STRATEGIC REVIEW OF MEDICAL TRAINING AND CAREER STRUCTURE

REPORT ON MEDICAL CAREER STRUCTURES AND PATHWAYS FOLLOWING COMPLETION OF SPECIALIST TRAINING

DEPARTMENT OF HEALTH

11TH APRIL 2014

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EXECUTIVE SUMMARY

1. Background

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

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

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

The Working Group will examine and make high-level recommendations relating to training and career pathways for doctors with a view to:

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

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

2. Focus of this Report

From January-April 2014, the Working Group prioritised work on career structures and pathways following completion of specialist training in order to report to the Minister for Health on these issues in this report.

3. Working Group Meetings and Stakeholder Consultation

The Working Group met on eight occasions and also held consultation meetings with stakeholders including trainee doctors, health sector union representatives and the Irish College of General Practitioners (ICGP). The Chair and members of the Working Group would like to express their sincere thanks to all those who attended consultation meetings for their time, helpful inputs and positive engagement.

4. Conclusions

This report focuses on future medical career structures and pathways following completion of specialist training[1] and, in particular, on career structures and pathways for Consultants.

The Working Group recognises that there are particular issues and challenges in relation to the recruitment and retention of doctors in services beyond the acute hospital setting, including public health medicine, general practice and mental health services. It is the Working Group's intention to examine these issues further with a view to reporting on them and making high-level recommendations, as appropriate, in the Group's final report in June 2014. Any other outstanding issues relating to medical career structures and pathways following training will also be addressed in the June report.

In arriving at its conclusions, the Working Group has considered the views of stakeholders, the HRB's international evidence review, relevant international and national developments in recent years, and the overarching future policy context – the Health Reform Programme.

4.1 The Central Role of the Consultant

At the outset, the Chair and members of the Working Group wish to acknowledge that the Consultant:

- Is central to the delivery of quality, safe care to patients;
- Is a vital resource for the efficient and effective functioning of the public health system;
- Plays a key leadership role in both management and clinical service provision.

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

The Working Group recognises that our medical workforce is an internationally mobile one and that, given the quality of Irish medical training and the global shortage of doctors, other countries are actively seeking to attract Irish medical graduates to work in their health systems.

While recognising that Irish medical graduates gain valuable experience working in health systems in other jurisdictions (both in Europe and elsewhere), in line with Ireland's national policy of health-worker self-sufficiency, the Group wishes to emphasise the importance of

[1] Attainment by the clinician of CSCST and qualification for registration on the Specialist Division of the Medical Council's register.

recruiting and retaining Irish medical graduates as Consultants in the public health system – both now and in the future.

In the context of the Health Reform Programme, the Working Group considers that the Consultant role must:

- Provide high-quality, safe patient care in a cost-effective manner;
- Be grounded in a team-based approach to clinical care with Consultants working as an integral part of a multidisciplinary team, acting together and sharing responsibility for patients with Consultant colleagues, and working alongside other health professionals including trainee doctors, nurses, and health and social care professionals;
- Be grounded in, responsive to and play a critical leadership role in developing new service delivery models and addressing service needs;
- Provide for Consultant-provided care based on clinical need;
- Facilitate integrated delivery of care to patients.

The Working Group recognises that Consultant roles and working practices have changed and evolved considerably in many disciplines over the past decade in response to system reconfiguration and service improvements e.g. the National Cancer Control Programme. The Working Group welcomes this development and considers that it is likely to become an increasing feature of the Irish healthcare landscape in the coming years – both in response to changing patient needs and expectations, and in response to clinical advances and developments, together with plans for a more integrated system of primary and hospital care.

4.2 Future Consultant Career Structures and Pathways

The Working Group notes feedback from stakeholders that the nature and composition of a doctor's work may change over time, with some doctors taking on non-clinical roles as their career progresses. Moreover, many doctors are branching off the traditional clinical path at various points in their careers to undertake secondments, fellowships and other short- or medium-term options.

In this context, the Working Group takes the view that, in the future, appointment as a Consultant should be considered as a key step in a medical career, with further opportunities for advancement, progression and personal development, rather than viewed as an end-point in itself. A more differentiated Consultant career structure, which takes account of relevant post-CSCST[2] experience obtained in Ireland or abroad would offer greater opportunities for progression, and would be in keeping with Consultant roles and career structures in other jurisdictions.

[2] Certificate of Satisfactory Completion of Specialist Training

There are a number of strands within which opportunities for advancement, progression and personal development for Consultants can be envisaged in the future. These include, but are not necessarily limited to:

- Clinical service provision;
- Clinical leadership and management;
- Research, training, academic, quality improvement and other roles.

4.2.1 Clinical Service Provision

In order to facilitate a Consultant-provided service, the Group strongly believes that the majority of doctors who are appointed as Consultants will be needed to, and will wish to, stay involved in active clinical service delivery as part of Consultant and multidisciplinary teams. In this regard, the Group considers that the establishment of the Hospital Groups, and the development and implementation of the National Clinical Programmes, offer opportunities for more varied clinical service delivery – within the overall service needs of a Hospital Group.

The Group also notes that the establishment of the Hospital Groups offers the potential for the development of a variety of lead roles within a Consultant team, which are likely to be of interest to particular Consultants depending on their personal interests and/or experience e.g. clinical training lead, service development lead, quality improvement lead etc.

The Group notes current challenges in respect of staffing of particular Consultant-level posts in some smaller or peripheral (Level 2/Level 3) hospitals and considers that the establishment of the Hospital Groups, with shared governance and the reconfiguration of services between sites, provides an opportunity to address this issue through the provision of more varied service delivery opportunities for doctors. Having considered examples from other jurisdictions, it does not consider that initiatives such as incentive or bonding schemes are a sustainable solution to problems in filling posts in smaller, more remote locations.

In addition, the Group notes the onerous out-of-hours commitment and demanding rotas associated with some smaller or peripheral hospitals, and the stated intention of trainees not to take up posts in sites where they consider services to be unsustainable or unsafe. The Group considers that the reconfiguration of services in the context of the Hospital Groups provides an opportunity to address this issue.

4.2.2 Clinical Leadership and Management

The Working Group believes that clinical leadership – at all levels – is important and that distributed leadership models (Mountford and Webb, 2009: 4) that empower Consultants in various roles have the potential to drive continuous quality improvement across the public health system.

In addition, experience internationally has demonstrated that the level of clinical leadership and management in hospitals and hospital groups correlates with hospital performance and clinical outcomes.

In this context, the Working Group considers that the establishment of the Hospital Groups provides an opportunity to enhance and refine existing clinical leadership and management structures further, building on the current Consultant/Clinical Director model. It is likely that the establishment of the Hospital Groups will drive the development of Group-level Service Departments in major service groups, such as surgery and anaesthesia. This in turn would generate the requirement for a Head of Department, reporting to the overall Clinical Director of the Hospital Group.

The Working Group sees the potential for the development of a more differentiated leadership/management career structure than currently exists. It considers that such a development would be desirable – in terms of efficient management of resources, improved service delivery, and opportunities for progression and personal development. Such a clinical leadership/management stream should be seen as a specific career choice by doctors and appointments to senior clinical leadership and management roles should be competitive, and based on merit and suitability.

4.2.3 Research, Training, Academic, Quality Improvement and Other Roles

The Working Group considers that health policy should give a clear commitment to research, development, quality improvement and lifelong learning, as integral components of the career pathway of Consultants.

At present, aside from Academic Consultant roles, Consultants have limited opportunities to engage – in a structured way – in research, clinical training, academic or quality improvement activities relevant to their clinical practice, area of specialisation and personal development.

The Working Group believes that both the health service and the individual can – and should – benefit from such activities. They should be integrated more formally into the work of Consultants than is currently the case and can be enabled through team-based working. In this regard, the Working Group notes that mechanisms that facilitate an on-going personal and professional development and accountability dialogue between the Consultant and Clinical Director, based on a partnership approach, are in place in other jurisdictions (e.g. the job planning process in the UK).

The Working Group also takes the view that there is a need to provide separate career paths for those doctors who seek (and who are needed) to dedicate much or all of their time to research, training or academic activities, which benefit patients. In this regard, the Group notes the joint HSE/HRB National SpR/SR Academic Fellowship Programme at the end of which individuals

are awarded both their doctorate and CSCST. The Group considers that this initiative can be built on in the coming years in order to build Ireland's medical research capacity and, ultimately, benefit the public health system and improve outcomes for patients.

4.3 Barriers to Recruiting and Retaining Consultants in the Public Health System

The Working Group wishes to emphasise a number of current matters which, if unaddressed, will continue to impact adversely on the recruitment and retention of Consultants to clinical service delivery and other roles in the public health system. These include:

- Variations in the rates of remuneration between new entrant Consultants and their established peers that have emerged since 2012;
- Lack of recognition in starting salary of relevant post-CSCST experience (gained in Ireland or elsewhere) at time of appointment to a Consultant post;
- Limited opportunities for flexible working at Consultant level – both in terms of flexibility within the Consultant's work commitment (e.g. research, training, quality improvement etc.) and in terms of family-friendly flexible working;
- Limited infrastructural and human capital support for newly appointed Consultants, including inadequate resourcing of the clinical service delivery role in terms of allocation of available theatre time and out-patient clinics, and the deployment of related resources;
- Unattractiveness of the working environment in some Level 2 and Level 3 hospitals[3], particularly with regard to unscheduled care;
- Lack of clarity for trainees around the planned availability (by specialty and location) of Consultant posts.

Finally, the Working Group wishes to note the concerns raised by trainees in relation to the culture of the health service and the need to develop a culture of mutual respect and constructive partnership.

5. Recommendations

Taking into account the conclusions above, and having regard to the Terms of Reference of the Strategic Review, the Working Group is making the following recommendations in relation to medical career structures and pathways for Consultants.

1. The Working Group recommends that the relevant parties commence, as a matter of urgency, a focused, timetabled IR engagement of short duration to address the barrier caused by the *variation in rates of remuneration between new entrant Consultants and their established peers* that have emerged since 2012. It further recommends that the relevant parties explore

[3] As set out in the *Smaller Hospitals Framework,* Level 2 hospitals will 'provide the majority of hospital activity including extended day surgery, selected acute medicine, local injuries, a large range of diagnostic services (including endoscopy, laboratory medicine, point-of-care testing, and radiology (CT, US and plain film X Ray)) specialist rehabilitation medicine and palliative care'. Level 3 hospitals 'will provide 24/7 acute surgery, acute medicine, and critical care (DoH, 2013: 8).

options, within existing contractual arrangements, to advance a *more differentiated Consultant career structure* as outlined in Section 5.3 (i.e. clinical service provision, clinical leadership and management, clinical research, academic, quality improvement and other roles).

2. With regard to *developing opportunities for flexibility within the Consultant's work commitment*, the Working Group recommends the development and introduction of a system of accountable personal development/work planning for all Consultants, aligned with professional competence schemes, as appropriate. This system should build on the existing Clinical Directorate Service Plan process and take into account similar processes in other jurisdictions. In relation to quality improvement, the Working Group notes that there is a comprehensive programme of work in the health service to train people in quality improvement skills and it would be desirable for provision to be made in work plans for those who will lead in this field.

3. With regard to *family-friendly flexible working*, the Working Group recommends that more individually-tailored time commitments should be made available, and facilitated where possible, for both new and existing Consultant posts. With regard to all new Consultant posts, the Working Group recommends that recruitment notices should indicate that a flexible working facility is possible.

4. In relation to *improving supports for newly appointed Consultants*, the Working Group recommends that the personal development/work planning process for Consultants outlined in Recommendation 2 above, should include an outline of the resources required to achieve the service and personal objectives set out in the plan. These should be agreed at time of appointment and should be reviewed annually by the Consultant and Clinical Director/Employer in the context of changing objectives and the resources available to the Consultant team. In addition, in tandem with the development of work plans, the Working Group recommends that all newly appointed Consultants should be offered the opportunity to avail of an appropriately individualised induction programme upon appointment.

5. The Working Group recommends that the reconfiguration of hospital services should be used as an opportunity to address the barrier of the *unattractiveness of the working environment in some Level 2 and Level 3 hospitals*. In this regard, the Working Group recommends that Hospital Group strategic plans should include proposals for rationalisation of services with unscheduled care rosters. The Strategic Advisory Group on the Implementation of Hospital Groups should define this as one of the criteria for the development and evaluation of these plans.

6. With regard to *improving clarity around availability of Consultant posts by specialty and* location, the Working Group recommends more centralised and coordinated workforce planning and better matching of new posts to service requirements and existing trainee capacity. The Group acknowledges the on-going work in HSE-MET to develop a model of

medical workforce planning, which will be of significant assistance in this regard and will support appropriate, competitive succession planning. While recognising the value of international experience, the Working Group recommends the continued development of post-CSCST fellowship capacity in Ireland in order to retain specialist medical expertise in the public health system in advance of appointment to Consultant posts.

Finally, the Working Group notes that culture is a key factor in recruiting and retaining staff, and it recommends that transformative cultural change should be a core driver of the HSE System Reform initiative.

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

	Recommendation	Relevant Parties	Key Deliverables	Target Date
1	The Working Group recommends that the relevant parties commence, as a matter of urgency, a focused, timetabled IR engagement of short duration to address the barrier caused by the *variation in rates of remuneration between new entrant Consultants and their established peers* that have emerged since 2012. It further recommends that the relevant parties explore options, within existing contractual arrangements, to advance a *more differentiated Consultant career structure* as outlined in Section 5.3 (i.e. clinical service provision, clinical leadership and management, clinical research, academic, quality improvement and other roles).	• HSE • DOH • D/PER • Staff associations • Labour Relations Commission	Agreement on a more differentiated Consultant career structure and associated rates of remuneration.	July 2014

2	With regard to *developing opportunities for flexibility within the Consultant's work commitment*, the Working Group recommends the development and introduction of a system of accountable personal development/work planning for all Consultants, aligned with professional competence schemes, as appropriate. This system should build on the existing Clinical Directorate Service Plan process and take into account similar processes in other jurisdictions. In relation to quality improvement, the Working Group notes that there is a comprehensive programme of work in the health service to train people in quality improvement skills and it would be desirable for provision to be made in work plans for those who will lead in this field.	• HSE • Staff associations • Employers	Personal development/work planning system developed and implementation date agreed.	Q4 2014
3	With regard to *family-friendly flexible working*, the Working Group recommends that more individually-tailored time commitments should be made available, and facilitated where possible, for both new and existing Consultant posts. With regard to all new Consultant posts, the Working Group recommends that recruitment notices should indicate that a flexible working facility is possible.	• HSE • Employers	All recruitment notices to reflect availability of flexible working facility.	Q3 2014

4	In relation to *improving supports for newly appointed Consultants*, the Working Group recommends that the personal development/work planning process for Consultants outlined in Recommendation 2 above, should include an outline of the resources required to achieve the service and personal objectives set out in the plan. These should be agreed at time of appointment and should be reviewed annually by the Consultant and Clinical Director/Employer in the context of changing objectives and the resources available to the Consultant team. In addition, in tandem with the development of work plans, the Working Group recommends that all newly appointed Consultants should be offered the opportunity to avail of an appropriately individualised induction programme upon appointment.	• HSE • Staff associations • Employers	See Recommendation 2 above.	Q4 2014
5	The Working Group recommends that the reconfiguration of hospital services should be used as an opportunity to address the barrier of the *unattractiveness of the working environment in some Level 2 and Level 3 hospitals*. In this regard, the Working Group recommends that Hospital Group strategic plans should include proposals for rationalisation of services with unscheduled care rosters. The Strategic Advisory Group	• HSE • Hospital Group management • SAG on the Implementation of Hospital Groups	Hospital Group strategic plans incorporate proposals for rationalisation of services with unscheduled care rosters.	Within 1 year of establishment of Hospital Group

	(SAG) on the Implementation of Hospital Groups should define this as one of the criteria for the development and evaluation of these plans.			
6	With regard to *improving clarity around availability of Consultant posts by specialty and* location, the Working Group recommends more centralised and coordinated workforce planning and better matching of new posts to service requirements and existing trainee capacity. The Group acknowledges the on-going work in HSE-MET to develop a model of medical workforce planning, which will be of significant assistance in this regard and will support appropriate, competitive succession planning. While recognising the value of international experience, the Working Group recommends the continued development of post-CSCST fellowship capacity in Ireland in order to retain specialist medical expertise in the public health system in advance of appointment to Consultant posts.	• HSE • DoH	Medical workforce planning model developed and implemented.	Q2 2015
		• HSE • DoH • HRB • Forum of Postgraduate Medical Training Bodies • University academic medical departments	Proposals for development of post-CSCST fellowship capacity.	Q4 2014

1 INTRODUCTION

1.1 Background

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

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

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

1.2 Terms of Reference

The Working Group will examine and make high-level recommendations relating to training and career pathways for doctors with a view to:

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

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

DEVELOPMENTS IN RECENT YEARS
• Progress in implementing recommendations on medical training and workforce planning from key reports, including the Fottrell and Buttimer reports.
POSTGRADUATE TRAINING AND EMPLOYMENT EXPERIENCE
• Assessment of the changes needed to improve the training and retention of graduates, while maintaining quality, including consideration of: ➢ provision of a clear pathway for training at every level from Intern to Specialist; ➢ the potential for reducing the duration of specialist training; ➢ appropriate task allocation between health professionals.

• Measures to improve the quality of the training and employment experience.
CAREER PATHS, STRUCTURES AND SUPPORTS
• Measures to improve career planning, mentoring supports and efficacy of communication.
• Measures to improve the career structures and flexibility of options for doctors following training, including the range of specialist (e.g. Consultant, GP, public health doctor etc.) and other hospital or community posts.

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

- The need to ensure quality, safe, patient-centred healthcare, grounded in the key domains of healthcare[4], and a safe and healthy working environment for doctors;
- Developments in the Clinical Programmes and recent reports and recommendations relevant to patient safety;
- Opportunities arising from the Health Reform Programme (for example, the development of Hospital Groups and the expansion of primary care services);
- Achievement of value for money for State investment in medical education and training;
- International good practice in regard to medical training and developments, including EU requirements.

The Working Group will also take into account:

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

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

1.3 Membership of Working Group

As at 31st March 2014, membership of the Working Group was as follows:

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

[4] Patient-centredness, safety, effectiveness, efficiency, access, equity

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

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

1.4 Meetings of Working Group (January-April 2014)

The Working Group held eight meetings during the period from 1st January 2014 - 9th April 2014 as follows. *During this period, the Group prioritised work on career structures and pathways following completion of specialist training in order to report to the Minister for Health on these issues in this report.*

DATE	MEETING
15th January 2014	Eighth meeting
18th February 2014	Ninth meeting
5th March 2014	Tenth meeting
19th March 2014	Eleventh meeting
26th March 2014	Twelfth meeting
28th March 2014	Thirteenth meeting
2nd April 2014	Fourteenth meeting
9th April 2014	Fifteenth meeting

To inform the Working Group's deliberations, the following presentations were made to the Group at its meeting of 5th March 2014:

- Career structures for permanent hospital doctors and GPs internationally (Dr Marie Sutton, Health Research Board);
- The feminisation of medicine in Ireland: key trends and issues (Dr Sara McAleese, RCSI).

1.5 Stakeholder Consultation

In keeping with the Terms of Reference of the Strategic Review, and in order to inform the development of the report, the Working Group met with stakeholders including trainee doctors, health sector union representatives and the Irish College of General Practitioners (ICGP) during the January-March 2014 period.

The full list of meetings held by the Working Group with stakeholders during the period from 1st January 2014-4th April 2014 is included below.

DATE	CONSULTATION MEETING
18th February 2014	Meeting with health sector union representatives
19th March 2014	Meeting with nominees of the Irish Medical Organisation NCHD Committee
25th March 2014	Meeting with representatives of the ICGP
25th March 2014	Meeting with nominees of the Forum of Irish Postgraduate Medical Training Bodies Trainee Sub-Committee

The Chair and Secretary also met with representatives of the Irish Hospital Consultants Association (IHCA) on 24th March 2014.

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

1.6 Summary of Consultation Meetings with Trainee Doctors

Consultation meetings with trainee doctors were structured around a limited number of questions relating to career structures and pathways following completion of training, which were circulated in advance for consideration.

At the consultation meetings, trainees emphasised their commitment to a quality, safe and efficient Irish public health service, and reiterated their desire to work at Consultant level in Ireland. As previously, they reported that morale among trainees at all levels is low and that they feel undervalued by the public health system.

Trainees identified a number of issues relating to current career structures and pathways following completion of specialist training that they considered are impacting on the recruitment and retention of Irish medical graduates in the public health system. These are summarised in Table 1.1 below.

Table 1.1: Summary of views expressed by trainee doctors

THEME	KEY POINTS
Consultant appointments and pay	• The additional 30% reduction in pay for new entrant Consultants from October 2012 is impacting adversely on recruitment and retention rates in the public health system. • Trainees strongly perceive an inequity resulting from the pay reduction (i.e. a lower rate of pay for the same responsibilities) and feel that they were singled out in this regard.
Flexible working arrangements	• Limited implementation of flexible working models, options and arrangements for Consultants is an issue in terms of recruitment and retention. • Job planning is a way of introducing greater flexibility into the Consultant role.
Resourcing the clinical role	• Lack of resources for newly appointed Consultants is a barrier to recruitment and retention, e.g. theatre access, out-patient clinic access, access to administrative support.
Service reconfiguration	• In order to have a Consultant-provided service, and in terms of improving quality, safety and service efficiency, trainees emphasised the need to progress implementation of hospital reconfiguration. • Trainees noted that smaller hospitals with onerous

	out-of-hours work and demanding rotas are a barrier to Consultant recruitment and retention.
Access to private practice	• Lack of access to off-site private work or to undertake private work outside of contracted public hours is an issue.
Organisational culture	• Trainees identified the culture of the health service, including poor treatment of doctors in the Irish health service, as a barrier to recruitment and retention. • A 'culture of participation, partnership and a dynamic of improvement' would benefit the patient.

In the course of the consultation meetings, trainees also recommended possible solutions to some of the issues they highlighted. These have been considered by the Working Group in the context of the conclusions and recommendations of this report.

2 Overview of Public Health Services and Associated Medical Career Structures and Pathways

2.1 Introduction

The purpose of this chapter is to provide an overview of the current configuration of public health services in Ireland and, against this backdrop, to set out the medical structures and pathways following completion of specialist training that currently exist.

2.2 Current Configuration of Public Health Services

2.2.1 Acute Hospital Services

Ireland's acute hospital system developed over many years and was originally organised around individual county hospitals. Today, serving a population of 4.59 million, there are 49 acute hospitals in the public hospital system providing a wide range of emergency, diagnostic, treatment and rehabilitation services. In 2013, acute hospitals treated 595,109 in-patients, 836,789 day cases, 1,123,083 attendances at Emergency Departments and assisted 67,995 births. There were over 1.1 million attendances at 33 adult Emergency Departments; of these, 382,784 people were admitted on an emergency basis.

	2009	2010	2011	2012	2013
Inpatient discharges	595,022	588,860	590,006	603,579	595,109
Day cases	675,611	728,269	812,844	832,476	836,789
OPD attendances	*3,394,677	*3,558,060	*No End 2011 Fig available	2,355,030	2,457,810
ED attendances	1,123,068	1,181,198	1,098,956	1,138,152	1,123,083
Births	74,602	74,279	73,092	70,523	67,995

*No OPD figure was produced for end 2011 as the HSE was moving to implement the OPD Data Quality Programme.

Medical care in the acute hospital setting is provided by Consultants, working in Consultant teams and on a multidisciplinary basis with other doctors, nurses, and health and social care professionals.

2.2.2 Primary Care Services

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

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

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

2.2.3 Public Health and Health Promotion

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

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

In Ireland, public health specialists contribute to implementing *Healthy Ireland: The Framework for Improved Health and Well-being 2013-2025* (DoH, 2013) through:

- Health protection activities (childhood immunisation; protection from epidemics and other health threats; response to incidents and disasters);
- Health promotion and improvement activities;
- Health service development activities (e.g. needs assessment; evaluating and improving the effectiveness and efficiency of healthcare performance).

2.2.4 Mental Health Services

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

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

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

2.3 The Role of the Medical Council

The Medical Council is the statutory body responsible for the regulation of doctors. Its objective is to protect the public by promoting and better ensuring high standards of professional conduct and professional education, training and competence among registered medical providers. It has a lay majority, comprising 13 non-medical members and 12 medical members. The Medical Practitioners Act 2007 is the legislation governing the Council's work and determines the Divisions of the register and the requirements for registration of doctors on the register.

Through its work, the Council promotes good professional practice among doctors in the interest of public safety. Its key responsibilities include:

- Maintaining the register of approximately 18,000 medical practitioners;
- Defining and applying standards of medical training and education, for both undergraduate and postgraduate levels;
- Promoting good medical practice and overseeing doctors' continuing professional development – since May 2011 it has become a legal requirement for doctors to maintain their professional competence by engaging in lifelong learning and skills development activities;
- Investigating complaints against doctors, including responding to concerns and taking action to protect the public, where necessary.

The health and well-being of doctors is an important consideration in the delivery of health services and the Council plays an important role in supporting doctors whose ability to practice may be impaired.

In addition, the Council plays a valuable role in collaborating with the Department of Health and other agencies in informing health policy.

2.4 Current Medical Career Structures and Pathways in the Irish Public Health System

2.4.1 The Medical Training Pathway

The first step in the medical career pathway is a five- or six-year undergraduate degree programme. There are six medical schools in Ireland; a number of which also offer accelerated four-year medical programmes for graduates of other disciplines.

After successfully completing medical school, a newly qualified graduate is required to successfully complete an Intern year in order to be registered to practise medicine in Ireland. Interns are required to have internship registration on the Medical Council's register. Internship registration is 'specifically for medical practitioners intending to practise in individually numbered, identifiable Intern training posts, so that they may complete their internship training in Ireland and be awarded a Certificate of Experience' (Medical Council, 2012: 5). The Intern Year is structured so that Interns can gain experience of a range of medical specialties in order to assist them in deciding on the area of medicine in which they want to specialise.

Following successful completion of the Intern Year, trainee doctors can then proceed to specialist training. The postgraduate medical training bodies are recognised and accredited by the Medical Council to provide postgraduate medical training within Ireland. The training bodies are responsible to the Medical Council for the structure of medical training programmes and their delivery against the 'Eight Domains of Good Professional Practice' as defined by the Council (see Appendix One).

The HSE has a range of statutory responsibilities regarding medical education and training under the Medical Practitioners Act 2007. These include: promoting the development of medical education and training in conjunction with the Medical Council and postgraduate training bodies; undertaking medical workforce planning; assessing annually the number of Intern and specialist training posts required; assessing annually the number of non-training NCHD posts required; and advising the Minister for Health on all matters relating to the development and coordination of medical education and training. In this context, in recent years the HSE has introduced service level agreements with the training bodies to fund Intern training, Basic Specialist Training (BST), Higher Specialist Training (HST), and a range of scholarship and other training opportunities.

The training bodies are responsible for the selection of trainees onto both BST and HST programmes, including their training, assessment, progression and, ultimately, for their certification as eligible for admission to the Specialist Division of the Medical Council's register. While training is generally made up of BST and HST, the programmes represent a continuum of training. Some of the training bodies have moved, or are moving, to a continuous or 'run-through' model of training with a single selection point.

Trainee doctors compete for access to proceed to BST for hospital-based training schemes or directly to specialist training in the case of General Practice. BST is between two and four years in duration. During this period, a trainee doctor is employed as a Senior House Officer (SHO) or Registrar in the hospital- or practice-based setting and under the supervision of a more experienced doctor/trainer. The number of BST training posts funded by the HSE and filled by the postgraduate medical training bodies for the 2013-2014 period is 1,627 (see Appendix Two).

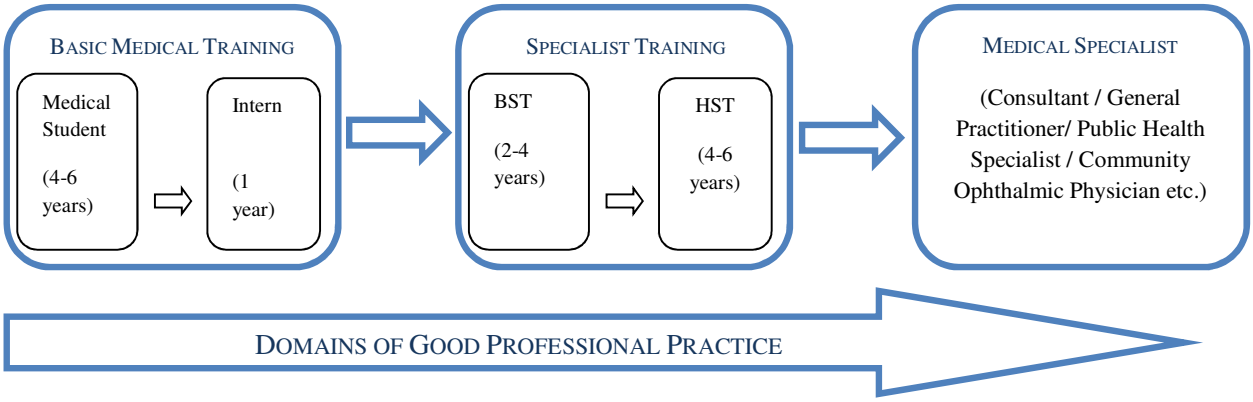
After BST, most hospital-based doctors seek to progress to HST. Entry to HST is highly competitive. In some specialties, less than half of those applying have progressed historically. In such circumstances, it may take a number of years for a doctor to be accepted onto a HST scheme.

HST is the final stage of training. It is designed to bring a doctor's knowledge and skills up to the standard required for registration on the Specialist Division of the Medical Council's register and subsequent independent, specialist practice. HST takes four to six years to complete, depending on the specialty. During this time a doctor is employed as a Specialist Registrar (SpR) (or as a Senior Registrar (SR) in the case of psychiatry). The number of HST training posts funded by the HSE and filled by the training bodies for the 2013-2014 period is 1,453 (see Appendix Three).

All trainee doctors are required to be registered on the Trainee Specialist Division of the Medical Council's register. This Division is 'specifically for medical practitioners who practise in individually numbered, identifiable postgraduate medical training posts, which are recognised by the Medical Council for training, while they are completing all or part of their medical specialist training in Ireland' (Medical Council, 2012: 5).

On satisfactory completion of HST, SpRs receive a Certificate of Satisfactory Completion of Specialist Training (CSCST) which allows them to enter the Specialist Division of the Medical Council's register. Figure 2.1 summarises the medical training pathway from undergraduate medical student to medical specialist.

Figure 2.1: The medical training pathway



2.4.2 Non-Consultant Hospital Doctors

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

Approximately 80% of NCHDs are registered on the Specialist Trainee Division of the Medical Council's register and are employed in training posts.

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

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

The current NCHD Contract, which was introduced in February 2010, covers NCHDs in training and non-training posts. It provides for:

- 5/7 working;
- An extended working day;
- A reporting relationship via the Consultant to the Clinical Director;
- Employment based on training and registration status;
- Direct HSE funding of postgraduate training bodies in place of provision of a direct training grant;
- A range of additional training supports and a series of measures to support implementation of the European Working Time Directive (EWTD), while facilitating and promoting medical education and training.

2.4.3 Consultants

In the public health system, a Consultant is a clinically independent medical practitioner registered on the Specialist Division of the Medical Council's register[5] who by reason of his/her training, skill and expertise in a designated specialty, is consulted by other registered medical

[5] This is a requirement since 2008.

practitioners and who has a continuing clinical and professional responsibility both for patients under their care or those patients on which they have been consulted. As noted previously, specialist registration is 'specifically for medical practitioners who have completed specialist training recognised by the Medical Council and can practise independently (unsupervised) as a specialist' (Medical Council, 2012: 6).

The current Consultant Contract was introduced in 2008. The Contract provided for a 37 hour working week delivered over the period 8am – 8pm Monday to Friday and for up to an additional 5 hours of structured overtime on Saturdays, Sundays and public holidays. Further flexibilities – including a 39 hour week and 5/7 rostering and 24 hour working – have been introduced subsequently under the Public Service Agreement 2010-2014 and the Public Service Stability Agreement 2013-2016 (Haddington Road Agreement).

Under Consultant Contract 2008, Consultants are required work as part of a Consultant team i.e. the Consultant provides diagnosis, treatment and care to patients under the care of other Consultants on his/her Consultant team and *vice versa*. The full implementation of Consultant team-based working was one of the elements of the Contract re-emphasised in the 2012 Labour Relations Commission (LRC) agreement on the implementation of the Public Service Agreement 2010-2014 (LRC, 2012: 6).

Consultants, as part of their contractual commitment, contribute to the education, training and supervision of students, NCHDs and trainee professionals including members of the multidisciplinary team.

Under the terms of the Contract, Consultants can apply for atypical working arrangements under the relevant health service scheme. The Contract also allows for the opportunity to restructure Consultant work commitments to facilitate structured research or educational programme development for a defined period, subject to: the agreement of the employer; funding being identified to support such activity for its duration; and the research being subject to appropriate research governance and ethics.

The Contract also requires that each Consultant reports to a Clinical Director.

As at 31st March 2014, there were 2,690 established Consultant posts in the public health system; an increase of 959 over the last decade. Table 2.1 overleaf provides an overview of Consultant numbers in wholetime equivalent terms (including Academic Consultants and Clinical Directors) as at 28th February 2014.

Table 2.1: Consultant numbers as at 28th February 2014

SPECIALTY	CONSULTANT NUMBERS (WTES)
Anaesthesia	357
Dentistry	16
Emergency Medicine	75
Intensive Care Medicine	2
Medicine	607
Obstetrics and Gynaecology	123
Paediatrics	134
Pathology	201
Psychiatry	355
Radiology	238
Surgery	452
Other	2
Total	**2,562**

Source: Health Service Personnel Census

2.4.4 Academic Consultants

Academic Consultant posts are joint appointments between Irish third-level academic institutions and the public health system. Posts are jointly approved by the health service and the Higher Education Authority (HEA). They are structured to ensure a minimum 50% commitment to the academic institution in the case of Professor posts and a minimum 30% commitment in the case of other academic posts.

They are graded respectively as: Senior Lecturer/Consultant; Associate Professor/Consultant; Professor/Consultant.

An Academic Consultant is accountable under the Consultant Contract 2008 for the delivery of the clinical component of the post and via the management/governance structures in place in the third level institution in relation to the delivery of the academic commitment.

2.4.5 Clinical Directors

The Consultant Contract 2008 introduced a new senior management position across the public health service – that of Clinical Director. The Contract describes Clinical Directors as key members of the local corporate management team and deals with the role of the Clinical Director from two perspectives; that of the wider corporate management and governance structure, and the extent to which the Clinical Director manages Consultants. In December 2008, the HSE commenced an appointment process for Clinical Directors under the Contract. Initial appointments were made for a two-year period on the basis of peer selection and management agreement.

As noted in Section 2.4.3, in September 2012, following a detailed engagement between health service management and Consultant representative organisations, the LRC issued a comprehensive set of proposals regarding implementation of the Public Service Agreement 2010-2014 by Consultants.

The LRC Agreement reinforced the requirement that each Consultant should report to their relevant Clinical Director and provided that management could delegate the reporting relationship of Consultants employed under Consultant Contract 1997 and other contracts from the CEO to the Clinical Director. The agreement also provided for a strengthened management role for Clinical Directors, including the following:

- Responsibility for driving improved clinical performance;
- Responsibility for leading on clinical issues on behalf of the employer as appropriate;
- Authority to determine the composition of Consultant teams and associated responsibilities;
- Authority to specify work schedules and how each Consultant's commitments will be discharged to ensure the most appropriate and cost-effective delivery of services;
- Authority to deploy Consultants to other hospitals and change the location at which Consultants deliver scheduled in-patient, out-patient, day case or diagnostic services to support changes in the roles of hospitals;
- Authority to deploy – in partnership with other senior managers – resources including nursing and diagnostic staff – to respond to organisational priorities;
- Responsibility for implementation of standardised leave scheduling, cross cover and other policies to ensure Consultant cover is maintained at all times;
- Responsibility for demonstrating that public patient access to the full range of public hospital services is determined solely by clinical need / priority and not insurance status; and for ensuring compliance with contractual limits on private practice;
- Responsibility for driving compliance with the European Working Time Directive and implementation of associated measures designed to reduce NCHD working hours.

To date the HSE has appointed 53 Clinical Directors in the wider acute services and 15 in the mental health services. The role of Clinical Director attracts an allowance.

2.4.6 General Practitioners

There are in the region of 2,500 General Practitioners (GPs) in Ireland, working in group practices, primary care centres, single practices and health centres around Ireland.

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

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

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

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

2.4.7 Public Health Specialists

In the public health system, a Specialist in Public Health Medicine is an independent medical practitioner registered on the Specialist Division of the Medical Council's register who occupies a senior role in the management and delivery of population health services.

This may include assessing the health status of the population or of specific groups within that population, identification of population health needs and strategies to address those needs, participating in the prevention, surveillance and control of infectious diseases and responding to environmental incidents which may affect public health.

As at 28th February 2014, there were 53 Specialists in Public Health Medicine and 8 Directors in Public Health Medicine employed in the public health system.

2.4.8 Community Ophthalmic Physicians

A Community Ophthalmic Physician is a clinically independent medical practitioner registered on the Specialist Division of the Medical Council's Register who examines, diagnoses and treats diseases and injuries of the eye. As at 28th February 2014, there were 27 Community Ophthalmic Physicians employed in the public health system.

2.5 Conclusion

This chapter sets out a brief overview of the current configuration of public health services in Ireland and the medical career structures associated with them as a background to the chapters that follow.

3 POLICY CONTEXT

3.1 Introduction

The purpose of this chapter is to outline the current and future policy context for the health system within which future medical career structures and pathways following completion of specialist training should be considered. Relevant international and national developments in recent years are discussed, in addition to the overarching future policy context – the Health Reform Programme.

3.2 Relevant International and National Developments in Recent Years

3.2.1 European Working Time Directive

From 1st August 2004, the European Working Time Directive (EWTD) has required that NCHDs receive:

- A 15 minute break every 4 hours 30 minutes or a 30 minute break every 6 hours or equivalent compensatory rest;
- 11 hours rest every 24 hours or equivalent compensatory rest;
- 35 hours rest once a week, twice a fortnight or 59 hours rest once a fortnight or equivalent compensatory rest;
- Work for no more than an average of 58 (August 2004), 56 (August 2007) or 48 (August 2009) hours a week.

Compliance with the Directive has presented significant challenges to the public health system in recent years. In October 2013, the Department of Health, the Department of Public Expenditure and Reform, the HSE and the IMO agreed to proposals from the LRC to support implementation of full EWTD compliance by the end of 2014. These measures include introduction of a maximum 24-hour shift, standardised measurement and reporting of hospital performance, changes to NCHD and Consultant rostering, recruitment of additional staff, task transfer and reconfiguration of hospital services. Implementation of the agreed proposals is currently underway. In November 2013, the European Commission decided to refer Ireland to the European Court of Justice because of non-compliance with the Directive as it was not satisfied with the rate of progress in resolving this long-standing problem.

3.2.2 Report of the National Task Force on Medical Staffing, 2003

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

- Devise an implementation plan for reducing substantially the average working hours of NCHDs to meeting the requirements of EWTD;
- Plan for the implementation of a Consultant-provided service;

- Address the medical education and training needs associated with the EWTD and the move to a Consultant-provided service.

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

- The priority must be to provide a safe, high quality service to all patients at all times. The current organisation, structure and staffing of the hospital system is failing to deliver the care, that at its best, the Irish system is capable of giving.
- NCHD working hours must be reduced in line with the EWTD. Appropriately implemented, this will help improve patient care and introduce safer working conditions for doctors.
- Health agencies should not attempt to meet the terms of the EWTD by recruiting more NCHDs. This would actually worsen the situation for both patients and doctors.
- Substantially more Consultants should be appointed as part of a move to a team-based Consultant provided service. This would give patients improved access to senior clinical decision makers.
- Considerations about capacity, workload and a critical mass of patients must influence where hospital services can be safely provided. Patients have better outcomes when treated in units with appropriate numbers of specialist staff, high volumes of activity and access to the right diagnostic and treatment facilities.
- The organisation and staffing of acute hospitals must be restructured to allow for the safe provision of emergency and elective care. The safe provision of specialist services, reductions in NCHD hours and the appointment of additional Consultants will require significant changes to service provision. It is also important to ensure that all patients, whether public or private, have equal access to services based on clinical need.
- Health professionals should work as part of a multi-disciplinary team, centred on delivering quality patient care over the full 24-hour period within an integrated network of hospitals. This will entail revised working arrangements for Consultants and NCHDs. It will also have implications for other health professionals and will involve the appointment of some new grades of staff.
- The number of hospital doctors should be regulated nationally through a single agency. Each NCHD post should also be subject to approval by a central training authority. While the number of Consultant, Specialist Registrar and Intern posts are regulated at present, uncontrolled growth in the number of Registrars and Senior House Officers is very undesirable. It can have implications for the quality of service to patients, and has affected the ability of individual doctors to access further training and achieve specialist registration. It has also hampered the efficient deployment of finite resources.
- Reductions in NCHD hours, the appointment of more Consultants working in teams, reorganisation of the acute hospital system and the provision of high quality medical education and training are all part of the implementation process. Compliance with the EWTD and the provision of a sustainable acute hospital service are possible only if

measures are taken to meet each of these goals (National Task Force on Medical Staffing, 2003: 17-19).

To date, implementation of the key messages of the Hanly Report is further advanced in some areas than in others. While there has been an increase in Consultant numbers over the past decade in order to move towards a Consultant-provided service, there has also been an increase in NCHD numbers over the same period – which is not entirely accounted for by an increase in the number of training posts. In addition, the reconfiguration of acute hospital services, as envisaged in the Task Force Report, has been slower than anticipated and, as indicated in Section 3.2.1 above, progress in achieving EWTD compliance has been disappointing.

3.2.3 Developments in Patient Safety

Patient safety has become both a national and international imperative in recent years, with increased emphasis on patient safety in policy reform, legislative changes and development of standards of care driven by quality improvement initiatives. The Commission on Patient Safety and Quality Assurance was established in Ireland in January 2007 and published its report in August 2008. The Commission's report provides the roadmap to developing a national culture of patient safety and recommends increased leadership and accountability throughout the service through new governance, management and reporting structures.

- Legislation on licensing of all public and private healthcare providers;
- Mandatory adverse incident reporting;
- Open disclosure on patient safety incidents;
- Participation of clinicians in a national programme of clinical audit;
- Improved research, education and training on patient safety;
- Patient involvement in service review and planning.

A National Patient Safety Advisory Group was established in 2011 by the Minister for Health. It provides a forum at national level for the maintenance of dialogue and interaction between key stakeholders in relation to the patient safety agenda and provides leadership, direction and policy advice for on-going work under the *Patient Safety First* initiative.

Legislative proposals are at an advanced stage of development for the introduction of a national licensing system. This will provide for a mandatory system of licensing for public and private health service providers. It will be designed to improve patient safety by ensuring that healthcare providers do not operate below core standards which are applied in a consistent and systematic way.

Patient safety has been made a priority within the HSE's Annual Service Plan 2014 through specific measures focused on quality and patient safety including healthcare acquired infections (HCAIs), medication safety and implementation of early warning score systems. Clinical

effectiveness is a key component of safe, quality care. To this end the Minister for Health established the National Clinical Effectiveness Committee (NCEC) in 2010 to provide a framework for national endorsement of clinical guidelines and audit.

A new Patient Safety Agency (PSA) is also to be established; initially on an administrative basis within the HSE structures in 2014.

3.2.4 Development and Implementation of the National Clinical Programmes

Since their foundation in 2010, the National Clinical Programmes have been one of the most significant positive developments in the public health system. A unique feature of the programmes is the close collaboration between the HSE and the medical professional bodies, in partnership with nursing, health and social care professionals, and in partnership with patients.

As part of the Clinical Strategy and Programmes Division of the HSE, the National Clinical Programmes are committed to making healthcare in Ireland demonstrably better and safer for patients and a more rewarding workplace for healthcare workers. Achieving this requires effective and supportive clinical leadership at all levels of the system.

Often, what is traditionally referred to as 'healthcare reform', are changes in the surroundings of care rather than changes in care itself. The Clinical Programmes have changed and continued to change how care is delivered using evidence based approaches to system reform.

The set-up of a National Clinical Programme brings together experts in the fields of healthcare including medicine, nursing, therapy and allied health, along with patients and patient organisations. Governance of a Programme includes the establishment of a National Working Group and Consultants' Clinical Advisory Group, which is a significant achievement from the outset. The role of these expert groups is to guide and govern the solutions put forward by the Programme's Working Group and this is further enhanced by collaborating and consulting with a range of significant stakeholders across the Irish healthcare system. The achievements of many of the Programmes clearly demonstrate a strong commitment to clinical practice improvement through effective clinical leadership.

3.2.5 Development of the Clinical Directorate Leadership Role

As noted in Chapter Two, the Clinical Director role was introduced to the Irish healthcare system under the 2008 Consultant Contract. Although some directorates had existed in individual institutions prior to that, there was no commonly accepted model that could be applied to all hospitals and mental health directorates, and there was no contractual link with the working practices of Consultants. Clinical Directors are now established in all hospitals and mental health services throughout the public health system.

In January 2014, following a collaborative exercise between HSE HR and the National Clinical Director Programme, Lead NCHDs were introduced on 8 pilot sites aligned to the directorate model. This initiative was a response to the historic deficit in NCHD representation at executive level in our hospitals and will contribute to the improvement of NCHD welfare and working conditions.

The role of Clinical Directors has adapted with changing priorities. Clinical Directors are playing an increasingly prominent role in the local implementation of national Clinical Programmes, in addressing service targets, and in refining the identification and management of risk within our healthcare system.

3.3 The Health Reform Programme

3.3.1 Overview of the Health Reform Programme

The central focus of the Government's Health Reform Programme is the creation of a single-tier health service, which is supported by a scheme of Universal Health Insurance (UHI). The Government set out the framework for delivering these reforms in its document *Future Health: A Strategic Framework for Reform of the Health Service 2012-2016* (DoH, 2012), which was published in November 2012. A white paper on UHI was published in April 2014.

Future Health sets out the main building blocks to achieve these reforms which are aimed at restructuring the delivery of health services across primary, community and hospital sectors. The Reform Programme is built on four key interdependent pillars:

1. *Health and wellbeing***:** to keep the population healthy rather than just simply treating ill people;
2. *Service reform*: to deliver a new, less hospital-focused model of care, which treats patients safely at the right time, with value for money, with the right service and as close to home as possible;
3. *Structural reform*: to implement the steps, including the necessary legal and structural changes to the health system, that will be required to fundamentally shift the model of public health care from a tax-funded system to combination of UHI and tax funding;
4. *Financial reform:* to ensure that the financing system is based on incentives that are aligned to fairness and efficiency, while reducing costs, improving control and delivering better quality.

Governance and reporting structures have been put in place to drive the Reform Programme including the HSE System Reform Group and the Health Reform Board, chaired by the Secretary General of the Department of Health.

3.3.2 Establishment of the Hospital Groups

The establishment of Hospital Groups was committed to in *Future Health*. It is intended that the Hospital Groups will in time, qualify as independent competing Hospital Trusts in the context of Universal Health Insurance. The Trusts will encompass a new governance system, which it is envisaged will deliver benefits associated with increased independence of hospitals, and greater control by local clinical and managerial leaders.

In May 2013, following Government approval, the Minister published two reports: the *Report on The Establishment of Hospital Groups as a transition to Independent Hospital Trusts* ('Report on Hospital Groups'), and *Securing the Future of Smaller Hospitals: a Framework for Development* ('Smaller Hospitals Framework').

The Report on Hospital Groups proposes an expansion of the Clinical Director role in the context of the establishment of the Hospital Groups, with the Clinical Director model evolving to operate across all hospitals within each Group, and covering the four specialty areas of Medicine, Peri-operative care, Women and Children and Diagnostics. The Report also proposes the development of a Chief Academic Officer role within each Group.

The establishment of acute hospitals into a small number of Groups, each with its own governance and management, will provide an optimum configuration for hospital services to deliver high quality, safe patient care in a cost effective manner (see Appendix Four). It will allow integration and improve patient flow across the continuum of care. Each Group will include a primary academic partner which will stimulate a culture of learning and openness to change within the hospital group. Smaller hospitals will be supported within the Hospital Group in terms of education and training, continuous professional development, the sustainable recruitment of high quality clinical staff, and the safe management of deteriorating and complex patients.

While the formation of Hospital Groups will allow the Groups to manage their own affairs and operate with maximum autonomy, it is essential to ensure a coherent approach to progress the rationalisation and reconfiguration of services aimed at achieving the optimal hospital service nationally. In this context, the Department of Health intends to set out an overarching policy framework to guide overall hospital services reorganisation, the development of HSE operational policy and the development of strategic plans by each Group.

Each Hospital Group is required to develop a strategic plan within one year of establishment. The plans will describe how they will provide more efficient and effective patient services; reorganise these services to provide optimal care to the populations they serve; and how they will achieve maximum integration and synergy with other groups and all other health services, particularly primary care and community care services.

The Strategic Advisory Group on the Implementation of Hospital Groups (SAG) has been established to provide objective advice and expertise to the Department, the HSE, Hospital Groups and, in particular, to the Minister on the implementation of Hospital Groups. The SAG will ensure that international best practice informs the implementation of Hospital Groups, particularly in relation to developing trends in acute healthcare service provision and governance.

3.3.3 Reforming the Primary Care System

The Government is committed to reforming the public health system to ensure that more care is delivered in the community. *Future Health* states that 'the first point of contact for a person needing healthcare will be primary care, which should meet 90%-95% of people's health and personal social care needs'.

Patients will be referred from primary care only when their needs for care are sufficiently complex; otherwise they will be managed through primary care. Primary Care Teams are comprised of GPs, nurses, speech and language therapists, occupational therapists, physiotherapists, social workers, healthcare assistants, home helps, managers and administrative staff. Primary care networks provide additional resources depending on assessed needs, such as dieticians and psychologists, to a number of primary care teams.

Primary care infrastructure, which is being delivered through a combination of public and private investment, will facilitate the delivery of multi-disciplinary primary care and represents a re-focusing of the health service to deliver care in the most appropriate and lowest cost setting.

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

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

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

It is envisaged that improved chronic disease management and a renewed focus on prevention in primary care will be reflected in the new GP contract, which will aim to provide for the enrolment of patients with GPs and primary care teams, structured reviews, individual care plans, call/recall systems for patients with chronic diseases and mechanisms to audit and report on outcomes.

3.3.4 Integrated Care

Future Health envisages the creation of a new integrated model of care that treats patients at the lowest level of complexity that is safe, timely, efficient and as close to home as possible. The aim of increasing integration is to shift the emphasis from episodic reactive care to care based on needs which is evaluated as to its impact on outcomes.

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

3.3.5 Continuing Reform of Mental Health Services

The implementation of *A Vision for Change* is a continuing policy priority and the Government is committed to reforming the service delivery model of delivery so that more and better quality mental health care is delivered in the community.

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

3.4 Conclusion

Developments in recent years and current reform of the public health system require that due consideration is given to ensuring that medical career structures and pathways on completion of specialist training are fully aligned with the future service delivery context and emerging models of patient care.

4 International Evidence Review

4.1 Introduction

As an input to its deliberations, the Working Group sought information on career structures for publicly funded tenured medical posts in other countries that were relevant to the situation in Ireland.

The Health Research Board (HRB) conducted the international evidence review on behalf of the Working Group and submitted its finalised report on 25th March 2014. The Chair and members of the Working Group are grateful to the HRB for their assistance and for prioritising this project within their overall programme of work.

4.2 Overview of HRB Review

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

The United States of America (USA) was excluded as the health services are mainly funded through private health insurance and specialist doctors are either self-employed or employed by private institutions and so their conditions of employment are not comparable either within or outside the USA.

The information to answer the questions was obtained by identifying and searching the websites of the medical regulatory bodies and medical association websites in the countries under review, by Google searches of the internet using a number of relevant search terms outlined in the methods section and by contacting relevant personnel in the ministries of health in the jurisdictions of interest. All data collected were extracted into a data collection form.

4.3 HRB Review Findings Relevant to this Report

4.3.1 Europe

All European countries have doctors who have completed specialist training and register such doctors as specialists in medicine (including public health) or in surgery. Generally there is one grade of specialist throughout Europe and these specialists are clinically independent practitioners. In Germany there is a hierarchy of specialists with a clearly defined career progression pathway. Progression in Germany is from basic specialist (*Fachartz*) to mid-level specialist (*Oberartz*), and to head of department (*Chefartz*) or clinical director with increased salary for each level which relate to level of authority and leadership roles.

Specialists in Europe are salaried or self-employed or a combination of both. The method of payment varies: for example, in Finland and the UK all specialists are salaried; in France, Germany and Netherlands specialists are salaried or self-employed in varying degrees. The Organisation for Economic Co-operation and Development (OECD) collects information on the salaries of specialists across Europe but differences in payment mechanisms and reporting make comparisons between countries difficult. The SEO Economic research group published an International Comparison of Remuneration of medical specialists in 2012 and they attempted to correct the 2009 OECD figures for remuneration of specialists, to take account of the differences in measurement. From their adjusted calculations the gross income of salaried medical specialists was highest in England (€175,586) followed by the Netherlands (€147,447), France (€131,716) and Germany (€121,097). Finland was not included in their report. For self-employed specialists the gross income was highest in the Netherlands (€259,131), followed by France (€176,042) and then Germany (€160,253). It is not clear if the gross income for salaried specialists includes professional development grants, indemnity cover, pensions and paid memberships to professional organisations. On the other hand, it is not clear if the salaries earned by the self-employed specialists are before or after other expenses are deducted such as rent, administration services, nursing services, professional development expenses, indemnity cover and pension contributions.

The full time equivalent (FTE) working hours for specialists across Europe are broadly similar with 40 hours per week being the norm. The search did not yield information on the reporting relationships of specialists across European countries with the exception of Germany and the UK. In Germany the senior specialist (*Chefartz*) is responsible for the entire department both in medical and legal terms. In the UK, specialists report to a clinical or medical director on quality of care issues or organisational issues including job plans and scheduling.

An outline of the responsibilities of the specialist post was only obtained for the Netherlands and the UK and relate to patient clinical care. Duties include: consulting; diagnosing; planning and evaluating treatment; and administration directly related to patient care. In both of these countries additional responsibilities were described which mainly relate to teaching and to medical/clinical governance. In the UK, the NHS has a 'flexible careers scheme for doctors' which is designed to enable doctors to move in and out of full-time and part-time work, reorganise their hours, take career breaks and wind down gradually before retirement. The scheme provides central funding and is designed to find working patterns for Consultants wishing to work less than 50% of a fulltime equivalent. Consultants wanting to work as part of a job share or part-time above these hours can apply for any substantive post. In Germany, more than one-fifth of specialists work part-time. For the remaining countries, information on flexible working arrangements was not obtained. Proleptic appointments as described in the medical literature are available in the UK but not in the Netherlands. However it must be emphasised that in the UK there is always open competition for all Consultant posts. Special arrangements for hard–to–fill posts were described only for the UK, with the Netherlands sources commenting

that there are no special arrangements for hard–to–fill posts on a national scale. With regard to the UK, the contract allows hospital trusts under certain circumstances to award a recruitment or retention premium in locations/specialties where the post is difficult to fill.

4.3.2 Canada

There is one grade of specialist in Canada. Specialist doctors are not employed by the state health system but contracted, and their remuneration is currently based on blended models that combine a base rate, a fee-for-service component and incentive or premium payments. Provincial and territorial ministries of health negotiate physician fee schedules with the relevant medical associations. Specialists are clinically independent practitioners and full-time equivalent hours are 40 hours per week. If the job involves shift work, fulltime is 12 (x12 hour) shifts per month. The Canadian Institute of Health Information publish gross clinical earnings per physician in each province and in 2011-2012 the gross clinical payment per physician was CD$328,000 in 2011–2012, but there is significant variation depending on the specialty and geographical location. This figure does not take account of overheads associated with practices.

Additional payments can be made for additional leadership or academic responsibility and these are usually made through academic funding payments or alternative funding payments. On-call payments are paid with the amount depending on the frequency and intensity of the on-call hours. Contractual hours are agreed on an individual basis and on-call hours are individualised to contract. Flexible working arrangements are possible and arrangements are agreed with the provincial health ministry and individual doctor or groups of doctors. There are a variety of allowances and benefits subject to area and local agreement and many of these are aimed at recruiting and retaining specialists in hard-to-fill (mainly rural) posts.

4.3.3 Australia

Generally there is one grade of specialist in Australia. However, New South Wales (NSW) has specialist and senior specialist positions. Most specialists involved in academic medicine will be working in a university hospital and some of their time allocated toward academic activities. For academic Consultants it is possible to progress academically to a higher grade such as professor.

Physicians in public hospitals either are salaried (but may also have private practices and additional fee-for-service income, of which they usually contribute a portion from the fees to the hospital), or are private specialist physicians who do some work in public hospitals, where they are paid on a per-session or fee-for-service basis for treating public patients. Any specialist with sufficient experience if they have the necessary skills can apply for clinical director with reimbursement for additional responsibility. Specialists are clinically independent practitioners with fulltime equivalent posts at 40 hours per week in all jurisdictions.

Earnings are partly determined by the different sources of funding for doctors' services. Medical specialists in public hospitals are usually paid a salary or by contract, with this being determined

by State bargaining agreements. In addition, some salaried specialists have rights to private practice which means that additional income can be earned from seeing private patients, either in a public hospital or private setting. Hours worked in excess are paid at penalty rates and on-call hours are individualised to contract. Examining three states (New South Wales, Western Australia and Queensland) salary ranges from $147,486 to $253,774 (Australian dollars) across these three states with slight variations from state to state. Also available to specialists are management and leadership incentives. The rates of payment for on-call vary from state to state. Working hours are negotiable with part-time permanent posts possible by agreement. The Commonwealth provides a range of financial and non-financial incentives with the aim of attracting and retaining the rural and remote health workforce under the Rural Health Workforce Strategy (RHWS).

4.3.4 New Zealand

There is one grade of specialist in New Zealand. The responsibilities of specialists in New Zealand are described as responsibility to their patients and to act as a patient advocate. The actual job descriptions for specialists are worked out locally. They are clinically independent practitioners. Generally each employee gets a statement of positions to whom the employee reports and for what purposes, i.e. clinical matters and other matters. It is unlikely there will be more than two such positions. For all clinical matters, the 'manager' is likely to be a senior medical specialist within the organisation and would ordinarily be the clinical leader or head of department.

Specialist salaries are covered by a universal national agreement with a range of NZ $149,750 – $206,000. Their working hours are negotiated but fulltime equivalent is 40 hours per week. Initial placement on the salary scale depends on the qualifications and experience of the specialist. The salary increases yearly subject to satisfactory performance. In New Zealand, doctors' salaries are set by the Government through negotiation between the district health boards and union and are consistent on a sliding scale across the whole country. The salaries differ depending on how many rostered hours the particular role requires and on years of work experience. Out of hours availability allowances are paid for doctors' on-call and extra payment for all out-of-hours rostered call duties including telephone consultations and visits. For academic posts, clinical directorship etc. the method of remuneration varies with some specialists paid more, some get time allowance, some get both and some are stand-alone positions.

The employer may pay special allowances or provide benefits in services to specialists where recruitment and retention is a problem. A bonding scheme was introduced in 2009 for medical graduates to encourage working in rural areas.

4.4 Conclusion

The international evidence review is a valuable resource and has been drawn on by the Group in framing the conclusions and recommendations of this report.

5 CONCLUSIONS

5.1 Introduction

This report focuses on future medical career structures and pathways following completion of specialist training[6] and, in particular, on career structures and pathways for Consultants.

The Working Group recognises that there are particular issues and challenges in relation to the recruitment and retention of doctors in services beyond the acute hospital setting, including public health medicine, general practice and mental health services. It is the Working Group's intention to examine these issues further with a view to reporting on them and making high-level recommendations, as appropriate, in the Group's final report in June 2014. Any other outstanding issues relating to medical career structures and pathways following training will also be addressed in the June report.

In arriving at its conclusions, the Working Group has considered the views of stakeholders, the HRB's international evidence review, relevant international and national developments in recent years, and the overarching future policy context – the Health Reform Programme.

5.2 The Central Role of the Consultant

At the outset, the Chair and members of the Working Group wish to acknowledge that the Consultant:

- Is central to the delivery of quality, safe care to patients;
- Is a vital resource for the efficient and effective functioning of the public health system;
- Plays a key leadership role in both management and clinical service provision.

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

The Working Group recognises that our medical workforce is an internationally mobile one and that, given the quality of Irish medical training and the global shortage of doctors, other countries are actively seeking to attract Irish medical graduates to work in their health systems.

[6] Attainment by the clinician of CSCST and qualification for registration on the Specialist Division of the Medical Council's register.

While recognising that Irish medical graduates gain valuable experience working in health systems in other jurisdictions (both in Europe and elsewhere), in line with Ireland's national policy of health-worker self-sufficiency, the Group wishes to emphasise the importance of recruiting and retaining Irish medical graduates as Consultants in the public health system – both now and in the future.

In the context of the Health Reform Programme, the Working Group considers that the Consultant role must:

- Provide high-quality, safe patient care in a cost-effective manner;
- Be grounded in a team-based approach to clinical care with Consultants working as an integral part of a multidisciplinary team, acting together and sharing responsibility for patients with Consultant colleagues, and working alongside other health professionals including trainee doctors, nurses, and health and social care professionals;
- Be grounded in, responsive to and play a critical leadership role in developing new service delivery models and addressing service needs;
- Provide for Consultant-provided care based on clinical need;
- Facilitate integrated delivery of care to patients.

The Working Group recognises that Consultant roles and working practices have changed and evolved considerably in many disciplines over the past decade in response to system reconfiguration and service improvements e.g. the National Cancer Control Programme. The Working Group welcomes this development and considers that it is likely to become an increasing feature of the Irish healthcare landscape in the coming years – both in response to changing patient needs and expectations, and in response to clinical advances and developments, together with plans for a more integrated system of primary and hospital care.

5.3 Future Consultant Career Structures and Pathways

The Working Group notes feedback from stakeholders that the nature and composition of a doctor's work may change over time, with some doctors taking on non-clinical roles as their career progresses. Moreover, many doctors are branching off the traditional clinical path at various points in their careers to undertake secondments, fellowships and other short- or medium-term options.

In this context, the Working Group takes the view that, in the future, appointment as a Consultant should be considered as a key step in a medical career, with further opportunities for advancement, progression and personal development, rather than viewed as an end-point in itself. A more differentiated Consultant career structure, which takes account of relevant post-CSCST experience obtained in Ireland or abroad would offer greater opportunities for

progression, and would be in keeping with Consultant roles and career structures in other jurisdictions.

There are a number of strands within which opportunities for advancement, progression and personal development for Consultants can be envisaged in the future. These include, but are not necessarily limited to:

- Clinical service provision;
- Clinical leadership and management;
- Research, training, academic, quality improvement and other roles.

5.3.1 Clinical Service Provision

In order to facilitate a Consultant-provided service, the Group strongly believes that the majority of doctors who are appointed as Consultants will be needed to, and will wish to, stay involved in active clinical service delivery as part of Consultant and multidisciplinary teams. In this regard, the Group considers that the establishment of the Hospital Groups, and the development and implementation of the National Clinical Programmes, offers opportunities for more varied clinical service delivery – within the overall service needs of a Hospital Group.

The Group also notes that the establishment of the Hospital Groups offers the potential for the development of a variety of lead roles within a Consultant team, which are likely to be of interest to particular Consultants depending on their personal interests and/or experience e.g. clinical training lead, service development lead, quality improvement lead etc.

The Group notes current challenges in respect of staffing of particular Consultant-level posts in some smaller or peripheral (Level 2/Level 3) hospitals and considers that the establishment of the Hospital Groups, with shared governance and the reconfiguration of services between sites, provides an opportunity to address this issue through the provision of more varied service delivery opportunities for doctors. Having considered examples from other jurisdictions, it does not consider that initiatives such as incentive or bonding schemes are a sustainable solution to problems in filling posts in smaller, more remote locations.

In addition, the Group notes the onerous out-of-hours commitment and demanding rotas associated with some smaller or peripheral hospitals, and the stated intention of trainees not to take up posts in sites where they consider services to be unsustainable or unsafe. The Group considers that the reconfiguration of services in the context of the Hospital Groups provides an opportunity to address this issue.

5.3.2 Clinical Leadership and Management

The Working Group believes that clinical leadership – at all levels – is important and that distributed leadership models (Mountford and Webb, 2009: 4) that empower Consultants in

various roles have the potential to drive continuous quality improvement across the public health system.

In addition, experience internationally has demonstrated that the level of clinical leadership and management in hospitals and hospital groups correlates with hospital performance and clinical outcomes.

In this context, the Working Group considers that the establishment of the Hospital Groups provides an opportunity to enhance and refine existing clinical leadership and management structures further, building on the current Consultant/Clinical Director model. It is likely that the establishment of the Hospital Groups will drive the development of Group-level Service Departments in major service groups, such as surgery and anaesthesia. This in turn would generate the requirement for a Head of Department, reporting to the overall Clinical Director of the Hospital Group.

The Working Group sees the potential for the development of a more differentiated leadership/management career structure than currently exists. It considers that such a development would be desirable – in terms of efficient management of resources, improved service delivery, and opportunities for progression and personal development. Such a clinical leadership/management stream should be seen as a specific career choice by doctors and appointments to senior clinical leadership and management roles should be competitive, and based on merit and suitability.

5.3.3 Research, Training, Academic, Quality Improvement and Other Roles

The Working Group considers that health policy should give a clear commitment to research, development, quality improvement and lifelong learning, as integral components of the career pathway of Consultants.

At present, aside from Academic Consultant roles, Consultants have limited opportunities to engage – in a structured way – in research, clinical training, academic or quality improvement activities relevant to their clinical practice, area of specialisation and personal development.

The Working Group believes that both the health service and the individual can – and should – benefit from such activities. They should be integrated more formally into the work of Consultants than is currently the case and can be enabled through team-based working. In this regard, the Working Group notes that mechanisms that facilitate an on-going personal and professional development and accountability dialogue between the Consultant and Clinical Director, based on a partnership approach, are in place in other jurisdictions (e.g. the job planning process in the UK).

The Working Group also takes the view that there is a need to provide separate career paths for those doctors who seek (and who are needed) to dedicate much or all of their time to research, training or academic activities, which benefit patients. In this regard, the Group notes the joint HSE/HRB National SpR/SR Academic Fellowship Programme at the end of which individuals are awarded both their doctorate and CSCST. The Group considers that this initiative can be built on in the coming years in order to enhance Ireland's medical research capacity and, ultimately, benefit the public health system and improve outcomes for patients.

5.4 Barriers to Recruiting and Retaining Consultants in the Public Health System

The Working Group wishes to emphasise a number of current matters which, if unaddressed, will continue to impact adversely on the recruitment and retention of Consultants to clinical service delivery and other roles in the public health system. These include:

- Variations in the rates of remuneration between new entrant Consultants and their established peers that have emerged since 2012;
- Lack of recognition in starting salary of relevant post-CSCST experience (gained in Ireland or elsewhere) at time of appointment to a Consultant post;
- Limited opportunities for flexible working at Consultant level – both in terms of flexibility within the Consultant's work commitment (e.g. research, training, quality improvement etc.) and in terms of family-friendly flexible working;
- Limited infrastructural and human capital support for newly appointed Consultants, including inadequate resourcing of the clinical service delivery role in terms of allocation of available theatre time and out-patient clinics, and the deployment of related resources;
- Unattractiveness of the working environment in some Level 2 and Level 3 hospitals[7], particularly with regard to unscheduled care;
- Lack of clarity for trainees around the planned availability (by specialty and location) of Consultant posts.

Finally, the Working Group wishes to note the concerns raised by trainees in relation to the culture of the health service and the need to develop a culture of mutual respect and constructive partnership.

[7] As set out in the *Smaller Hospitals Framework,* Level 2 hospitals will 'provide the majority of hospital activity including extended day surgery, selected acute medicine, local injuries, a large range of diagnostic services (including endoscopy, laboratory medicine, point-of-care testing, and radiology (CT, US and plain film X Ray)) specialist rehabilitation medicine and palliative care'. Level 3 hospitals 'will provide 24/7 acute surgery, acute medicine, and critical care (DoH, 2013: 8).

6 RECOMMENDATIONS

Taking into account the conclusions in Chapter Five, and having regard to the Terms of Reference of the Strategic Review, the Working Group is making the following recommendations in relation to medical career structures and pathways for Consultants.

1. The Working Group recommends that the relevant parties commence, as a matter of urgency, a focused, timetabled IR engagement of short duration to address the barrier caused by the *variation in rates of remuneration between new entrant Consultants and their established peers* that have emerged since 2012. It further recommends that the relevant parties explore options, within existing contractual arrangements, to advance a *more differentiated Consultant career structure* as outlined in Section 5.3 (i.e. clinical service provision, clinical leadership and management, clinical research, academic, quality improvement and other roles).

2. With regard to *developing opportunities for flexibility within the Consultant's work commitment*, the Working Group, recommends the development and introduction of a system of accountable personal development/work planning for all Consultants, aligned with professional competence schemes, as appropriate. This system should build on the existing Clinical Directorate Service Plan process and take into account relevant processes in other jurisdictions. In relation to quality improvement, the Working Group notes that there is a comprehensive programme of work in the health service to train people in quality improvement skills and it would be desirable for provision to be made in work plans for those who will lead in this field.

3. With regard to *family-friendly flexible working*, the Working Group recommends that more individually-tailored time commitments should be made available, and facilitated where possible, for both new and existing Consultant posts. With regard to all new Consultant posts, the Working Group recommends that recruitment notices should indicate that a flexible working facility is possible.

4. In relation to *improving supports for newly appointed Consultants*, the Working Group recommends that the personal development/work planning process for Consultants outlined in Recommendation 2 above, should include an outline of the resources required to achieve the service and personal objectives set out in the plan. These should be agreed at time of appointment and should be reviewed annually by the Consultant and Clinical Director/Employer in the context of changing objectives and the resources available to the Consultant team. In addition, in tandem with the development of work plans, the Working Group recommends that all newly appointed Consultants should be offered the opportunity to avail of an appropriately individualised induction programme upon appointment.

5. The Working Group recommends that the reconfiguration of hospital services should be used as an opportunity to address the barrier of the *unattractiveness of the working environment in*

some Level 2 and Level 3 hospitals. In this regard, the Working Group recommends that Hospital Group strategic plans should include proposals for rationalisation of services with unscheduled care rosters. The Strategic Advisory Group on the Implementation of Hospital Groups should define this as one of the criteria for the development and evaluation of these plans.

6. With regard to *improving clarity around availability of Consultant posts by specialty and location*, the Working Group recommends more centralised and coordinated workforce planning and better matching of new posts to service requirements and existing trainee capacity. The Group acknowledges the on-going work in HSE-MET to develop a model of medical workforce planning, which will be of significant assistance in this regard and will support appropriate, competitive succession planning. While recognising the value of international experience, the Working Group recommends the continued development of post-CSCST fellowship capacity in Ireland in order to retain specialist medical expertise in the public health system in advance of appointment to Consultant posts.

Finally, the Working Group notes that culture is a key factor in recruiting and retaining staff, and it recommends that transformative cultural change should be a core driver of the HSE System Reform initiative.

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

	Recommendation	Relevant Parties	Key Deliverables	Target Date
1	The Working Group recommends that the relevant parties commence, as a matter of urgency, a focused, timetabled IR engagement of short duration to address the barrier caused by the *variation in rates of remuneration between new entrant Consultants and their established peers* that have emerged since 2012. It further recommends that the relevant parties explore options, within existing contractual	• HSE • DOH • D/PER • Staff associations • Labour Relations Commission	Agreement on a more differentiated Consultant career structure and associated rates of remuneration.	July 2014

	arrangements, to advance a *more differentiated Consultant career structure* as outlined in Section 5.3 (i.e. clinical service provision, clinical leadership and management, clinical research, academic, quality improvement and other roles).			
2	With regard to *developing opportunities for flexibility within the Consultant's work commitment*, the Working Group recommends the development and introduction of a system of accountable personal development/work planning for all Consultants, aligned with professional competence schemes, as appropriate. This system should build on the existing Clinical Directorate Service Plan process and take into account similar processes in other jurisdictions. In relation to quality improvement, the Working Group notes that there is a comprehensive programme of work in the health service to train people in quality improvement skills and it would be desirable for provision to be made in work plans for those who will lead in this field.	• HSE • Staff associations • Employers	Personal development/work planning system developed and implementation date agreed.	Q4 2014
3	With regard to *family-friendly flexible working*, the Working Group recommends that more individually-tailored time commitments should be made available, and facilitated where possible, for both new and existing Consultant posts. With	• HSE • Employers	All recruitment notices to reflect availability of flexible working facility.	Q3 2014

	regard to all new Consultant posts, the Working Group recommends that recruitment notices should indicate that a flexible working facility is possible.			
4	In relation to *improving supports for newly appointed Consultants*, the Working Group recommends that the personal development/work planning process for Consultants outlined in Recommendation 2 above, should include an outline of the resources required to achieve the service and personal objectives set out in the plan. These should be agreed at time of appointment and should be reviewed annually by the Consultant and Clinical Director/Employer in the context of changing objectives and the resources available to the Consultant team. In addition, in tandem with the development of work plans, the Working Group recommends that all newly appointed Consultants should be offered the opportunity to avail of an appropriately individualised induction programme upon appointment.	• HSE • Staff associations • Employers	See Recommendation 2 above.	Q4 2014
5	The Working Group recommends that the reconfiguration of hospital services should be used as an opportunity to address the barrier of the *unattractiveness of the working environment in some Level 2 and Level 3 hospitals*. In this regard, the	• HSE • Hospital Group management • SAG on the Implementation of Hospital Groups	Hospital Group strategic plans incorporate proposals for rationalisation of services with unscheduled care rosters.	Within 1 year of establishment of Hospital Group

	Working Group recommends that Hospital Group strategic plans should include proposals for rationalisation of services with unscheduled care rosters. The Strategic Advisory Group (SAG) on the Implementation of Hospital Groups should define this as one of the criteria for the development and evaluation of these plans.			
6	With regard to *improving clarity around availability of Consultant posts by specialty and* location, the Working Group recommends more centralised and coordinated workforce planning and better matching of new posts to service requirements and existing trainee capacity. The Group acknowledges the on-going work in HSE-MET to develop a model of medical workforce planning, which will be of significant assistance in this regard and will support appropriate, competitive succession planning. While recognising the value of international experience, the Working Group recommends the continued development of post-CSCST fellowship capacity in Ireland in order to retain specialist medical expertise in the public health system in advance of appointment to Consultant posts.	• HSE • DoH	Medical workforce planning model developed and implemented.	Q2 2015
		• HSE • DoH • HRB • Forum of Postgraduate Medical Training Bodies • University academic medical departments	Proposals for development of post-CSCST fellowship capacity.	Q4 2014

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Appendix One: The Eight Domains of Good Professional Practice

The Medical Council has defined eight domains of good professional practice (see figure below). These domains describe a framework of competencies applicable to all doctors across the continuum of professional development from formal medical education and training through to maintenance of professional competence (Medical Council, 2011: 14).

Appendix Two: BST Training Posts Filled by Training Bodies, 2013-2014

Specialty	Training Numbers
Anaesthesia	70
Emergency Medicine	55
General Practice	315
General Internal Medicine	565
Obstetrics and Gynaecology	75
Ophthalmology	42
Paediatrics	98
Histopathology	23
Psychiatry	204
Surgery	180
Total	**1,627**

Appendix Three: HST Training Posts Filled by Training Bodies, 2013-2014

Specialty	Training Numbers
Anaesthesia	140
Emergency Medicine	37
General Practice	337
Obstetrics and Gynaecology	50
Cardiology	46
Dermatology	19
Endocrinology and Diabetes Mellitus	28
Gastroenterology	33
General Internal Medicine	4
Genito-urinary Medicine	1
Geriatric Medicine	34
Infectious Disease	12
Medical Oncology	16
Nephrology	27
Neurology	27
Palliative Medicine	14
Rehabilitation Medicine	3
Respiratory Medicine	44
Rheumatology	23
Occupational Medicine	6
Ophthalmology	13
Paediatrics	84
Chemical Pathology	3
Haematology	25

Histopathology	43
Immunology	2
Microbiology	23
Child and Adult Psychiatry	23
General Adult	57
Public Health Medicine	11
Diagnostic Radiology	82
Radiation Oncology	13
Cardiothoracic Surgery	8
General Surgery	46
Neurosurgery	9
Ophthalmic Surgery	12
Otolaryngology	26
Paediatric Surgery	3
Plastic Surgery	15
Trauma and Orthopaedic Surgery	42
Urology	12
Total	**1,453**

APPENDIX FOUR: COMPOSITION OF HOSPITAL GROUPS

Initially, the Hospital Groups are being established on a non-statutory administrative basis. Seven hospital groups have been established on a non-statutory administrative basis each of which will operate under a single, management structure as follows: (i) Dublin North East; (ii) Dublin Midlands; (iii) Dublin East; (iv) South/South West; (v) West/North West; (vi) Midwest and (vii) Children's Hospital Group.

NO.	COMPOSITION
i	*Dublin North East:* Beaumont Hospital; Our Lady of Lourdes Hospital, Drogheda; Connolly Hospital; Cavan General Hospital; Rotunda Hospital; Louth County Hospital; Monaghan Hospital. (Academic Partner: RCSI).
ii	*Dublin Midlands:* St James's Hospital; The Adelaide & Meath Hospital, Dublin, including the National Children's Hospital; Midlands Regional Hospital, Tullamore; Naas General Hospital; Midlands Regional Hospital Portlaoise; the Coombe Women & Infant University Hospital. (Academic Partner: TCD).
iii	*Dublin East:* Mater Misericordiae University Hospital; St Vincent's University Hospital; Midland Regional Hospital Mullingar; St Luke's General Hospital, Kilkenny; Wexford General Hospital; National Maternity Hospital; Our Lady's Hospital, Navan; St Columcille's Hospital; St Michael's Hospital, Dun Laoghaire; Cappagh National Orthopaedic Hospital; Royal Victoria Eye and Ear Hospital. (Academic Partner: UCD).
iv	*South/South West:* Cork University Hospital/CUMH; Waterford Regional Hospital; Kerry General Hospital; Mercy University Hospital; South Tipperary General Hospital; South Infirmary Victoria University Hospital; Bantry General Hospital; Mallow General Hospital, Lourdes Orthopaedic Hospital, Kilcreene. (Academic Partner: UCC).
v	*West/North West:* University Hospital Galway and Merlin Park University Hospital; Sligo Regional Hospital; Letterkenny General Hospital; Mayo General Hospital; Portiuncula Hospital; Roscommon County Hospital. (Academic Partner: NUIG).
vi	*Midwest:* Mid-Western Regional Hospital, Limerick; Ennis General Hospital; Nenagh General Hospital; St John's Hospital Limerick; Mid-Western Regional Maternity Hospital; Mid- Western Regional Orthopaedic. (Academic Partner: UL).
vii	*Children's Hospital Group:* The acute paediatric services in Dublin; Our Lady's Children's Hospital - Crumlin, Children's University Hospital Temple Street, and the paediatric service in AMNCH – Tallaght. (Academic Partner: All Universities)