RETAINING OUR DOCTORS

MEDICAL WORKFORCE EVIDENCE, 2013-18

CHALLENGES AND RESPONSES
Retaining our Doctors

Medical Workforce Evidence, 2013-18

RCSI Health Workforce Research Group

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Ireland’s Medical Workforce Challenges and Responses

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

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

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

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

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

Implementation has been successful, in part, although some critical recommendations have not been fully implemented, or implementation has not had the desired impact (see Annex 1). In some cases, actions need to be taken by stakeholders, e.g. government departments, which are not represented on the Implementation Monitoring Group. The frustrations of trainees is evidenced from the biennial consultations with trainees that are captured in a series of progress
reports published between July 2014 and July 2017 that are on the Department of Health website – see here; and specifically in section 2.2 of the most recently published sixth progress report (July 2017) – see here. Recent RCSI research confirms the representativeness of these findings (see Section 5.5 of this report).

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

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

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

a) Designated training time for trainees is being impacted by the shortage of consultants at training sites, in comparison to international norms (see Section 6. Medical Workforce Planning, Specialty Reviews):

i) A lack of consultants is placing excessive service demands on trainees, impacting on the time available to them for training and for opportunities to develop competencies required to become specialists.

ii) Consultant shortages and inconsistent structuring of their participation in training impact negatively on the quality and consistency of training that some NCHDs currently experience – see Section 5.5 and Table 5.2 of this report. This is despite training bodies recognising the importance of – and consultant contracts including clauses to deliver on – NCHD training.¹

b) Performance of non-core tasks continues to take up a significant amount of trainees’ time, particularly at the earlier stages of training. This involves carrying out a range of basic non-medical tasks that are often not expected of trainees in the countries to which NCHDs emigrate. This is a poor use of Ireland’s valuable, highly trained medical workforce; and it impacts negatively on their training. Industrial relations obstacles, relating to the positions adopted by professional associations, have hampered progress in tackling this issue.

c) Participants at the RCSI November 2017 policy dialogue reported that intern induction practices are inconsistent, and generally there is a lack of monitoring of tasks undertaken by interns. For example, interns, who should be the best-protected and supported hospital doctors, sometimes do not know who has been allocated to them as a specialist trainer (see Sections 3.3 and Section 5.4

¹‘Protected training’ and ‘non-core tasks’ were the focus of the 2014 SRMTCS Recommendations 1.1 and 1.2 respectively. The implementation monitoring group assessed the delivery of Rec 1.1 (protected training) as ‘Green’, but the impact of the recommendation as ‘Amber’. Rec 1.2 (non-core tasks) was judged to be ‘Amber’.
of this report). Many doctors go abroad directly after internship where they often report more positive experiences. Examples of good practice internship programmes were discussed, e.g. structured entry and exit events in the North East of Ireland.

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

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

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

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

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

\(^2\) A significant proportion of non-trainees are in long-term non-training posts (personal communication NDTP), with a small minority being NCHDs temporarily out of training programmes. This corresponds with the term ‘service posts’. Some NCHDs are temporarily outside of training programmes.
The complex set of reasons why trainees intend to leave or have left Ireland to make their careers abroad means that actions are needed on many fronts. The evidence on this is summarised in Section 5. *Doctor Emigration from Ireland: Push and Pull factors.*

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

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

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

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

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

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3 “Access to specialist training posts is to be given the green light for non-European Union (EU) qualified doctors, under new proposed priority legislative changes due to be published shortly...” Irish Medical Times, 2nd May 2018 – see here. This is a useful example of how political commitment, from the highest levels, can bring about positive and timely changes.
call rotas’. Experienced trainees report that they are now less likely to develop close working relationships with a range of consultant trainers.

d) The status of SRMTCS Rec 2.1, “Agreement on a more differentiated Consultant career structure and associated rates of remuneration”, was deemed to be ‘Green’. However, differences between pre- and post-2012 contracts continue to rankle, despite efforts to recruit consultants into higher entry points of the new consultant contract. Differences in salary scales and terms and conditions of service are felt to be inequitable, which continues to impact negatively on the morale of new consultants. An additional disincentive to trainees taking up permanent posts in Ireland are the growing disparities in salary levels between Irish public sector consultant posts and salaries in countries that compete for Irish trained specialists.4

e) Medical workforce recruitment processes are driving two unwanted phenomena: i) the rising ratio of non-trainees to trainees, and ii) the appointments of locums, including not-fully trained specialists, as consultants – see Section 4 and Section 6.5 of this report.

i) The recruitment of trainees is controlled centrally by the HSE in collaboration with the training bodies, and the number of training posts is linked to projected medical workforce requirements. However, the recruitment of non-trainees is the responsibility of each individual hospital / agency (e.g. Mental Health services). Some model 2 and 3 hospitals, are under pressure to recruit non trainee doctors in order to address service demands.

ii) The Consultant Applications Advisory Committee (CAAC) advises the HSE centrally on applications for medical consultants and advises on qualifications for consultant posts. Where posts are approved significant delays can occur in this translating into a filled, permanent consultant post at hospital level. These delays may impact on attracting good quality applicants or may lead to a creation of temporary or locum consultant posts in an effort to maintain service delivery.

iii) Recent Medical Workforce Planning Reviews for General Practice (Section 6.2), Emergency Medicine (Section 6.3) and Paediatrics (Section 6.4) report that in these specialties in 2016, about 15% of consultant posts were filled by locums who had not completed specialist training. More recent data for these particular specialties may result in lower estimates; and other specialty reviews (to be published), may show different rates.

iv) Model 2 and some 3 hospital consultant positions do not attract applications from trainees who have completed national training programmes. Reasons for this, as proposed at the November 2017 policy dialogue, include that such posts do not allow the opportunity to

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

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

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

a) Model 2 (and for less common specialties, model 3) hospitals lack sufficient patient through-put and resources to make full use of trained specialists. In some specialties (notably surgery), there is a need for a critical mass of surgeons and patient volumes to maintain skills. A strong volume-outcome relationship has been reported across a wide range of services, especially in the case of more complex surgical procedures. For the same reasons, such hospitals have limited potential and cannot be accredited as training sites for trainees.

b) Despite successive reports and a clear consensus that more specialised hospital care can best (and in some cases can only safely) be delivered in larger model 3 and model 4 hospitals, political interests, compounded by difficulties for some communities in accessing hospitals with a better range of specialties can mean that what is best for patients is overridden. Optimal hospital configuration for better patient care does not mean that model 2 hospitals should be closed. However, it does mean that imaginative solutions need to be found to ensure service quality and safety, efficient use of resources, and access to care (see 4.a below).

Responses

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

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

b) Highly trained, motivated, and well-managed health professionals – doctors, nurses and other health and social care professionals – are the critical determinant of excellent patient health outcomes. It was generally agreed that hospital groups, even if they are not a perfect approach, need to be funded (and have the budget flexibility) to hire, manage, motivate and deploy staff to work in adequate sized clinical teams. Implementation would need to avoid introducing differences in terms and conditions of service that could lead to unwanted effects of competition between hospital groups.

c) Hospital Groups, with concentrations of highly specialised consultants at the centre, should not be seen as a panacea. In Surgery, most demand is for the least complex procedures and there is a challenge in ensuring that the hospital specialist workforce that are trained and appointed have the right skill sets to meet population needs. Hospitals require:

i) optimal ratios of trained and trainee specialists – including a balance of generalists and more specialised staff – with a strategy for reducing reliance on non-trainees over time (see Section 5a Consultant-delivered Paediatric Service Pilot Scheme);

ii) multi-disciplinary teams that provide optimal, integrated, cost-effective care through networks that span primary care and community services, with appropriate access to hospital services as outlined in the SláinteCare Report and the National Strategic Framework for Health and Social Care Workforce Planning (see below and Section 6 of this report).

d) Hospital Groups could provide opportunities for piloting new workforce models to address dysfunctional workforce configurations and to operationalise new policy directions (see section 6). Delays in establishing and making Hospital Groups functional, in some form or other, mean that these opportunities are being missed.

5. The Business Case for Implementation of a Consultant-delivered Paediatric Service Pilot Scheme, University Hospital Waterford Paediatric Department, May 2016 captures many of the features of the health models envisaged in the new policy directions (see Section 6.6 and Annex 2 of this report). Amongst other recommendations, it specifies performance indicators that can be used to measure the benefits of a consultant-delivered specialist service.

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

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5 The pilot programme has been developed by the National Clinical Programme for Paediatrics and Neonatology, the HSE Acute Hospitals Division and the NDTP. It is being funded under the HSE Corporate Plan 2015-2017 goal to “provide fair, equitable and timely access to quality, safe health services that people need”. 
envisioned in the *National Strategic Framework for Health and Social Care Workforce Planning* report.

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

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

      i) estimates that an “additional 20% (593) consultants will be put in place by year 4” (of implementation) (Page 69). And €235m cost for GPs will be needed as part of a 6-year Transitional and Legacy Funding package (See Table 3 p11) the report recommends that: “recruitment of hospital consultants and NCHDs should be to Hospital Groups rather than to individual hospitals, as part of meeting the medical staffing needs of smaller hospitals”.

      ii) recommends a move away from professional ‘silos’ towards integrated workforce planning, with an emphasis on developing appropriate skill-mixes across cadres and professions; and that specialist appointments be made not only to hospitals, but also to Community Health Organisations.

      iii) proposes that new Integrated Care Regional Organisations be given responsibility for staff recruitment, working within the National Strategic Framework for Health, under a Health Service National Centre, delivering a National Service Plan.

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

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

7. **Implementation**

The new HSE *Health Workforce Planning Unit*, noted for establishment under the National Strategic Framework for Health and Social Care Workforce Planning, once
fully established, will bring together and forge links between national clinical care programmes, national specialty training colleges and faculties, and other health professions bodies. New interdisciplinary ways of working should start with doctors and nurses, piloting models that link hospitals, primary and community care.

8. The need for commitment

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

Ruairí Brugha, May 2018