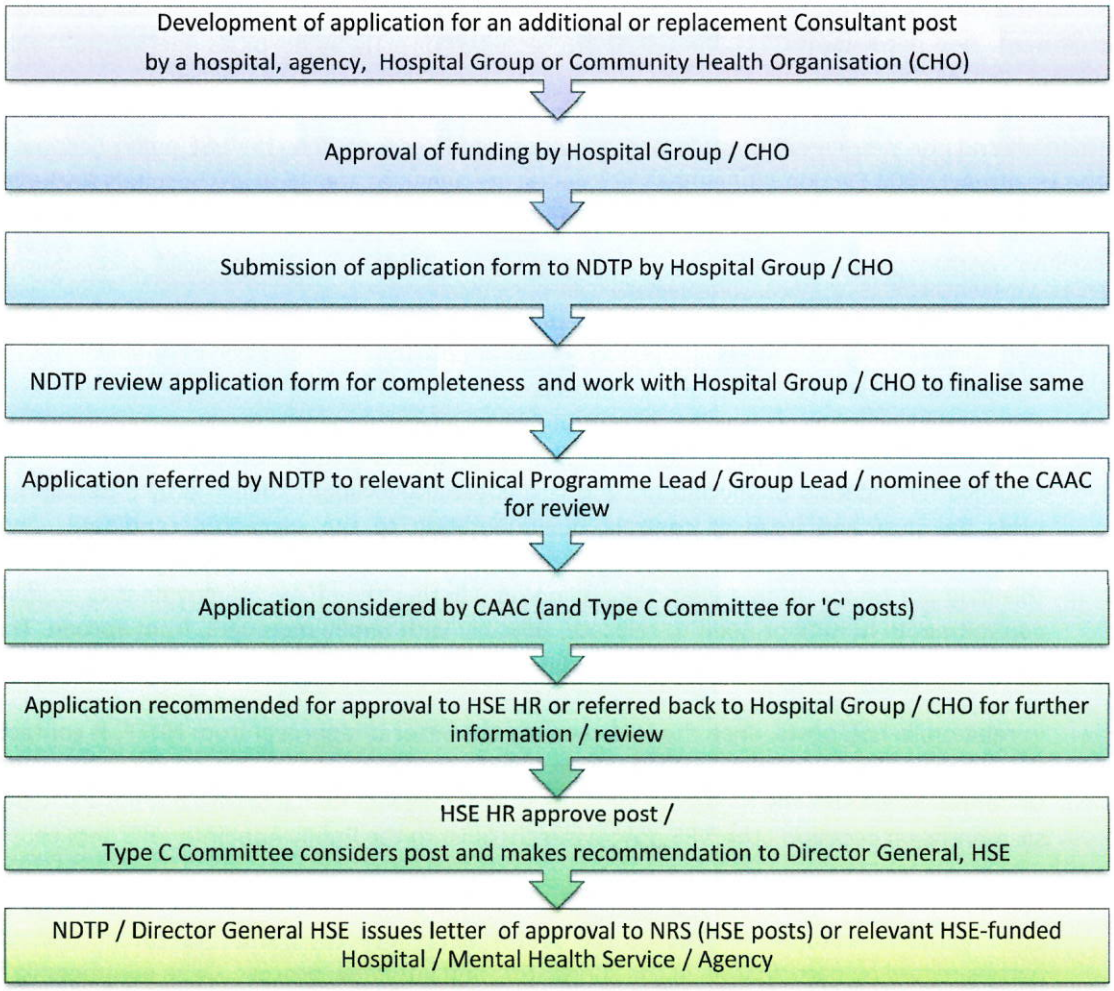
or

- in the case of applications for a Type C post, forwards the application to the Type C Committee for further consideration and recommendation.

Recommendations made to the HSE by the CAAC are subject to decision by the National Director of Human Resources to whom this function has been delegated by the Director General of the HSE. Recommendations made to the HSE by the Type C Committee are subject to decision by the Director General of the HSE.

In both cases, the HSE communicates approved decisions by way of a letter of approval, signed by either the Medical Workforce Lead, HSE HR or by the Director General. Such letters of approval issue within a fortnight of the Director General decision in the case of Type C applications.

The following summarises the current application and approval process for a Consultant post arising from the HSE's regulatory and contractual obligations:




### iv) Recruitment to Consultant posts

As a public sector agency, the HSE recruits staff under licence from the Commission for Public Service Appointments (CPSA). The Commission's primary statutory responsibility is to set standards for recruitment and selection of public sector employees. These standards are published as Codes of Practice. Implementation of the Codes is assessed via regular monitoring and auditing of recruitment and selection activities.

Permanent Consultant staff within the HSE are recruited via the HSE National Recruitment Service (NRS), which delivers recruitment services relating to all grades of staff to HSE hospitals, mental health services and agencies.[4]

Under the Public Service Management Act 2004 the HSE is licensed to recruit to positions in the HSE. Taking account of the HSE's obligations under its recruitment licence, the NRS uses the Public Appointments Service (PAS) as the centralised provider of recruitment, assessment and selection services relating to permanent Consultant posts. The PAS and its predecessor, the Local Appointments Commission have been responsible for recruiting Consultants on behalf of the public health service for over sixty years. The PAS has indicated that it has no objection, should the HSE

[4] with the sole exception of staff recruited via training bodies or NCHDs in non-training posts

wish to restructure the process, to the NRS taking full responsibility for all aspects of Consultant recruitment. Non-permanent Consultant staff are recruited directly by hospitals and mental health services.

Permanent and non-permanent Consultant staff within agencies funded by the HSE under Section 38 of the Health Act 2004 Section 38 Agencies (23 non-acute agencies and 16 acute hospitals (including 'voluntary' hospitals) are recruited directly by the relevant Hospital / Mental Health Service / Agency.

This means that there are significant differences in the processes and timescale for recruitment to HSE-funded hospitals or agencies as opposed to Consultant posts in HSE hospitals or agencies.

- HSE-funded hospitals / agencies may proceed to advertisement directly on receipt of the letter of approval from NDTP. They have discretion regarding interview board formation and the recommendation of the interview board is generally rapidly followed by a decision to offer the post and issue of contract documentation to the successful candidate. Once contract documentation is finalised, the candidate is free to take up appointment, however this may not be for up to a year, depending on whether they have employment or training commitments to fulfil or need to relocate, possibly with family members, from abroad. This delay may require the appointment of a non-permanent Consultant.

- In relation to HSE posts, once the NRS receives the letter of approval from NDTP, it contacts the relevant Hospital Group or CHO within twenty four hours to finalise a job specification. Once this is agreed – the timescale for same is generally less than a month but has exceeded six months on occasion - the NRS progresses the post to the Public Appointments Service.

  The Public Appointments Service then advertises the post within three weeks of receipt of documentation from the NRS. While the post is being advertised, the PAS contact relevant parties regarding participation in the shortlisting and interview process. Once membership is finalised, shortlisting and interview dates are agreed. While formation of an interview board could previously take a long number of months, a decision in February 2015 by the Director General of the HSE to reduce interview boards to a maximum of five members has had the effect of reducing the timescale by 50%. Nevertheless, PAS informed the Committee that in some cases, the nomination of interview board members is taking much longer than can be reasonably expected.

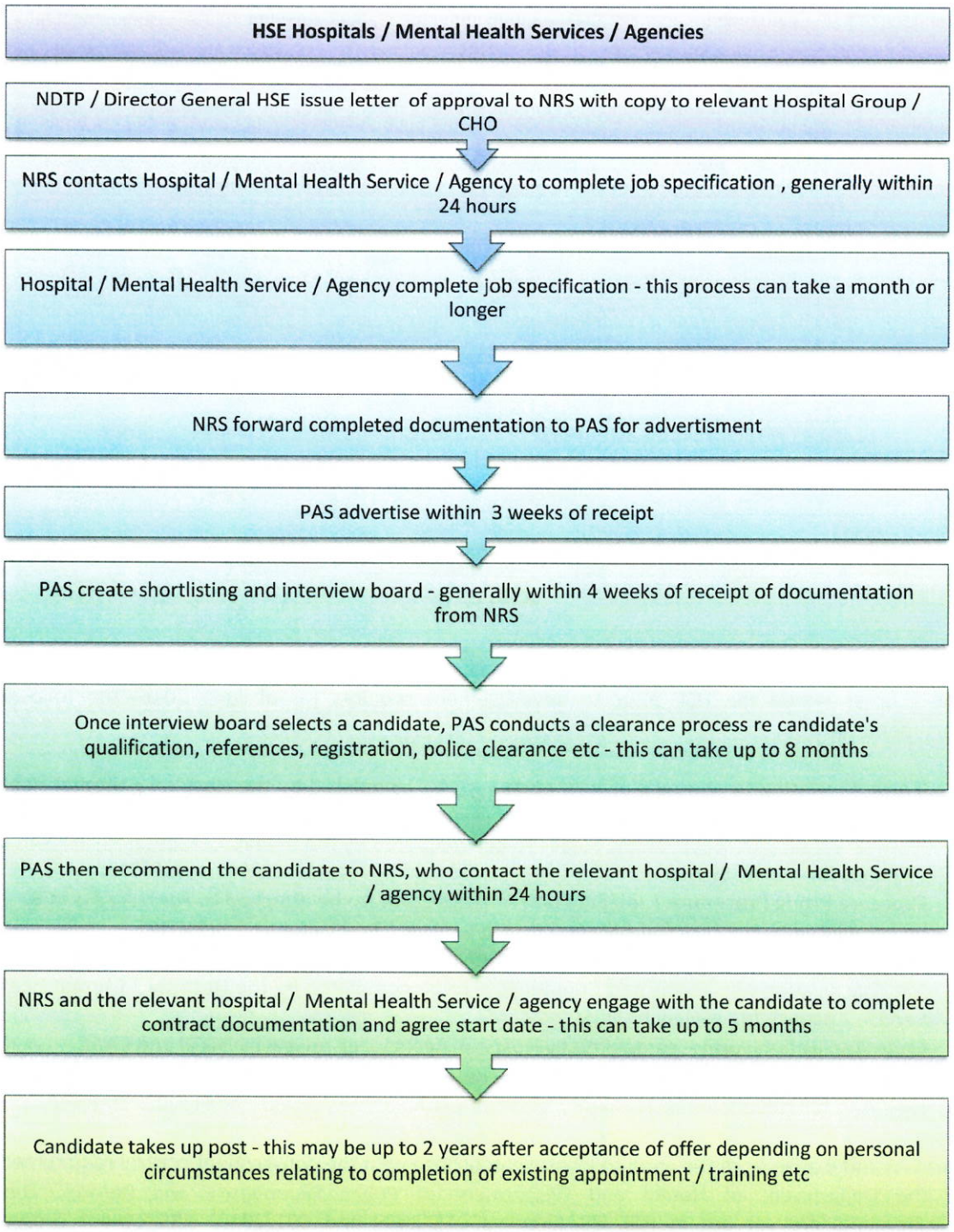
  Following interview, PAS commences a clearance process for the candidate recommended by the interview board. On completion of clearance, PAS recommends the candidate to the NRS for appointment. This process can take up to eight months where, for example, the candidate requires specialist registration or delays to complete an employment or training contract abroad.

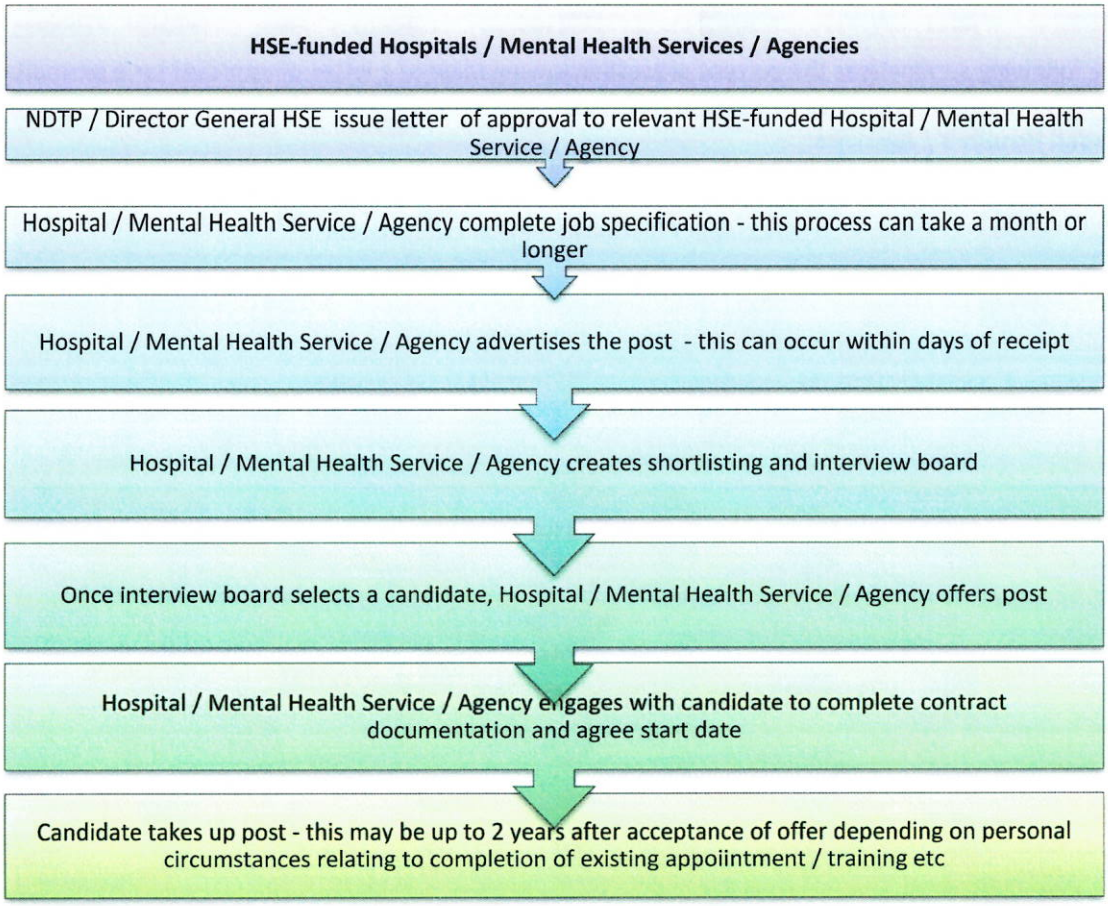
  On receipt of this information, NRS request – within twenty four hours – management in the relevant hospital / / Mental Health Service / agency (generally the Clinical Director and Medical Manpower Manager) to liaise with the candidate regarding the signing of contract documentation. It is understood this process can take up to five months, depending on the extent to which the hospital / Mental Health Service / agency progresses the matter and the candidate attempts to negotiate particular terms and conditions.

  Nevertheless, as with HSE-funded hospitals / Mental Health Services / agencies, once contract documentation is finalised, the candidate is free to take up appointment. However

this may not be for up a year, depending on whether they have employment or training commitments to fulfil or need to relocate, possibly with family members, from abroad and this delay may require the appointment of a non-permanent Consultant.

The following summarises the current process following issue of a letter of approval for a permanent Consultant post as it applies to posts in HSE Hospitals / Mental Health Services / Agencies and HSE-funded Hospitals / Agencies:






The process within the HSE prior to advertisement requires (as of June 2016) the following documentation:

- 'Form A' relating to approval of new posts – to be completed by the Hospital / Mental Health Service / Agency for review by NRS
- 'Form B' relating to replacement posts - to be completed by the Hospital / Mental Health Service / Agency for review by NRS
- Exposure Prone Procedure / Job Function Analysis Form (to be attached to Form A / Form B) - to be completed by the Hospital / Mental Health Service / Agency for review by NRS
- Job Order Form to be completed by Hospital / Mental Health Service / Agency for review by NRS
- Job Specification and Terms and Conditions – to be completed by the Hospital / Mental Health Service / Agency for review by NRS
- CAAC Application Form – completed by Hospital Agency, for review by NDTP and CAAC
- Clinical Programme Lead evaluation form – completed by Clinical Programme Lead / nominee of the CAAC for submission by Hospital / Mental Health Service / Agency and review by CAAC

Forms A and B arise from the need to ensure compliance with the employment control requirements of the Department of Health and Department of Public Expenditure and Reform. These requirements are set out in HSE HR Circulars 015/2009 and 001/2010. NRS cannot progress

recruitment unless a fully approved Form A or B is submitted alongside other documentation for a post.

'Form A' is completed in cases where the post to be filled is either; a new service development provided for in a National Service Plan or, a new additional post arising from the reform programme, or a funded vacancy in the staff category of management/administration. In the latter case, the sanction of the National Director of Human Resources in required, where redeployment options have been exhausted. A form is completed for each individual post. 'Form B' is completed where the post is a replacement of an approved and funded vacancy, by recruitment or by redeployment/reassignment and by exception from general restrictions on recruitment. The post must be a critical front-line vacancy and essential to the delivery of public services or performance of an essential front-line function. Every effort must have been made to fill by restructuring or reorganisation of the previous post.

The 'Exposure Prone Procedure / Job Function Analysis Form' is completed by the applying Hospital / Mental Health Service / Agency. It arises from the requirements of the Department of Health's report on the Prevention of Blood Borne Diseases in the health care setting and recommendations made by the associated Committee. Exposure prone procedures are those invasive procedures where there is a risk that injury to the worker may result in the exposure of the patient's open tissues to the blood of the worker. This has implications for potential candidates in terms of work exposure and related occupational health screening. The HSE's obligations regarding exposure prone procedures are set out in HSE HR Circulars 19/2008 and 12/2009.

The 'Job Order' Form is a one page form setting out contact details for HR and other staff in the relevant Hospital / Mental Health Service / Agency and other information to support processing of the post.

The 'CAAC Application Form' (now termed 'Proposed / Approved Consultant Appointment' document) is the form used by the CAAC to evaluate the rationale and purpose of the post. As part of this process, Clinical Programme Leads / nominees of the CAAC are requested to provide comments on the application for the post and complete a short evaluation form setting out same.

## v) Interaction with Candidates

As described above, HSE and HSE-funded agencies begin a formal interaction with potential candidates for Consultant posts once the post is advertised. Informal contact may have taken place during the final stages of specialist training, arising from candidate enquiries or contacts with Consultants or other staff in particular hospitals / Mental Health Services / agencies. As noted above, once recommended by an interview board for appointment, it can take a number of months – particularly where the candidate does not yet hold specialist registration in Ireland – to verify a candidate's qualifications, experience and training. Should a candidate be offered a post, a protracted discussion can occur regarding terms and conditions and placement on the salary scale.

A further delay arises where candidates seek to agree a start date which may be months or years into the future. While this is often to allow completion of training, completion of an existing employment contract or relocation from outside Ireland it often results in the appointment of a non-permanent Consultant pending the candidate taking up the post. In a limited number of cases, candidates indicate some time later that they will not be taking up the offer and the post must then be offered to the next on the panel, or in the absence of a panel, re-advertised. Potential candidates for Consultant posts can register their interest at any time on www.publicjobs.ie to be notified of Consultant vacancies when they arise.

## 6. Key findings

Section 6 of this report sets out the various stages of the Consultant post application, approval, recruitment and candidate engagement process. Section 7 sets out the Group's findings and actions for implementation in each area.

Two key findings determined the structure and nature of the Group's actions for implementation – that Consultants remain central to the delivery of safe, high quality care to patients and service users and that a significant driver of the large number of vacant posts was a Consultant recruitment and retention crisis.

### i) The role of Consultants

The HSE is facing unprecedented challenges meeting increasing demands while delivering significant efficiency savings and managing changing health delivery systems - all within a new Hospital Group and CHO configuration. In this context, Consultants, working as part of coordinated Consultant and multi-disciplinary teams are fundamental to the delivery of safe, high quality medical care.

Currently, noting the employer's role regarding the provision of appropriate resources, Consultants are responsible for the delivery of expert clinical care as both individuals and members of a team. Consultants must also contribute to teaching, training, management of departments and development of local services through their Clinical Directorate while being continuously challenged to improve the quality and safety of their and their team's patient care. Successful implementation of health service reform and improvement in service delivery requires that Consultants are involved in the wider management and leadership of the organisations they work in.

This requires that Consultants and managers work together collaboratively and innovatively. Consultant planning and appointment is an important mechanism for organising resources effectively to support patient care and ensure healthcare delivery organisations and Consultants benefit.

National policy remains the development of a Consultant-provided service as per the Report of the National Task Force on Medical Staffing (Hanly Report) and the Reports of the Strategic Review of Medical Training and Career Structures (MacCraith Reports 2013-14). The MacCraith Reports and associated agreements brokered by the Labour Relations Commission provide for a more differentiated Consultant career structure, within the existing contractual arrangements, where the Consultant participates in or focuses on clinical leadership and management, clinical and academic research, teaching, quality improvement and other roles. The MacCraith Report envisages that Consultants would undertake such activities as members of a team of Consultants at specialty / Clinical Directorate level and at various stages and levels of commitment throughout their careers.

### ii) Difficulties recruiting and retaining Consultants

Noting the work undertaken prior to its establishment, the Committee took the view that a key driver of the large number of vacant posts was a Consultant recruitment and retention crisis. A range of factors contributed to this crisis, many of them unrelated to the work of the Committee. Nevertheless, relevant contributing factors included:

- that the health service had not linked the creation of additional Consultant posts to the availability of potential candidates – many of whom were doctors in HSE-funded training or who had recently completed HSE-funded training.
- potential candidates for Consultant posts could not easily access information on forthcoming opportunities.
- employers took lengthy periods to progress applications for approval of replacement posts.
- central guidance dealt only with limited aspects of the application, approval and recruitment process and was out of date.
- once posts were approved there were further delays before posts were advertised.
- such delays required appointment of non-permanent Consultants to meet service needs pending the permanent appointment.
- advertisements lacked detailed information on the job and role which was commonly provided in other jurisdictions.
- once posts were offered candidates often delayed taking up appointment.
- when starting new Consultants experienced inconsistent induction processes and were often faced with limited resources and a struggle to access same.

### iii) Income is an important determinant of successful recruitment and retention

A key concern for many potential candidates for Consultant posts in recent years has been income. Starting salary, progression through points on the salary scale, how new appointees compare to colleagues appointed in earlier years and access to private practice all influence decisions by potential candidates to apply or to accept an offer of a post.

In October 2012, during Ireland's financial crisis and following negotiations with medical representative organisations on the implementation of the Public Service Agreement, the Minister for Health unilaterally reduced new entrant Consultant salary rates by 30%. While this reduced the cost of Consultant posts to the health service, it resulted in significant challenges to successful recruitment in a range of settings.

In January 2015, arising from proposals by the Labour Relations Commission, revised, increased, salary rates were introduced as part of a new Consultant pay and career structure. Consultants who had been appointed on the 2012 salary rate received a pay increase and back pay to September 2014. New entrants Consultants were appointed on the new, increased rate.

The 2015 salary rates represent a partial restoration of pre-October 2012 rates, albeit Consultants appointed under these rates take longer to progress to the final point on the scale and the final point is below that paid to Consultants appointed prior to 1st October 2012.

While access to private practice differs depending on contract type, it also varies by specialty and location of the post. The Consultant Contract 2008 aimed to address this by providing for a substantial difference between Type A salary, where the Consultant has no access to private practice and Types B, B* and C. However, changes to Consultant remuneration have reduced the difference between Type A and other contract types.

### iv) Deficiencies in governance and administration

In summary terms, poor governance and administration processes prior to and during the application and approval process and subsequently in the recruitment and appointment process made it difficult to rapidly and efficiently create and fill Consultant posts.

The Committee identified a number of stages within which these process improvements could be categorised and addressed. These are described below:

- governance and administration
  - multi-step and over-complicated – endorsing the findings of the Reports of the Strategic Review of Medical Training and Career Structures (MacCraith Reports 2013-14),
  - historically inadequate workforce planning/monitoring – also a finding of the MacCraith Reports,
  - Hospital Groups / Hospitals / Mental Health Services are not explicit in services provided and deployed,
  - on / off decisions on recruitment affecting all stakeholders and creating credibility issues
  - many vacant posts filled by locums / temporary Consultants;

- prior to submission of applications for permanent posts
  - lack of Employer knowledge of potentially available Applicants,
  - lack of Applicant knowledge of potentially available Employers and or vacant posts;

- during the application process
  - poor Job Planning - unclear specialty strategy, lack of clarity on resource provision, poor in-house 'collegiate' planning; poor matching of posts to service requirement,
  - poor Applications for Consultant posts from Hospital Groups / CHOs and a poor Application Form,
  - delay in processing replacements – often after incumbent retires,
  - too many non-permanent posts;

- during the recruitment process
  - too many steps and delays e.g. NRS awaiting documentation,
  - remuneration issues resulting in delays to the decision to accept an offer pending 'negotiation',
  - on / off decisions on recruitment affecting all stakeholders and creating credibility issues,
  - some hospitals struggle to recruit Consultants in any specialty or in a particular specialty,
  - a mismatch between training/experience versus clinical /professional opportunity,
  - flexible options not facilitated,
  - unattractive rosters, particularly in Model 2 and 3 hospitals;

- during the appointment process
  - inadequate on-boarding and induction - a finding of the MacCraith Reports,
  - probation – inconsistent and no national guidance;

- relating to the review and continuing support processes
  - inadequate development of Consultant's Clinical Directorate Service Plan (Section 9 (a) and (b) Consultant Contract 2008 regarding the Job Plan)
  - not reviewed annually – for example, Recommendation 9(b) of the MacCraith Reports stated that "In relation to *improving supports for newly appointed Consultants*, the Working Committee 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".

## 7. Findings and actions for implementation

### i) Recent developments

The Committee's findings and associated actions for implementation are set out below. They are underpinned by the principle that all Consultant appointment must be based on merit and that recruitment processes are open and transparent and conform with all legal and regulatory obligations.

Prior to dealing with the wider issues, the Committee noted a number of recent developments which have facilitated or have the potential to facilitate Consultant recruitment. These include:

- Development of a standardised job description format for Consultant Psychiatrist posts, agreement between the HSE Mental Health Division and the PAS regarding fast-tracking of Consultant Psychiatrist posts, cessation of 'bulk interviewing' where a single interview process covered multiple posts and the nomination of potential external experts by the College of Psychiatrists of Ireland for all PAS interview panels for Consultant Psychiatrist posts.

- Agreement between the Forum of Irish Postgraduate Medical Training Bodies, the HSE and the PAS regarding the involvement of College/Faculty Assessors in providing lists of external experts who may be nominated by the PAS to the interview panels for Consultant posts in HSE Hospitals / Agencies. This ensures that the interview board for Consultant appointments is able to access, as standard, an external expert from the relevant postgraduate training body qualified to provide independent professional advice, to assess the candidate and to assure the panel that the successful appointee is suitably clinically qualified for the post.

- Significant work to progress standards for conduct of induction, probation and appraisal in relation to Consultant posts. In this regard it is noted that:
  - induction is a process by which employees are received and welcomed to the organisation. It is a method of formally introducing the Consultant to their work location and colleagues. It is intended to provide a clear understanding of their job, role and responsibilities and the mission and values of the wider organisation.
  - the probation process follows induction, and is used to assess whether the Consultant is suitable for permanent appointment and to allow both the Consultant and the employer to identify issues for resolution prior to confirmation of permanent appointment.
  - appraisal takes place for the duration of the Consultant's appointment. It is a two way process allowing the employer to assess the Consultant's performance and the Consultant to feedback and register any constraints or suggestions as to what may be done to improve the working environment. It is designed to assist Consultants to improve the way they work and the services they provide themselves and with others. Appraisal will be progressed subject to consultation with relevant medical representative organisations and will be in context of the wider approach to performance management / achievement across the health service.

  Further details are provided at Appendices II, III and IV of this report.

- Ongoing engagement with the PAS regarding the process associated with Consultant recruitment, including:
  - The conduct of a job analysis of the role of Consultant in the Irish public health service to ensure selection and interview processes are grounded in the skills, experience and personal qualities required
  - the number of people / agencies / processes involved in the current recruitment process

- the potential to align the Consultant interview process with that used for other senior employees in the public service where separate interviews are used to assess the competencies associated with the role and the requirements of working as a senior employer.
- Greater use of videoconferencing / SKYPE / telecommunications in interview process – to promote greater access to candidates working outside Ireland

### ii) A strategic approach to Consultant recruitment

It should be noted that at a strategic level, the Irish public health service has a need to continuously attract, recruit and retain experienced Medical Consultants. The landscape of medical recruitment has changed and reforms to our recruitment methodologies are needed to actively attract Medical Consultants to posts in Ireland.

This is a complex area with a number of concurrent themes which need to be drawn together in a cohesive strategy. There are many challenges including attracting and recruiting Consultants into particular specialist areas and to some geographical areas where there is a resultant need to increase the applicant base for Consultant posts. In order to address this a pro-active and dynamic attraction, recruitment and retention strategy is required to include:

- gaining market intelligence on existing or potential applicant pools
- establishing long-term relationships with potential applicants including the use of social media
- more positive targeting of specific individuals where appropriate within a merit-based selection process
- providing a more personal and supportive recruitment and appointment process in order to more practically support applicants
- offering greater opportunities for flexible working
- selling Ireland and its regions as a country of lifestyle and living standard opportunities and advantages

These initiatives when acted upon will help Consultant appointees experience more positive journeys through their appointment and employment with the Irish public health service.

The Committee has expanded on the areas addressed at i) and ii) above in the actions for implementation set out below. Appendix V provides detail on specific processes to support efficient Consultant recruitment in the Mental Health Services. For clarity and future reference, actions are presented in a tabular format.

| iii) Preparation of an application for a Consultant post | | | |
|---|---|---|---|
| **Finding** | **Actions for implementation** | **Action by** | **Timeline** |
| 1.1 There are too many steps in the current processes for application, approval and recruitment of Consultant posts, particularly in relation to HSE posts. Documentation associated with current processes is bureaucratic and is not fit for purpose. Taken together, these have had the effect of creating unnecessary delays and promoting growth in non-permanent Consultant posts to meet service needs. | The Committee recommend that all documentation associated with approval of a Consultant appointment is included in a single Consultant Appointment Document pack – to include a 'Proposed / Approved Consultant Appointment' document. The pack should include proposed nominees for shortlisting and interview board membership and contact details for the relevant Clinical Director / Executive Clinical Director. The pack should be used throughout the post creation, approval and recruitment process and be made available to candidates as background information | NDTP<br>NRS<br>PAS | July 2016 |
| | The Committee recommends that NDTP and NRS progress the development of an online application system for posts accessible to employers, regulatory and recruitment functions. This system should eliminate the multiple forms in use currently | NDTP<br>NRS | July 2017 |
| 1.2 The Committee noted that clarity regarding funding was essential if posts were to progress without delay from application to appointment. In some cases posts had been placed on hold following approval as concerns had emerged regarding funding | The Committee recommends that both the 'Proposed / Approved Consultant Appointment' document and related pack explicitly provide for confirmation of funding in line with the Hospital Group / CHO Funded Workplan and same is certified by the Hospital Group CEO / CHO Chief Officer and National Directors, Acute Hospitals and Mental Health Divisions | NDTP<br>Acute Hospitals Division | July 2016 |
| 1.3 The Committee noted that input from the universities regarding applications for Consultant posts varied between Hospital Groups and that there was no standard process in place to facilitate same. This meant that many of the links with universities were developed on an ad hoc basis | The Committee recommends that the Chief Academic Officer review and contribute to applications for Consultant posts within Hospital Groups | Hospital Groups | July 2016 |
| 1.4 The Committee found that in many cases, there was little or no consultation or engagement with the relevant Consultant grouping prior to submission of an application for a Consultant post | The Committee recommends that the relevant Consultant grouping is consulted prior to submission of an application and that this consultation is recorded on the 'Proposed / Approved Consultant Appointment' document | CEOs, Group CDs / ECDs and HR in CHOs and Hospital Groups | July 2016 |
| 1.5 The Committee was informed that additional and replacement posts were often progressed without appropriate workload evaluation, resulting in new appointees being assigned inappropriate workload and consequent retention difficulties | The Committee recommends that the 'Proposed / Approved Consultant Appointment' document provide for an evaluation of current practice and workload and confirmation from the relevant Clinical Programme / Group Lead / nominee of the CAAC that the proposed workload was appropriate to the post | Clinical Programme / Group Leads / nominee of the CAAC | July 2016 |

| Finding | Actions for implementation | Action by | Timeline |
|---|---|---|---|
| 1.6 The Committee noted the significant delays associated with submission of replacement posts – often in excess of 6 months and in some cases lasting years. This is a significant driver of both Consultant vacancies and the creation of non-permanent Consultant posts and negatively affects recruitment, retention and career progression | The Committee recommends – subject to appropriate protection of personal data - collation and regular publication of retirement dates and notification of Hospital Groups and CHOs. The particular circumstances applying in the Mental Health Services in terms of retirement on the basis of 'added years' should be taken into account | NDTP | June 2017 |
| | The Committee recommends that:<br>- as a first step, 'Proposed / Approved Consultant Appointment' documents for new posts from the relevant Hospital Group / CHO are held pending action on replacements,<br>- as a second step, the relevant HSE National Division progress replacement posts to approval where no action has been initiated locally in the last **12 months** | Acute Hospitals Division<br>Mental Health Division | January 2017 |
| 1.7 The Committee noted that the current application documentation did not adequately reflect the job description, appraisal and performance processes and the supports necessary for the Consultant to provide an effective service. Further documentation was required at later stages in the process prior to advertisement | Noting Action 1.1 above, the Committee recommends that all documentation necessary to support the creation of a Consultant post is incorporated into a single set of documents that is used throughout the post creation, approval and recruitment process (the Consultant Appointment Document pack) and is made available to candidates as background information on the post. The documents should be piloted before full implementation | NDTP<br>NRS | July 2016 |
| 1.8 The Committee noted that in most cases, the relevant Hospital Group / CHO did not have or did not include in application documentation a particular strategy for development of the specialty or sub-specialty service to which the Consultant post application related | The Committee recommends that the:<br>- 'Proposed / Approved Consultant Appointment' document require a statement of Hospital Group / CHO / Mental Health Service specialty strategy<br>- That consideration be given to development / revision of the 'Clinical Directorate Service Plan' at Appendix III of Consultant Contract 2008 to provide for development of the service in line with strategic planning | Hospital Groups / CHOs | July 2016 |
| 1.9 The Committee noted a legacy of poor workforce planning regarding the medical workforce following the dissolution of Comhairle na nOspidéal and the Postgraduate Medical and Dental Board and merger of same with the HSE. | The Committee strongly recommended that the existing NDTP medical workforce planning project (a subset of wider health workforce planning) be resourced and prioritised. In the interim, the Committee recommends use of the 2014 NDTP Benchmarking report | NDTP | Ongoing |
| 1.10 The Committee noted that while Clinical Programmes were in place in a wide range of areas, there was no national framework for appropriate specialty / sub-specialty development | HSE Clinical Strategy and Programmes, in collaboration with Hospital Groups and the HSE Mental Health and Acute Hospitals Divisions should lead the development of a National and Group Framework for specialty development | CS&P<br>Hospital Groups<br>Mental Health Division | March 2017 |

| Finding | Actions for implementation | Action by | Timeline |
|---|---|---|---|
| 1.11 The Committee found that limited and inadequate information on potential Irish-trained candidates for posts was available and that it did not inform national or group planning for Consultant posts | The Committee recommends that:<br>- NDTP publish and distribute data on the output of training programmes on an annual basis and<br>- NDTP together with NRS, engage regularly with Postgraduate Medical Training Bodies, trainees and graduates of training programmes regarding Consultant posts including by use of social networks and other communication tools | NDTP<br>NRS | Ongoing |
| | The Committee recommends that the NRS undertake regular assessment of the candidate pool for Consultant posts internationally | NRS | Ongoing |

## iv) Assessment of applications for Consultant posts

| Finding | Actions for implementation | Action by | Timeline |
|---|---|---|---|
| 1.12 The Committee noted the need for formal and regular review of CAAC membership, participation, standing orders and output to ensure accountability and assurance that appropriate governance arrangements were in place | The Committee recommends that existing Standing Orders be reviewed and agreed and the CAAC output form part of standard HSE performance reporting | NDTP | Oct 2016 |
| 1.13The time periods associated with assessment of applications by NDTP, Clinical / Group Leads / nominees of the CAAC and the Acute Hospital and Mental Health Divisions are not standardised, nor is feedback consistent. This results in delays in the consideration of applications and a lack of clarity regarding the rationale for decisions at this level | The Committee recommends that applications are submitted to NDTP once reviewed by the relevant Clinical Programme. A standard feedback form should be completed as part of this process for consideration by CAAC. This process should ensure that the relevant Clinical Programme as well as advising the Hospital / Mental Health Service / Agency, can advise the CAAC directly of any national / strategic issues arising in relation to a particular post. This process should take no more than **3 weeks.** | Clinical Programme / Group Leads / nominee of the CAAC | July 2016 |
| 1.14The CAAC is not currently required to conform to any particular timescale for the consideration of applications. This means that there is a lack of clarity as to timelines for progress of applications / resolution of issues | The Committee recommends that CAAC:<br>- consider and make a decision as to approve, refer for resubmission or reject an application within **8 weeks** of the closing date for receipt of appropriately completed applications by NDTP<br>- Terminate consideration of applications where no response has been received from the applicant Hospital / Mental Health Service / Agency to queries after **3 months** and inform Hospital / Mental Health Service / Agency of same | NDTP CAAC | November 2016 |
| 1.15The HSE is not currently required to conform to any particular timescale regarding a decision on a CAAC recommendation. This has the potential to delay issue of letters of approval and progress of approved posts | The Committee recommends that<br>- HSE HR make a decision regarding posts recommended for approval by CAAC and authorise the issue of a letter of approval within **1 week** of receipt from NDTP;<br>- That letters of approval published on the HSE website<br>- That prior to development of the website above letters of approval are copied on issue to the PAS and the Forum of Postgraduate Medical Training Bodies | Medical Workforce Lead, HSE HR | November 2016 |

| v) The recruitment process | | | |
|---|---|---|---|
| **Finding** | **Actions for implementation** | **Action by** | **Timeline** |
| 1.16 Following receipt of a letter of approval from NDTP, NRS is currently required to liaise with Hospital Groups / CHOs regarding the completion of a job specification for the post. This can result in delays of up to two months before the post can be progressed | Noting action 1.1 above, the Committee recommends that NRS seek only confirmation that the Hospital Group / CHO wishes to proceed with the post. In the absence of such confirmation within **10 working days**, NRS should revert to NDTP to ensure the letter of approval is rescinded | NRS | November 2016 |
| 1.17 There is no set time period within which Section 38 Hospitals / Agencies or the PAS must advertise posts once they receive authorisation to do so. This can result in significant delays in particular instances | The Committee recommends that on receipt of authorisation the Section 38 Hospital / Mental Health Service / Agency or the PAS should advertise the post (unless filled with by transfer between posts) within **two weeks**. It is noted that PAS require Interview Board membership prior to advertisement. In the case of Section 38 Hospitals / Mental Health Services / Agencies, failure to advertise should result in intervention by the relevant HSE Division | Section 38 Hospitals / Mental Health Services / Agencies | Sept 2016 |
| 1.18 The Committee found inconsistent advertisement practices associated with Consultant posts, including lack of provision for flexible working, no reference to approved permanent posts in advertisements for related non-permanent posts and other issues | The Committee recommends that:<br>- standard advertisement content which includes reference to provision for flexible working is implemented;<br>- publication of vacancies and Letters of Approval document on www.HSE.ie | NDTP / HSE HR | Sept 2016 |
| 1.19 The Committee identified delays in the period from advertisement to interview arising from difficulty establishing interview boards and – in some cases - the size of interview boards. It was noted that currently, interview boards for HSE posts are set at a maximum of 5 members | The Committee recommends that:<br>- in circumstances where 2 or more sites with a commitment of at least 30% in the post or in the case of Section 62 or Academic Consultant appointments, provision be made – subject to agreement of each party - for expansion to a maximum of 6 members, including an Independent Chair, external expert, an academic, senior manager and two representatives of the department;<br>- that CHO / Hospital Groups respond to PAS requests within **1 week**;<br>- this will enable PAS to form interview / shortlisting boards within **2 weeks** of receipt of authorisation from the HSE;<br>- that the PAS may draw the external nominee for the Interview Board from the Panels (of more than 1 member) provided by the Forum;<br>- The Forum obtain Panels from the Postgraduate Training Bodies who will develop same on an annual basis;<br>- Section 38 Hospitals / Agencies should retain discretion regarding the constitution of their own interview / shortlisting boards subject to implementation of a **two week** timeframe for forming boards | PAS<br>Section 38 Hospitals / Agencies | November 2016 |

| Finding | Actions for implementation | Action by | Timeline |
|---|---|---|---|
| 1.20 The Committee noted the progress in the conduct of interviews for Consultant Psychiatrist posts albeit there was a need to formalise existing arrangements | - The Committee recommends that taking account of 1.19 above, that the 5 member board for Psychiatry posts include an Independent Chair, external expert (drawn from a panel provided by the College of Psychiatry of Ireland), senior manager and two clinicians – who is / are the relevant Executive Clinical Directors or local specialty lead;<br>- Clinicians must be employees of the public service, permanent and on the relevant division of the Specialist Register;<br>- Interview Boards should deal with posts in a maximum of two Community Health Organisations simultaneously. | PAS | July 2016 |
| 1.21 The Committee found that delays in the 'clearance' process for candidates successful at PAS interviews can be up to 8-10 weeks arising from difficulties for the PAS obtaining information and delays in candidates providing required documentation | The Committee recommends that the HSE / PAS restructure the clearance process to the greatest extent possible within legal / regulatory constraints to ensure that clearance information sought from candidates is provided in a timely fashion | PAS<br>HSE HR<br>NRS | December 2016 |
| 1.22 The Committee found that a lack of clarity regarding the progression of the PAS process and the stages involved in same | The Committee recommends that the PAS provide statistics regarding the volume of Consultant recruitment and associated timescales including formation of interview boards, candidate clearance and recommendation to the HSE | PAS | July 2016 |
| 1.23 The Committee noted the PAS plans to review the Consultant interview process to align it with that in place for senior public service employees | The Committee recommends that PAS progress its review of the Consultant recruitment process to:<br>- Progress a job analysis of the Consultant role<br>- assess the need to comprehensively evaluate the candidate's professional competencies and the extent to which the candidate has the management, leadership and other skills associated with the role of Consultant, including by use of presentations and other methodologies ;<br>- evaluate use of occupational personality questionnaires and other assessment tools<br>- evaluate the structure of interview boards and training of boards<br>- Enable greater use of videoconferencing / SKYPE / telecommunications in interview process – to promote greater access to candidates working outside Ireland<br>- Provide for limits to the term of any panels created as part of the interview process | PAS (end year) | January 2017 |

| Finding | Actions for implementation | Action by | Timeline |
|---|---|---|---|
| 1.24 The Committee noted the issues associated with medical registration costs and how the HSE determined eligibility to compete for Consultants posts in terms of specialist registration. Effectively, existing Medical Council and Postgraduate Training Body costs meant that specifying registration as an eligibility requirement would be a deterrent to applications from particular candidates | The Committee recommends that HSE HR work with the Medical Council to:<br>- identify the most appropriate means of meeting registration costs while attracting the appropriate range of candidates, including final year specialist trainees<br>- contact doctors formerly registered on the Specialist Division members to invite them to renew registration and provide support to them in doing same<br>- ensure that the Medical Council and Postgraduate Training bodies work to proactively recognise qualifications granted / training certified in non-EEA states<br>- make provision for reimbursement of registration fees by the employer to permanent / non-permanent candidates who remain in employment for more than two years following appointment | Relevant HSE Division<br><br>Medical Council | Sept 2016 |
| 1.25 The Committee noted issues associated with delays in candidates progressing applications for specialist registration and / or agreeing start dates and the associated requirement to employ non-permanent Consultants, in some cases for over a year | The Committee recommends that:<br>- Candidates for HSE posts in clearance with the PAS who are applying for specialist registration copy their Medical Council application to the PAS;<br>- Within legal / regulatory constraints, PAS regularly apprise the HSE (and where relevant the Medical Council) of candidates in clearance;<br>- Salary and superannuation information is provided to the candidate at the earliest possible point in the process and with regard to 1.27 below<br>- Contract documentation is signed at the earliest possible point in the process<br>- Implementation of HSE HR Circular 004/2014 or in certain circumstances candidates are required to agree a start date which is no later than **6 months** from the date of contract offer. In the absence of same, the offer should lapse | PAS / NRS | November 2016 |

## vi) Appointment to a Consultant post

| Finding | Actions for implementation | Action by | Timeline |
|---|---|---|---|
| 1.26 The Committee noted the significant risk issues arising from poor compliance by health service employers with national requirements regarding the creation and approval of non-permanent Consultant posts and subsequent issues regarding acquisition of Contracts of Indefinite Duration by individuals who did not meet the stated requirements to work as Consultants | The Committee recommends that measures are adopted to cease the poor employment practice which gives rise to contracts of indefinite duration and risk to the public arising from provision of services by persons who are not appropriately qualified. Taking account of individual contractual entitlements these measures should include the HSE:<br>- reviewing the extent to which permanent posts have been created or filled in breach of appropriate sanction<br>- acting as a matter of urgency to enforce existing regulatory requirements and that sanctions are implemented for non-compliance with qualifications, to include funding<br>- clarifying the scope of practice of the individuals referenced above and related designation as 'Consultants'<br>- working with the Department of Health, the Medical Council and representative bodies to examine the use of the term 'Consultant' in relation to the Specialist Division | NDTP / HSE HR<br><br>Relevant HSE Division<br><br>HSE HR / DoH | June 2017 |
| 1.27 The Committee found delays of up to five months in the issue of contract documentation to successful candidates and in some cases, lengthy periods of negotiation prior to the candidate signing documentation | The Committee recommends that:<br>- NRS put in place an expert mechanism to determine candidates incremental credit entitlement, with provision for further discussion with the Hospital Group / CHO and continued appeal to the existing Incremental Credit Committee<br>- subject to the above, contract documentation is issued to candidates within **2 weeks** of confirmation of the successful candidate.<br>- That candidates are clearly informed of the required start date and the provision for extension of same by a maximum of 3 months in line with HSE HR Circular 004/2013 | NRS<br>Section 38 Hospitals / Agencies | November 2016 |
| 1.28 The Committee noted the use of the facility for transfer of an existing permanent Consultant into a new, approved permanent post and the absence of a formal process relating to same | The Committee recommends that in the case of transfer between posts:<br>- a formal interview / skills match process is used to assess candidates and records of same are kept,<br>- that successful candidates are released by their current employer with regard to the standard timeframe for appointment to the new post | CHOs<br>Hospital Groups | November 2016 |

| Finding | Actions for implementation | Action by | Timeline |
|---|---|---|---|
| 1.29 The Committee noted that employers made little use of the provision for proleptic appointments contained in Consultant Contract 2008 and in the HSE letter of approval for the post. This meant that the opportunity to appoint recently qualified candidates subject to further training / acquisition of qualifications was underused and retention of trainees reduced accordingly | Noting Action 1.1 above, the Committee recommends that the existing provision for proleptic appointments be detailed in revised Guidance on creation and recruitment to Consultant posts in accordance with CPSA codes and based on the merit principle | HSE HR<br><br>Relevant HSE Division | July 2016 |
| 1.30The Committee noted that the absence of key clinical, administrative and professional resources required to ensure newly appointed Consultants can make the most effective contribution to service provision | The Committee recommends the inclusion in the 'Proposed / Approved Consultant Appointment' document of a Job Plan and statement of resources associated with the range of services to be provided as per Appendix I of this report | Hospital Groups / CHOs | July 2016 |
| 1.31 The Committee noted delays in the issue and/or finalisation of contract documentation for successful candidates. In some cases, delays of up to 5 months have occurred | The Committee recommends that Consultant recruitment is prioritised at Hospital Group / CHO level and that Hospitals / Agencies are required to complete contract documentation within **2 weeks** of notification of the successful candidate | Hospital Groups CHOs | November 2016 |
| 1.32 The Committee noted that induction (including onboarding) processes were absent in many instances and that newly appointed Consultants were introduced to employment in a limited and haphazard manner – a key driver of poor retention rates in some locations | The Committee recommends that<br>- The induction policy set out at Appendix II of this report is adopted by the HSE and HSE-funded agencies<br>- In addition to the policy areas highlighted in the Appendices, HSE HR develop training content to bring these policies to fruition. These incorporate the full Consultant life cycle from recruitment, on-boarding, induction and professional development<br>- HSE HR ensure that this training is effectively delivered consistently to the HR community supported by the development of a check-list for each of the CEO / Hospital Manager / Clinical Director / Executive Clinical Director for any new employee confirming their role and responsibility in the recruitment processes | Relevant HSE Division<br><br>HSE HR | December 2016 |
| 1.33 The Committee noted the inconsistent operation of the probation period provided by Consultant Contract 2008 and the risk of performance or other issues arising. This included a lack of engagement on supports needed for newly appointed Consultants | The Committee recommends that the approach to the implementation of Probation set out at Appendix III of this report be adopted and implemented by HSE and HSE-funded agencies | Relevant HSE Division | November 2016 |

| Finding | Actions for implementation | Action by | Timeline |
|---|---|---|---|
| 1.34 The Committee noted the inconsistent use - or absence in some cases - of performance management / appraisal processes relating to Consultant posts, including a failure to regularly review job descriptions and associated requirements for implementation of same | The Committee recommends that:<br>- HSE NRS and PAS immediately commence a job analysis of the role of a Consultant to support interview / selection processes<br>- the forthcoming HSE Performance Achievement Process be structured to take account of the particular needs of Consultants and ensure regular review / appraisal of performance and individual needs for effective service delivery;<br>- Hospitals / Agencies implement – subject to consultation in line with the Public Service Agreements - the appraisal process described at Appendix IV of this report;<br>- Hospitals / Agencies make full use of Section 12 e) of Consultant Contract 2008 and the related Clinical Directorate Service Plan | NRS<br>PAS<br>HSE HR<br><br>Relevant HSE Division | November 2016 |
| 1.35 The Committee found that there was inconsistent use of exit interviews and related measures and a consequent absence of data on why Consultants left post and associated poor retention rates in some locations | The Committee recommends that Exit interview guidance and a related reporting system be detailed in revised Guidance on creation and recruitment to Consultant posts. This should involve exit interviews by the relevant Medical Manpower Manager and Clinical Director / Executive Clinical Director of each Consultant leaving post | HSE HR<br><br>Relevant HSE Division | November 2016 |

## vii) Information, guidance and implementation

| Finding | Actions for implementation | Action by | Timeline |
|---|---|---|---|
| 1.36 The Committee noted the absence of a single, national source of information on the process for creating and recruitment to Consultant posts and the consequent confusion and misinformation regarding existing processes | The Committee recommends a revision and expansion of the HSE website to rapidly address this information deficit | HSE HR | November 2016 |
| 1.37 The Committee noted that the existing guidance on the approval of and recruitment to Consultant posts was significantly out of date and did not address the range of issues required by health service employers | The Committee recommends that the revised Guidance on creation and recruitment to Consultant posts which is attached at Appendix VI of this report be issued to HSE and HSE-funded Hospitals / Agencies by HSE HR | HSE HR | November 2016 |
| 1.38 The Committee's actions for implementation must be integrated with HSE performance and accountability systems if they are to be implemented | The Committee recommends that:<br>- Implementation of this report is led by HSE HR and HSE HR nominate a designated staff member to lead same;<br>- implementation of these actions is integrated with HSE performance achievement and HSE National Performance Oversight Group (NPOG) processes and that where concerns exist regarding lack of implementation, these are initially raised with the relevant Clinical Directors / Executive Clinical Directors and Medical Manpower Managers; then with HR staff at Hospital Group / CHO level before being progressed to HSE HR nationally | HSE HR | ongoing |

* * *

## Appendix I – Job Planning and resources to support Consultant appointment

A key recommendation of the MacCraith Report was that there was a need to document the relationship between work objectives, flexible working, available resources, supports and other matters. Taking that into account, a key support for a new or replacement Consultant post is a Job Plan which includes provision for:

- the Consultant's role in implementation of a Consultant-provided service and measures to support development of same;
- what work the Consultant does for the public health service employer and in the case of Academic Consultants, what work the Consultant does for the academic institution;
- job objectives and related supports from the employer(s);
- timetabling and location of work;
- how timetabled work will align with service objectives and delivery targets;
- the extent and role of flexible working in relation to implementation of targets;
- the commitments that the Consultant may have outside their primary employment;
- the resources necessary for the work to be achieved, including

  Generic resources:
  - Dedicated workspace
  - Computer facilities, internet access, offsite access
  - Access to relevant databases / medical literature
  - Multidisciplinary team (including medical staff as appropriate)
  - Secretarial / administrative support
  - Access to training opportunities
  - Support for Continuing Professional Development
  - Support for audit
  - Time to participate in supporting professional activities

  Specific items:
  - Time – leave and external duties
  - Access to clinical facilities appropriate to Consultant's specialty including, for example:
    - Theatre
    - Day Unit
    - Outpatient Department
    - Minor Operations
    - Endoscopy
    - Community facilities

The Job Plan should be reviewed as part of the appraisal process. This review should involve identification and documentation of the resources necessary to deliver the service required. Should absence of resources or organisational barriers limit the extent to which the Consultant can perform their duties effectively, the Consultant, Clinical Director / Executive Clinical Director / employer should meet to identify means of addressing the issues or identifying new, achievable objectives.

Finally, the Consultant's salary and superannuation arrangements should be confirmed in keeping with the Terms of Employment (Information) Acts 1994-2001.

## Appendix II - Induction

### 1. What is Induction?

Induction is a process by which employees are received and welcomed to the organisation. It is a method of formally introducing the employee to their work location and colleagues. A clear understanding of their job, role and responsibilities and the mission and values of the wider organisation will be provided. An effective Induction process – together with appropriate use of probation - will ensure that the Consultant is supported in achieving expected performance levels. It will also ensure that the new Consultant is aware of the importance of team-working within the HSE and their role within the team.

It is important to induct, so that Consultants can gain the necessary information to perform their duties to the highest standard possible.

### 2. Policy and guidance

The HSE issued guidelines on Induction for staff in 2006. Revised guidelines were agreed in 2015 are due for publication shortly. In that context, HSE hospitals / agencies have a single national induction policy and guidance. Set out below is guidance for HSE-funded agencies regarding induction as it may be applied to Consultants.

Induction should complement and support the probation process described at Appendix II of this document.

### 3. Aims of an effective Induction

The aim of induction is:

- To ensure that each Consultant receives a structured welcome and introduction to their immediate work environment and the wider organisation;
- To outline the organisation's responsibilities and values;
- To assist in the promotion of the culture and philosophy of the organisation;
- To clarify expectations of both Consultant and employer in relation to codes of conduct, policies and procedures, Consultant services etc.;
- To clarify the role of Consultant and performance expectations;
- To commence a process of structured feedback on performance;
- To promote an emphasis on customer/client focus;
- To promote an environment of effective health, safety and welfare.

### 4. Benefits of an effective Induction

An effective induction process provides the CEO / Hospital Manager / Clinical Director / Executive Clinical Director with a framework to clearly communicate policies and procedures to the

Consultant; provides a structured welcome and support and clarity on role expectations for the individual Consultant on commencing employment, promotion, transfer or secondment; helps the Consultant to fit in, enabling integration into the service area, enhancing effectiveness and performance; promotes a shared vision within the organisation; and assists in fulfilling statutory obligations

## 5. Roles and responsibilities

Induction is the responsibility of both the employer and Consultant. The employer has the responsibility to ensure that all staff are inducted in a reasonable time frame and the Consultant has responsibility to fully engage with the process.

The employer is responsible for:

- Ensuring that Induction is a Key Performance Indicator for Senior Managers;
- Supporting the process and agreeing the release of staff to attend scheduled Induction;
- Training;
- Ensuring that managers in their areas release staff for the Site Induction Training, including where appropriate foreseeing resources for replacement of front-line staff;
- Tailoring the induction process to include local policies and procedures;
- Ensuring that all aspects of the Induction process are completed within the specified time frames and for progressing through each checklist with the new Consultant;
- Identifying a work colleague
- Reviewing and compiling the necessary back-up materials ahead of the new Consultants arrival;
- Ensuring that either the CEO / General Manager / Clinical Director / Executive Clinical Director or designated person is available on the first day to meet the new Consultant;
- Scheduling appointments over the first day, week, 3 months, 6 months to have regular, short meetings with the new Consultant.

The Consultant is responsible for cooperating fully with the process, attending scheduled training and seeking clarification on any documentation, if necessary, before sign-off.

The Work Colleague is responsible for welcoming the new Consultant into the organisation and to assist and support the new Consultant to become familiar with their work environment and surroundings

## 6. Induction schedule for the new Consultant

Before the new Consultant joins the Department, all necessary workspace, equipment and appropriate access to resources should be in place. The CEO / Hospital Manager / Clinical Director / Executive Clinical Director should contact the new Consultant before the agreed start date if appropriate. Separately, The CEO / Hospital Manager / Clinical Director / Executive Clinical Director should ascertain if the new Consultant has any specific Disability or Diversity requirements. The CEO / Hospital Manager / Clinical Director / Executive Clinical Director should arrange all appropriate initial training. Relevant staff, including reception/security and other relevant people, should be notified of the Consultant's start date by the CEO / Hospital Manager / Clinical Director / Executive Clinical Director or delegated person.

It is essential that the new Consultant is met on the first day and welcomed into the Department.

The CEO / Hospital Manager / Clinical Director or delegated person introduces the new Consultant to colleagues and other key staff in the organisation including the designated work colleague. The CEO / Hospital Manager / Clinical Director / Executive Clinical Director provide appropriate information to the new Consultant in relation to their role and responsibilities and expected level of performance. The Consultant will be given details of all training arranged by the CEO / Hospital Manager / Clinical Director.

The CEO / Hospital Manager / Clinical Director / Executive Clinical Director will progress from the induction to the probation process in the case of newly appointed Consultants who have not held a permanent post or acted in the post prior to commencing work.

Otherwise it will be necessary in the first weeks to set time aside to progress through a process that involves setting objectives/priorities/targets and discussing initial performance and development needs and ways of meeting these. Meetings should be arranged in the first few months between the CEO / Hospital Manager / Clinical Director / Executive Clinical Director and the Consultant to discuss how well the Consultant is performing their duties and to identify what other support is required by the Consultant if necessary.

* * *

## Appendix III - Probation

### 1. Purpose of probation

A key element of the initial stages of a Consultant appointment is probation. The purpose of probation is to assess whether the Consultant is suitable for permanent appointment and to allow both the Consultant and the employer to identify issues for resolution prior to confirmation of permanent appointment. The following sets out guidance on the use of probation in relation to Consultant appointments.

### 2. Application of probation to Consultants

Section 3 of Consultant Contract 2008 – 'Probation' - deals with probation and provides for a 12 month probationary period for Consultants offered permanent appointments. In the case of joint appointments, it should be noted that the Consultant must successfully complete probation for each employer - failure to do so for one employer affects the entire appointment.

Consultants who either hold permanent posts in the Irish public health system or who have acted in the post on a non-permanent basis while the post is being filled permanently do not have to serve the probationary period.

Section 2 a) of the Contract explicitly excludes non-permanent Consultants – those offered fixed term, fixed purpose or locum appointments – from this 12 month period.

### 3. Reviews during probation

The employer is required to undertake a formal review not more than 6 months after the date of appointment. In this context, it is recommended that the review of the probationary period is aligned with review of the Consultant's job plan and work schedule. The review should include the Consultant, the Clinical Director / Executive Clinical Director and a senior manager.

A key aspect of the probationary process is that the employer ensures that there is clarity regarding service and performance standards, particularly in relation to workload, working relationships, individual skills, including those relating to management and teaching / training of staff, policies and procedures. The Newcastle upon Tyne Hospitals NHS Foundation Trust Procedure for Managing Probationary Periods offers a useful summary of the responsibilities of the employer during probationary meetings. It states that at each meeting, the manager should aim to:

"a) highlight areas where the employee is doing well;
b) focus on successes, as well as, failures;
c) explain clearly and in precise terms any areas in which the employee is falling below the required levels;
d) explore the possible reasons for any failure to meet the required standards;
e) listen to what the employee has to say;
f) discuss and agree whether or not any specific training or coaching is required;
g) discuss any other relevant matters such as timekeeping, attendance, general conduct or attitude;
h) deliver any necessary criticism in a constructive way;

i) avoid assuming that unsatisfactory performance is caused by something within the employee's control

j) invite the employee to comment on issues such as the extent to which he or she has integrated into the department and how well he or she is getting on with colleagues;

k) give the employee an opportunity to ask questions or raise concerns about any aspect of his or her employment."

**4. Extension of probation**

As noted above, the contract requires that employers operate a probationary period of 12 months. The employer may extend the period to 18 months, but must communicate the reasons for this to the Consultant in writing. During the probationary period, the employer must ensure that the probationary Consultant is subject to ongoing review.

**5. The end of the probationary period**

Consultant Contract 2008 requires that at the end of the probationary period, the Employer either certifies that the Consultant's service has been satisfactory and confirm the appointment on a permanent basis or certifies, with stated specified reasons, that the Consultant's service has not been satisfactory, in which case the Consultant will cease to hold his/her appointment.

The Contract notes that in the event that the Employer fails to certify that the Consultant's service is not satisfactory, they will be deemed to have been appointed on a permanent basis. Taking that into account, Employers must –without delay - communicate the outcome of the probationary period in writing to the Consultant at the earliest possible opportunity.

**6. Serious misconduct during probation**

In cases where an allegation of serious misconduct is made against a probationary Consultant, the Contract requires that the issue is dealt with in accordance with Stage 4 of the Disciplinary Procedure (attached at Appendix II to Consultant Contract 2008).

**7. Termination**

The Contract provides that employment may be terminated by either the Employer or Consultant during the probationary period. Should employment be terminated by the Employer, the Employer shall set out in writing the specific reasons for such termination.

**8. Standardised form for review of Consultant probation**

Set out below are standardised indicators which may be used during review of the probationary period

| | |
|---|---|
| **Name:** | |
| **Department:** | |
| **Commencement Date:** | |
| **Review No:** | |
| **Date of Review:** | |
| **Review Committee** | |

1. Rarely
2. Sometimes
3. Meets
4. Sometimes exceeds
5. Often exceeds

## Leading on Clinical Practice and Service Quality

**Definition:** Sets and monitors standards and quality of service, contributes to proactive improvement as part of a multi-disciplinary team.

| | **Behavioural Indicators** | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 1. | Regularly reviews practice and clinical standards of care and measures them. | ☑ | ☐ | ☐ | ☐ | ☐ |
| 2. | Possesses sound knowledge of procedures and protocols in operational matters. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. | Demonstrates professional development and high standards in all aspects of practice | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. | Does a regular review of service user perspectives and of complaints and of incidents and seeks out methods to achieve better outcomes. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. | Demonstrates high standards of practice in own work areas including punctuality and attendance and acts as a professional role model for the staff. | ☐ | ☐ | ☐ | ☐ | ☐ |

## Integrity and Ethical Stance

**Definition:** Holds an appropriate and effective set of professional and managerial values and beliefs and behaves in line with these.
Promotes and consistently supports ethical and value-based staff practices.

| | **Behavioural Indicators** | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 1. | Always follows through on issues and behaves in a manner that is consistent with own and the organisation's espoused values and practices; will check back to others where there are value or integrity issues. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. | Shows fairness and consistency in dealing with direct reports and other staff; doesn't generally operate hidden agendas and doesn't give preferential treatment. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. | Is able to treat personally sensitive information with confidentiality; is careful not to speak in an indiscrete or hurtful way about others. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. | Admits mistakes and is willing to take responsibility when things go wrong as a result; doesn't misrepresent self for personal gain. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. | Is generally honest and truthful in dealing with individuals; elicits trust from others on this basis. | ☐ | ☐ | ☐ | ☐ | ☐ |

## Negotiation, Communication and Influencing Skills

**Definition:** Gets a message across fluently and persuasively in a variety of different media (oral, written and electronic).
Makes a compelling case to positively influence the thinking of others. Is strategic in how he / she goes about influencing others; shows strong listening and sensing skills.

1. Rarely
2. Sometimes
3. Meets
4. Sometimes exceeds
5. Often exceeds

| Behavioural Indicators | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| 1. Marshals information cogently to make a persuasive case; communicates information clearly in the spoken word; makes well-structured and persuasive presentations. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Can communicate in a rational mode as appropriate and is professional in managing all professional relationships and interactions | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Has strong two-way listening skills; is able to elicit information from others in a non-threatening way and can read between the lines. Can impart information in a non-threatening way | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Able to argue position, point of view, in a reasonable professional manner and tone | ☐ | ☐ | ☐ | ☐ | ☐ |

## Sustained Personal Commitment

**Definition:** Is personally committed to achieving end goals and the continuous improvement of the service.

**Behavioural Indicators**

| | | | | | |
|---|---|---|---|---|---|
| 1. Shows a strong degree of self-awareness, seeking feedback from colleagues. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Accepts both negative and positive feedback and acts thereon. | ☐ | ☐ | ☐ | ☐ | ☐ |

## Clinical Development

**Definition:** Always demonstrates sound clinical judgement and clinical skills.

**Behavioural Indicators**

| | | | | | |
|---|---|---|---|---|---|
| 1. Participates in appropriate Continuing Medical Education. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Utilises evidence based medicine in daily practice. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Has shown evidence of undergraduate & postgraduate teaching abilities. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Undertakes and encourages research in area of expertise. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Demonstrates ability to work as part of a Multi-Disciplinary Team. | ☐ | ☐ | ☐ | ☐ | ☐ |

| Committee Comments: |
| --- |

| Consultant's Comments: |
| --- |

| Signed by Chair of Committee: | Signed by Consultant: |
| --- | --- |

## Appendix IV – Consultant Appraisal in Ireland

### 1. What is appraisal?

Job appraisal is a process that takes place in many work settings and often includes the whole workforce hierarchy. It is largely a two way process allowing an employer to assess an employee's performance and an employee to feed back to their employer and register any constraints or suggestions as to what may be done to improve the working environment.

Appraisal in the medical setting is not a process of assessment that one passes or fails, and should not be about scrutinising doctors to see if they are performing poorly. Appraisal is about helping individuals to improve the way they work and the services they provide, themselves and with others. Appraisal goes beyond simply judging individuals on what they have achieved over the past year. It offers a framework for planned, constructive, professional dialogue. It provides the opportunity for reflection about current performance and progress. This is used as a platform to set goals for future professional practice and development which will also contribute to the needs of the organisation in which the individual works. Appraisal should therefore be a positive, constructive process which is mutually beneficial to both the individuals being appraised and also to the organisation in which they work.

As medical structures, institutions and reporting lines become more complex in Ireland, appraisal should be looked upon as a mechanism set up to value, clearly position and maximise the effectiveness of each and every Consultant within the health service for their patients and their own benefit and that of the institution within which they work. It is not part of any re-validation process in this jurisdiction.

### 2. Why introduce appraisal for Consultants now?

Both the Consultants Contract and the McCraith report suggest that Consultants should have a personal plan and that there should be a regular performance monitoring arrangement or review. For these purposes this is referred to as "appraisal".

Section 9 (Scope of Post) of the Consultants Contract 2008 states:

a) "The scope of this post is as set out in the HSE letter of approval for this position at Appendix 1 and the Job Description as issued by the Employer. These describe the Consultant's service commitments, accountabilities and specific duties.
b) The Consultant's annual Clinical Directorate Service Plan will detail how these are to be implemented and will be validated by a series of performance monitoring arrangements.
c) Certain decision-making functions and commensurate responsibilities may be delegated to the Consultant by the Employer. These will be documented in the Clinical Directorate Service Plan.
d) The Consultant may apply through the Employer to the Health Service Executive to change the structure of this post as set out in the HSE Letter of Approval. Any change in the structure of the post is subject to the determination of the HSE.
e) The Consultant may apply for atypical working arrangements under the relevant health service scheme."

The McCraith 'Strategic Review Of Medical Training And Career Structures' stated: "In relation to improving supports for newly appointed Consultants, the Working Committee 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 (Executive) Clinical Director/Employer in the context of changing objectives and the resources available to the Consultant team."

**3. What is in it for me?**

Appraisal will only succeed, and be of value to individual participants, if they recognise that the process provides appraisees with opportunity and support for reflection, and constructive feedback on which personal and professional development can be based. Also, through this process, the appraisee can raise and discuss issues of concern relating to their contribution to the range and quality of clinical services provided.

**4. How will the appraisal system work?**

At the core of the appraisal process will be an annual meeting (or no greater than 3 yearly at the outset) between the Consultant (appraisee) and his/her appraiser. The purpose of this meeting is to ensure the opportunity for constructive dialogue through which the doctor being appraised can reflect on his/her work and consider how to progress his/her professional development. These meetings will provide a positive process to give Consultants feedback on their performance, to chart their continuing progress and to identify and plan for their work and development needs. The appraisal meeting should be arranged well in advance to afford the opportunity for the appraiser and appraisee to gather together the necessary data to support a meaningful and constructive dialogue at the meeting.

The following questions should be thought through in advance of and considered at the appraisal meeting:

- Am I a good Consultant and do I perform well?
- Am I up to date?
- Do I work well as part of a team?
- What resources and support do I need?
- Am I clear about my service objectives?
- Am I meeting my service objectives?
- What are my development needs and how might these be met?

Documentation will be required to support and record the evidence, discussion and outcomes associated with the appraisal process under the headings outlined above. This will be agreed and jointly signed off by the appraiser and appraisee.

The Hospital Manager / Chief Executive / CHO Chief Officer has overall responsibility for ensuring appraisal of Consultants takes place and he/she will receive copies of those completed forms which summarise the outcome of the appraisal.

Appraisal is a confidential process. The meetings will be held in private and the completed documentation will, at all times, be treated as confidential. Documentation will only be seen by the

appraiser and appraisee and will be restricted to the Hospital Manager / Chief Executive and Clinical Director / Executive Clinical Director.

**5. Who will appraise me?**

Firstly, it is a clear requirement that appraisal of a Consultant will always be carried out by another Consultant on the Medical Register. The recommended framework for "cascading" Consultant appraisal will be the medical management structure. Ideally, therefore, Consultants would be appraised by their respective Clinical Directors / Executive Clinical Directors who, in turn, would be appraised by their Group Clinical Director. In many situations the number of Consultants may be too great to expect the Clinical Director to be the appraiser for all of them. In such circumstances, local discussions will be required to agree an effective and acceptable "cascade" structure. For example, if there is a Medical Board Chairman or Head of Department structure, they might be identified as appraisers.

Special arrangements will also need to be made for the appraisal of clinical academics or Consultants who regularly work in more than one hospital or group. In both cases, the Consultant concerned should only have one appraisal and one appraiser, but there will have to be input from other hospitals or agencies where the Consultant has public commitments the university / group academic lead. The precise arrangements will have to be agreed between the organisations concerned and with the individual doctor to be appraised.

The Hospital Manager / Chief Executive / CHO Chief Officer is ultimately responsible for ensuring that appraisal takes place and that an appropriate appraiser is identified and that the person nominated is capable and appropriate to undertake the role.

* * *

## Appendix V – Consultant recruitment in the Mental Health Services

### 1. Introduction

Consultant posts in the public mental health services in Ireland are deployed in line with A Vision for Change, the national policy on mental health services and the HSE Mental Health Division Service Plan priorities.

The following sets out measures to support efficient and informed processing of applications for new and replacement Consultant posts in the Mental Health Services. These should be read in conjunction with the rest of this report.

### 2. Applications for posts

The sequence of application within the mental health services is recommended to be as follows:

(i) The preliminary application is the responsibility of the ECD supported by the Business Manager. This is in their role as line manager of Consultants with responsibility for clinical services and a particular role in strategic development of the mental health service.
Hence, the ECD should coordinate the completion of the forms in consultation with the relevant Clinical Director/Lead Consultant for the specialty (CAMHS, General Adult, Psychiatry of Old Age, MHID) where appropriate.

(ii) For replacement posts, consideration should be given to any necessary reconfiguration required in line with current service needs/developments locally and nationally.

(iii) New posts must be based on identified local need and/or Service Plan priorities and must be in line with A Vision for Change.

(iv) As part of the set of documents, the ECD will coordinate the completion of the job description/specification, a work schedule and identify with name and contact details the Consultant to be responsible for induction. The latter could be the ECD or the CD in the specialty as appropriate.

(v) This application to be discussed and agreed with the Mental Health Management Team. In the current system the form is then sent to the ISA Manager for approval and then to the Chief Officer. The ISA Manager will change to the Head of Mental Health Services with the implementation of the CHO Report. The Chief Officer is required to sign the application which is then submitted to the CAAC for consideration.

### 3. CAAC

The Mental Health Division has a nominee to CAAC. The nominee is the NCAGL who also provides the opinion on behalf of the Mental Health Clinical Programmes. The College of Psychiatrists of Ireland also has a nominee on the CAAC.

**4. Letters of approval**

Letters of approval from CAAC are now sent to the Head of Operations in the Mental Health Division and copied to the local services. Within the Mental Health Division, the Head of Operations will have a shared database with the Mental Health Division Performance and Planning Section so that the Workforce Planner can be kept up to date with progress.

**5. Expression of Interest in an Internal transfer**

When the post is returned to the Chief Officer, there may be an application by an existing permanently appointed consultant in the relevant Specialty and on the Specialist Division of the Register working in that mental health service an Internal Transfer and this should be facilitated where appropriate.

It should be note that Consultants may transfer into an approved vacant Consultant post, subject to:

- The Consultant holding a permanent post;
- The Consultant holding the qualifications specified by the HSE for the post;
- The conduct of a formal interview or skills match process which includes the following elements:
  - Publication of the vacancy (e.g. advertisement, email notification)
  - Submission and evaluation of Curriculum Vitae
  - A formal interview / skills match process to include representation from outside the Hospital Group or Community Health Organisation
  - Written communication of the outcome of the process to NDTP and retention of records of the process

In such cases, the vacated post will then have to be resubmitted as a replacement post to CAAC. Otherwise the Job Plan, Job Description, work schedule and contact for induction in the CAAC application documentation is sent to the NRS. It should be possible for the NRS to, by return, forward it to the PAS for interview.

**6. PAS**

Details on the current process used by the Mental Health Division were agreed with the PAS in 2015 and include specialty representation nominated by the College of Psychiatrists of Ireland together with the ECD or the relevant specialty nominee from the local service. All consultant nominees must hold a permanent appointment in a HSE or publicly funded hospital/agency and be on the relevant Specialty Register.

The PAS currently seeks references for mental health posts in advance of the interview process and this should continue.

**7. Joint Appointments**

Joint appointments between the mental health services and acute hospitals are clinically appropriate in some specialty or subspecialty posts e.g. Psychiatry of Old Age or Child and Adolescent Psychiatry consultant posts with ring fenced hours for consultation/liaison work in acute hospitals.

At both Executive and ECD/CD level in the CHO and acute hospital, there must be agreement that a joint appointment is appropriate together with relevant details such as

- Hours of work
- Scope of work
- Interview process for Section 38 hospitals e.g. through PAS or the hospital
- Nominees

The reporting relationship will be to the service/hospital paying the postholder's salary. There are also other issues to be covered such as the induction and appraisal process to be agreed.

**8. Workforce Planning**

The Mental Health Division has appointed a Workforce Planner who, as part of her responsibility, and in conjunction with the Operational and Clinical Advice Sections of the Mental Health Division will work with the NDTP. This will involve liaison with the College of Psychiatrists of Ireland as required.

The Mental Health Division and its Workforce Planner will put in place a process whereby notification is simultaneously sent to the NDTP when a Consultant takes up a post, including those who transfer internally into a recently approved post.

*  *  *

## Appendix VI – Guidance on creation, approval of and recruitment to Consultant posts

Guidance on successful Consultant recruitment, appointment and retention in Hospitals, Mental Services and Health Agencies is set out below

# Towards Successful Consultant Recruitment, Appointment and Retention in Hospitals, Mental Services and Health Agencies

# Guidance

*December 2016*

**Purpose of guidance**

This document sets out guidance and standards relating to the creation and approval of Consultant posts by the HSE and recruitment to such posts. It takes account of the Health Service Executive (HSE) role in the regulation of Consultant posts under the Health Acts and the requirements of HSE and HSE-funded agencies under the Public Service Management Recruitment and Appointments Act.

The guidance is for the attention of and use by those involved in the decision to recruit a Consultant to a HSE or HSE-funded hospital / agency. It can also be provided to each stakeholder within the recruitment process, including prospective employees and interested candidates.

Queries may be made by email to doctors@hse.ie in relation to Section A and by email to andrew.condon@hse.ie in relation to Sections B and C.

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## Glossary

The following acronyms and terms are used in this report:

CAAC – Consultant Applications Advisory Committee
CAU – Consultant Appointments Unit
CHO – Community Healthcare Organisation
CPSA – Commission for Public Service Appointments
DoH – Department of Health
DEPR – Department of Public Expenditure and Reform
HSE – Health Service Executive
HR – Human Resources
NDTP – National Doctors Training & Planning
NCHD – Non-Consultant Hospital Doctor
NRS – National Recruitment Service
PAS – Public Appointments Service

# A – Guidance for Employers

## 1. What is a Consultant?

Consultant Contract 2008 sets out a definition of a Consultant in the Irish public health system. It states that a Consultant is defined as a registered medical or dental practitioner 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 for patients under his/her care, or that aspect of care on which (s)he has been consulted.

Consultants are clinically independent in relation to decisions on the diagnosis, treatment and care of individual patients. This clinical independence derives from the specific relationship between the patient and the Consultant in which the patient places trust in the Consultant personally involved in his/her care to make clinical decisions in the patient's best interests and to take continuing responsibility for their consequences.

Noting the above, Consultants are subject to statutory and regulatory requirements and corporate policies and procedures.

Consultants are expected to have a substantial and direct involvement in the medical diagnosis, treatment and delivery of care to patients. Each patient, either within a hospital or mental health service setting, should have a named Consultant who has continuing responsibility for his/her diagnosis, treatment and care.

The Consultant may discharge his / her responsibilities through a direct personal relationship with the patient; shared responsibility with other Consultants who contribute significantly to patient management or delegation of aspects of the patient's care to other appropriate staff. Delegation of responsibility to other doctors or staff by a Consultant is subject to the Consultant being satisfied that the relevant staff member has the necessary professional capability and the continued provision of a commensurate level of diagnosis, treatment and care to the patient.

In any event, the Consultant retains a continuing overall responsibility for the care of the patient.

Consultants generally work in a leadership role but invariably as part of a clinical team. The primary purpose of a specialist team is to ensure that Consultant provided services to patients are on a continuing basis. In effect this requires that Consultants provide diagnosis, treatment, care and discharge of patients under the care of other Consultants on his/her specialist team and vice versa, where appropriate. The membership of the Consultant specialist team will be determined in the context of the local working environment. The team may be defined at specialty/sub-specialty level or under a more broadly based category e.g. general medicine, general surgery.

## 2. Consultant Contract and Contract Type

Currently, a range of contractual arrangements apply to Consultants working in the public health system, including Consultant Contract 2008, Consultant Contract 1997, the Academic Consultant Contract 1998 and Consultant Contract 1991. These arise from legacy agreements. However, since 2008, the only contract available to either new entrants or Consultant moving to a different post is Consultant Contract 2008, which is held by over 80% of all permanent Consultants.

Consultant Contract 2008 varies in two important areas. Firstly, it varies in relation to access to private practice. The four different Contract Types – A, B, B* and C differ only in respect of access to private practice. Detailed guidance on same is available at Sections 20-22 of Consultant Contract 2008 and in HSE guidance here. Secondly, the Contract varies depending on whether the post is classified as a standard clinical post or an academic post (a Professor, Associate Professor or Senior Lecturer). Section 15 of the Contract applies only to academic posts. In the case of part-time or posts where the Consultant has opted for flexible working pro-rata arrangements are made. Otherwise, identical contract terms apply.

## 3. Regulation of Consultant posts by the HSE

Consultant posts in publicly-funded hospitals and health agencies are regulated under Section 57 of the Health Act, 2004.

The HSE's regulatory function covers all Consultant appointments in the public health service in Ireland including the HSE hospitals, voluntary hospitals, Mental Health Services and other agencies whether additional, replacement, temporary or locum and irrespective of the extent of the commitment involved or source of funding of the appointment. It includes:

- new and replacement permanent Consultant posts;
- locum and temporary (non-permanent) Consultant posts;
- structuring / restructuring of Consultant posts;
- determination of the Type of Contract / Category of Contract to apply to Consultant posts and various functions relating to changes in Type of Contract / Category of Contract;
- determination of the qualifications to apply to Consultant posts;
- determination of the title of Consultant posts.

## 4. Requirement to seek approval before making a Consultant appointment

In summary terms, the requirement to seek approval before making a Consultant appointment arises from the following:

- the regulation of posts by the HSE to ensure that
  - that persons employed as Consultants in the public health service are appropriately qualified and competent, and
  - that the viability of and need for the post with regard to the safe delivery of Consultant services has been confirmed
- the need for employers to seek the prior approval of the HSE before making a Consultant appointment (whether permanent or non-permanent) and comply with the HSE Letter of Approval in making the appointment.
- that it is illegal for an employer to proceed with such an unregulated appointment which has not been approved by the HSE.
- the extent to which unregulated appointments may
  - not be appropriately qualified or competent,
  - block or delay the submission of applications for HSE-approved posts and
- contribute to the ad hoc development of services which may not be in line with local or national policy
- the Protection of Employees (Fixed Term Work) Act, 2003 - which has particular implications for health employers offering repeated fixed-term (temporary and locum) appointments to

individual candidates as repeated appointments can result in employees acquiring contracts of indefinite duration.

## 5. Assignment of regulatory functions within HSE

The HSE's regulatory functions regarding Consultants are delivered by the National Doctors Training & Planning Unit (NDTP), part of the HSE Human Resources Division.

## 6. Committees advising HSE on Consultant appointments

Consultant Contract 2008 as agreed by the HSE, medical unions, Department of Health & Children and Department of Finance provides (at Appendix X of Consultant Contract 2008) for two committees – the Consultant Applications Advisory Committee (CAAC) and Type C Committee - to advise the HSE on the regulation of Consultant posts.

The Committees also provide an agreed contractual mechanism for delivery of the HSE's statutory functions and decision-making regarding change of contract type, change of structure of post, qualifications, change of title and related appeals. Both Committees include representation from a range of medical specialties, hospital and health management nominees from the Department of Health, Postgraduate Training Bodies, patient advocates and representatives of the Irish Medical Organisation and Irish Hospital Consultants Association. NDTP provides administrative support to the Committees, which meet monthly.

Consultant Contract 2008 also includes a series of provisions relating to individual Consultants changing contract type or restructuring their post. These provisions closely follow those set out in Consultant Contract 1997.

In summary, Section 22 c) of the Contract provides for Consultants to have their Contract Type reviewed by the CAAC / Type C Committee where significant changes occur in a particular area in the delivery of acute hospital care. The Contract notes that a decision on applications for change will be considered by the CAAC together with the views of the Employer. Section 22 d) states that a decision on such application will be made following the advice of the CAAC. Section 22 e) outlines the role of the Type C Committee in considering requests for designation of posts as Type C and indicates that a decision on such application will be made by the HSE following the advice of the Type C Committee. Section 9 d) relates to the restructuring of Consultant posts and states that applications for restructuring are made through the local hospital / agency to the HSE for advice by CAAC.

## 7. How is the need for a Consultant post identified?

By way of summary, HSE and HSE-funded hospitals / Mental Health Services / agencies utilise HSE funding to progress

- Replacement posts (where funding has been in place for a number of years).
- Additional posts (where funding is provided in the relevant annual HSE Service Plan approved by the Department of Health).
- Additional posts (where funding which is not anticipated in the HSE Service Plan is identified within the hospital / Mental Health Service / agency, at a Hospital Group or CHO level or at

national level).

In this context, Consultant posts can be progressed by hospitals / Mental Health Service / agencies in line with existing funding (replacement posts), service planning or outside the national service planning framework.

The decision to progress a particular replacement or additional post is made at Hospital Group / CHO level and is subject to:

- Fiscal Parameters; the extent to which funding is available within the relevant hospital, mental health service or agency budget.
- Hospital / agency level, Hospital / CHO and/or national prioritisation in terms of development or ongoing provision of clinical services.
- The HSE Pay and Numbers framework approved by the Department of Health (DoH) and the Department of Public Expenditure and Reform (DPER) which provides for the creation and replacement of posts subject to availability of the required pay resource.

The Accountability Framework governing the creation of Consultant posts can be summarised as: Funded Workforce Plan - Divisional Plan - Community Health Organisation Workforce Plan - Hospital Group Workforce Plan

Prior to making application for recruiting a Consultant, consideration needs to be given as to whether the post is required to be filled. This is a decision generally taken by Human Resources / Medical Manpower, Clinical Directors, Executive Clinical Directors and approved by the CEO of the Hospital Group or the Chief Officer, Community Health Organisation.

It is important to note that Consultant retirements can be anticipated and detailed reports provided by relevant HR systems.

## 8. Proposed / Approved Consultant Appointment document

The application process for creation, approval, recruitment and engagement of a Consultant post has been integrated into a single pack of documents, the most important of which is the Proposed Consultant Appointment document.

As part of the application process, employers are required to submit information on the post, the Business Case used to support approval of the post, an indicative Consultant Work Practice Plan for the post and a Job Description.

Once approved, the document is renamed as the 'Approved Consultant Appointment' document and should be made available to candidates.

Blank documents for completion by hospitals / Mental Health Services / agencies applying for posts are available from NDTP at www.hse.ie/doctors. Hospitals / Mental Health Services / Agencies that wish to recruit a permanent or additional temporary Consultant post should complete the form and submit to email: consultant.applications@hse.ie

## 9. Job Planning and resources to support Consultant appointment

Prior to submitting an application for a Consultant post, employers should note that a key support for a new or replacement Consultant post is a Job Plan which includes provision for:

- the Consultant's role in implementation of a Consultant-provided service and measures to support development of same, including extended consultant presence where appropriate;
- what work the Consultant does for the public health service employer and in the case of Academic Consultants, what work the Consultant does for the academic institution;
- job objectives and related supports from the employer(s);
- timetabling and location of work, including extended consultant presence;
- how timetabled work will align with service objectives and delivery targets;
- the extent and role of flexible working in relation to implementation of targets;
- the commitments that the Consultant may have outside their primary employment;
- the resources necessary for the work to be achieved, including

  Generic resources:
  - Dedicated workspace
  - Computer facilities, internet access, offsite access
  - Access to relevant databases / medical literature
  - Multidisciplinary team (including medical staff as appropriate)
  - Secretarial / administrative support
  - Access to training opportunities
  - Support for Continuing Professional Development
  - Support for audit
  - Time to participate in supporting professional activities

  Specific items:
  - Time – leave and external duties
  - Access to clinical facilities appropriate to Consultant's specialty including, for example:
    - Theatre
    - Day Unit
    - Outpatient Department
    - Minor Operations
    - Endoscopy
    - Community facilities
    - Other, as appropriate

The Proposed Consultant Appointment document includes provision for a Job Plan which, following appointment, should be reviewed as part of the appraisal process.

## 10. Evaluation of applications

Applications for permanent Consultant posts, change in contract type or restructuring of a Consultant post are submitted to the CAAC via NDTP and are considered by the CAAC on the advice of the relevant Clinical Programme. The CAAC considers and advises on each application in the context of information received from NDTP staff, published policy, workload statistics, precedent, literature review, professional advice & knowledge, developments in medical education and training, relevant local information, demography and any other relevant advice (e.g. from relevant clinical programmes or expert advisory groups). With the sole exception of applications for a change of

contract type to Type C – which are sent to the Type C Committee and follow a similar process there – the CAAC considers the matter and either:

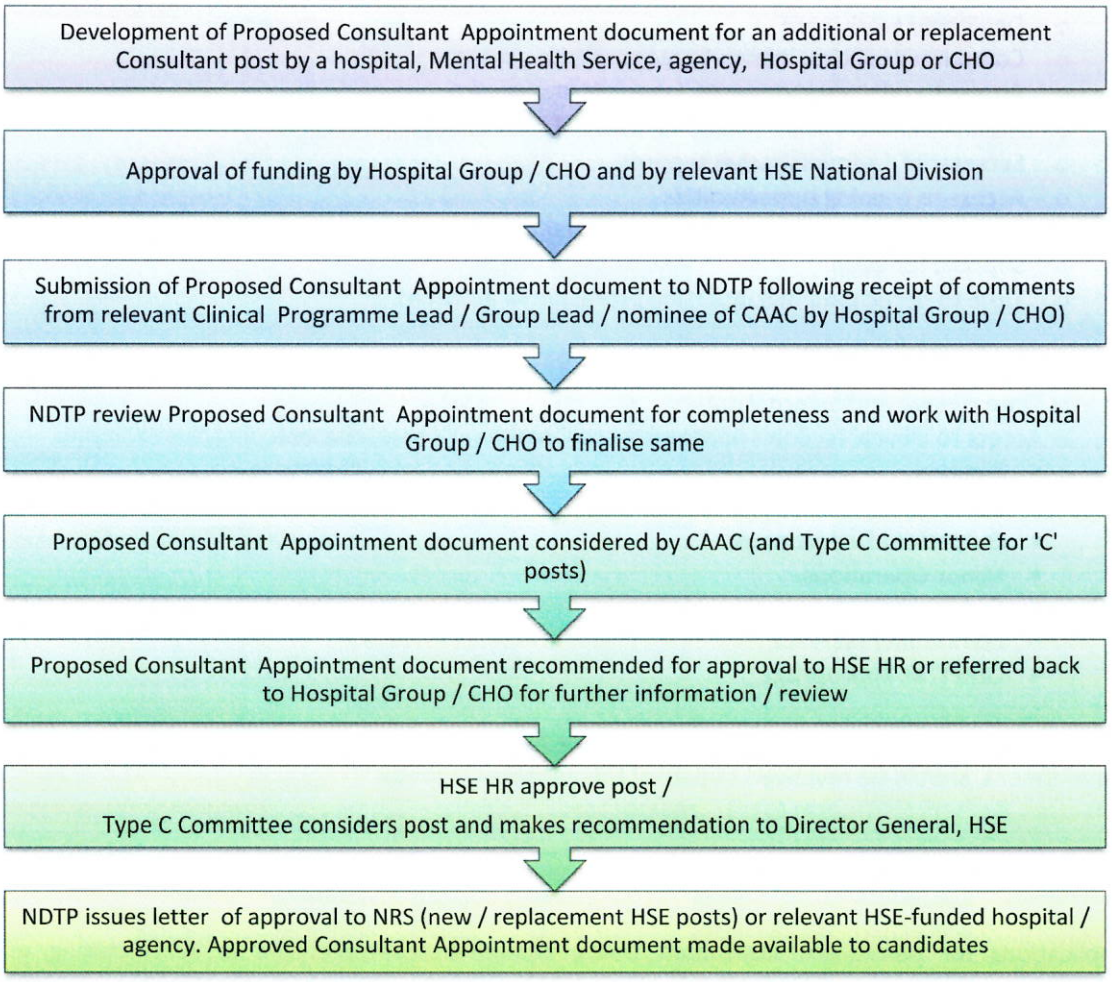
- makes a recommendation to the HSE, sometimes with particular conditions to be met prior to issue of a Letter of Approval or defers consideration of the post pending clarification

or

- in the case of applications for a Type C post, forwards the application to the Type C Committee for further consideration and recommendation.

Recommendations made to the HSE by the CAAC are subject to decision by the National Director of Human Resources to whom this function has been delegated by the Director General of the HSE. Recommendations made to the HSE by the Type C Committee are subject to decision by the Director General of the HSE.

The following summarises the application and approval process for a permanent Consultant post arising from the HSE's regulatory and contractual obligations: timescales




## 11. Applications for temporary or locum Consultant posts

Temporary Consultant appointments may be required between a permanent post becoming vacant

and it being filled on a permanent basis; in the interval between a permanent post having been approved by the HSE and it being filled on a permanent basis; or, in addition to the existing complement of Consultants, to provide services for a fixed period of time or purpose.

The essence of a locum appointment is that a post or office is occupied in a non-permanent capacity for a period by someone other than the legal post holder. The locum acts in place of the post holder. Such circumstances can arise where the holder of the permanent appointment is absent due to holiday, sick leave, study leave, career break etc.

When the anticipated period during which a locum will be required is short-term in nature, there is no need to seek approval from NDTP. However for any period exceeding one month where a locum is required, approval must be sought from NDTP and an application form submitted.

Applications should be submitted as follows:

- Health service employers seeking approval for a locum Consultant during the period when a permanent post holder is on a period of leave, e.g.: maternity leave, sick leave, unpaid leave, leave of absence or career break; or the permanent post holder is seconded to another role on a temporary basis, e.g. clinical programme lead, Clinical Director; or the permanent post holder has been appointed to the post, but has not yet commenced employment, should follow the procedure set out in the HSE HR Circular 021/2015, available at: http://www.hse.ie/eng/staff/Resources/HR_Circulars/circ02115.html and submit to NDTP at email: consultant.applications@hse.ie.

- Health service employers seeking approval for a temporary Consultant post during the period between a permanent post becoming vacant and it being filled on a permanent basis; or the interval between a permanent post having been approved by the HSE and it being filled on a permanent basis should follow the procedure set out in in HSE HR Circular 021/2015, available at: http://www.hse.ie/eng/staff/Resources/HR_Circulars/circ02115.html and submit to NDTP at email: consultant.applications@hse.ie

OR

- Health service employers seeking approval for a temporary post which is additional to the existing complement of Consultants and is to provide services for a fixed period of time or purpose should complete and submit the Proposed Consultant Appointment document available at www.hse.ie/doctors and submit to NDTP at email: consultant.applications@hse.ie

## 12. Qualifications for Consultant appointments

All qualifications specified by the HSE for medical Consultant posts require that Consultants be registered as a Specialist in the relevant specialty on the Specialist Division of the Register of Medical Practitioners maintained by the Medical Council in Ireland in the relevant specialty. A schedule of the qualifications applicable to the different types of Consultant posts is available at: http://www.hse.ie/eng/staff/Leadership_Education_Development/MET/consultantapplications/quals1/

## 13. Issuing of HSE approval for Consultant posts

In the case of permanent or additional temporary posts, following a CAAC recommendation, the HSE communicates approved decisions by way of a Letter of Approval, signed by the Medical Workforce Lead, HSE HR; or in the case of decisions regarding Type C posts or a change of contract type to Type C, following a Type C Committee recommendation, by way of a letter from the Director General. Letters of Approval are not issued for temporary or locum posts where an approved permanent post is in place.

The Letter of Approval includes details relating to the post, such as the title, sub-specialty (if any), location of sessions, and the requisite professional qualifications. The Letter of Approval letter forms the basis of the job description and duties for the post and forms part of the Consultants' contract to be signed by the Consultant appointed to the post.

Letters of Approval are issued within a fortnight of the relevant CAAC meeting or the Direct General decision in the case of Type C applications and are published online on www.hse.ie

Where an application for an permanent, temporary or locum Consultant post is refused or deferred, it would be illegal to proceed with the appointment and any employer proceeding to create a post which has not been approved by the HSE leaves itself open to legal risks arising from claims involving holders of unregulated posts.

Once approval issues, HSE posts are progressed to the PAS for advertisement and competition. Posts for HSE-funded hospitals and agencies (including voluntary hospitals) are advertised and are filled by those hospitals / agencies. These steps are set out below in Guidance for Applicants.

# B – Guidance for Applicants

## 14. Treatment as a new entrant

All potential applicants for Consultant posts should note that any appointee to a Consultant post in the Irish public health service will be treated as a new entrant for superannuation (pension) purposes irrespective of previous public service in Ireland or another EU member state if they have left public service employment in Ireland or another EU member state for more than six months and have not worked in the public service since. More information is available from the HSE National Recruitment Service (for applicants to HSE posts) or the employer (for applicants to posts in HSE-funded agencies) or from the HSE website here: http://www.hse.ie/eng/staff/benefitsservices/Pension_Management/

One way for applicants who undertook medical training in Ireland and worked as a NCHD to avoid future treatment as a new entrant is to apply for a career break from their employer if they intend to leave public service employment for either work in the private sector in Ireland or work abroad for a period of six months or more. Information on career breaks for NCHDs is here: http://www.hse.ie/eng/staff/Resources/HR_Circulars/circ0112014.html and here: http://www.hse.ie/eng/staff/Resources/HR_Circulars/circ102014.html

## 15. Qualifications for Consultant appointments

As noted above, all qualifications specified by the HSE for medical Consultant posts require that Consultants be registered as a Specialist in the relevant specialty on the Specialist Division of the Register of Medical Practitioners maintained by the Medical Council in Ireland in the relevant specialty. A schedule of the qualifications applicable to the different types of Consultant posts is available at: http://www.hse.ie/eng/staff/Leadership_Education_Development/MET/consultantapplications/quals1/ .

## 16. Eligibility to compete for a Consultant post

The HSE Letter of Approval for a Consultant post sets out the eligibility requirements for entry to any competition or recruitment process associated with post.

It notes that while the successful interviewee must be registered as a Specialist in the relevant specialty on the Specialist Division of the Register of Medical Practitioners maintained by the Medical Council of Ireland before taking up appointment, candidates will be allowed a maximum of 180 calendar days from date of interview to secure this registration and produce evidence of special interest training where relevant

Should the successful candidate not be registered as a Specialist on the Specialist Division of the Medical Register at that time, the post may be offered to the next suitable candidate (or, in the case of HSE posts, the Public Appointments Service may choose not to recommend that candidate to the employer). Should no suitable candidate exist, a further recruitment process may be initiated.

## 17. Proleptic appointments

Proleptic appointments refer to appointments where the candidate is offered the post subject to them acquiring a particular qualification or skill within a certain period of time after appointment. Taking this into account, the HSE Letter of Approval for the post and Section 2 d) of Consultant Contract 2008 provide for proleptic appointment to a post as follows:

> "Should the Consultant be required by the terms of the offer of appointment to comply with specified requirements or conditions (including a requirement or condition that (s)he shall acquire a specified qualification) before the expiration of a specified period the employment shall be terminated unless within that period the Consultant has complied with such requirements or conditions."

It is open to the employer to make such an appointment subject to compliance by both the employer and the proleptic appointee to the requirements of the contract as set out above.

## 18. Recruitment Standards

As a public sector agency, the HSE recruits staff under licence from the Commission for Public Service Appointments (CPSA). The Commission's primary statutory responsibility is to set standards for recruitment and selection of public sector employees. These standards are published as Codes of Practice. Implementation of the Codes is assessed via regular monitoring and auditing of recruitment and selection activities.

Permanent Consultant staff within the HSE are recruited via the HSE National Recruitment Service (NRS), which delivers recruitment services to HSE hospitals, mental health services and agencies. [5]

Taking account of the HSE's obligations under its recruitment licence, the NRS uses the Public Appointments Service (PAS) as the centralised provider of recruitment, assessment and selection services relating to permanent Consultant posts.

Non-permanent Consultant staff are recruited directly by hospitals and mental health services.

Permanent and non-permanent Consultant staff within agencies funded by the HSE under Section 38 of the Health Act 2004 Section 38 Agencies (23 non-acute agencies and 16 acute hospitals (including 'voluntary' hospitals) are recruited directly by the relevant hospital / agency.

## 19. The recruitment process

The recruitment and appointment process is carried out jointly by the NRS and the PAS, as described above.

a) Advertisement

All HSE-funded Medical Consultant posts are advertised on www.publicjobs.ie and www.hse.ie In addition job alerts via email and text are issued to potential applicants who have registered with

[5] In relation to medical staff this includes all grades with the exception of staff recruited via training bodies or NCHDs in non-training posts

www.publicjobs.ie

Hospitals and Community Healthcare Organisations can request and fund additional specialist advertising in medical journals, websites and elsewhere for individual roles if required and should make this request directly to the NRS.

b) Informal enquiries

A contact point for informal enquiries is included in the advertisement and in the job specification. The NRS seek an "informal enquiries" contact in the site where the vacancy exists. This contact should be knowledgeable about the post and the service and should be available during the weeks of advertisement to answer any queries that potential applicants may have.

c) Application and application documentation

The PAS prepare an information booklet which provides all necessary information about the post, the terms and conditions of employment and the selection process. This is available at advertisement stage and provides useful and practical information to any potential applicant. The relevant booklet for each individually advertised post is available at www.publicjobs.ie

In addition to this Guidance, the Approved Consultant Appointment document and HSE Letter of Approval for the post are made available to applicants. The Approved Consultant Appointment document contains information on the post, the Business Case used to support approval of the post an indicative Consultant Work Practice Plan for the post and a Job Description.

Each applicant must complete an application form for each post they are interested in. This application form captures information about the applicants' education and professional development, registration and work experience and skills. Written guidance is provided by the PAS for completion of application forms. Applicants must also submit a detailed Curriculum Vitae (CV). The application form and detailed CV are used as the foundation for determination of whether the applicant is eligible to apply for the post, short-listing and interview.

d) Selection Boards: Short-listing and Interview Boards

For posts in Acute Hospitals (other than Psychiatry) the PAS seek potential short listing and interview board nominations from the designated contact in the Hospital Group. For Psychiatry posts the PAS seek nominations from the Human Resources Manager, National Mental Health Division. Nominations and contact details must be provided within 5 work days of request.

The HSE Director General has stipulated there should no more than 5 short listing and interview board members other than in relation to small number of Academic posts or joint appointments between two or more employing institutions, where the number can be expanded to 6. The selection board – which should have a gender mix - compilation is as follows:

- An Independent Chair- nominated by PAS
- 1 Consultant in a relevant specialty/sub- specialty, nominated by PAS
- 1 Clinical Director or Consultant - nominated by the Hospital Group Clinical Director
- 1 Academic- nominated by the Chief Academic in the Group, or in the case of Joint Section 62 appointments, by the University
- Hospital Group CEO/ Senior Management Nominee

For Psychiatry posts the nominees are

- An Independent Chair - nominated by PAS
- The relevant ECD who may nominate the Lead in the specialty where appropriate (e.g. where ECD is in a different specialty in Psychiatry).
- Specialty nominee selected by PAS from nominees provided by the College of Psychiatrists of Ireland.
- Relevant CHO Chief Officer or nominee.

Short listing is carried out using pre-defined criteria based on the requirements of the role. Applicants are informed of the results of the short listing exercise. Any candidate short listed is invited to interview.

e) The interview process

Interviews are carried out using assessment criteria based on the requirements of the role. Individual marks are given for specific areas in the interview. Candidates must pass each individual assessment area. Recruitment panels of qualified individuals may be created from which vacancies may be filled. Qualification and placement on a panel is not a guarantee of appointment to a position. It should be noted that as of June 2016, the format of the recruitment and selection process is under review

f) Validation of proposed appointee

Following successful interview the highest scoring candidate is considered for the post. The candidate is required to undergo a pre-employment/ clearance process and are supported throughout the process by the PAS. This pre-employment process includes Garda/ International Police clearance, validation of IMC registration, pre-employment health assessment and validation of professional qualifications and experience. On successful completion of these pre-employment criteria the PAS recommends the candidate for appointment to the HSE NRS.

g) Recommendation

Following receipt of a recommendation from the PAS the NRS contacts the candidate and the site where the vacancy exists. The candidate is asked to contact the site and agree a start date with the named contact in the site. The candidate is supported throughout this process by the NRS. Should the candidate withdraw at any stage, the next ranked candidate may be recommended for appointment to the post, should they meet the standard required. Alternatively, the post may be readvertised.

h) Timeframes and start date

The NRS requests that the recommended candidate and receiving site agree a future start date **within 5 working days** of the request from NRS. Issues that impact agreement on start date are typically incremental credit entitlement, salary scale type and queries regarding terms of contract.

i) Appointment

Once the start date has been agreed by the candidate and the receiving site and confirmed in writing the NRS draw up and issue a contract of employment. The NRS sends an employee personnel file to the Medical Manpower Manager/ named HR contact which includes a signed copy of the contract,

terms and conditions and the PAS recruitment file. **Candidates are provided with a maximum period of 6 months to take up duty in the post.** Should the candidate not be available at that time, the employer may withdraw the offer.

**20. Induction**

a) What is Induction?

Induction is a process by which employees are received and welcomed to the organisation. It is a method of formally introducing the employee to their work location and colleagues. A clear understanding of their job, role and responsibilities and the mission and values of the wider organisation will be provided. An effective Induction process – together with appropriate use of probation - will ensure that the Consultant is supported in achieving expected performance levels. It will also ensure that the new Consultant is aware of the importance of team-working within the HSE and their role within the team.

It is important to induct, so that Consultants can gain the necessary information to perform their duties to the highest standard possible.

b) Policy and guidance

The HSE issued guidelines on Induction for staff in 2006. Revised guidelines were agreed in 2015 are due for publication in the third quarter of 2016. In that context, HSE hospitals / Mental Health Services / agencies have a single national induction policy and guidance. Set out below is current guidance for both HSE and HSE-funded Hospitals / Mental Health Services / agencies regarding induction as it may be applied to Consultants.

Induction should complement and support the probation process described at Appendix II of this document.

c) Aims of an effective Induction

The aim of induction is:

- To ensure that each Consultant receives a structured welcome and introduction to their immediate work environment and the wider organisation, including their clinical team and wider specialty group;
- To outline the organisations responsibilities and values;
- To assist in the promotion of the culture and philosophy of the organisation;
- To clarify expectations of both Consultant and employer in relation to codes of conduct, policies and procedures, Consultant services etc.;
- To clarify the role of Consultant and performance expectations;
- To commence a process of structured feedback on performance;
- To promote an emphasis on customer/client focus;
- To promote an environment of effective health, safety and welfare.

d) Benefits of an effective Induction

An effective induction process provides the CEO / Hospital Manager / Clinical Director / Executive Clinical Director with a framework to clearly communicate policies and procedures to the Consultant; provides a structured welcome and support and clarity on role expectations for the individual Consultant on commencing employment, promotion, transfer or secondment; helps the

Consultant to fit in, enabling integration into the service area, enhancing effectiveness and performance; promotes a shared vision within the organisation; and assists in fulfilling statutory obligations

e) Roles and responsibilities

Induction is the responsibility of both the employer and Consultant. The employer has the responsibility to ensure that all staff are inducted in a reasonable time frame and the Consultant has responsibility to co-operate fully with the process.

The employer is responsible for:

- Ensuring that Induction is a Key Performance Indicator for Senior Managers;
- Supporting the process and agreeing the release of staff to attend scheduled Induction;
- Training;
- Ensuring that managers in their areas release staff for the Site Induction Training, including, where appropriate, anticipating and securing resources for replacement of front-line staff;
- Tailoring the induction process to include local policies and procedures;
- Ensuring that all aspects of the Induction process are completed within the specified time frames and for progressing through each checklist with the new Consultant;
- Identifying a work colleague
- Reviewing and compiling the necessary back-up materials ahead of the new Consultants arrival;
- Ensuring that either the CEO / Hospital Manager / Clinical Director or designated person is available on the first day to meet the new Consultant;
- Scheduling appointments over the first day, week, 3 months, 6 months to have regular, short meetings with the new Consultant.

The Consultant is responsible for cooperating fully with the process, attending scheduled training and seeking clarification on any documentation, if necessary, before sign-off.

The Work Colleague(s) responsible for welcoming the new Consultant into the organisation; to assist and support the new Consultant to become familiar with their work environment and surroundings

f) Induction schedule for the new Consultant

Before the new Consultant joins the Department, all necessary workspace, equipment and appropriate access to resources should be in place. The CEO / Hospital Manager / Clinical Director / Executive Clinical Director should contact the new Consultant before the agreed start date if appropriate. Separately, The CEO / Hospital Manager / Clinical Director / Executive Clinical Director should ascertain if the new Consultant has any specific disability or diversity requirements. The CEO / Hospital Manager / Clinical Director / Executive Clinical Director should arrange all appropriate initial training. Relevant staff, including reception/security and other relevant people, should be notified of the Consultant's start date by the CEO / Hospital Manager / Clinical Director / Executive Clinical Director or delegated person.

It is essential that the new Consultant is met on the first day and welcomed into the Department.

The CEO / Hospital Manager / Clinical Director / Executive Clinical Director or delegated person introduces the new Consultant to colleagues and other key staff in the organisation including the designated work colleague. The CEO / Hospital Manager / Clinical Director / Executive Clinical Director provides appropriate information to the new Consultant in relation to their role and

responsibilities and expected level of performance. The Consultant will be given details of all training arranged by the CEO / Hospital Manager / Clinical Director / Executive Clinical Director.

The CEO / Hospital Manager / Clinical Director / Executive Clinical Director will progress from the induction to the probation process in the case of newly appointed Consultants who have not previously held a permanent post or acted in that particular permanent post on a temporary basis prior to commencing permanent employment.

Otherwise it will be necessary in the first weeks to set time aside to progress through a process that involves setting objectives/priorities/targets and discussing initial performance and development needs and ways of meeting these. Meetings should be arranged in the first few months between the CEO / Hospital Manager / Clinical Director / Executive Clinical Director and the Consultant to discuss how well the Consultant is performing their duties and to identify what other support is required by the Consultant if necessary.

# C – Guidance for Consultants after appointment

## 21. Probation

a) Purpose of probation

A key element of the initial stages of a Consultant appointment is probation. The purpose of probation is to assess whether the Consultant is suitable for permanent appointment and to allow both the Consultant and the employer to identify issues for resolution prior to confirmation of permanent appointment. The following sets out guidance on the use of probation in relation to Consultant appointments.

b) Application of probation to Consultants

Section 3 of Consultant Contract 2008 – 'Probation' - deals with probation and provides for a 12 month probationary period for Consultants offered permanent appointments. In the case of joint appointments, it should be noted that the Consultant must successfully complete probation for each employer - failure to do so for one employer affects the entire appointment.

Consultants who either hold permanent posts in the Irish public health system or who have acted in the post on a non-permanent basis while the post is being filled permanently do not have to serve the probationary period.

Section 2 a) of the Contract explicitly excludes non-permanent Consultants – those offered fixed term, fixed purpose or locum appointments – from this 12 month period.

c) Reviews during probation

The employer (CEO / Hospital Manager / Clinical Director / Executive Clinical Director) is required to undertake a formal review not more than 6 months after the date of appointment. In this context, it is recommended that the review of the probationary period is aligned with review of the Consultant's job plan and work schedule. A key aspect of the probationary process is that the employer ensures that there is clarity regarding service and performance standards, particularly in relation to workload, working relationships, individual skills, including those relating to management and teaching / training of staff, policies and procedures.

- listen to what the employee has to say;
- focus and highlight successes but recognise, explore and explain failures to meet required standards;
- discuss and agree whether or not any specific training or coaching is required;
- discuss any other relevant matters such as timekeeping, attendance, general conduct or attitude;
- invite comment on issues concerning integration into the department and with colleagues;
- give the employee an opportunity to ask questions or raise concerns about any aspect of his or her employment.

d) Extension of probation

As noted above, the contract requires that employers operate a probationary period of 12 months. The employer may extend the period to 18 months, but must communicate the reasons for this to

the Consultant in writing. During the probationary period, the employer must ensure that the probationary Consultant is subject to ongoing review.

e) The end of the probationary period

Consultant Contract 2008 requires that at the end of the probationary period, the Employer either certifies that the Consultant's service has been satisfactory and confirm the appointment on a permanent basis or certifies, with stated specified reasons, that the Consultant's service has not been satisfactory, in which case the Consultant will cease to hold his/her appointment.

The Contract notes that in the event that the Employer fails to certify that the Consultant's service is not satisfactory, they will be deemed to have been appointed on a permanent basis. Taking that into account, Employers must - without delay - communicate the outcome of the probationary period in writing to the Consultant at the earliest possible opportunity. If the Consultant has not successfully completed probation, the Employer should inform NDTP by email to doctors@hse.ie that the post is now vacant.

f) Serious misconduct during probation

In cases where an allegation of serious misconduct is made against a probationary Consultant, the Contract requires that the issue is dealt with in accordance with Stage 4 of the Disciplinary Procedure (attached at Appendix II to Consultant Contract 2008).

g) Termination

The Contract provides that employment may be terminated by either the Employer or Consultant during the probationary period. Should employment be terminated by the Employer, the Employer shall set out in writing the specific reasons for such termination.

Set out below are standardised indicators which may be used during review of the probationary period

## Consultant Review

| | Behavioural Indicators | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 1. | Always follows through on issues and behaves in a manner that is consistent with own and the organisation's espoused values and practices; will check back to others where there are value or integrity issues. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. | Shows fairness and consistency in dealing with direct reports and other staff; doesn't generally operate hidden agendas and doesn't give preferential treatment. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. | Is able to treat personally sensitive information with confidentiality; is careful not to speak in an indiscrete or hurtful way about others. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. | Admits mistakes and is willing to take responsibility when things go wrong as a result; doesn't misrepresent self for personal gain. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. | Is generally honest and truthful in dealing with individuals; elicits trust from others on this basis. | ☐ | ☐ | ☐ | ☐ | ☐ |

## Negotiation, Communication and Influencing Skills

**Definition:** Gets a message across fluently and persuasively in a variety of different media (oral, written and electronic).
Makes a compelling case to positively influence the thinking of others. Is strategic in how he / she goes about influencing others; shows strong listening and sensing skills.

6. Rarely
7. Sometimes
8. Meets
9. Sometimes exceeds
10. Often exceeds

| | Behavioural Indicators | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 1. | Marshals information cogently to make a persuasive case; communicates information clearly in the spoken word; makes well-structured and persuasive presentations. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. | Can communicate in a rational mode as appropriate and is professional in managing all professional relationships and interactions | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. | Has strong two-way listening skills; is able to elicit information from others in a non-threatening way and can read between the lines. Can impart information in a non-threatening way | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. | Able to argue position, point of view, in a reasonable professional manner and tone | ☐ | ☐ | ☐ | ☐ | ☐ |

## Sustained Personal Commitment

**Definition:** Is personally committed to achieving end goals and the continuous improvement of the service.

**Behavioural Indicators**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. | Shows a strong degree of self-awareness, seeking feedback from colleagues. | ☐ | ☐ | ☐ | ☐ | ☐ |

2. Accepts both negative and positive feedback and acts thereon. ☐ ☐ ☐ ☐ ☐

## Clinical Development

**Definition:** Always demonstrates sound clinical judgement and clinical skills.

**Behavioural Indicators**

1. Participates in appropriate Continuing Medical Education. ☐ ☐ ☐ ☐ ☐
2. Utilises evidence based medicine in daily practice. ☐ ☐ ☐ ☐ ☐
3. Has shown evidence of undergraduate & postgraduate teaching abilities. ☐ ☐ ☐ ☐ ☐
4. Undertakes and encourages research in area of expertise. ☐ ☐ ☐ ☐ ☐
5. Demonstrates ability to work as part of a Multi-Disciplinary Team. ☐ ☐ ☐ ☐ ☐

| **Committee Comments:** |
|---|
| |

| **Consultant's Comments:** |
|---|
| |

| **Signed by Chair of Committee:** | **Signed by Consultant:** |
|---|---|
| | |

## 22. Appraisal

a) What is appraisal?

Job appraisal is a process that takes place in many work settings and often includes the whole workforce hierarchy. It is largely a two way process allowing an employer to assess an employee's performance and an employee to feed back to their employer and register any constraints or suggestions as to what may be done to improve the working environment.

Appraisal in the medical setting is not a process of assessment that one passes or fails, and should not be about scrutinising doctors to see if they are performing poorly. Appraisal is about helping individuals to improve the way they work and the services they provide, themselves and with others. Appraisal goes beyond simply judging individuals on what they have achieved over the past year. It offers a framework for planned, constructive, professional dialogue. It provides the opportunity for reflection about current performance and progress. This is used as a platform to set goals for future professional practice and development which will also contribute to the needs of the organisation in which the individual works. Appraisal should therefore be a positive, constructive process which is mutually beneficial to both the individuals being appraised and also to the organisation in which they work.

As medical structures, institutions and reporting lines become more complex in Ireland, appraisal should be looked upon as a mechanism set up to value, clearly position and maximise the effectiveness of each and every Consultant within the health service for their patients and their own benefit and that of the institution within which they work. It is not part of any re-validation process in this jurisdiction.

b) Why introduce appraisal for Consultants now?

Both the Consultants Contract and the McCraith report suggest that Consultants should have a personal plan and that there should be a regular performance monitoring arrangement or review. For these purposes this is referred to as "appraisal".

Section 9 (Scope of Post) of the Consultants Contract 2008 states:

e) "The scope of this post is as set out in the HSE Letter of Approval for this position at Appendix 1 and the Job Description as issued by the Employer. These describe the Consultant's service commitments, accountabilities and specific duties.
f) The Consultant's annual Clinical Directorate Service Plan will detail how these are to be implemented and will be validated by a series of performance monitoring arrangements.
g) Certain decision-making functions and commensurate responsibilities may be delegated to the Consultant by the Employer. These will be documented in the Clinical Directorate Service Plan.
h) The Consultant may apply through the Employer to the Health Service Executive to change the structure of this post as set out in the HSE Letter of Approval. Any change in the structure of the post is subject to the determination of the HSE.
f) The Consultant may apply for atypical working arrangements under the relevant health service scheme."

The McCraith 'Strategic Review Of Medical Training And Career Structures' stated: "In relation to improving supports for newly appointed Consultants, the Working Committee 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 (Executive) Clinical Director/Employer in the context of changing objectives and the resources available to the Consultant team."

c) What is in it for me?

Appraisal will only succeed, and be of value to individual participants, if they recognise that the process provides appraisees with opportunity and support for reflection, and constructive feedback on which personal and professional development can be based. Also, through this process, the appraisee can raise and discuss issues of concern relating to their contribution to the range and quality of clinical services provided.

d) How will appraisal work?

At the core of the appraisal process will be an annual meeting (or no greater than 3 yearly at the outset) between the Consultant (appraisee) and his/her appraiser. The purpose of this meeting is to ensure the opportunity for constructive dialogue through which the doctor being appraised can reflect on his/her work and consider how to progress his/her professional development. These meetings will provide a positive process to give Consultants feedback on their performance, to chart their continuing progress and to identify and plan for their work and development needs. The appraisal meeting should be arranged well in advance to afford the opportunity for the appraiser and appraisee to gather together the necessary data to support a meaningful and constructive dialogue at the meeting.

The following questions should be thought through in advance of and considered at the appraisal meeting:

- Am I a good Consultant and do I perform well?
- Am I up to date?
- Do I work well as part of a team?
- What resources and support do I need?
- Am I clear about my service objectives?
- Am I meeting my service objectives?
- What are my development needs and how might these be met?

Documentation will be required to support and record the evidence, discussion and outcomes associated with the appraisal process under the headings outlined above. This will be agreed and jointly signed off by the appraiser and appraisee.

The Chief Executive has overall responsibility for ensuring appraisal of Consultants takes place and he/she will receive copies of those completed forms which summarise the outcome of the appraisal. Appraisal is a confidential process. The meetings will be held in private and the completed documentation will, at all times, be treated as confidential. Documentation will only be seen by the appraiser and appraisee and will be restricted to the Chief Executive and (Executive) Clinical Director.

e) Who will appraise me?

Firstly, it is a clear requirement that appraisal of a Consultant will always be carried out by another Consultant on the Medical Register. The recommended framework for "cascading" Consultant

appraisal will be the medical management structure. Ideally, therefore, Consultants would be appraised by their respective Clinical Directors who, in turn, would be appraised by their Group / Executive Clinical Director. In many situations the number of Consultants may be too great to expect the Clinical Director to be the appraiser for all of them. In such circumstances, local discussions will be required to agree an effective and acceptable "cascade" structure. For example, if there is a Medical Board Chairman or Head of Department structure, they might be identified as appraisers.

Special arrangements will also need to be made for the appraisal of clinical academics or Consultants who regularly work in more than one hospital or group. In both cases, the Consultant concerned should only have one appraisal and one appraiser, but there will have to be input from the university/group academic lead. The precise arrangements will have to be agreed between the organisations concerned and with the individual doctor to be appraised.

The Hospital Chief Executive / Chief Officer CHO is ultimately responsible for ensuring that appraisal takes place and that an appropriate appraiser is identified and that the person nominated is capable and appropriate to undertake the role.

## 23. Movement between Type of Contract / Category of post

The procedures for movement between different Types of Contract under the Consultants Contract 2008 and categories of post under the Consultants Contract 1997 and related forms for completion are available from the NDTP website at www.hse.ie/doctors

## 24. Restructuring of Consultant posts

Applications to restructure a Consultant post should be submitted to NDTP via the Hospital Group CEO / Community Health Organisation CO setting out the:

- circumstances giving rise to the restructuring;
- the current structure of the post;
- the proposed new structure;
- the view of the Consultant holding the post;
- the view of the Employer.

The view of the Hospital Group CEO / Community Health Organisation CO should be attached to the application prior to it being forwarded to NDTP. A form for completion is available from the NDTP website at www.hse.ie/doctors

## 25. Expression of interest to transfer between Consultant posts

Consultants may transfer into an approved vacant Consultant post, subject to:

- The Consultant holding a permanent post;
- The Consultant holding the qualifications specified by the HSE for the post;
- The conduct of a formal interview or skills match process which includes the following elements:
  - Publication of the vacancy (e.g. advertisement, email notification)
  - Submission and evaluation of Curriculum Vitae
  - A formal interview / skills match process to include representation from outside the Hospital

Group or Community Health Organisation
- Written communication of the outcome of the process to NDTP and retention of records of the process

## 26. Change of title of Consultant posts

The procedures for change of title of Consultant post and a form for completion are available from the NDTP website at www.hse.ie/doctors

## 27. Exit interviews

Each Consultant leaving post should be invited to participate in an exit interview conducted either by the Clinical Director, HR or Medical Manpower Manager. A note should be taken of the interview and the reasons offered for leaving recorded. The employer should ensure that these reasons are communicated to NDTP as part of the application process for replacement.

Questions that should inform the exit interview include:

- What is your primary reason for leaving?
- Did anything trigger your decision to leave?
- What was most satisfying about your job?
- What was least satisfying about your job?
- What would you change about your job?
- Did you receive enough training to do your job effectively?
- Did you receive adequate support to do your job?
- Did you receive sufficient feedback about your performance?
- What would you improve to make the workplace better?
- Were you happy with you pay, benefits and other incentives?
- What was the quality of the supervision/management you received?
- Did any health service / employer policies or procedures (or any other obstacles) make your job more difficult?

A sample Exit Survey is attached below.

## Exit Questionnaire

Thank you for taking the time to complete this questionnaire. This questionnaire is designed to provide you with an opportunity to comment **in confidence** on your experiences in the workplace.

**Please note that this information will only be used to assess general employment trends and to make improvements to the workplace where possible.**

**Section 1: Employment Statistics**

**1.1 Position Title and/or Department:** _____

**1.2 Length of service:** _____**years** _____ **months**

**1.3 Gender:** Male Female

**1.4 Age Range:** 18 – 25 26 – 30 31 - 35 36 – 40 41 - 45
46 – 50 51 – 55 56 - 60 60 +

**1.5 Country of origin:** _____

**Section 2: Reason for Leaving**

**2.1 Reason for leaving. Please rank top 3 reasons:**
**(1 = most significant reason, 2 = second most significant reason, etc)**

Career change (e.g. commencing a new career in a different field of work) ☐

Career development

Location (e.g. Travel time to and from work)

Retirement

Early retirement

Ill health

Dissatisfaction with job

Dissatisfaction with Line Management

Not granted a transfer within the Service

Other (Please Specify) _____

**2.2 Please rate the following as factors influencing you to decide to leave the Service:**

| | Influence → | | | |
|---|---|---|---|---|
| **Factors within this Service** | No Influence | 1 Low | 2 Medium | 3 High |
| Higher salary in new job | | | | |
| Better development & training opportunities in my new job | | | | |
| Better promotional opportunities in my new job | | | | |
| I am unhappy with relationships with my colleagues | | | | |
| Working conditions / staff facilities within the service | | | | |
| Other (please specify) | | | | |

| **Factors outside this Service** | No Influence | 1 Low | 2 Medium | 3 High |
|---|---|---|---|---|
| Lower cost of living & property | | | | |
| Better quality of life | | | | |
| Less commuting times in new employment | | | | |
| Caring for family members | | | | |
| Leaving the country to live abroad | | | | |
| Relationship Related - Moving to live with spouse / partner in another part of the country / world | | | | |
| Retirement | | | | |

| | | | | |
|---|---|---|---|---|
| Other (please specify) | | | | |

**2.3 Which most accurately describes your destination upon leaving?**

Other Irish health service provider
Other international health service provider
Other Irish public sector organisation
Community service organisation
Private sector organisation
Private sector – self-employed
Home duties
Unemployment
Other _____

**Section 3: HR Feedback**

**3.1 Have you enjoyed your time in the Service?** **Yes** **No**

**3.2 Would you recommend the Service as an employer?** **Yes** **No**

**3.3 Please rate the following as factors that have influenced your satisfaction while in the Service:**

| **Factors within this Service** | Positive | Neutral | Negative |
|---|---|---|---|
| Relationships with colleagues | | | |
| Salary | | | |
| Training & development opportunities | | | |
| Promotion opportunities | | | |
| Physical working environment | | | |
| On the job training | | | |
| Skills & expertise utilised appropriately here | | | |
| Support from your Line Manager | | | |
| Recognition of your work | | | |

**3.4 How would you rate the Service as an employer on a scale of 1-5?**

**← Poor Strong →**

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|

**3.5 What would you consider to be the strengths of the Service as an employer?**

1. _____
2. _____
3. _____

**3.6 What measures should the Service take to retain staff into the future?**

1. _____
2. _____
3. _____

**3.7 Any other information or feedback that you feel is relevant:**

**If you would like the opportunity to have a discussion with a member of the HR team before your leaving date please contact: xxx**

*Thank you for taking the time to complete this questionnaire.*

**Please return to:**

**xxx**