Preparing Ireland's Doctors to meet the Health Needs of the 21st Century

Report of the Postgraduate Medical Education and Training Group

The Postgraduate Medical Education and Training Group's vision is that

"Ireland's postgraduate education and training environment will be attractive to all medical graduates and deliver high-quality programmes that will result in a sufficient number of fully-trained, highly competent doctors to deliver a patient-centred, high-performance health service for this country."

Foilsítear an leagan Gaeilge den tuarascáil seo ar an dlúthdhiosca iniata.

The Irish language version of this report is published on the attached CD.

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Foreword–Tánaiste and Minister for Health and Children

I am very pleased to publish the Report of the Postgraduate Medical Education and Training (MET) Group. I would like to thank Dr Jane Buttimer and her fellow MET Group members for their hard work. I would also like to express my appreciation to those organisations and individuals who contributed to the development of the report through the MET Group's extensive consultation process.

The Department of Health and Children has in the past few years given significant attention to evaluating medical education and training at postgraduate specialist training level through the MET Group and at undergraduate level jointly with the Department of Education and Science in the Working Group chaired by Professor Pat Fottrell.

This report focuses, in particular, on postgraduate specialist training which aims to provide high quality training programmes which will produce fully trained competent specialists with the knowledge, skills, values and attitudes to serve the public in the Irish healthcare system in the 21st century.

The outcome is a coherent reform agenda which challenges us to accept that change is not only possible, but vital. I look forward to the implementation of a comprehensive package of measures based on this Report.

Mary Harney T.D.
Tánaiste and Minister for Health and Children

Chairperson's Introduction

The Report of the Postgraduate Medical Education and Training Group addresses the much needed reform of specialist education and training in Ireland and makes recommendations on the actions required to deliver on the Group's vision set out at the front of this Report.

Improving the quality of the population's health and delivering high quality, safe patient care very much depends on the availability of a sufficient number of doctors trained in the competencies and specialties required by the Irish health system in the new century.

Health service reforms and the increasing complexity of medicine have altered the relationship between medicine and the society it serves. These changes, together with reducing working hours, the imminent reform of undergraduate medical education and training, the fact that many Irish graduates who train or work abroad stay abroad, and international medical shortages, underline the critical importance of ensuring that the postgraduate medical education and training system rises to the challenges thereby posed. While the quality of Irish medical education and training ultimately depends on the degree to which the proposed health reforms are implemented, there is an urgent need to implement most of the recommendations in this report independent of the reform process.

This Report, taken together with the Report of the Undergraduate Medical Education and Training Working Group, should serve as a blueprint for integrated reform across the continuum from undergraduate and postgraduate education and training to continuing professional development. This Report draws on the vast knowledge and expertise of the Group members in education and training and health service reform. I would like to thank each one of them for their dedication and am confident that they will continue to assist in the process of delivering the necessary changes.

The work involved an extensive consultation process with Government Departments (Health and Children, Finance, and Education and Science), the Medical Council, the Postgraduate Medical and Dental Board, all of the bodies involved in training, the Health Service Executive and the Higher Education Authority. I am very grateful for their input and look forward to seeing them continue to work together, thereby ensuring that the Group's vision becomes a reality.

I would also like to thank the Department of Public Health Medicine and Epidemiology, University College Dublin (UCD) for its work in producing the *Career Tracking Study*, carried out on behalf of the Group, which underpins many of the recommendations in the Report.

Finally, I would also like to thank my great team, the Secretariat, who supported the whole process and brought the Report to fruition.

Dr. Jane Buttimer, Chairperson

Membership of the Postgraduate Medical Education and Training (MET) Group

Chairperson

Dr. Jane Buttimer,

Medical Director, Medical Education and Training, Department of Health and Children

Members

Dr. Ruth Barrington,

Chief Executive Officer, Health Research Board

Dr. Margaret O'Riordan,

Irish College of General Practitioners (replaced Dr. Richard Brennan, Chairperson, ICGP)

Mr. John Bulfin,

National European Working Time Directive (EWTD) Implementation Co-ordinator, Health Service Executive, Midland Area

Prof. Gerard Bury,

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Mr. Bernard Carey,

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Prof. Muiris X. FitzGerald,

Chairperson, Education and Training Committee, Medical Council and Dean of Medicine, Faculty of Medicine University College Dublin

Mr. John Gloster,

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Mr. Fergal Costello,

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Mr. Asam Ishtiaq,

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Prof. Gerry Loftus,

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Prof. T.J. McKenna,

Consultant Physician in Endocrinology and Diabetes Mellitus, St. Vincent's University Hospital, Dublin

Mr. Larry O'Reilly,

Principal Officer, Department of Health and Children

Ms. Mary McKeon,

Principal Officer, Department of Finance

Dr. Mick Molloy,

Specialist Registrar in Emergency Medicine, Cork University Hospital
(nominated by the Irish Medical Organisation)

Dr. Jenny Porter,

Consultant Anaesthetist, Longford/Westmeath General Hospital, Mullingar
(nominated by the Irish Hospital Consultants Association) (resigned 16 February 2005)

Mr. Pawan Rajpal,

Consultant General Surgeon, Cavan/Monaghan General Hospital
(nominated by the Irish Hospital Consultants Association)

Prof. Arthur Tanner,

Director of Surgical Affairs, Royal College of Surgeons in Ireland

Dr. Cillian Twomey,

Consultant Physician in Geriatric Medicine, Cork University Hospital and St. Finbarr's Hospitals, Cork.

Secretariat

Mr. Peter Heffernan,

Executive Officer (Secretary to MET Group), Department of Health and Children

Ms. Arleen Heffernan,

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Assistant Principal Officer, Department of Health and Children

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Terms of Reference

'Having regard to section 3.4.3 of the **Report of the National Task Force on Medical Staffing**, to examine and report to the Minister for Health and Children on the measures required to:

1. Accommodate NCHD training in all postgraduate training programmes within a 48-hour working week.
2. Facilitate NCHDs in addressing any skills deficits which may hinder entry to the specialist register.
3. Safeguard both training and service delivery during the transition to a 48-hour working week.
4. Identify the barriers to improving graduate retention.
5. Address obstacles to the conduct of academic health research.
6. Improve access to international training opportunities for Irish doctors in training.

The Group is also asked to consider and make recommendations on:

7. Issues relating to competence-based specialist training.
8. The role of the university sector in postgraduate medical education and training.
9. The implications of the draft EU Directive on the recognition of professional qualifications as it relates to medical practitioners.

The Group will

10. Engage closely with the appropriate section of the Department of Health and Children to assist it in accommodating the integrated education and training functions proposed by the Task Force within the structures announced by the Government in June 2003 following publication of the Brennan and Prospectus Reports.

The Group will, where appropriate, liaise on other relevant issues with the Department of Health and Children, the Working Group on Undergraduate Medical Education and Training, and the Primary Care Task Force.

The Group will undertake any other tasks that may be agreed between the Group and the Minister.'

Executive Summary

Executive Summary

At the launch of the *Report of the National Task Force on Medical Staffing*[1] in October 2003, the Minister for Health and Children invited the Task Force's Medical Education and Training (MET) Group, under the continued chairmanship of Dr Jane Buttimer, to remain in place in order to complete its work on postgraduate medical education and training in line with revised terms of reference. In this second phase, the Group focused on postgraduate medical education and training issues arising from the Task Force Report, and the medical education and training implications of the implementation of the *European Working Time Directive* (EWTD). It also took account of the Health Strategy *Quality and Fairness – A Health System for You*, the Primary Care Strategy *A New Direction,* and the National Health Research Strategy *Making Knowledge Work for Health*. A separate joint working group was established by the Ministers for Health and Children and Education and Science to address undergraduate issues.

The reform of the health system has gathered pace with the establishment of the Health Service Executive (HSE) and the changed role of the Department of Health and Children. These changes will significantly alter the environment in which the postgraduate medical education and training system will operate.

The recommendations in this Report should be implemented urgently in accordance with the Action Plan in *Section 10.3*, independent of the wider health reform programme. In many ways the changes to the delivery of medical education and training underpin the whole process and are vital to its success. Conversely, success in reforming medical education is likely to mirror the degree of success in implementing the overall health reform programme which includes increased consultant numbers, increased bed capacity, reorganisation of acute hospitals, review of ancillary professions and restructuring of primary care, continuing care and ambulance services. The overall reform programme will require strong leadership and doctors' training should prepare them to perform key roles in the implementation of the required changes.

The MET Group has consulted widely with all the stakeholders in medical education and training through a series of meetings, written submissions, questionnaires and a major national seminar in January 2004, together with formal consultation prior to completion of this Report.

The MET Group commissioned an important research project – *"Career Tracking Study – Factors affecting career choices and retention of Irish medical graduates"* – which is published on the CD accompanying this Report. The evidence-base from the study underpins many of the Group's recommendations.

The MET Group's recommendations will have implications for the role and work practices of consultants, General Practitioners (GPs), other specialists[2] and non-consultant hospital doctors (NCHDs)[3] , which it is acknowledged may require negotiation and should be addressed in the appropriate forums. However, the Group believes that there are compelling service, quality and economic reasons for reform in medical education and training.

[1] Key documents cited in this Report are listed in the bibliography *(Appendix A)*

[2] The term "specialist" used in this Report includes consultants, general practice principals, and specialists in public health medicine and occupational medicine

[3] The term "NCHD" as used in this Report refers to all doctors in training whether in a hospital or community-based setting

Priority Recommendations

The MET Group considers that the following recommendations are the highest priority for immediate action:

- A robust governance structure capable of driving forward the major reforms proposed in Ireland's medical education and training system in a co-ordinated manner with an emphasis on effectiveness (outcomes) and efficiency (value for money) (Department of Health and Children, Health Service Executive (HSE), other Government Departments).
- Independent, expert evaluation of the training value of NCHD posts (HSE-MET*).
- Legislation to assign appropriate medical education and training functions to the HSE and, where appropriate, the Medical and Dental Councils (Department of Health and Children).
- Development of financial/information systems and information communications technology (ICT) infrastructure to generate an evidence-base to underpin and support implementation of the recommendations in the Report (HSE, Medical Council and Training Bodies**).
- Graduate retention measures, including the implementation of the National Flexible Training Strategy and an increase in consultant numbers (HSE and Training Bodies).
- Systematic annual workforce planning exercises to identify the appropriate numbers required at various levels of training in each specialty and subspecialty based on the staffing needs of the service (HSE).
- Ongoing cooperation, collaboration and liaison between all the key stakeholders.
- Detailed assessment of and agreement on the resource requirements needed to implement these recommendations, where such costings are not currently available (HSE and Department of Health and Children).
- Implementation of the Training Principles to be Incorporated into New Working Arrangements for Doctors in Training (HSE, health employers).

** Health Service Executive – Medical Education and Training Unit.*

*** The postgraduate Training Bodies recognised by the Medical Council in Ireland are listed in Appendix B.*

Department of Health and Children

With the establishment of the HSE, the role of the Department of Health and Children will change to have a primary focus on policy making, monitoring and evaluation, and on preparation of legislation. A section should be identified within the Department with specific responsibility for formulation of national policy and strategy on medical education and training and research and for the monitoring and evaluation of its implementation (Recommendations 1, 52).

In formulating national policy the Department should take into account service provision and service development, competing markets for Ireland's medical graduates (Recommendation 15), graduate retention measures (Recommendation 9), NCHDs in posts with limited training value, the delivery of medical education and training in a multidisciplinary context (Recommendation 32) and ensuring that doctors at all levels are educated and trained to meet the needs of patients in a reformed health system. The Department should consult closely with the new HSE medical education and training unit (HSE-MET), which will be the main body responsible for implementing national policy (Recommendations 57, 58).

The Department of Health and Children should, after consultation with key stakeholders, make appropriate provision within the new Medical Practitioners Bill for the HSE to co-ordinate and develop postgraduate medical education and training through structures which safeguard the independence of these functions from its service-related responsibilities (Recommendation 58). The legislation should also assign other appropriate medical education and training functions to the HSE and Medical Council (Recommendation 1).

The Department should aim to build on existing relationships and to foster and develop appropriate linkages between the various professional training systems (e.g. medical, dental, nursing, health and social care professions) in consultation with the relevant units within the Department as well as appropriate external agencies (Recommendation 32). Formal links with the Department of Education and Science, the HEA and the HSE should be established to develop a national strategy on the delivery of medical education and training from undergraduate through to postgraduate and continuing medical education/continuing professional development (CME/CPD) including provision for the necessary infrastructural and ICT investments at an early stage (Recommendations 43, 56, 61). The Department should also consider the implications for medical education and training of the changing role of the private sector and the potential contribution of that sector to enhancing medical education and training (Recommendation 20).

Health Service Executive

Since January 1st 2005, the HSE is responsible for the day-to-day running of the health service. The quality of the service provided to Irish patients is strongly influenced by the quality of the education and training of the doctors and other professionals delivering that service. It is therefore critical that the HSE establish structures

to guarantee excellence in medical education and training (Recommendation 2). Apart from the likely improvements in health outcomes, it is clear from the findings of the *Career Tracking Study* that high quality in medical education is a factor likely to influence doctors abroad – among them many graduates of Irish medical schools – to opt into, or out of, a medical career in Ireland. Failure to pursue excellence in this area may well risk the loss of Ireland's graduates to countries perceived as offering a superior postgraduate training environment. Competitive advantage and economic considerations would suggest that significant efforts should be made to avoid a "brain drain" from Irish medicine and the unnecessary loss of the substantial Exchequer investment in the primary medical degrees of the doctors concerned. The HSE should consider these issues when developing its recruitment and retention plan (Recommendation 16).

The HSE is the largest employer in the country and with that comes a duty to ensure certain responsibilities are met, including those relating to the health, safety and welfare and training of its staff. The recommendations in this Report are intended to enhance existing provisions or to establish such provisions where none currently exist.

Section 7 (5) (c) of the Health Act 2004 provides that the HSE in performing its functions, shall have regard to *"the policies and objectives of the Government or any Minister of the Government to the extent that those policies and objectives may affect or relate to the functions of the Executive"*. Existing Government policy in relation to medical education and training is largely based on the recommendations in the *Report of the National Task Force on Medical Staffing*. The following are within the remit of the HSE:

- Service-independent, expert assessment of the training value of proposed NCHD posts as a required part of the HSE's approval process for such posts (Recommendations 1, 19).
- Establishment of a robust Medical Education and Training structure (HSE-MET) which incorporates the functions specified in the *Report of the National Task Force on Medical Staffing* and has clear lines of accountability (Recommendation 2).
- Allocation of sufficient funding for medical education and training on an ongoing basis and the development of a standardised financial system for the funding allocations to postgraduate medical education and training and a governance and accountability structure that ensures value for money (Recommendation 64).
- Increasing consultant numbers with a corresponding decrease in the numbers of doctors in training in particular at SHO and Registrar level which can lead to a more streamlined career path (Recommendation 18).
- Defining NCHDs' duties and ensuring the correct skill mix is achieved in line with the Reports of the *National Task Force on Medical Staffing* and the *Joint Working Group on the Working Hours of NCHDs* (Recommendations 36, 38).

- Progress the phasing out of NCHD posts with limited training value within a feasible and realistic timeframe, in line with Government policy and in tandem with the implementation of wider health service reforms, by:
  - Ensuring that all advertisements for NCHD posts state whether the post is approved for training as part of a recognised training programme (Recommendation 18).
  - Creating only NCHD posts which are part of a formal specialty training scheme (Recommendation 18).
  - Reviewing the position of doctors in long-term Registrar posts and addressing the issues arising (Recommendation 31).

It is also a high priority that the HSE:

- Establishes the current funding base for postgraduate medical education, training and research, and makes recommendations on additional funding requirements (Recommendation 63).
- Determines the medical workforce planning needs of the health service, including interns and community-based services (Recommendations 47, 53, 59) and publishes an annual report with projected requirements (Recommendation 21).
- Promotes and facilitates healthcare staff to work and train in multidisciplinary teams (Recommendation 33).
- Continues to provide funding and resources to develop a much needed ICT infrastructure to assist employers, the Medical Council, universities and Training Bodies to develop databases to help monitor and implement policies on training (Recommendations 18, 53, 61, 62).

The HSE should continue the work and consultation process undertaken to date on establishing an interim group to assist the HSE to develop HSE-MET (Recommendation 57) and should ensure that the procedures for creating or filling NCHD posts include the independent verification of the training value of a post before appointing a doctor in training to that post within the context of a feasible and realistic timeframe (Recommendations 18, 19). It should also ensure that the "Training Principles" *(Appendix D)* as agreed with the Training Bodies and other stakeholders are incorporated into new working arrangements for doctors in training arising from the implementation of the European Working Time Directive (EWTD) (Recommendation 36).

The findings of the Career Tracking Study highlight the importance of working conditions in improving graduate retention. The HSE should promote best human resource (HR) policy in relation to conditions of employment, particularly anti-discrimination (Recommendation 28), family-friendly (Recommendation 14) and ethical recruitment policies (Recommendation 26). The Flexible Training Strategy should be actively promoted by extending protected time to trainers and trainees on flexible training schemes, by providing equal opportunities in employment for those who wish to work flexibly and by funding the implementation of the Flexible Training Strategy on a phased basis over the next five years (Recommendations 11, 13).

The health and welfare of doctors in training should be considered and appropriate occupational health services should be established for all employees including doctors in training and any implications in this regard arising from NCHDs' "temporary employment" status should be reviewed (Recommendation 40).

The HSE should work with the Training Bodies and, where appropriate, the Medical Council to:

- Provide funding for an agreed number of doctors to train abroad in subspecialties in which there is a shortage or an inability to complete subspecialty training in Ireland, aiming to encourage doctors to train in a subspecialty which will meet a service need in accordance with workforce planning requirements (Recommendation 24).
- Facilitate time-limited schemes for entry onto the Register of Medical Specialists (Recommendation 30).
- Develop agreed standards for medical education, training and research facilities on-site, including provision for their utilisation by multidisciplinary teams (Recommendation 34).

The HSE should also fund suitable graduates for research in top-quality research teams to enable achievement of higher degrees (e.g. PhD, MD, MCH etc.) and provide funding for an agreed number of PhD fellowships for those interested in a research career and ensure that there are a sufficient number of trainers and mentors in academic medicine (Recommendations 50, 51).

The HSE should implement the policy, developed by the Department of Health and Children, to increase the annual intake of GP trainees from the current 88 to 150 by 2008. This figure should be revised on a regular basis in line with health service workforce requirements, gender issues, expected retirements etc. (Recommendation 47).

HSE-MET Structure

The medical education and training structure recommended by the National Task Force on Medical Staffing was intended to address the current fragmentation in the co-ordination, management, regulation, inspection, control and funding of postgraduate medical education and training in Ireland. The Government decided not to establish an independent statutory authority but instead to allocate the functions to the HSE. The Group wishes to emphasise that the HSE-MET structure should have sufficient independence to avoid the risk of being overwhelmed by service pressures particularly in its role in the approval of NCHD posts (Recommendation 58). It also recommends that the HSE develops its role in medical education and training in close consultation with all the key stakeholders (Recommendation 57). This would facilitate not alone the delivery of medical education and training of the highest quality but also the provision of high-quality patient care and an integrated approach to the development and implementation of policy. HSE-MET should also have a strong role in the governance of medical education and training (Recommendation 2).

As well as the functions recommended by the National Task Force on Medical Staffing (pp. 22-23 of

its Report), the following recommendations are also made by the MET Group in relation to HSE-MET:

- HSE-MET's role in phasing out NCHD posts with limited training value should involve an independent, expert evaluation of the training value of NCHD posts as part of the approval process (Recommendations 1,18,19). A matching scheme for all NCHDs and Interns based on transparent and published criteria should be established (Recommendation 17).
- HSE-MET should facilitate the integration and streamlining of undergraduate, postgraduate and continuing medical education/continuing professional development (CME/CPD) by developing evidence-based implementation strategies, plans and outcome measures so as to ensure that students progress from competence to proficiency in their careers in a multidisciplinary setting at the different levels of training (Recommendation 34). It should also provide a forum for medical education and training regulators, providers and other relevant parties to contribute to the development and delivery of generic modules which will be specified by the Training Bodies but may be provided by the universities or other third-level institutions (Recommendation 44).
- HSE-MET should promote family-friendly policies (Recommendation 14), including flexible training. It should undertake an information campaign on the Flexible Training Strategy and monitor the implementation of the Strategy in line with Government policy on an ongoing basis (Recommendation 12). It should also ensure that occupational health services are available to all doctors in training including primary care and rural locations and establish a mentoring network (Recommendations 22, 41).
- In primary care, HSE-MET should:
  - Facilitate medical students and trainees at undergraduate and postgraduate level being educated and trained in primary health care, including spending more accredited time in GP practices.
  - Ensure that the educational and training needs of general practice (including the availability of a sufficient number of trainers) are taken into account in the new health service structure.
  - Establish appropriate structures to address the needs of the non-hospital specialties as well as the hospital-based specialties (Recommendation 48).

  This may have resource implications, including the need for additional trainers.
- Facilitate time-limited schemes.
- Funding should be provided for HSE-MET continue to support the Intern Co-ordinators and Tutors Network (Recommendation 54).
- Information from the National and Local EWTD Implementation Groups *(Appendix H)* should be used by HSE-MET to assess protected time, training facilities, the number and sessional commitments of academic /clinicians, etc and update the agreed "Training Principles" to ensure that the quality of service and training is maintained as the EWTD is progressively implemented culminating in a 48-hour maximum average working week by 2009 (Recommendation 37).

Medical Council

The Medical Council's role in ensuring that the quality of education and training meets the highest possible standards should include the promotion of international best practice and of the implementation of the "Training Principles". The Council should encourage the 13 postgraduate Training Bodies to provide training programmes with a clear beginning and end of training, with a seamless progression from provisional registration and general professional training through to completion of higher specialist training while maintaining the competitive element (Recommendation 8).

In relation to the Council's role of setting standards and further developing its strategy, it should continue to define and publish the mission and outcomes objectives of postgraduate medical education and training. The Council in consultation and agreement with other interested parties should develop mechanisms to support the delivery by the Council of its functions in setting and maintaining standards in medical education and training (Recommendation 8).

The Council should also, with the health service employers and Training Bodies, ensure that trainers and trainees deliver on their training responsibilities (Recommendation 4).

The Medical Council has a major role in Continuing Professional Development (CPD) whereby it could advise the HSE on the value of a sabbatical placement for CPD purposes in line with emerging Government policy. It should also consider the role that universities /medical schools can play in developing a structured form of CPD with the Training Bodies (Recommendation 45).

With regard to interns, the Medical Council should ensure conformity with international standards by considering the Intern Year as the first year of postgraduate training (Recommendation 55).

Recognised Postgraduate Training Bodies

The thirteen postgraduate Training Bodies recognised by the Medical Council *(Appendix B)* have made much progress in recent years with their higher specialist training programmes. There is still considerable room for improvement particularly in the early stages of the training cycle, in the overall duration of training, in research and on trainees' health and welfare issues and in achieving the highest international standards.

The Training Bodies should continue to investigate international best practice and develop competency-based assessment, as opposed to time-based progression. They should allow sufficient flexibility in their training programmes to accommodate research, academic study and for appropriate generic competencies to be transferable between specialties (Recommendation 10). This would assist in addressing the duration of training as well as affording greater opportunities to those in posts with limited training value. The Training Bodies and the Medical Council should devise robust once-off time-limited affirmative educational

schemes for entry onto the Register of Medical Specialists to assist with raising the standard of patient care (Recommendation 30). The quality of the Register should not be compromised in this process and neither should such a scheme be an alternative stream of training to the Higher Medical Training Programmes.

The Training Bodies, through their inspection process, should ensure that progress is being made in the implementation of the "Training Principles" and that the agreed minimum standard of on-site training facilities is being met. They then should make recommendations to employers and HSE-MET where improvements are required (Recommendations 37, 39). The Training Bodies should also further develop their co-ordinated generic inspection scheme and supporting ICT system and ensure that the interested parties, including employers, receive timely feedback on inspection outcomes (Recommendation 7). With the agreement of the employer, each Training Body should ensure that each consultant team has a designated trainer with a clear job description and practice plan and that each trainee is assigned to a trainer (Recommendation 6).

The Training Bodies should recognise research as a core competency of all postgraduate medical programmes and consider recognising up to two years for suitable candidates to pursue a higher degree (Recommendation 49). They should also develop (in association with the universities/medical schools and third level institutions) generic core modules e.g. management, leadership, clinical governance and information technology which can be delivered to groups of trainees from different disciplines (Recommendations 3, 35).

The Training Bodies should improve communication with their trainees with regard to work-life issues, particularly the availability of flexible training (Recommendation 13). The perception that seeking flexible training would militate against progress within the training programme should be addressed.

An over-arching body should also be established to co-ordinate and assist the delivery of medical education and training by the postgraduate Training Bodies. This work should be carried out in liaison with the Medical Council, the HSE and the universities/medical schools, where appropriate, in order that more effective and efficient training can be achieved. Consideration should be given to appropriate representation of stakeholders on the body (Recommendation 60).

The Training Bodies should enhance the health and welfare of all doctors by:

- Introducing a module on the health of doctors including caring for colleagues and caring for self, possibly as part of the generic management module (Recommendation 42).
- Including the development and implementation of confidentiality protocols in their curricula (Recommendation 42).
- Providing for assessment and retraining after a long illness (Recommendations 29, 42).
- Developing career support for trainees who are

unlikely to progress in a specialty so that they may transfer their competencies to another specialty.

- Publish, in conjunction with HSE-MET, the numbers to be accepted onto each training programme (Recommendation 23).

The Training Bodies should enhance international training opportunities and help to improve graduate retention by developing methods of retaining links with their trainees and graduates working abroad; considering reciprocal arrangements or exchanges with overseas sites and exploring further centres of excellence in a variety of countries best suited to their specialty (Recommendation 25).

Universities/Medical Schools/Third Level Institutions

The universities/medical schools/third level institutions should, in co-ordination with the postgraduate Training Bodies, have a central role in postgraduate medical education and training in the areas complementary to clinical practice[4], in developing generic modules, diplomas and masters' programmes, research pathways and virtual laboratories (Recommendation 46).

Employers and Training Bodies at Local Level

Employers should define the duties of NCHDs and ensure the appropriate skill mix on the basis of the *Hospital Activity Analysis Report*[5] and earlier reports such as the *Report of the National Joint Steering Group on the Working Hours of Non Consultant Hospital Doctors* (Recommendations 36, 38).

Employers should implement the Flexible Training Strategy (Recommendation 11). Flexible training should be promoted as an element of family-friendly policy. It is equally important that family-friendly initiatives are made available to those training or working full-time, who should not be expected to bear an unduly disproportionate burden in relation to geographic location of rotations, including rotations through large and small sites, night work, on-call duties etc. (Recommendation 14).

Employers and Training Bodies should ensure that each trainee is assigned to a designated trainer (Recommendation 6) and ensure a system is in place to receive feedback from the Training Bodies' inspection process with the aim of enabling continuing quality improvements (Recommendation 7). Employers should ensure that service demands are not met from allocated training time. Equally, however, Training Bodies, employers and the Medical Council should ensure that trainers and trainees deliver their contractual obligations (Recommendation 4). The employers have a key role to play in implementing the "Training Principles" (Recommendation 39).

Implementation

An Action Plan is set out in *Section 10.3*. In addition co-ordinated structures should be established to drive the reforms and continue to provide efficiency (value for money) and improved effectiveness (outcomes) in the delivery of postgraduate medical education and training (Recommendations 56, 57, 60).

[4] Skills complementary to clinical practice, clinical governance, communication skills, management skills, leadership, team working, information communication technology and web-based literature searches.

[5] Hospital Activity Analysis, Nine Pilot Sites, Summary Report – August 2005. York Health Economics Consortium, University of York. http://www.hsea.ie/Publications/05.09.02.HAA Report – Nine Pilot Sites.pdf

An Interdepartmental Group should be established to develop integrated policies on medical education and training (Recommendation 56). These policies should take account of the continuum of medical education and training from undergraduate to postgraduate to continuing professional development and ensure doctors are trained effectively to deliver the highest quality patient care and population health in a multidisciplinary environment.

The Department of Health and Children should continue with the preparation of legislation within its planned timetable (Recommendations 1, 58).

The Group also recommends that the HSE continues its work on the establishment of an Interim Group to assist in a) developing the permanent medical education and training structures within the HSE in line with Government policy and b) implementing this Report (Recommendation 57).

It is also recommended that the HSE should devise an implementation plan in respect of its role in medical education and training, in consultation with all interested parties. This should form part of the Executive's annual service plans in future.

The Group recommends that the Training Bodies establish an overarching body which should, similarly, devise an implementation plan for the recommendations relating to Training Bodies as a group (Recommendation 60).

1. Introduction

1.1 Medical Education and Training Group – Phase I (National Task Force on Medical Staffing)

The National Task Force on Medical Staffing was established in February 2002 by the then Minister for Health and Children, Mr Micheál Martin T.D. Its purpose was to devise an implementation plan for reducing substantially the average working hours of non-consultant hospital doctors (NCHDs) to meet the requirements of the European Working Time Directive (EWTD); to plan for the implementation of a consultant-provided acute hospital service; and to address the medical education and training needs associated with the EWTD and the move to a consultant-provided service.

The Medical Education and Training (MET) Group, chaired by Dr. Jane Buttimer, was an advisory group set up under the Task Force. After an extensive consultation process, this group submitted an Interim Report to the Task Force Steering Group in August 2002. Section 3.4 of the *Report of the National Task Force on Medical Staffing* (October 2003) included the recommendations of the MET Group and highlighted issues requiring further consideration. The MET Group also produced a *Flexible Training Strategy*, which was published at the same time.

1.2 Postgraduate Medical Education and Training Group – Phase II

At the launch of the *Report of the Task Force on Medical Staffing* in October 2003, the Minister for Health and Children invited the Task Force's MET Group to remain in place in order to complete its work on postgraduate medical education and training in a second phase in line with revised terms of reference *(see page (x))*. In this second phase, the Group focused on postgraduate medical education and training issues arising from the Task Force Report and the medical education and training implications of the implementation of the EWTD. It also took account of the Health Strategy *Quality and Fairness – A Health System for You*, the Primary Care Strategy *A New Direction*, and the National Health Research Strategy *Making Knowledge Work for Health*. A separate joint working group established by the Minister for Health and Children and the Minister for Education and Science, under the chairmanship of Professor Patrick Fottrell, was tasked with addressing undergraduate issues.

1.3 Ireland's Medical Education and Training System

Medical education and training in Ireland is the responsibility of the Department of Health and Children at postgraduate level and the Department of Education and Science at undergraduate level. These two Departments have devolved certain areas of responsibility to other agencies which in turn have further delegated responsibility for delivery and funding. The evolution of postgraduate medical education and training in the absence of an integrated national strategy for medical education and training has resulted in a fragmented system. There has been inadequate investment in medical education and training over the years, with no specific allocation of funding for facilities on clinical sites, lecturers, off-site facilities,

Information Communication Technology (ICT), student welfare, etc. Despite this, Irish postgraduate medical education and training is well-regarded internationally and Irish-trained doctors fare well in competing for posts in the world arena. However, the landscape of the health service is changing worldwide and the shortage of doctors internationally has led to competing markets for doctors before and after qualification.

Undergraduate Medical Education

Currently there are five medical schools in the Republic of Ireland: the medical faculties of University College Cork (UCC), University College Dublin (UCD), Trinity College Dublin (TCD), National University of Ireland Galway (NUIG) and the Royal College of Surgeons in Ireland (RCSI). The duration of training is 5 or 6 years depending on the college.

After students complete their undergraduate course in a medical school, they must successfully complete an Intern Year in a clinical setting to become fully registered with the Medical Council. The fully registered doctor is then eligible to commence the postgraduate phase of training.

Postgraduate Medical Education and Training

The purpose of postgraduate medical education and training is to prepare the doctor for independent practice as a medical specialist. In Ireland it is provided through a mixture of formal education and vocational training. Doctors in postgraduate training receive their formal training through the relevant Training Body and must be employed in clinical environments, usually on a series of rotations, to receive their vocational training. These doctors are also referred to as NCHDs.

A doctor usually does a minimum of 2 years as a Senior House Officer (SHO). This period of training is called General Professional Training (GPT) or Basic Surgical Training/Basic Specialist Training (BST) depending on the specialty.

After 2 -3 years as an SHO, the doctor can apply for a Registrar post. This post provides a promotional opportunity to those doctors who have completed GPT/BST and are awaiting a place on a Higher Specialist Training (HST) programme.

Doctors must compete to obtain a place on a HST programme in their preferred specialty. These programmes are generally 4 – 6 years duration depending on specialty and sub-specialty. During this time the doctor is employed as a Senior Registrar (SR) or Specialist Registrar (SpR), the former term having been retained by the training programme in Psychiatry. When training is successfully completed the doctor is awarded a Certificate of Satisfactory Completion of Specialist Training (CSCST) and is then eligible to apply to the Medical Council for entry on the Register of Medical Specialists.

During the training period, doctors may obtain other qualifications (e.g. Fellowship or Memberships of the relevant College) and may also carry out research at home or abroad and publish papers, which form the basis for a higher degree in a university (MD, MCh, PhD).

Medical Council's Role in Postgraduate Medical Education and Training

Under the Medical Practitioners Act 1978, the Medical Council is responsible, among other functions, for ensuring that the quality of education and training meets adequate and suitable standards and that all requirements of relevant EU Directives are satisfied including the *Doctors' Directive* (93/16/EEC[6]) and the *SLIM Directive* (2001/19/EEC[7]). The Medical Council has to date recognised thirteen postgraduate Training Bodies *(listed at Appendix B)* and has delegated some of its responsibilities for the quality and delivery of training in medical specialties to these bodies.

Postgraduate Medical and Dental Board

Under the Medical Practitioners Act 1978, the Postgraduate Medical and Dental Board (PGMDB) is responsible, among other functions, for the promotion and co-ordination of postgraduate education and training and for the provision of career guidance to registered medical practitioners and dentists. The PGMDB provides funding to the Training Bodies to meet their costs in organising training programmes to meet the standards required by the Medical Council.

As noted at *Section 1.4* below, the Government has endorsed the proposals for health agency restructuring in the *Prospectus Report*, which recommended consolidation of a number of agencies including the transfer of the monitoring and approval of specialist posts and the funding for continuing postgraduate medical and dental education to the HSE, with other functions of the PGMDB to move to the Medical and Dental Councils. Legislation to give effect to this policy has not to date been enacted.

Close collaboration between the PGMDB, the HSE and the Medical and Dental Councils over the coming year will be required to facilitate as smooth a transition as possible to the envisaged consolidated structure.

The need for change

The wide-ranging medical education and training reforms proposed in this report are essential to:

- Increase the overall competence of doctors and the quality of health care provided to patients in Ireland.
- Underpin the wider health reform programme.
- Prepare the next generation of graduates and the existing medical workforce for their new roles in a changed health service model.
- Ensure the supply of a sufficient number of skilled doctors across all specialties to meet the projected requirements for consultants, GPs and other specialists.
- Protect the State's significant investment and ensure value for money in educating and training Ireland's doctors through measures to improve the rate of medical graduate retention within the Irish health service.
- Modernise and improve governance in medical education and training to the benefit of patients and doctors alike.
- Position Ireland as a high-quality medical research environment so as to further develop Ireland's knowledge-based economy.

[6] Council Directive 93/16/EEC of 5 April 1993 to facilitate the free movement of doctors and the mutual recognition of their diplomas, certificates and other evidence of formal qualifications, OJ L 165, 7.7.1993.

[7] Directive 2001/19/EC of the European Parliament and of the Council of 14 May 2001 amending Council Directives 89/48/EEC and 92/51/EEC on the general system for the recognition of professional qualifications and Council Directives 77/452/EEC, 77/453/EEC, 78/686/EEC, 78/687/EEC, 78/1026/EEC, 78/1027/EEC, 80/154/EEC, 80/155/EEC, 85/384/EEC, 85/432/EEC, 85/433/EEC and 93/16/EEC concerning the professions of nurse responsible for general care, dental practitioner, veterinary surgeon, midwife, architect, pharmacist and doctor, OJ L 206, 31.7.2001.

The Health Reform programme which is underway in Ireland is driven by the Health Strategy *Quality and Fairness*, the Primary Care Strategy *A New Direction,* the *Audit of structures and functions in the health system* (Prospectus), the report of the *Commission on Financial Management and Control Systems in the Health Service* (Brennan) and the *Report of the National Task Force on Medical Staffing* (Hanly). The Health Strategy, centred on a whole-system approach to health in Ireland, goes beyond the traditional concept of "health service" and is about developing a system in which best health and social well-being are valued and supported. This all adds up to a major change in the delivery of the health service to the public.

Reform of the health system has been gathering pace with the establishment of the Health Service Executive and the changing role of the Department of Health and Children. These changes will significantly alter the environment in which the postgraduate medical education and training system will operate.

In order to meet this challenge Ireland must ensure that doctors are trained to a high standard and are equipped to treat patients within the reformed health system. Innovations in the delivery of medical education and training, and significant improvements in the amounts and methods of funding are needed. The medical education and training stakeholders should strive to deliver the highest quality of medical education and training based on meeting and indeed exceeding international standards, thereby fulfilling the vision for postgraduate medical education and training which is outlined at the front of this Report. This will bring rewards to the country not only by improving population health and patient care but also by improving the research, education and knowledge resources of the health sector.

The MET Group acknowledges that many factors contribute to better health outcomes and that better training is not a panacea for all ills. However, the Group is convinced that the much needed reforms recommended in this Report will increase the overall competence of doctors and the quality of health care in Ireland. The Irish medical education and training system must gear itself towards an ethos of ongoing quality improvement to avoid the risk of falling behind countries who may effectively be Ireland's competitors in the market for the best doctors. There is evidence from the *Career Tracking Study* (CTS) conducted for the MET Group *(see Section 3.10)* that many of Ireland's graduates already view other MET systems and career opportunities as being better than the Irish system.

Many Irish-trained doctors working abroad cite insufficient consultant-level opportunities as the main barrier to returning to Ireland. However, various medical workforce projections point to a significant increased requirement for consultants and other specialists in future years. This may require a considerable increase in the number of EU undergraduates at additional cost to the Exchequer. It makes economic sense that every effort is made to retain in the Irish health service as many as possible of the graduates from Irish medical schools and attract back as many as possible of the skilled medical practitioners abroad

who received much of their training in Ireland. This would ensure that maximum benefit is gained from the very substantial resources invested in educating and training Ireland's doctors.

A strong research environment is central to ensuring the quality of medical education and training and improves the quality of care provided to patients. Such an environment retains and attracts high calibre people to the country, enhances research skills - clinical, translational, epidemiological and health service - and leads to greater clinical insights and the evidence for better healthcare. Greater research activity in the health service also contributes to the national goal of developing Ireland's knowledge based economy and society because of the close link between the health service and the objectives of many high prestige commercial development companies based here.

The MET Group has used its expertise to address these issues. The recommendations in this Report should be implemented urgently, independent of the wider health reform programme in accordance with the Action Plan in *Section 10.3*. In many ways the changes to the delivery of medical education and training underpin the whole reform process and are vital to its success. Conversely, success in reforming medical education is likely to mirror the degree of success in implementing the overall health reform programme which includes increased consultant numbers, increased bed capacity, reorganisation of acute hospitals, review of ancillary professions and restructuring of primary care, continuing care and ambulance services. The overall reform programme will require strong leadership and doctors' training should prepare them for key roles in the implementation of the required changes.

1.4 Current Government Policy on Medical Education and Training

On 30 September 2003, the Government

- Approved publication of the *Report of the National Task Force on Medical Staffing* (Section 3.4 of which set out detailed recommendations on medical education and training) together with a *National Flexible Training Strategy*.
- Accepted in principle the Report's core conclusions that compliance with the EWTD requires, inter alia, that the changes proposed in the Report should proceed in a way that safeguards the education and training element of the NCHD role.
- Approved implementation by the interim National Hospitals Office (NHO) of key recommendations of the Report on a phased basis including the regulation of hospital medical posts.
- Approved implementation of other key recommendations including:
  - Phasing out of non-training NCHD posts *[i.e. posts of limited training value]* and ensuring that in future the approval of NCHD posts is subject to compliance with certain training criteria.
  - Developing recommendations on training of NCHDs within a 48-hour working week.

Speaking at the launch of the Report on 15 October 2003[8] , the then Minister for Health and

Children, Mr Micheál Martin T.D., elaborated on the Government's decision with regard to future medical education and training structures. He stated that the Task Force had recommended a dedicated central training authority but, although the Government had endorsed the need to draw together the various functions relating to medical education and training, they believed that this would be best achieved within the reformed health structures announced in June 2003 on foot of the Brennan and Prospectus Reports. The Minister indicated that he anticipated that these functions would best be carried out within the Health Service Executive (HSE). The functions approved in principle by Government were[9] that:

"The current fragmentation in the co-ordination, management, regulation, inspection, control and funding of postgraduate medical training should be addressed by vesting in [an appropriate agency] a wide range of specified executive powers which would include:

- *A role in controlling all NCHD posts[10] through a requirement for explicit approval by the [agency], based on training criteria, to be provided for a specified time, e.g. 3 or 5 years, as a condition for the creation or replacement of those posts and for the release of funding to the employing authorities for those posts.*
- *Aligning the number of medical training programmes and the number of trainees to, at a minimum, meet estimated specialist staffing needs of the health service on an ongoing basis.*
- *Coordinating, in collaboration with the postgraduate Training Bodies and the Medical Council, the provision and accreditation of specialty training programmes and training posts.*
- *Collaborating with the postgraduate Training Bodies and other MET agencies, to achieve agreed efficiencies and value for money improvements through greater standardisation and co-ordination in areas such as recruitment processes, hospital inspections, processes of assessment, shared information systems, data collection and publications (e.g. common procedures, entry requirements and guidelines).*
- *Responsibility and accountability for strategic development of medical education in Ireland, including the Flexible Training Strategy discussed in this Report.*
- *Independent evaluation and supervision of all aspects of medical education and training, including undertaking or commissioning appropriate studies.*
- *Ensuring that there is a systematic mentoring system for all doctors in training at every level of training.*
- *Ensuring and commissioning if necessary, a continuing programme of research and development of the educational methods employed.*
- *Ensuring that all doctors in training are exposed to research principles and methodologies.*
- *Ensuring that opportunities exist for those undertaking approved academic research to compete for appropriately funded and supported educational contracts/agreements, which should continue to include proper provision for insurance liability.*
- *In consultation with the Medical Council and Training Bodies, to facilitate the policy and*

[8] The Minister's speech at the launch of the Report of the National Task Force on Medical Staffing: http://www.dohc.ie/press/speeches/2003/20031015.html

[9] Extract from the "Report of the National Task Force on Medical Staffing" – para 3.4.2 A

[10] Reference to NCHD posts in this Section is in the context that all NCHD posts will be training posts

strategy in relation to Continuing Professional Development (CPD), including Continuing Medical Education (CME) and Competence Assurance (CA).

- *Ensuring that non-statutory funding, from whatever source, complies with the highest ethical and quality standards in postgraduate medical education and training.*
- *Setting minimum entry criteria for training posts on the advice of the Training Bodies".*

The Task Force further recommended that:

- *"The [agency] should have its own budget and be sufficiently staffed and resourced for the development and implementation of medical education and training.*
- *The [agency] should be the recognised funding agency for medical education and training.*
- *The [agency] should be representative of the public interest and the key stakeholders involved in medical education and training.*
- *The [agency] should not be involved in the day-to-day delivery of medical education and training.*
- *Further consideration should be given to the [agency] in the context of the forthcoming independent review of the structures and functions of health agencies".*

The Prospectus Report, which was endorsed by the Government in June 2003, recommended that *"the monitoring and approval of specialist posts in accordance with agreed standards, together with the funding for continuing postgraduate medical and dental education, should transfer to the Health Service Executive (HSE). The remaining functions of the Postgraduate Medical and Dental Board (PGMDB) would move to the relevant organisations, the Medical Council/Dental Council. Other issues of concern related to the proposed consolidation could be dealt with in the review of legislation".*

1.5 Work Undertaken by the MET Group

Over the last three years the MET Group has consulted widely with all the stakeholders in medical education and training through a series of meetings, written submissions, questionnaires and a major national seminar held in January 2004[11] :

National Seminar on Postgraduate Medical Education and Training:

The main conclusions of the seminar were that the Government should press ahead with implementing the recommendations in the Report of the National Task Force on Medical Staffing, including:

- A dedicated, structured framework with responsibility for medical education and training with a wide range of integrated functions.
- Phasing out NCHD posts with limited training value.
- All doctors in training to be in well organised, high quality training posts.
- Protected training time.
- Increased numbers of consultants.

[11] The seminar proceedings can be accessed at http://www.dohc.ie/publications/hanly_seminar.html

- Multidisciplinary team working.
- Flexible training and working conditions.

Interim Report to the Minister: Recommendations to the Minister for Health and Children on the Provision of Medical Education and Training in the context of the European Working Time Directive (June 2004) at *Appendix C*.

These recommendations (relating to the 58 hour working week) were made to the Minister for Health and Children in order to safeguard training during the introduction of the EWTD as from 1st August 2004. The main recommendations were:

- Agree rosters between the employing authorities, the Training Bodies and the Medical Council.
- Establish an interim structure to co-ordinate, drive and manage postgraduate medical education and training.
- Reallocate duties inappropriate to NCHDs.
- Begin to phase out NCHD posts of limited training value.
- Structure should reflect the continuum from undergraduate through to postgraduate and continuing professional development.

To date a number of the recommendations have been implemented including:

- Agreement with employers on training requirements in new rosters *(see "Training Principles" below)*.
- Employer representation on the MET Group.
- Proposals and discussions with the HSE on interim training structures initiated.
- Establishment of a project on the development of a national NCHD database.

Training Principles to be Incorporated Into New Working Arrangements for Doctors in Training[12] (July 2004) at Appendix D.

These principles were drafted on the basis of extensive consultation and were agreed by employers' representatives, the postgraduate Training Bodies, the Medical Council, the MET Group and other interested parties. The principles identified will be incorporated into the work practices of doctors in training on a phased basis as the health reforms are rolled out. The general principles are grouped under the headings:

- Maximising Training Opportunities.
- Governance and Managing Change.
- Curriculum.
- Trainer and Trainee Roles.
- Training Principles in Rosters.

There are also specific principles relating to individual specialties.

The National and Local EWTD Implementation Groups provide forums in which these principles can become part of working practice strategy and plans and working conditions.

[12] Information and guidelines on the European Working Time Directive can be accessed at the link below including "Training principles to be incorporated into new working arrangements for doctors in training" http://www.doh.ie/ewtd

2. Governance and Quality Assurance

2.1 Governance

A significant element of the Government's programme for health service reform is the strengthening of governance and accountability arrangements across the health system. The *Prospectus Report* states:

"To date in Ireland the mechanisms that are central to effective clinical governance have generally been patchy in their development.... The role to be played by HIQA and the hospitals accreditation programme in progressing this agenda will be critical. So too will programmes being put in place by the professional regulation and Training Bodies to ensure ongoing review of competence of their members. Acknowledgement and credit must be given to those who have worked in Ireland on individual initiatives which will play a role in the broader clinical governance agenda as we move forward. Substantial progress has been made in involving clinicians in management and governance functions at a number of hospital sites, e.g. Cork University Hospital, St James's Hospital, Coombe Women's Hospital. But structural reform and improved information on the processes and effects of treatment will be of limited value unless they are underpinned by a coherent policy and legal framework. This should allow for evidence to be fed back effectively into day-to-day operations and ensure continuous quality improvement. While respecting the importance of the patient/doctor relationship for quality control and broader governance reasons, it is essential that clinicians be within the direct accountability line."

Governance arrangements should reflect the efficiency (value for money), effectiveness (outcomes) and overall quality of services provided. Corporate governance is also an essential prerequisite for quality education and training. It is the system by which the educational organisation will direct and control its functions and relate to its stakeholders in order to manage its business and achieve its vision and objectives and meet the necessary standards and accountability.

Clinical governance should provide the framework by which an organisation (be it the Department of Health and Children, the HSE or a Training Body) is accountable for the quality of the medical education and training/service. Because clinicians are at the core of both clinical work and education and training, they should be at the heart of clinical governance. Recognition of this fact, by clinicians, managers and policy-makers is central to establishing responsible autonomy in medical education and training. To be effective, clinical governance should reach every level of the health care organisation. Structures and processes should be put in place in ways that will engage clinicians and generate improvements in medical education and training.

It is expected that specific reform of medical education and training governance will be legislated for in the new Medical Practitioners Bill whereby education and training functions for the HSE and the Medical Council will be assigned. The Department of Health and Children will continue with its legislative, evaluation and policy role in medical education and training. In formulating

national policy the Department should take into account service provision and service development, competing markets for Ireland's medical graduates, graduate retention measures, NCHDs (many of them non-EU citizens) in posts with limited training value, the delivery of medical education and training in a multidisciplinary context and ensuring that doctors at all levels are educated and trained to meet the needs of patients in a reformed health system.

Section 1.4 above outlines the existing policy framework on medical education and training, which underpins proposals for a permanent medical education and training structure at national level.

Clinicians in Management

The Report of the National Task Force on Medical Staffing envisages a much greater role for doctors in the managerial process, which is likely to be reflected in revised consultant contracts. The Clinicians in Management Ireland Group, formed to enhance and promote the role of clinicians who wish to become involved in management roles or functions within the Irish health service has stated that it has become *"acutely aware of the need for education and training at undergraduate and postgraduate level in basic management skills to facilitate all doctors in clinical practice and evolving health service"*.

The HSE-Office of Health Management (HSE-OHM) recognised this need and produced *"Guidelines on Commissioning Management Development Programmes for Doctors in Higher Specialist Training"* based on the OHM's experience in arranging the delivery of such programs to doctors in higher specialist training. The guidelines outline best practice regarding the content, delivery and provider specifications when commissioning management development programmes for doctors in higher specialist training.

The OHM considers that programmes for the management development of doctors in higher specialist training should have the following programme objectives:

- The development of a strategic understanding of the role of the doctor in the Irish health services within the context of a rapidly changing health care environment.
- The development of skills to effectively lead an inter-disciplinary team delivering patient-centred care.
- The acquisition of skills and understanding in relation to clinical leadership, managing people, resource management and education and training.

Trainers and NCHDs' responsibilities

All physicians should as part of their professional obligations recognise their responsibility to participate in practice-based postgraduate training of medical doctors. The Training Bodies should specify the expertise required and responsibilities and duties of designated trainers and ensure that they participate in appropriate "training the trainer" courses.

NCHDs should be responsible for fulfilling their obligations under their learning contract in the context of their training programmes.

The Medical Council, the HSE and the Training Bodies should have the capacity to audit these functions and ensure that NCHDs and their trainers are meeting their responsibilities. For this reason, each trainee should be assigned to a designated trainer.

Recommendations

At national level:

1) The Department of Health and Children should:

   - Prepare legislation after consultation with key stakeholders assigning appropriate medical education and training roles in the new Medical Practitioners Bill for the HSE (including provision for independent assessment of the training value of an NCHD post as a requirement for approval) and for the Medical Council (including approval, inspection, monitoring and, where necessary, withdrawal of approval, as to the adequacy and suitability of postgraduate training provided by the recognised Training Bodies).

   - Identify a section within the Department with specific responsibility for the formulation of national policy and strategy on medical education and training and research.

2) The HSE after consultation with all the relevant bodies and based on Government policy should put in place robust national medical education and training structures to:

   - Co-ordinate overall governance for medical education and training and the delivery of clinical components.

   - Build on the clinical governance model with explicit standards of good practice, information systems to underpin these, clear lines of accountability and authority to take action if standards are not met.

   - Closely and systematically align medical education and training with the needs of the health system and ensure conformity to international best practice.

3) All Training Bodies in consultation with the HSE should review their curricula/assessments to ensure that there is sufficient emphasis on leadership, management and clinical governance to enable the trainee specialists of the future take on leadership roles in clinical governance/the managerial process. This generic curriculum should be standardised across all of the training programmes. The universities and medical schools in consultation with the Training Bodies should play a part in delivering standardised modules.

4) The Medical Council, the HSE and the Training Bodies should hold trainers and trainees accountable for the delivery of their contractual and training contract responsibilities.

5) The Clinicians-in-Management[13] (CIM) programme should be extended to all hospital sites. HSE-MET and the relevant policy sections of the Department of Health and Children should examine at an early stage the scope for involving consultant trainers in the management of medical education and training in line with the CIM programme.

At local level:

6) The relevant Training Body should ensure that:

- Each consultant team, with the agreement of the employer, assigns lead responsibility for educational governance to a designated consultant.
- Each trainee is assigned to a designated trainer.

7) Following inspections:

- The Training Bodies and the Medical Council should provide feedback to employers and relevant parties in a timely manner.
- Employers should ensure that systems are in place to consider feedback from inspections with a view to implementing quality improvements.

[13] The term "clinician" used in this report includes all specialists, consultants and allied health personnel

2.2 Standards for Quality Improvement

Internationally there is a growing emphasis in medical education and training on quality improvement and outcome measurement with its indispensable components of institutional self-evaluation, external review and consultation. There has been criticism that medical education and training has not adjusted adequately to changing conditions in health care delivery systems and to the needs and expectations of society. Recognition that it now needs to be more clearly defined is encompassed in internationally-agreed standards. The World Federation of Medical Education (WFME) recommends a set of global standards classified into nine areas and 38 sub-areas *(Appendix F)*. Standards are specified for each sub-area using two levels of attainment:

- Basic standard.
- Standard for quality improvement.

In line with changes worldwide, medical education in Ireland should be more closely and systematically aligned with the needs of the health system and conform to international best practice. In the past this alignment and international comparison has been an informal process.

Medical Council

In late 2004, the Department of Health and Children provided €50,000 to the Medical Council towards their "Defining Learning Outcomes" project. The aim of this project is to develop explicit and measurable outcomes for postgraduate training and begin the process of integrating them into medical education and training in Ireland. The Council will describe a practice-based training process resulting in a medical doctor competent to undertake comprehensive, up-to-date practice in a professional manner, unsupervised and independently, or within a team, in keeping with the needs of the health system. Both broad and specific competencies to be acquired by trainees will be specified and linked to competencies acquired as a result of basic medical education.

The WFME standards will play a crucial part in this project. The Medical Council has already successfully integrated the WFME Basic Standards into its undergraduate accreditation processes, and used them as the benchmarks for its most recent round of medical school inspections. The new governance, curricular and development structures are showing evidence of benefit at the undergraduate level. Now the Council aims to use the WFME Postgraduate Standards to develop learning outcomes in this area.

The Medical Council is of the opinion that mechanisms to support the Council in this work, including appropriate funding arrangements should be developed in consultation and agreement with the stakeholders concerned.

Recommendation

8) The Medical Council should:

- Set out a 3-year (2006-2008) strategy identifying plans and targets for the delivery of the Council's responsibilities in postgraduate medical education and engage closely with the key stakeholders on the implementation and annual review of the strategy.
- Continue with its work on defining, and publicising, in consultation with the professional organisations and all other stakeholders, the mission and outcome objectives of postgraduate medical training using the WFME standards.
- Encourage the 13 Training Bodies to provide training programmes with a clear beginning and end of training, with a seamless progression from provisional registration and general professional training (GPT/BST) through to completion of higher specialist training while maintaining the competitive element.
- Engage closely with health service managers at national, regional and local levels in order to ensure that postgraduate training requirements are met.
- Develop mechanisms to support the delivery by the Council of its functions in setting and maintaining standards in medical education and training, in consultation and agreement with the stakeholders concerned.

3. Graduate Retention

3.1 Context

In recent years, a shortage of doctors has developed internationally. Significant numbers of Irish medical graduates go abroad for various reasons (including training, work and lifestyle issues) and many do not return to Ireland. There has been a longstanding concern amongst policy-makers in other countries[14] regarding the loss of their medical graduates. Even though Ireland has not yet experienced shortages at specialist level, or a shortage of applicants for the accredited training programmes, the paradox is that there is a considerable dependence on medical graduates from outside the EU while at the same time many Irish medical graduates go abroad and do not return. Recent workforce plans and the publication by FÁS of a *Healthcare Skills Monitoring Report* point to a significant increased requirement for consultants and other specialists. This may require a considerable increase in the number of EU undergraduates at additional cost to the Exchequer and therefore it makes economic sense that every effort is made to retain the graduates from Irish medical schools.

For many doctors who have left the country the main barrier to their return to Ireland[15] is that there are insufficient consultant-level opportunities in Ireland. The loss of young graduates and experienced clinicians from the public health system is a matter of serious concern. It is essential to the maintenance and development of the Irish health service that policy-makers understand why Irish-trained doctors may choose firstly to leave and secondly to not return to medical employment in Ireland, with a view to identifying measures to ensure that Ireland can address this problem and gain maximum benefit from the very substantial resources invested in educating and training Ireland's doctors. Emigration should be a choice not a necessity.

To gain a greater understanding of the issues which need to be addressed, the MET Group commissioned the Department of Public Health Medicine and Epidemiology, University College Dublin (UCD) to undertake a medical *Career Tracking Study* (CTS). This study is published on the CD accompanying this Report (see an overview of the findings at *Section 3.10 below*).

The focus of the study was on the career choices of doctors from two graduation years (1994 and 1999) and the factors which may have facilitated or hindered their career progress and choices. It confirmed that medical emigration from Ireland is much higher than other countries such as the UK. Over 40% of respondents were working abroad at the time of the study and a significant percentage of these were in training. It is likely that this trend will continue or deteriorate, as almost 60% of the 1999 graduates have indicated that they intend to go abroad. In another study 93% of interns between March and June 2003 indicated they would go abroad in the future[16].

The main reason identified in the study for going abroad is to avail of better training facilities. However, a significant number also find competition for entry onto higher specialist training programmes a major hindrance. Whilst a period abroad does not necessarily entail doctors not returning to posts in Ireland, there is some

[14] Reasons for considering leaving UK medicine: questionnaire study of junior doctors' comments; Moss PJ et al; BMJ, 27th Nov 2004, Vol. 329, p.1263

[15] The Tierney Report in 1993 recommended moving from a ratio of 1:2 between consultants and NCHDS to 1:1 over a ten year period. Instead 13 years later the ratio in 2005 was 1:2.14 while at the same time the numbers of consultants had risen by 68%.

[16] Working And Training As An Intern: A National Survey of Irish Interns; Finucane P and O'Dowd T; Medical Teacher, March 2005, Vol. 27, No. 2, pp. 107-113

evidence of a significant level of long-term or permanent emigration, e.g. a recent study of the 1978 graduates showed that 25 years after graduation 25% were still working overseas[17].

The study concludes that, based on a conservative estimate (extrapolating over a 10 year period), some 700 Irish-trained doctors based outside Ireland may at least consider a return to medicine in Ireland and thus constitute a potentially very valuable resource in addressing in part the consultant/specialist workforce expansion proposed by the National Task Force on Medical Staffing and specialist vacancies in the non-hospital context. The study identifies perceptions of problems associated with posts in Ireland and factors that may influence doctors abroad to return to medicine in Ireland.

The Department of Health and Children and the HSE should develop graduate retention strategies to ensure that as many as possible of the doctors in whom the Exchequer and the education and health system have invested so much remain in or return to the Irish health service. The study findings would suggest that the main areas which need to be addressed in a retention strategy are:

- Availability of consultant posts.
- Improved quality of training programmes.
- Flexible training and working including family-friendly work environment.
- Recruitment procedures.
- Recognised training posts for all doctors in training.
- Support for doctors in training.
- International education and training opportunities.
- Non-EU graduates of Irish medical schools.

However, it is acknowledged that there is significant benefit to be gained from the current mobility of Irish medical graduates and that "pull" and "push" factors need to be recognised – i.e. doctors may still opt to live abroad even if all the perceived problems at home were to be resolved, as evidenced by the identification in the study of factors other than lack of training /career opportunities as reasons for leaving - e.g. wish to travel; pursue career abroad, social reasons etc. Issues such as affordability of housing/ accommodation, traffic conditions, climatic advantages and a host of other factors may also arise. It is also acknowledged that the choice to stay in Ireland may be limited as appointments to both specialist and recognised training posts are usually highly competitive.

3.2 Availability of Consultant Posts

The Government's endorsement in 2003 of the central recommendations contained in the *Report of the National Task Force on Medical Staffing* envisages a shift from the present consultant-led service to a team based consultant provided service, involving a doubling of consultant numbers in tandem with corresponding reductions in NCHD numbers in order to deliver improvements in patient care.

The CTS makes it clear that the single most important factor likely to influence Irish-trained doctors abroad to return to medicine in Ireland

[17] Medical Graduates of the National University of Ireland in 1978: Who and where are they?; Finucane, Loftus, O'Callaghan; Irish Medical Journal, January 2005, Vol. 98, No. 1; www.imj.ie

is the availability of consultant posts (1994 cohort). 62% working in medical employment in ROI had completed their training 10 years after graduation of which only 16% were in consultant posts. Realistically, no significant progress is likely in relation to improving the rates of graduate retention until implementation commences on the policy of increasing consultant numbers in the context of team-based working, i.e. breaking the cycle whereby, typically, each new consultant post generates a "requirement" for an NCHD team (e.g. 1 Registrar and 2 SHOs) to provide the service. This will not work in the future and it is vital that all stakeholders cooperate in replacing that structure with the alternative model set out in the *Report of the National Task Force on Medical Staffing* and in this Report – i.e. placing consultant teams at the heart of service provision supported by an appropriate ratio of trainees, the overall numbers of which are aligned to projected staffing requirements.

Furthermore, significant progress cannot be expected on phasing out the large number of NCHD posts of limited training value until implementation of the recommended consultant expansion commences.

The Faculty of Public Health has also advised the Group that the possible return of highly qualified and fully trained specialists in public health medicine to work in Ireland is adversely affected by the lack of consultant status.

3.3 Improved Quality of Training Programmes

The CTS found that many respondents consider Irish postgraduate training below the standard of training abroad and that experience abroad increases a doctor's chances of achieving consultancy in Ireland. Graduates working in Ireland were also more dissatisfied than those working abroad. This may relate to the fact that 28% of graduates working in medical employment in ROI and still in training were not in formal training schemes, of which 68% were in Registrar posts which are often of limited training value. One-quarter of 1999 graduates and nearly one fifth of 1994 graduates working in Ireland identified poor structure, quality and organisation of training as a major problem with their current post. These figures, however, mask large variations between specialties on this issue, ranging from just 10% in General Practice expressing this concern up to 56% in Medicine. The main reason for going abroad identified by both male and female graduates in each cohort was to avail of better training facilities.

The study findings are consistent with the 2003 Study of Irish Interns which showed that over 60% considered that training in Ireland was not as good as in other countries. It may indicate that the poor perception of postgraduate training in Ireland is being reinforced over time, with the attendant risk of a "brain drain" phenomenon.

The CTS also highlighted that the duration of postgraduate training in Ireland is long e.g. 38% of the 1994 graduates had not completed

their training ten years after graduation. The proliferation of NCHD posts which are not part of structured training programmes has led to a situation where a significant number of doctors do not appear to be attaining training credit toward qualification. This in turn means that large numbers of doctors at BST/GPT level are competing for a small number of HST posts leading to longer training times. This issue must be seen in the context of other countries (e.g. the UK) which are developing new streamlined training programmes using competency-based methodologies.

The MET Group supports existing Government policy on defining the role of NCHDs as an important element in the improvement of training received on clinical sites. In the CTS 42% of the more recent graduates working in medicine in Ireland (1999 cohort) believed that a major problem with their current post was the time spent on inappropriate tasks.

In order to optimise scarce resources and retain as many as possible of the doctors trained in Ireland, postgraduate training needs to become more streamlined. Existing bottlenecks should be removed. Indications are that efforts are being made in this regard.

Example: Medicine

From July 1, 2005, the Irish Committee on Higher Medical Training (ICHMT), RCPI has commenced restructuring general training by:

- Linking individual SHO posts into 2 year rotational schemes either in the same hospital or between two hospitals with a view to eventually having only two year schemes approved for GPT.
- Promoting the continuum of training from GPT to HST to the concept of life long learning/continuing professional development (CPD).

In the last 7 years ICHMT has also implemented structured HST programmes and are currently developing second generation curricula in all specialties which will focus on core generic skills as well as a variety of assessment methods including competency in key clinical skills.

Competency-based training

Health services the world over are finding it increasingly difficult to recruit into and retain doctors in their systems. This is very much the case in many of the English-speaking countries where Irish graduates typically emigrate. Among the reasons for this is the length of time that it takes for a doctor to complete training.

A competency-based model of medical education would allow training authorities and the Medical Council to assess the qualifications and competencies held by doctors-in-training as they develop expertise in certain areas. It would also facilitate assessment of doctors who may have moved out of training and are returning to medicine or who have trained under a different education system.

Internationally, and in line with best practice and the WFME Standards, there is increased

emphasis on the competency-based approach at most stages of undergraduate and postgraduate medical training. The UK Postgraduate Medical Education and Training Board (PMETB) is in the process of introducing more streamlined training programmes with a competency-based approach and a structured path to a specialist post. This is likely to be very attractive to EU graduates including Irish graduates.

The basic elements of competency-based training consist of breaking down the overall roles of a doctor, translation of these roles ("competencies") into outcomes, and assessment of trainees' progress in these outcomes on the basis of demonstrated performance. Progress is defined solely by the competencies achieved and not time spent in formal educational settings. Assessments are based on a set of clearly defined outcomes so that the Training Bodies and trainers can make judgments about whether or not each doctor-in-training has achieved these outcomes.

There are essentially four stages in the competency-based approach – "knows", "knows how", "shows how" and "does".

Most professional bodies recognise these stages of professional competence. Methods of assessment change as doctors progress. The minimum that a doctor must be able to do before he or she can move on to the next stage of professional practice and training is specified. Certification of senior trainees and reaccreditation of established practitioners focuses on performance. Assessment makes use of portfolios, peer and self assessment, and clinical outcomes. ICT can be used to great benefit in the assessment process.

Example: Surgery

In keeping with the National Task Force on Medical Staffing recommendations, the Department of Health and Children provided €100,000 on a once-off basis to support the Royal College of Surgeons in Ireland (RCSI) in preparing tomorrow's surgeons for the new model of health service delivery.

This funding has enabled RCSI to participate in the Joint Committee for Higher Surgical Training (JCHST) Intercollegiate Curriculum Development Project. This is a collaborative effort between the four Royal Surgical Colleges and all ten surgical specialists associations in the UK and Ireland. Its aim is to take account of the demands of the EWTD and develop a modern, seamless and flexible model for higher surgical training. The goal is to deliver planned, high quality, competency-based training, that will be assessed by fair and unbiased testing, and which will be fully quality assured. The curriculum model is service-led, modular, flexible and modern.

To date all the participants have developed a common framework for specialty syllabuses comprising of an introduction, a syllabus and a portfolio. The syllabuses have been set around the four concepts of knowledge, technique, professional skills and judgement. Trainees' competencies will be assessed using a four point scale. As their skill increases, the number

of conditions and operations at which they are expected to be competent will also increase.

The curriculum materials have been uploaded into a fully searchable, hypertext web-based database. This means that the curriculum for specialty surgical training is transparent, consistent, flexible, accurate, searchable and adaptable.

Enabling Lifelong Learning

Clinical governance demands that all those involved in health care commit themselves to lifelong learning in order to keep up to date with the evidence that informs and supports clinical practice. Continuing Medical Education (CME) and Continuing Professional Development (CPD) is a key responsibility of individual practitioners, a core function of Training Bodies and a crucial component of the Medical Council's Competence Assurance Scheme as well as an issue for employers.

Accessing evidence is an important part of CME/CPD requiring both access to a knowledge base and the development of sophisticated search skills in order to retrieve appropriate papers and appraise them critically. Health care libraries and librarians are in a unique position to meet both needs.

A well-resourced knowledge base is fundamental to lifelong learning and evidence-based practice. Doctors require access to both traditional library resources and services (e.g. books, journals, document supply services, physical space to read and study and a professionally-staffed reference and information service) and the increasing range of virtual library resources (e.g. health databases, online journals and the Internet in general). The skills necessary to access all of these resources have to be learned and practised – from the basic library induction session to the complex skills needed to retrieve information from an online journal. Doctors require an ongoing programme of information skills training if they are to achieve self-sufficiency and confidence in retrieving the information necessary for evidence-based practice.

Recommendations

At national level:

9) The Department of Health and Children should consider graduate retention issues when developing policies on medical education and training and should actively track annual graduate retention trends in this area.

10) The Training Bodies should:

- Develop competency-based assessment, which would begin to address negative perceptions regarding structures, quality and organisation of postgraduate training.
- Develop tools to assist in learning, teaching, evaluating and continuous quality improvement.
- Streamline training programmes so that trainees can progress efficiently from GPT/BST to HST programmes and that doctors are equipped with skills to enable life long learning.
- Allow sufficient flexibility in their training programmes to accommodate the pursuit of academic study and research, and facilitate transferability of appropriate competencies between specialties.
- Ensure that doctors are practised in information retrieval skills required by evidence-based practices.
- Ensure that library and journal access meet the agreed standards as part of the generic inspection process.

3.4 Flexible Training and Working

The increasing emphasis on work-life balance and the rising trend in female medical graduates[18] is clear evidence of the need for family-friendly policies and plans in order to retain medical graduates in the system and optimise their career potential. While acknowledging that full time training/work will remain the choice of the majority of doctors, some will want or need to train and work in a more flexible environment as indicated in the CTS. The study showed that 5 years after graduation 12% of females were working less than full time and increased to 33% 10 years after graduation. A third of graduates of both sexes working less than full time expressed a wish to return to full-time work in the future if the conditions were family friendly.

The MET Group's *Flexible Training Strategy (see Appendix E)* was adopted by Government as part of the *Report of the National Task Force*

[18] Females represented 53.5% of undergraduate enrolments in 2001/02, 53.7% in 2002/03 and 55.5% in 2003/04 (Source: HEA)

on Medical Staffing in 2003. Funding was provided in 2002 and in successive years by the Department of Health and Children for 20 flexible Specialist/Senior Registrar (SpR/SR) training posts spread across the thirteen Training Bodies. The Postgraduate Medical and Dental Board (PGMDB) initiated a pilot Flexible Training Scheme on the basis that the posts were additional to the existing complement. A Director of Flexible Training was appointed.

To date, 22 doctors have been trained (currently 16 are being trained) under this scheme. The SpR/SR posts were divided among the specialties as follows: 4 in Anaesthetics, 4 in Paediatrics, 4 in Obstetrics, 2 in Psychiatry, 5 in Medicine, 2 in Pathology and 1 in surgery. Although two male doctors are currently participating on the scheme the demand to date for flexible training appears to be mainly from female doctors with young children. Recently the PGMDB decided to extend the scope of its Flexible Training Scheme (hitherto confined to SpR/SR) so as to include GP Registrars in their 3rd, 4th and 5th year of training.

A specific number of flexible training posts need to be supernumerary posts in order to maintain the minimum numbers of doctors required for a roster. The commitment by the trainee must be at least 50%, in order to comply with the relevant EU Directive[19] and to complete training in a reasonable amount of time. However, if the demand for flexible training increases significantly, the supernumerary arrangement will not be sustainable as the clinical sites will not be able to accommodate large numbers of trainees nor is there unlimited funding. Therefore, of the graduates working in medical employment in ROI, the long-term solution may be to recruit trainees on a flexible training basis with two trainees sharing a regular post.

The CTS has shown that:

- In the 1994 cohort general practitioners were most likely to be working less that full time (17 out of 53), followed by public health medicine (4 out of 9) and anaesthetists (4 out of 10).
- The lack of flexible/part time training is considered to be a major problem by 24% of the 1994 respondents and 34% of the 1999 cohort.

However, the Group has been advised by the Training Bodies that they consider there is little demand for flexible training and that all those who wish to train flexibly are accommodated. This view, compared to the evidence from the CTS, indicates a gap between the perception of the Training Bodies and that of the trainees.

It has also come to the Group's attention that, unlike other countries e.g. UK where many advertisements welcome job sharing applicants, there are still no defined procedures/ advertisements for doctors wishing to work to job share/work flexibly.

In addition 40% of the CTS respondents had a medical spouse which is also likely to lead to a flexible training and work requirement, and difficulties in mobility if both partners are seeking consultant/specialist training posts.

[19] Directives 2005/36/EC (OJ L 255, 30/09/2005, pp. 22-142) and 93/16/EEC (OJ L 165, 07/07/1993, pp.1-24).

Awareness of Flexible Training Strategy

The Flexible Training Strategy sets out a role for each of the stakeholders. To date, there is little evidence that it is being implemented. The vast majority of doctors surveyed (over 80% in each cohort) were not aware of the Government's Flexible Training Strategy. In view of the high priority given to flexible training/working factors in response to a number of different survey questions in the CTS, it is important that all stakeholders commence implementation of the Strategy immediately and a concerted information campaign is undertaken to ensure widespread awareness of the Strategy.

Recommendations

At national level:

11) The HSE should ensure that:
- Protected time for trainers and trainees extends to flexible training schemes.
- Equal opportunities exist in employment for those who wish to work flexibly and that there is a career path for those wishing to work less than full time by inviting applicants who wish to do so when advertising suitable posts.
- Funding is made available over the next five years to implement the *Flexible Training Strategy.*

12) HSE-MET should ensure that:
- An information campaign on the *Flexible Training Strategy* is undertaken.
- Implementation of the Strategy on an ongoing basis is in line with Government policy, including reviews of funding and participation levels.

13) The Training Bodies should promote and implement the *Flexible Training Strategy* and improve communication with their trainees with regard to work-life issues. The perception that seeking flexible training would militate against progress within the training programme should be addressed. Equal opportunities should exist whether training full-time or flexibly.

At local level:

14) Every effort should be made to accommodate family-friendly policies for flexible trainees. It is equally important that family-friendly initiatives are made available to those training or working full-time, who should not be expected to bear an unduly disproportionate burden in relation to geographic location of rotations, rotations through large and small sites, night work, on-call duties etc.

3.5 Recruitment Procedures

The recruitment of NCHDs is not standardised. Hospitals can recruit Interns, SHOs and Registrars directly without reference to any training criteria (though the grade of SpR/SR is more strictly regulated). When an employer advertises a post, the advertisement does not always state whether the post is part of a structured training programme recognised by a postgraduate Training Body (as evidenced by CTS findings that 12% were either not in a post accredited for training or were unsure of the status of the post).

A national computerised matching scheme, similar to the Central Applications Office (CAO) scheme to process applications for third-level education courses would offer advantages over the current variable system. Much research into this area has been carried out by the PGMDB and this should be accessed. The Royal College of Physicians of Ireland (RCPI) has been funded by the Department of Health and Children to initiate a matching scheme for all medical SHOs. The advantages of such a system include improved:

- Efficiency – reduced number of applications.
- Transparency - clear entry criteria and defined training posts.
- Fairness – with objective scoring of applicants.
- Ranking by career options and geography.

It is anticipated that this matching scheme will be rolled out to all training colleges over time.

A problem also arises once doctors have completed their training. If they cannot obtain a post as a consultant within a reasonable timeframe they may leave the country for further training or better prospects *(See Section 3.8)*.

The CTS shows that a considerable number of Irish graduates go abroad for postgraduate specialist and/or sub-specialist training and that the majority would consider returning if suitable jobs become available. Nevertheless, some are lost permanently to the Irish health system. As noted above, a third of medical graduates were still working abroad 25 years after graduation. The introduction of incentives should be considered to ensure that the State gets a return on its investment. One of the main obstacles at the moment is the shortage of consultant posts and associated pension issues. A substantial increase in the consultant complement as recommended by the National Task Force on Medical Staffing appears almost certain to attract significant numbers of graduates back to Ireland. *See also Sections 3.2 and 3.8.*

Migration of doctors both into and out of the country is likely to remain on the policy agenda in the long term. There are "push" factors (e.g. shortage of consultant posts, quality of training) and "pull" factors (e.g. skill shortages, lifestyle factors). There are two possible policy positions on the issue - the World Health Organisation (WHO) stance is to manage the migration process, the other stance is non intervention[20].

The MET Group supports existing Government policy on increased consultant numbers and workforce planning so that the required numbers of doctors are trained in each specialty and

[20] International recruitment of health professionals (Editorial); BMJ 29 January 2005 Vol 330 p 210

subspecialty which will lead to a streamlined career progression and maintain a competitive element for consultant-level posts both in hospitals and in community-based practice. The HSE in implementing these policies should factor in anticipated social and demographic changes, for example the need for neurologists and geriatricians to meet the needs of an ageing population; endocrinologists to deal with diabetes and obesity; GPs to cater for growing rural populations.

Recommendations

15) The Department of Health and Children should consider international migration patterns of doctors when developing policies on medical education and training.

16) The HSE after consultation with the relevant parties should have a comprehensive recruitment and retention plan, including innovative measures (e.g. further specialty or sub-speciality training) to retain on an interim basis the services of doctors who have completed higher specialist training but have not been appointed as consultants.

17) HSE-MET should:

- Harness research on matching scheme(s) already carried out by PGMDB and the RCPI and establish a matching scheme for all NCHDs and Interns, based on transparent, published criteria.
- Ensure transparency in the recruitment process.
- Ensure transparency in the allocation of intern positions.

3.6 Recognised Training Posts for all Doctors in Training

The Health Reform Programme envisages a new work environment for all employees of the health service. For doctors, this means changes in medical education and training to meet the needs of a new, patient-centred service. The National Task Force on Medical Staffing recommended in its Report, endorsed in principle by Government, that all doctors in training should be in posts which are recognised as having a structured training content that allows the trainee to progress towards accreditation. Other Reports have also highlighted the need to regulate training posts based on training criteria. These include the Tierney Report *Medical Manpower in Acute Hospitals (1993)* and the *Report of the Forum on Medical Manpower (2001)*.

A key difficulty at present is the lack of reliable data (or indeed clear definitions) on the training status of existing NCHD posts and agreement on the definition of a training post. However, it was the general opinion of the Group that about half of the 4,000 NCHDs in the system are not in

training posts recognised as part of a structured training programme i.e. of limited training value. A high proportion of doctors in such posts may be non-EU doctors trained outside Ireland. The Group acknowledges that non-EU doctors make a significant and continuing contribution to Ireland's health services and that their legitimate concerns regarding their future in a reformed medical education and training and health service framework deserve serious consideration.

The number of posts not recognised for training has grown over a number of years because of both service demands and the practice of newly appointed consultants requiring a full team of NCHDs. The old model of 1 consultant plus 3 NCHDs should begin to move to the new service model consisting of consultant teams providing the service with, where appropriate, NCHD support based on projected service and staffing requirements.

While training cannot be separated from service and those in non-recognised posts are still obtaining a limited degree of training, doctors must complete a recognised specialist training programme to ensure that all the skills and competencies required for independent practice are met. Patient care should be delivered by doctors who are trained to the highest standard. The current system also contributes to lengthy duration of training for some doctors and to doctors remaining long term in posts with limited training value.

The National Task Force on Medical Staffing also acknowledged the significant contribution non-EU doctors make to the Irish Health System and made recommendations regarding perceived barriers to their access to recognised training schemes and subsequently to consultant posts. These were addressed in the Report of the Task Force (p. 53 H) and are dealt with further in this Report (*Section 3.9* in particular).

The CTS provides some evidence that 72% of graduates of Irish medical schools were in formal training schemes. A further 16% were in accredited training posts but a worrying 12% were either not in an accredited training post or were unsure as to the status.

The process of ensuring that all doctors in training are in recognised training posts should be implemented as a priority based on an agreed phased timetable. The lack of any reliable data on the numbers in training posts means that this task cannot be fully completed until an information system is in place. It is essential therefore to have an accurate database on all NCHDs, updated in a timely manner and on an ongoing basis. In November 2004, the Department of Health and Children provided a substantial once-off funding programme to enhance medical education and training. Work on this database project has commenced with the MET Group drawing together expertise from the Medical Council, Irish Medical Organisation, HSE-NHO, PGMDB and the Department of Health and Children. This group attempted to define the types of non-specialist posts in the health service, where they are, if they are approved for training and how they are filled. A pilot questionnaire was circulated to interested parties.

Recommendations

At national level:

18) The HSE should:

- Ensure that all advertisements for NCHD posts state whether the post is approved for training as part of a recognised training programme inline with previous accepted recommendations of the task force and the report on working hours.
- Ensure the completion of the information systems database on trainees and training posts.
- Commence implementation of the policy on increasing consultant numbers in the context of team-based working and, with the Training Bodies, introduce new models of medical staffing structures moving from the traditional team structure (e.g. 1 Registrar and 2 SHOs).

and in line with Government policy and agreed targets on phasing out NCHD posts of limited training value within the context of a feasible and realistic timeframe, should

- Only create new/additional NCHD posts if they are part of a formal specialty training scheme.
- In the medium term start to replace all NCHD posts of limited training value with accredited training posts.

19) HSE-MET should carry out the role for the HSE of controlling training posts through a requirement for explicit approval based on training criteria, after consultation with the Training Bodies, as a condition for creation or replacement of those posts in line with Government policy within the context of a feasible and realistic timeframe.

Role of the Private Sector in Medical Education and Training

There is significant cross-over between public and private medical practice in Ireland. Many GPs serve a mix of public (General Medical Service (GMS)) and private patients, while a significant number of public hospital consultants also have private practices. However, general practice apart, a similar degree of cross-over does not apply to specialist training, notwithstanding that the publicly resourced medical education and training system is the main source of medical staffing for the private health sector.

In addition, while it is a very important development in terms of meeting the capacity requirements for patient care in the short term, a potential unintended consequence of the growing role of the private hospitals sector may be to have an adverse impact on the capacity of the public

system to meet the training needs of NCHDs and therefore, to deliver a sufficient number of fully trained doctors across all the specialities. As the volume and type of cases are increased in the private sector including the operation of the National Treatment Purchase Fund (NTPF), the resulting decrease in the public sector means fewer clinical episodes for educational purposes.

At a time of much discussion on the future role of the private sector in Irish medicine, it is important that this debate takes account of the potential implications for medical education and training of this role and indeed considers the potential for a meaningful private sector contribution to and enhancement of medical education and training provision.

Recommendation

20) The Department of Health and Children, in developing policy initiatives on the future role of the private sector in Irish medicine, should have regard to the implications for medical education and training and the potential contribution of that sector to the enhancement of medical education and training. In any service agreements being developed by the HSE and the NTPF, every effort should be made to maximise education and training opportunities that may arise from that relationship.

3.7 Career Advice for Doctors in Training

The MET Group shares the view expressed in the *Report of the National Task Force on Medical Staffing* that significant obstacles to advancement for some NCHDs include poor career planning and poor awareness of key selection criteria for training posts. The Group reiterates the Task Force's recommendation that there should be systematic career counselling and mentoring for all doctors at all stages of their career. When these services are being developed, it should be borne in mind that the career advice needs of non-EU/ non-Irish doctors may be different as they are less familiar with the Irish health system.

The CTS highlights the need for a systematic career advice/mentoring programme to be delivered by the Training Bodies at critical stages in medical training to assist doctors in making choices and progressing within a suitable career path. The study found that 75%-80% of respondents had not attended a structured career advice session and that most doctors rated such advice as they did receive as "basic" or "inadequate" /"non-existent". Up to a quarter of the graduates did not follow their intended career paths. This is wasteful of valuable resources and probably lengthens training time.

While a number of important projections on medical consultant staffing and medical training

requirements have been prepared recently[21], there is no plan for the ongoing application of medical workforce and medical training projections to all specialties, which could identify future required, available training slots in the various specialties on an annual basis. While it is critical to have national medical specialty projections for health service planning it would also be helpful to have such plans and projections to assist these medical graduates choosing a career path. It would also help the trainers mentor the trainees and be of great assistance to health service management in meeting medical staffing requirements on a pro-active basis.

Recommendations

At national level:

21) The HSE should publish an annual report detailing projected medical vacancies at all levels by specialty and subspecialty to meet future health care requirements as part of the overall workforce planning process (e.g. for the 10 subsequent years). Such a resource could also assist trainers in mentoring and trainees in choosing suitable career paths.

22) HSE-MET should ensure systems are in place including designated mentors to deliver career advice, support the mentoring process and ensure it is disseminated to all NCHDs particularly those in smaller clinical sites. This may best be done over the web.

23) The Training Bodies should, in consultation with HSE-MET, publish annually the numbers to be accepted on each GPT/BST/HST programme by geographical location and also the estimated numbers for the next few years to allow doctors in training make informed decisions about their future careers.

3.8 International Training Opportunities

As noted, a significant number of doctors who train in Ireland undertake some element of their training abroad. This may be for one or two years during their postgraduate specialty training or after they have completed their specialty training in order to do research, sub-specialty training or gain wider experience. This is generally encouraged by postgraduate Training Bodies as a positive training experience. It also helps the specialist of the future to build international links and gain an understanding of the strengths and weaknesses of other health systems *(See Section 3.5)*. This international experience contributes ultimately to the quality of the Irish health system and patient care. The adoption and implementation of the internationally accepted WFME standards by the Medical Council as noted in *Section 2.2* will facilitate the mobility of trainees within the EU.

[21] These include projections in the Report of the National Task Force on Medical Staffing, the Report of the Working Group on Undergraduate Medical Education and the FÁS Healthcare Skills Monitoring Report.

Also in this context, the MET Group considered the recommendation of the National Task Force on Medical Staffing that *"further consideration should be given to interviewing SpRs for consultant positions in their second or third last year of training and seconded to another country e.g. USA, Canada, or Australia for sub-specialty training"*. However, the MET Group considers that it is inappropriate that trainees in their second or third years should essentially be earmarked for consultant posts without a thorough international trawl for those already trained in the specialty to be assessed for such a consultant post.

The current position is that many of the Training Bodies/individual trainers have informal links with international centres and trainees rotate between these posts. In addition the RCSI have official exchange programmes in operation for a limited number of doctors, in particular Beaumont Hospital/Johns Hopkins and Beaumont Hospital/University of Washington, St Louis, Missouri. Informally the RCSI accepts trainees on secondment from abroad to be trained in Ireland; they are assigned to posts which are vacant for the year a trainee is abroad. The Irish College of General Practitioners (ICGP) is now developing two structured schemes. Prior to this, leave of absence was the only method by which experience abroad could be obtained. The Faculty of Public Health Medicine considers that their SpRs could benefit from experience in developing countries in areas such as emergency response and project work.

There is therefore considerable variation in the extent to which trainees in the various specialties are going abroad for training and a corresponding lack of an information system to monitor the arrangements. Provided a Training Body has satisfied itself as to the training value of the post abroad, the time spent in the post is recognised for a defined period, usually one year and generally not more than two.

Many professions facilitate sabbaticals for the purposes of gaining wider experience. In the medical profession, provision for a sabbatical scheme may enhance CPD/CME by allowing a doctor to work in another country. Consideration should be given to sabbatical schemes for the purposes of Continuing Professional Development (CPD) for trainers in their posts for a defined period in order that they can update skills. In addition, in view of the predicted expansion of consultant numbers, consideration should be given to pro-actively taking experienced physicians, researchers, educators, mentors, professors and lecturers on extended sabbaticals from recognised international centres. The benefits would be multi-factorial. The Irish service would get the benefit of their different methods of teaching, working and mentoring. The individuals would have an opportunity to enrich themselves by seeing a different culture and operating in a different health service. It would also strengthen links with international centres allowing for more regular planned exchanges.

Recommendations

At national level:

24) The HSE should:

- In consultation with HSE-MET and the Training Bodies, provide funding for an agreed number of doctors to train abroad in subspecialties in which there is or is likely to be a shortage in Ireland or an inability to complete subspecialty training in Ireland, conditional on returning within a specified period of time. This may encourage doctors to train in a subspecialty to fill a service need identified in the workforce planning process.
- Provide appropriate facilities to practise in such subspecialty to ensure that there is maximum return on the investment.
- Ensure the other recommendations in this Report which would influence doctors' return are implemented.

25) The Training Bodies should:

- Develop methods of retaining links with their trainees and graduates working abroad.
- Consider reciprocal arrangements or exchanges with overseas sites for trainees, trainers, mentors, professors, educational lectures, etc).
- Explore further centres of excellence in a variety of countries best suited to their specialty, e.g. Public Health Medicine in developing countries, research needs.

3.9 Non-EU Graduates of Irish Medical Schools

The *Career Tracking Study* attests to the recent rapid growth in the proportion of non-EU graduates of Irish medical schools – from approximately 6% of all respondents (1994 cohort) to 20% (1999 cohort). In 1978 only 2% were non-EU graduates[17]. In 2003/04, 61% of entrants to the undergraduate medical schools were non-EU citizens. The medical schools say that the increase is due to the "cap" on the numbers of EU students and their financial dependence on the fees from the students outside of the EU. This issue is being addressed by the Working Group on Undergraduate Medical Education.

Anecdotal evidence suggests that, while most non-EU graduates return to their home countries on graduation, a growing number may wish to continue to work in Irish medicine. The MET Group believes that non-EU graduates of Irish medical schools should be recognised as a major potential resource for Irish medicine and should be afforded

equal opportunities if they seek to pursue a medical career in Ireland. Initiatives in this regard should be subject to an appropriate ethical code of practice recognising the medical staffing requirements of other countries, especially developing countries and the individual doctor's preferences in the matter.

The MET Group notes with concern that more than half of all non-Irish graduates of Irish medical schools, surveyed as part of the CTS indicated that they had either "perhaps" or "definitely" experienced discrimination on grounds of nationality, with over one-third reporting definite experience of nationality-based discrimination.

Recommendation

26) The HSE should bear in mind ethical recruitment policies when sourcing all health service personnel, while affording equal opportunities to non-EU nationals who have graduated from Irish schools and who wish to remain in the Irish health service.

3.10 Career Tracking Study - Overview

The evidence-base provided by this important piece of research, underpins a number of key recommendations elsewhere in this Report. The findings are summarised below and noted where appropriate throughout the Report.

This Section includes a brief overview of the key findings of the study together with specific recommendations relating to the improvement of graduate retention, including suggested avenues for further research.

Overview of study findings

The study focused on the career choices of doctors and factors facilitating or hindering medical career progress and choices. Two cohorts of graduates from Irish medical schools were surveyed, 1994 and 1999.

The study includes some reassuring findings, including that attrition rates in both cohorts are low and satisfaction levels are high, with three in four graduates indicating they are very satisfied or satisfied with the current position of their career. However, graduates working outside the Republic of Ireland (ROI) were more satisfied with the current position of their career than graduates in the ROI. The findings highlight the large proportion of Irish medical graduates who go abroad to work and the potential pool of graduates, representing a significant resource for consultant recruitment across a fairly wide age-span, who might be persuaded to return to post here should conditions be right. It is evident that there is an increasing emphasis on work-life balance among females and also younger male graduates.

Some key findings in the study include:

- 94% of respondents (of whom 54% are in Ireland and 46% abroad) were still in medical employment.
- Numbers considering or decided on returning to medical employment in Ireland: 60% of the 210 doctors working in medicine outside Ireland plus half of 28 doctors not in medical employment. On the basis of a conservative extrapolation over a 10 year period, the study concludes that some 700 doctors based outside Ireland may at least consider a return to medicine in Ireland.
- Of those decided on or considering a return to a medical post in Ireland, the main factors that may influence a decision to return to medicine in Ireland varied significantly by cohort, gender and specialty. Overall key influencing factors, however, included:
  - Availability of consultant posts.
  - Flexible training or working opportunities.
  - Location of medical post.
  - Acceptable workload.
  - Working hours.
  - Acceptable on-call commitments.
  - Better working conditions.
  - Part-time training or working opportunities.
  - New job compatible with partner's career.
  - Encouragement and support.
  - Better pay.
- Common "major problems" - cited by both cohorts of graduates working in Ireland with regard to current posts - included:
  - Flexible working or training opportunities.
  - Availability of consultant posts.
  - Balancing work-life commitments.
  - Lack of support from management.
  - Workload.
- Other significant problems identified included:
  - 1994 graduates: taking time off; lack of childcare facilities; low job security; on-call work commitments.
  - 1999 graduates: time spent on inappropriate tasks; part-time training or working opportunities; covering for absent doctors; quality and organisation of training; working hours.
- Reasons given for working less than full-time included:
  - Difficulty combining work with family commitments when full-time.
  - Desire to spend more time with children.
  - Positive choice to work less than full-time.
  - Workload when full-time.
  - Priority of partner's career.
- **Career advice:** 75%-80% of respondents had not attended a structured career advice session. Most doctors rated the advice they have been given as "basic" or "inadequate" /"non-existent", while about 1 in 4 rated the advice they have received as "good" or "excellent".

- **Flexible Training Strategy:** The vast majority (80%) of doctors surveyed stated they were not aware of the Government's *Flexible Training Strategy.* The Strategy is reproduced at *Appendix E*.
- More than 55% indicated that their experience of medical school had not prepared them well for jobs undertaken so far.
- Over one-third of all non-Irish doctors surveyed indicated that they had "definitely" experienced discrimination on grounds of nationality, rising to over 50% when those who said that they had "perhaps" experienced such discrimination are added. About one-sixth of women reported "definitely" experiencing, and a further quarter said that they had "perhaps" experienced, gender-based discrimination. About one-fifth of female doctors said they had either "definitely" or "perhaps" experienced discrimination based on their age, with fewer men (approx. 10%-12%) reporting actual or possible age-based discrimination.

Gender-specific issues

The CTS notes a number of gender-related differences, including

- Acceptable working hours and availability of flexible or part-time training were significantly greater attractions to favoured careers for females than males.
- In the 1994 cohort, 2.5% of male and 10.2% of female respondents were not in medical employment compared with the 1999 cohort (4.2% male and 5.1% female respectively). It is not suggested, however, that this finding is unique to medicine.
- A lower percentage of females than males are working in medical posts abroad.
- Of graduates working in medicine in Ireland, more male than female respondents work full-time, though the gender difference is significant only for the 1994 cohort, of which 94% of men work full-time compared to 67% of women.
- Of graduates working in medicine in Ireland, significant differences regarding the major problems cited in respect of current posts included:
  - Issues cited by proportionately more women than men (in one or both cohorts):
    - Lack of part-time training or working opportunities.
    - Working conditions (1999 cohort).
    - Low job satisfaction.
    - No key mentor in current post (1994 cohort).
  - Issues cited by proportionately more men than women (in one or both cohorts):
    - Lack of availability of consultant posts.
    - Training programme not available in Ireland.
    - No time for participation in CME/CPD.
    - Time spent carrying out inappropriate tasks.
    - Difficulty with taking time off.
    - Difficulty with re-entry after time away.
    - Workload.

    - Working hours.
    - Working conditions (1994 cohort).
    - Difficulties with study leave.
    - Difficulty with balancing work-life commitment.
- Of those working outside Ireland at present, far fewer women than men in both cohorts intend to work full-time rather than part-time in the future on return to a medical post in Ireland.
- Of graduates not now in medical employment in Ireland, there were some significant gender-based differences with regard to the main factors cited as influencing respondents towards returning to a medical post in Ireland, including the following issues cited by proportionately more women than men (in one or both cohorts):
    - Flexible training or working opportunities.
    - Part-time training or working opportunities.
    - Acceptable on-call commitments.
    - A solution to childcare problems.
    - New job compatible with partner's career.
- Of graduates in medical employment in Ireland more women than men intend taking a career break at some stage though the disparity between the sexes appears to be decreasing in tandem with a trend whereby far more doctors of both sexes among more recent graduates plan taking a career break.
- Fewer women than men were likely to be working abroad.

These findings highlight the increased need for flexible and part-time time training and working opportunities for female medical graduates in particular, and the importance of moving quickly to implement the *Flexible Training Strategy* (relevant recommendations in *Section 3.4*).

Further Study

The CTS includes recommendations on areas where further study may be indicated, including:

- Periodic follow up studies of the 1994 and 1999 cohorts of medical graduates to identify changes over time in workforce participation, work commitment, career choice and workforce flexibility.
- Identification of stages at which graduates decide to go abroad and the main determinants at each stage.
- Doctors' experiences of barriers to preferred career progression.
- Motivations of graduates abroad not intending to return to a medical post here.

The study also recommends that response rates to this type of study may be improved by:

- Having a tracking system in place specifically for graduates abroad.
- Introducing a system whereby medical students generally would be invited to give consent to the future use of their contact details (e.g. held on college databases etc) for the purposes of relevant bona fide studies.

Recommendations

27) HSE-MET should make available the findings of the CTS (and any future similar studies) to be utilised by all stakeholders as an evidence base to underpin policy proposals to enhance graduate retention in Irish medicine. Consideration should be given to commissioning the follow-up studies recommended in the CTS and other similar studies in order to build up an ongoing and detailed evidence base on graduate retention and attrition rates and the positive and negative factors affecting career progression and graduate retention in Irish medicine.

28) The HSE, after consultation with all interested parties, should identify and implement educational and other measures aiming to further counteract discrimination against health sector staff (including doctors in training from internship onwards) particularly on the grounds of nationality or ethnicity, gender or age.

4. Addressing Skills Deficits

4.1 Context

In order to have high quality patient care and ensure that Ireland retains doctors in the health service there is a need to consider the reasons why a doctor may need training outside of the recognised training programmes. The reasons include:

(a) A number of doctors leave medicine before training is completed and may wish to return to training without having to start from year one again.

(b) A number of doctors leave medicine after they have completed training but need some retraining before they are proficient enough to continue in practice.

(c) Some doctors have been practicing for a long time and need some training in new methodologies and skills complementary to clinical practice (see also Section 2).

(d) Some doctors have been in NCHD posts for a long time with limited structured training.

(e) Some doctors come from other countries and wish to practise in Ireland whose qualifications are not equivalent to those in Ireland.

The MET Group acknowledges the likelihood that a disproportionate number of the doctors referred to at (d) above may be non-EU doctors with primary degrees from other countries. The Group recognises the significant and continuing contribution of non-EU doctors to Ireland's health services. The recommendations in this Section, though by no means exclusive to non-EU doctors, are intended to go a significant way towards addressing their legitimate concerns regarding their future in a reformed medical education and training and health service framework. The objective of the HSE and its MET unit should be that all NCHDs should have an opportunity to compete for admission to training programmes leading to specialist registration.

4.2 Re-entry Schemes

The *Report of the National Task Force on Medical Staffing* recognised the importance of addressing the needs of doctors who at present face barriers in accessing postgraduate medical training, including facilitating re-entry to medicine for those who have left the profession for a period of time. The Short Course Aimed at Late Entrants (SCALES) scheme operated by the ICGP is one such model, though it does not currently provide a path to full accreditation leading to entry on the Register of Medical Specialists. The pilot projects devised by the Joint Committee of Postgraduate Training Bodies as a result of funding provided by the Department of Health and Children were a welcome beginning, but a concerted effort will be required involving a range of stakeholders to afford structured re-entry opportunities across all or most specialties on an ongoing basis.

Recommendation

29) The recognised Training Bodies should be encouraged and resourced to create suitable retraining options to afford opportunities:

a) For doctors who have left medicine to re-enter the profession.

b) For doctors to resume progress through higher training schemes after a long absence leading ultimately to qualifications recognised by the Medical Council – i.e. Certificate of Satisfactory Completion of Specialist Training (CSCST) and/or specialist registration.

4.3 Time-limited Schemes for Entry onto Register of Medical Specialists

At present entry to the Register of Medical Specialists in the Medical Council is based on formal training criteria – i.e. having Certification of Satisfactory Completion of Specialist Training in Ireland or equivalent recognised qualifications from other countries. However, as part of the Medical Council's Register of Medical Specialist appeals process, and in conjunction with the relevant Training Body, the appellant has the option, where appropriate, to undertake additional training in order to gain entry onto the Register. The appeals process and the schemes are in line with the relevant EU Directives.

The issues are complex. On the one hand, it is essential that the standards required for entry onto the Specialist Register are not compromised. It is clear that strict adherence to the attainment of formal accreditation through formal training schemes offers significant assurance in this regard.

On the other hand, it seems reasonable to consider affording opportunities for assessment of competence as specialists to doctors, many of them non-EU doctors who have made a contribution to the Irish health service over many years, who may have experienced barriers in accessing formal training schemes but who have nonetheless attained a standard of clinical competence on a par with peers with formal qualifications through the informal mechanisms of on-the-job training.

The National Task Force on Medical Staffing recommended that innovative schemes to assess training should be considered "to facilitate entry to the Specialist Register for doctors in long-term registrar, locum consultant or private consultant posts", with the caveat that these schemes should be available for a specified time period only.

In late 2004 the Department of Health and Children provided €245,000 to the Joint Committee of Postgraduate Training Bodies for specific projects to develop and implement

such schemes. The Committee considered that, as a first step, the position of doctors currently in long-term registrar and other long-term posts within the hospital system should be reviewed regarding current contractual status, permanency, qualification and training and extent of participation in CME/CPD. On that basis, the following projects were approved:

- ICHMT, RCPI is developing a Fixed Term Training Appointment (FTTA) system that delivers a predetermined quantum of supervised training, tailored to the needs of the Registrars. The ICHMT is prepared to consider a limited number of applicants for short periods of Higher Medical Training. These appointments will be held for a period of up to two years with the intention of providing for a specific and limited training need, such as the acquisition of more advanced procedural skills, or some other form of "top-up" training.
- Development by the Faculty of Public Health Medicine of a Summer School for Senior Area Medical Officers/Area Medical Officers who wish to complete the Faculty's Membership Exam.
- Development by the RCSI of an assessment examination based on the present intercollegiate exit examination (FRCSI) aimed at assessing the training and therefore the competence of applicants who have not passed through the accredited training programmes.
- Development of an Innovative Assessment/ Retraining scheme by the Institute of Obstetricians and Gynaecologists which will make available a number of Fixed Term Training Appointments to provide top-up training and an avenue for Registrars to upgrade their skills whose path to specialist registration is blocked.
- Further development by the ICGP of its existing SCALES programme, commencing September 2005, which will be open to those wishing to return to practise after a career break and for those who had trained in other areas but now wish to work part-time in general practice.

The MET Group welcomes the initiative of the Department of Health and Children in providing substantial once-off funding in 2004 to the Joint Committee of Postgraduate Training Bodies for these projects. While these developments will not directly lead to doctors being accredited for entry to the Register of Medical Specialists in all cases, they provide real opportunity for these doctors to advance to the appropriate career step for ultimate entry on to the Register e.g. accessing formal training opportunities hitherto unavailable to them.

On balance, the Group is of the view that an opportunity should be provided to such doctors to have their competence assessed with a view to possible waiver of some stages of formal training requirements leading to entry onto the Specialist Register. While this issue is by no means confined to non-EU doctors (as noted above), it may be that positive attempts to address the matter may go some way to addressing the nationality-based, gender and age discrimination perceived by many doctors who participated in the CTS. Doctors who have given significant service within the Irish health system and who have, or can develop, the skills required to achieve entry onto the Specialist

Register should be given an opportunity to demonstrate or develop those skills and move into a more structured career path. Any such schemes, however, should be made available strictly on the basis of maintaining quality standards and should be subject to a relatively short (2-4 years) window of opportunity. The Group wishes to emphasise that innovation in training must not compromise patient care and educational standards and it is not intended as an alternative stream of training to higher medical training programmes.

Recommendations

30) The HSE should work with the Medical Council, the postgraduate Training Bodies and other stakeholders to ensure that time limited opportunities for alternative mechanisms for entry to the Irish Register of Medical Specialists are created at an early date without compromising the value of the Register of Medical Specialists.

31) The position of doctors currently in long-term registrar posts and other long-term posts within the hospital system should be reviewed by the HSE regarding current contractual status, permanency, qualification and training and extent of participation in CME/CPD taking into account educational quality and service needs. Following the review appropriate measures should be put into place by health employers to ensure that insofar as possible doctors in future should not occupy such posts for longer than a specified period (e.g. 1 or 2 years).

4.4 Multidisciplinary Skills

As patient care becomes more complex, effective collaboration between medical, nursing and health and social care professionals is required to provide high quality treatment and care. There is also evidence that patient treatment and care can be enhanced where different specialties work together as a team (e.g. cancer services).

Multidisciplinary[22] collaboration requires co-ordinated working to ensure that services meet the patient's total needs, and not just one aspect of their care. Specialist doctors and nurses, health and social care professionals and other health care staff have overlapping skills/knowledge and need to work closely together to provide a seamless high quality service and also to avoid duplication and ensure clarification of information on service provision.

The MET Group considers that all programmes from undergraduate level through postgraduate and continuing medical education should include modules on key skills complementary to clinical practice in a multidisciplinary setting. It is envisaged that the university sector would have

[22] Multidisciplinary in this context means "appropriate interaction and engagement of medical staff from different specialties with other health care professionals and workers for the benefit of complete patient care"

a role in delivering modules (in co-ordination with the Training Bodies' curricula) in these areas at all levels *(See Section 6)*. This should also help facilitate the continuum in education through the undergraduate, intern, postgraduate and CPD periods.

Recommendations

At national level:

32) The Department of Health and Children should, after consultation with all interested parties, bring forward policies on medical education and training in a multidisciplinary context.

33) The HSE and other health employers should facilitate and promote working and training in multidisciplinary teams.

34) HSE-MET should consider the potential for appropriate multidisciplinary use of on-site and off-site facilities, to maximise value for money.

35) The Training Bodies should develop generic core modules on team-working in a multidisciplinary context which can be delivered to groups of trainees from different disciplines.

5. Working Time and Working Conditions of Doctors in Training

5.1 Medical Education and Training and the European Working Time Directive

The European Working Time Directive (EWTD) is a catalyst for change, affording us an opportunity to examine how medical education and training is delivered in each specialty at each level and to improve the quality of the training, while seeking solutions to delivering training within a shorter working week.

The EWTD provides that by 1 August 2009, all doctors in training cannot be required to work an average of more than 48 hours per week, measured over a standard reference period of not more than 6 months.

Implementation of the EWTD needs adequate resourcing to avoid potential adverse consequences on patient care, working conditions of specialist/trainers and the education and training of doctors. It is within these parameters that the training dimension must be considered. All stakeholders should cooperate to ensure full compliance with and implementation of the EWTD.

The education and training dimension has been recognised as a key requirement of EWTD implementation with the adoption of the "Training Principles to be incorporated into new working arrangements for doctors in training" *(see Appendix D)*. The MET Group welcomes the inclusion of the "Training Principles" in the terms of reference for the National and Local EWTD Implementation Groups (NIG and LIGs) *(see Appendix H)*. The Group also recognises the representation of the medical education and training sector on the National Implementation Group as a positive step.

The MET Group considers that training time should be protected for the trainer and the trainee so that the quality of training is safeguarded during the implementation of the EWTD. Training opportunities will be available both outside and within core and rostered hours. Ideally, all rostered and core working hours should provide training opportunities, including a combination of experiential and didactic training. However, new technologies will need to be employed to exploit opportunities for medical education and training. This will require an investment in training facilities to include access to e-learning, video-conferencing, well-stocked libraries, etc. in accordance with the "Training Principles".

In order to ensure that NCHD time is used to the optimum the activities of NCHDs on-site should be more clearly defined and structured. The CTS showed that time spent on inappropriate tasks was perceived as a significant problem amongst the 1999 graduates and that workload, working hours and on-call were major problems for both cohorts. In April 2005, LIGs in each of the 9 pilot hospitals facilitated a Hospital Activity Analysis.[23] The analysis recorded NCHD activity in a range of specialties over a 2 week period. The activity analysis aimed to produce detailed data on NCHD activity to inform changes to work practices, roles and better matching of staff and other resources to clinical activity, particularly at night.

[23] Hospital Activity Analysis, Nine Pilot Sites, Summary Report – August 2005. York Health Economics Consortium, University of York.
http://www.hsea.ie/Publications/05.09.02.HAA Report – Nine Pilot Sites.pdf

Recommendations

At national level:

36) The HSE should:

- Ensure that the agreed "Training Principles" are incorporated into new working arrangements as the EWTD is implemented.
- Avoid any temptation to comply with reduced hours requirements by expanding NCHD posts without reference to their training content.
- Ensure that training facilities on all clinical sites meet an agreed minimum standard.
- Ensure that the required training of other healthcare workers is commenced to support necessary changes in roles and skill mix *(see "At local level" below)*.

37) HSE-MET should:

- Use feedback from the National and Local EWTD Implementation Groups *(see Appendix H)* to determine the level of protected time required, the numbers and sessional commitments of academic/clinicians, the impact of expansion of the EU, any identified deficits in on-site training facilities, etc.
- Review the "training principles" as the EWTD is implemented to ensure that the quality of both service and training is maintained and/or enhanced.
- Establish formal liaison structures to ensure excellent information flow and cooperation between the training and service sectors in order that the quality of care for patients and the quality of education and training received by the doctors treating them are maintained and/or enhanced.

At local level:

38) Employers should clearly define NCHD duties and ensure the appropriate skill mix as recommended in the *Report of the National Task Force on Medical Staffing* and as supported by the evidence from the publication of the "Hospital Activity Analysis" project and other reports such as the 2000 study by the *National Joint Steering Group into the working hours of non consultant hospital doctors*.

39) Employers, designated trainers and the trainees should ensure that training time is being used for training appropriate to the training programme. The degree to which the "Training Principles" are implemented should be assessed in the inspection of the posts.

5.2 Maintaining Doctors' Health

Doctors in training have serious inbuilt stressors with frequent changes of job and location, in many cases concentrated during a period of formation of life-long relationships, starting a family etc. Currently NCHDs work long hours during which time the lives of others depend on them while they increase their knowledge base exponentially. The phased application of the EWTD to doctors in training may alleviate some of these stressors through shorter working hours, minimum daily and weekly breaks etc., hopefully marking a definitive break from previous experiences of extremely long weekly hours and rosters. This should also have a beneficial affect on patient care.

The 1st National Conference on the Health of Doctors, hosted by the Irish College of General Practitioners and the Medical Council, was held in February 2005. Given medical workforce shortages in many developed countries, the retention of doctors (including keeping them healthy), is a growing issue for governments internationally[24] . This important conference highlighted the need for a co-ordinated system to enable doctors to address their personal health and occupational health needs, and concluded that the issue needs to be tackled at primary, secondary and tertiary levels. Doctors who become ill may become concerned about the effect on their training.

Modules on dealing with illness should be integrated into the education and training of doctors from undergraduate through to postgraduate level and as part of continuing professional development. Issues which need to be addressed include reduction and elimination of stigma about illness, methods of selection of students into postgraduate training, education about self and family care, how to refer and deal with peers who are ill and understanding of systems available to doctors who are ill e.g. rehabilitation facilities, disability and insurance. Doctors need to understand that part of being a doctor is knowing how and when to seek help and deal with stressors e.g. death, seriously ill patients, personal problems and medico-legal issues. As in other occupations, it must be understood that sick leave is normal and to be expected from time to time and that doctors should have their own general practitioner.

[24] Resident Burnout; Thomas NK; JAMA, December 15, 2004 – Vol. 292.23 p 2880-2889

Recommendations

At national level:

40) The HSE should establish robust occupational health structures for all employees including doctors. Any implications in this regard arising from NCHDs' "temporary employment" status should be reviewed.

41) HSE-MET should:

- Ensure that these occupational health services are available to all doctors in training, including those in primary care and rural locations.
- Establish a mentoring network that takes account of retraining needs following illness.

42) HSE-MET should:

- Include a module on the health of doctors, as part of the generic management module.
- Include the development and implementation of confidentiality protocols in their curricula.
- Provide for assessment and retraining after a long illness/absence.

6. Role of Universities in Postgraduate Medical Education and Training

Up to now medical education and training at undergraduate level has been very much separate to that at postgraduate level. *The Report of the National Task Force on Medical Staffing and the Report of the Working Group on Undergraduate Medical Education* recognise the need for a continuum from undergraduate to internship through to postgraduate and Continuing Professional Development (CPD). The changing environment in which doctors will be delivering their services will include clinicians integrated into the managerial process, in clinical governance systems including a consultant team-provided service, better use of technology and consultants delivering training as well as continuing training in a more structured manner. Doctors will have to begin to hone the necessary skills early in their training and continue developing them throughout their careers.

Currently each of the 13 Training Bodies delivers their postgraduate training programmes with little formal input from the universities/medical schools. The MET Group believes that it would be of advantage to postgraduate medical education and training if the universities/medical schools were more involved in certain aspects of postgraduate medical education and training.

The Group consulted the Council of Deans of Faculties with Medical Schools in Ireland (CDFMSI) to explore the future role of the universities/ medical schools in postgraduate training, and had two meetings with the Council. The consultation process, including a submission from CDFMSI was very helpful and has informed the recommendations below.

Section 8 emphasises the importance of research in the training of doctors and that the universities have a key role to play in this regard. However, it is also important to optimise the talent of young doctors, many of whom may wish to pursue areas of interest other than research in the generic curriculum e.g. management, clinical governance, ICT, critical appraisal skills.

The implementation of key changes already in train, such as the Clinicians in Management Programme and multidisciplinary teamwork plus those recommended in the Reports of the *Forum on Medical Manpower* and *National Task Force on Medical Staffing*, e.g. a move to a consultant-provided service based on consultants working in teams, will depend to a large extent on the response at all levels of training.

Recommendations

At national level:

43) The Department of Health and Children should develop national policy with the Department of Education and Science, in consultation with the HEA, the HSE and all other key stakeholders on the appropriate role of universities and other third level institutions in the delivery of postgraduate medical education and training in Ireland, including provision for the necessary infrastructural and ICT investments at an early stage.

44) HSE-MET should:

- Promote the integration of undergraduate and postgraduate training when developing strategies, plans and outcome measurements.
- Provide a forum for regulators, providers and other relevant parties to contribute to the development and delivery of generic modules and research opportunities which will be specified by the Training Bodies but may be provided by the universities or other third level institutions.

45) The Medical Council should consider the role the universities/medical schools can play in developing a structured form of CPD with the Training Bodies.

At regional level:

46) The universities/medical schools/third level institutions should, in co-ordination with the postgraduate Training Bodies, have a central role in postgraduate medical education and training in the areas complementary to clinical practice, in developing generic modules, diplomas and masters' programmes, research pathways and virtual laboratories.

7. Primary Health Care

The education and training programmes of doctors in the community (general practitioners, public health doctors, etc.) have a significant impact on the number of training places required in the hospital setting at the General Professional Training (GPT) level. In addition their education and training needs within the hospital setting may be different from those in other programmes. Conversely, GP sites may be developed to provide extra clinical training places to other NCHDs.

Education and training in Primary Health Care is changing due to the evolving nature of the service. The demands on the primary health care sector will increase as:

- There is an emphasis on comprehensive primary care services being delivered in the community, capable of meeting 90-95% of people's health needs.
- Hospitals become more specialised.
- The population ages with more need for community-based services.
- Hospital stays become shorter.
- Preventive care is given a higher priority.
- More students and trainees are introduced into practices.
- Increasing need and demand for delivering psychiatric treatment and care in the primary health care setting.

General Practice workforce requirements urgently need review. The following factors need to be taken into consideration in such a review:

- Implications of the Primary Care Strategy.
- Changing lifestyle of general practitioners.
- Changing gender balance.
- Significant GP retirements over next decade (40% are due for retirement within the next 8-10 years).
- Increasing trend towards early retirement.
- Increased focus on prevention, rehabilitation and health promotion.
- Development of interdisciplinary primary care.
- Transfer of clinical activity to Primary Care.
- Increasing expectations of the public.
- Up to date census projections on increasing and ageing population.
- Special needs of deprived areas.
- Special needs of rural areas.
- Multicultural needs.

The Irish College of General Practitioners (ICGP) is the accrediting body for specialist training in general practice. There are eleven training GP programmes distributed on a geographical basis. The training programme is four years in duration with two years spent in hospital posts and two years in the community.

The ICGP is in the process of introducing further programmes e.g. advanced GP Trainers, Health and Practice, retraining/upskilling courses, training the trainer course and a range of distance learning courses (including a Masters in Medical Education in conjunction with Queens University Belfast), all of which have received funding from the Department of Health and Children.

The ICGP has advised the MET Group that, in light of recent health service reform, it is establishing a National Steering Committee for GP Training, which is to include representatives of all stakeholders and have an appropriate relationship with HSE-MET.

The CTS showed that over 30% of all graduates are either training or working in general practice. Difficulty in taking time off, hours of work and lack of part-time training are seen as the major problems for these graduates.

Recommendations

At national level:

47) The HSE should:

- Implement the policy, previously adopted by the Department of Health and Children, to increase the annual intake of GP trainees from the current 88 to 150 by 2008. This figure should be regularly assessed in line with health service workforce requirements, GP age profiles and expected retirements and return of graduates who have trained in general practice abroad.
- Ensure that plans for Primary Health Care includes measures to retain doctors in General Practice.

48) HSE-MET should:

- Ensure that the educational and training needs of general practice including the availability of a sufficient number of trainers are taken into account in the new health service structures.
- Facilitate medical students and trainees at undergraduate and postgraduate level being educated and trained in primary health care, including spending more accredited time in GP practice settings.
- Implement any relevant primary health care medical education and training elements which may be approved by Government arising from the recommendations of the forthcoming report of the Expert Mental Health Group.
- Establish appropriate structures to address the education and training needs of both hospital-based specialties and non-hospital based specialties.

This may have resource implications, including the need for additional trainers.

8. Research Environment

A strong research environment is central to ensuring the quality of medical education and training and improves the quality of care provided to patients. Such an environment retains and attracts high calibre people to the country, enhances research skills - clinical, translational, epidemiological and health service - and leads to greater clinical insights and the evidence for better healthcare. Greater research activity in the health service also contributes to the national goal of developing Ireland's knowledge based economy and society because of the close link between the health service and the objectives of many high prestige commercial development companies based here.

The rationale for, and the benefits of research to the health service were addressed by the Department of Health and Children in depth in *"Making Knowledge Work for Health"*, the Health Research Strategy published in 2001. The Report made commitments that, when implemented fully, will enhance capacity for the conduct of high quality clinical research in the Irish Health Service, leading in turn to greatly enhanced medical education and training.

The reform of health service structures provides an opportunity to enhance a research culture in the health service. Sections 7(6) & 7(7) of the Health Act 2004 explicitly enable the HSE to support research in that:

> *"(6)The Executive may undertake, commission or collaborate in research projects on issues relating to health and personal social services, but, in considering whether to do so, it shall have regard to any decision by another body or person within the State to undertake, commission or collaborate in such projects.*
>
> *(7) The power given by subsection (6) includes the power to collaborate in research projects involving parties from outside the State."*

Clinical research facilities associated with major academic teaching hospitals have been funded under the Higher Education Authority (HEA)'s programme for research in third level institutions and there was a competitive call by the Wellcome Trust and the Health Research Board (HRB) during 2005 for clinical research. Science Foundation Ireland is also contributing significantly to the research environment and has made internationally competitive awards available for the research community. However, as also referred to in *Section 6*, there is a need for more collaborative links between the universities, other third level institutions and the Training Bodies to underpin clinical research. Research capacity (bench research expertise, basic laboratory techniques, biostatistics, bioinformatics etc) is largely based in universities and can be accessed only through formal, funded arrangements.

The acquisition of experience in overseas research and clinical work to complement that available in Ireland is important but can only occur optimally where there are funded secondment arrangements, of sufficient duration, negotiated with overseas academic centres, and recognised for accreditation by Irish Training Bodies *(see Section 3.8)*.

Unlike the UK or the USA, the Irish system has not until recently offered posts at consultant/

specialist level with a major commitment to research. The Health Research Board made the first two clinician scientist awards in 2005 to enable specialists in post to focus in a major way on their research interests. The extension of this call to highly qualified individuals who do not already hold a specialist post in an Irish institution is not possible under the current terms of the consultant contract. The current number of specialists with a major commitment to research in the country is small. In the absence of the clinician-investigator career pathway there are few opportunities in the service for those interested in a career in health research. The case for the appointment of consultants /clinical scientists with a major time commitment to research and for protected time for research for other consultants was made by Comhairle na nOspidéal in its Report in 2002 on academic/ clinical research consultants.

Research Training and Postgraduate Medical Education

Training in research should take place to different levels during the postgraduate education and training of medical practitioners. The ability to understand and interpret research results is a core competency of all postgraduate training and every doctor in training should learn these skills. Such training could best be delivered by way of all trainees having to complete non-generic modules on research methodologies (including statistical interpretation, critical appraisal skills and lecture review). The MET Group would welcome greater encouragement of doctors who wish to undertake a Masters programme offered by a university and taken concurrently with the more practical aspects of postgraduate training. For graduates who wish to deepen their research skills, up to two years research in top quality research teams that are accredited for this purpose should be funded and the Training Bodies should consider the amount of credit which could be given for research within their programmes. This part of higher training where appropriate might also be taken abroad, again in accredited research teams and in a planned way, leading to e.g. an MD or PhD. Any such funding would be on the basis that the doctor would return to Ireland and provide a service within the Irish health service for an agreed period of time.

A small number of graduates will want to specialise in research as a career option. These graduates should be facilitated to undertake a PhD, which is increasingly the recognised qualification for a research career in medicine. Medical graduates who undertake a PhD should be supported either by fellowship awards run on a competitive basis by the HRB for this purpose or in otherwise approved international training sites. These graduates undertaking a PhD should be facilitated to complete their higher training in their chosen specialty. A coherent framework to promote clinical academic medicine in the UK has been proposed in detail by the Academic Medical Royal Colleges, in a document in November 2004, *Clinical Academic Medicine – The Way Forward* and in the Report of the Academic Careers Subcommittee of Modernising Medical Careers in March 2005 – *Medically and Dentally Qualified Academic Staff; Recommendation for Training the Researchers and Educators of the Future*. The

move in other countries to strengthen academic medicine emphasises the need to strengthen the research and academic element in postgraduate training to avoid the risk of losing some of Ireland's top graduates permanently to other countries.

The establishment of a world-class clinical trials structure linked to industry and international centres of excellence would greatly enhance the research environment in Ireland and at the same time enable top-class training in research.

Scientific Evaluation of Graduate Medical Education

While advances in science and medicine are subjected to intense scientific scrutiny, most innovations in graduate medical education (GME) are reported as opinion pieces[25]. The academic community should subject GME to the same scientific rigour as traditionally applied to biomedical investigations. The reforms suggested in this Report will require ongoing evaluation and an evidence-based approach in order to ensure high-quality medical education and training and value for money (e.g. more being spent achieving desired approach).

[25] Graduate Medical Education Research in the 21st Century and *JAMA* On Call, Lim JK and Golum RM, JAMA 15 December 2004 Vol. 292 No. 23 p 2913.

Recommendations

49) The Training Bodies should:

- Recognise research as a core competency of all postgraduate medical programmes and require trainees to have satisfactorily completed one of the non-clinical skills generic research modules on research methodologies, e.g. statistical interpretation, critical skills appraisal.
- Consider the amount of credit given for research within their programmes for candidates who have demonstrated excellence and wish to pursue higher degrees such as MD or PhD.
- Engage closely with the university/medical schools in planning and delivering the curriculum for research in postgraduate medical education and in the mentoring process.

50) The HSE should fund:

- An agreed number of suitable medical graduates to undertake paid research training in top quality research teams at home or abroad to enable achievement of higher degrees (e.g. PhD, MD, MCH etc.).
- A number of fellowships (to be agreed between the HSE and the HRB) in high quality training environments, on a competitive basis via the HRB, for postgraduates who wish to make a career in research and undertake a PhD programme.

51) To ensure that there are sufficient numbers of trainers and mentors in academic medicine and research, changes to the academic consultant contract should be made to facilitate the appointment of consultants/specialist/clinical scientists i.e. those who wish to have a major commitment to research and are willing to train and mentor trainees.

52) The priority recommendations in this Report *(See Executive Summary)* should be underpinned by a Government/HSE-funded GME scientific evaluation programme. The Department of Health and Children should use the evidence from GME research programmes in its medical education and training policy and evaluation role. Future policies and strategies on medical education and training should be guided by the evidence produced by this programme.

9. Intern Year

The future of the intern year was addressed in the *Report of the Medical Manpower Forum* and has been discussed in some detail within the National Task Force on Medical Staffing and the MET Group. A final decision on the matter by the Medical Council is expected shortly. It is understood that consideration is being given to a proposal that the Intern Year would no longer be considered part of the undergraduate stream but would be the first postgraduate year. This is the standard internationally and would be in line with the World Federation of Medical Education (WFME) standards.

The Medical Council organised a symposium in 2002 on the future development of the Intern Year. It drew attention to the lack of consistency in the quality and organisation of individual internships and to the need for proper structures and appropriate protocols and guidelines to ensure that benefit is gained by all interns as they make the critical transition from medical student to registered medical practitioner. The principal outcome of the symposium was a decision to establish a 'Network of Intern Co-ordinators and Tutors' to further develop the education and training aspects of the Intern year, and the broad remit of the new Network was identified. The terms of reference *(Appendix G)* were agreed subsequently. Funding was secured from the Department of Health and Children in November 2003 to appoint a temporary Project Manager for 6 months to assist in setting up the Network and assist in devising standards/ protocols with implementation and monitoring recommendations. Preliminary work has been done on curriculum and core competencies but these have yet to be developed, finalised and agreed. The MET Group welcomes the appointment, in June 2005, of a Project Manager to develop this project.

Recommendations

At national level:

53) The HSE should:

- Ensure that there are a sufficient number of intern places to meet service needs and facilitate graduate retention.
- Continue to provide funding and resources to develop the much needed information systems to assist the employers, Medical Council, universities and Training Bodies to monitor and implement policies on trainees.

54) HSE-MET should continue to support the Intern Co-ordinators and Tutors Network and the Network's membership should be broadened to include HSE representation.

55) The Medical Council should:

- Ensure conformity with international standards by considering the Intern Year as the first year of postgraduate training.

10. Next steps

10.1 Integrated Approach to Implementing Recommendations

Responsibility for postgraduate medical education and training in Ireland is scattered over so many agencies and bodies that it will require a strong governance system to enable the co-ordinated effort required to deliver on the recommendations in this Report. While this Report focuses primarily on postgraduate medical education and training, that sector does not stand alone but forms part of the continuum of medical education and training from undergraduate through to postgraduate levels and CME/CPD. There are many issues in postgraduate and undergraduate education on which co-ordination and co-operation would be mutually beneficial. The same consultants who teach postgraduates often teach undergraduates also. Similarly, common-user facilities such as seminar rooms, libraries, audio-visual facilities and lecture theatres span the needs of all the stages, pointing to the need for a suitable governance and accountability structure between undergraduate and postgraduate sectors for advanced planning in monitoring, quality control and output measurement. There should also be linkages between the relevant government departments and agencies which have direct and indirect responsibilities for medical education and training.

The recommendations in this Report should be implemented urgently, independent of the wider health reform programme in accordance with the Action Plan in Section 10.3. In many ways the changes to the delivery of medical education and training underpin the whole process and are vital to its success. Conversely, success in reforming medical education is likely to mirror the degree of success in implementing the overall health reform programme which includes increased consultant numbers, increased bed capacity, reorganisation of acute hospitals, the review of ancillary professions and the restructuring of primary care, continuing care and ambulance services. The overall reform programme will require strong leadership and doctors' training should prepare them for performing key roles in implementing the changes.

The Department of Health and Children, the HSE and the Training Bodies should devise implementation plans on the recommendations relating to them.

Policy Development

The role of the Department of Health and Children in the new health service structure will be much more tightly focused on:

(a) Strategic health policy formulation and evaluation.

(b) Development of legislative and regulatory frameworks for health.

(c) Resource issues including negotiation of the annual estimates and ongoing review of expenditure within the Department of Health and Children's Group of Votes.

(d) Approval of a National Service Plan, prepared by the HSE in compliance with the Department's stated priorities, setting out the type and quantity of services to be provided each year.

(e) Performance measurement and management of the wider delivery system, including:

i. Monitoring service and budget outturns.

ii. Review of the HSE's annual reports and of its quarterly commentaries on performance against objectives.

iii. Evaluation of value for money in service delivery.

(f) Setting and ensuring adherence to governance and accountability standards.

(g) Overall development of human resources, workforce planning, research and strategic policy setting.

(h) Supporting the Minister and the wider democratic process.

(i) Liaising with and representing the Minister and the Department in dealings with other government, non-government, national and international agencies.

The Department of Education and Science (and the HEA) are responsible for undergraduate medical education but overlap with the Department of Health and Children (and the HSE) on the provision of clinical training facilities and integrated workforce/training planning. The Department of Finance is responsible for providing sufficient funding to facilitate provision of high quality medical education and training and the required staffing levels.

Recommendation

At national level:

56) The policy issues arising from this Report should be addressed by an Inter-Departmental Steering Group on postgraduate medical education and training representative of the Departments of Health and Children, Education and Science, Finance, the Health Service Executive and the Higher Education Authority.

HSE-MET

Many of the issues considered in this Report and the recommendations arising therefrom are complex in nature and require the participation and cooperation of multiple stakeholders. The strategic policy issues will require national co-ordination at Departmental/Health Service Executive level through a shared governance model. The implementation and monitoring programme will require ongoing consultation with and input by the various stakeholders concerned.

The need for an independent medical education and training structure to co-ordinate postgraduate training has been highlighted throughout this Report. The obvious need for co-ordinated implementation of the

recommendations means that the highest priority should be given to the establishment of a robust HSE-MET structure to participate in a partnership of equals with service delivery structures, and with a mutual emphasis on ensuring that both educational and service imperatives are met. The MET Group wishes to emphasise that HSE-MET must have sufficient independence to avoid the risk of being overwhelmed by service pressures, particularly in its role in the approval of NCHD posts. It should have a remit for all training schemes including specifying the number of SpR posts and accreditation of training locations in both hospital and non-hospital settings. HSE-MET should be capable of facilitating the cross-body information flow required for an efficient medical education and training service. It should also prove to be cost-effective by eliminating unnecessary duplication of work among the myriad of bodies involved in postgraduate medical education and training by having an overview of all activities in this arena.

Recommendations

57) The HSE should, in consultation with relevant stakeholders, continue its initiative to establish an interim group to assist the HSE to develop HSE-MET and equip it for its role in the co-ordination, monitoring and funding of postgraduate medical education and training. Term of Reference and the appointment of a Chairperson would be a matter for the HSE to progress in consultation with its stakeholders.

58) The draft legislation being prepared by the Department of Health and Children should take account of the need for HSE-MET to be given sufficient independence to safeguard the quality of medical education and training in line with Government policy.

Workforce planning

Section 22(4) of the Health Act 2004 establishing the HSE provides that

> *"The Executive shall, with the approval of the Minister given with the consent of the Minister for Finance, determine (b) the grades of the employees of the Executive and the numbers employed in each grade".*

The HSE is responsible for workforce planning in the health service which includes the numbers of consultants required in public hospitals. However, in the context of aligning the numbers of doctors in training with workforce requirements, consideration should also be given to the workforce requirements for voluntary and private hospitals, primary and public health care, community and continuing care, occupational health care, the defence forces, the prison services, academic medicine, research, CME, CPD, health-related tribunals, etc.

Co-ordination in this area is imperative so that sufficient numbers of doctors are trained, aligned to projected consultant-level vacancies in each

specialty and subspecialty, so as to meet the needs of the health services. This means that overall requirements must be determined and communicated to the bodies training doctors from undergraduate through to intern and postgraduate levels in a timely manner. It also means that the Training Bodies and associated hospital/primary health care sites need to review their capacity to train the required number of doctors (clinical placements, intern posts etc).

Co-ordination of the requirements at undergraduate and postgraduate levels will be best achieved through ongoing structured collaboration between the HSE and the HEA and, where appropriate, the Departments of Health and Children and Education and Science.
The time lag between entry to undergraduate medicine and the production of a specialist is in the region of 15-20 years. There is an urgent need to confirm the numbers needed in each specialty in order to ascertain how many need to be trained each year and the capacity of each Training Body to respond.

Recommendation

59) The HSE should review workforce planning requirements regularly. Regular reviews of the clinical capacity within the service should be determined in consultation with primary, public and community care stakeholders. The appropriate number of doctors required to be trained for each specialty and subspecialty should be determined based on the outcome of structured workforce planning and clinical training capacity reviews.

Co-ordination of the Activities of the Postgraduate Training Bodies

The thirteen postgraduate Training Bodies have come together to form a Joint Committee of Postgraduate Training Bodies. This has proven very useful in the co-ordination of some activities which are common to all Training Bodies.
For example, an information system is being developed between the Training Bodies for the purpose of generic hospital inspections. The Department of Health and Children has provided funding to support these initiatives.
There are also a number of medical training modules that would be common to all specialties, e.g. management, ethics, clinical governance, information communication technology (ICT) and health and safety (including hygiene). These modules should be jointly developed by all the Training Bodies rather than individual Training Bodies commissioning different companies to develop separate modules on the same theme.

Recommendation

At national level:

60) An over-arching body should be established to co-ordinate and assist the delivery of medical education and training by the postgraduate Training Bodies. This work should be carried out in liaison with the Medical Council, the HSE and the universities/medical schools, where appropriate, with a view to achieving better effectiveness and efficiency, in such areas as:

- The use of funding in an efficient manner.
- Implementing the recommendations in this Report.
- Ensuring uniform high standards of the generic modules in the training curricula.
- Further development and implementation of a generic inspection scheme for all specialties and supporting Information Communication Technology systems (ICT).

Consideration should be given to appropriate representation of stakeholders on the body.

Information Systems

Good governance requires the availability of current, accurate and appropriate information. This is best achieved by having an integrated ICT infrastructure and the best information systems to underpin policies, strategies and plans. The lack of investment in medical education and training infrastructure has led to a deficiency of information throughout the system. There is a paucity of statistical data which in turn means that there is no solid evidence-base on which to develop policies on medical education and training or support work force planning. Data sources are scattered, non-standard and rarely up-to-date. The reform of the health system and the education and training system will need to be strongly supported by the use of ICT. Standardisation in terminology and the types of data collected as well as centralisation of information systems is needed.

Recommendations

61) The HSE should include in its estimates the development, maintenance and upgrade of ICT to meet the needs of medical education and training and workforce planning. Projects which are already underway should be co-ordinated with similar projects to ensure value for money and avoid duplication.

62) All stakeholders involved in the provision, regulation and co-ordination of medical education and training[26] should maintain and share quality data. ICT systems already developed by individual Training Bodies which may have application in other specialties should be expanded and shared rather than recreated, e.g. SHO matching schemes and competency-based curriculum.

10.2 Funding Implications and Cost Outline

Funding Implications

A study was commissioned by the Working Group on Undergraduate Medical Education and carried out by Indecon Economic Consultants on undergraduate education which will provide a more accurate basis for the cost of undergraduate medical education and training. This included consideration of the study previously carried out by Lynch[27] (updated 1995 and 1999) which estimated the cost to the teaching hospitals of undergraduate and postgraduate training. He estimated that the extra costs to teaching hospitals for undergraduate and postgraduate MET were in the order of 10-15% of their inpatient costs. However, these estimates excluded many of the wider costs of postgraduate education and training including:

- Administration and other running costs of the 13 recognised Training Bodies.
- Development of training modules and courses.
- Cost of mentoring and career guidance.
- Costs of carrying out inspections.
- PGMDB costs.

The funding for postgraduate medical education and training is not defined in the allocations to hospitals and other health care settings. Given this lack of financial data it is impossible to be definitive on the current costs or the funding required for implementing the recommendations in this Report. The MET Group agrees that some efficiencies can be achieved by better governance and accountability structures spanning undergraduate and postgraduate education and training and by the Training Bodies working in cooperation with one another to develop generic modules and information systems. In addition, the issue of accountability for the use of the postgraduate training grant which NCHDs receive on top of their salary as a refund in respect of specified postgraduate examinations course fees etc. should be examined.

[26] E.g. Department of Health and Children, Health Service Executive, Medical Council, Postgraduate Medical and Dental Board, the recognised postgraduate specialist training bodies, Department of Education and Science, Higher Education Authority and medical schools

[27] Medical Education, Training and Research: The Cost to Teaching Hospitals, 1993, Lynch F, Department of Finance Analysis and Operations Research Section, Report No. 10/93 (unpublished).

The Group also considers that funding of medical education and training does not receive priority, is not ring-fenced, not quantifiable, and therefore, is permanently at risk. This needs to be taken into account in the estimates for implementing this Report.

Recommendations

63) One of the first tasks for HSE-MET is to undertake a study to establish an estimate of the current and capital costs of postgraduate medical education and training and to make recommendations on the level of resources required to implement the changes needed to underpin the reform of medical education and training.

64) The HSE should put in place a standardised financial system for funding allocations to postgraduate medical education and training and a governance and accountability structure which can ensure value for money in the delivery of medical education and training.

65) Consideration should be given to requiring that only courses recognised by HSE-MET, Medical Council, Training Bodies or PGMDB (and where attendance is approved by the NCHD's trainer) would qualify for utilising future NCHD educational grants.

Cost Outline

Role of Department of Health and Children

The Department of Health and Children is currently being restructured. The future role of the Department is outlined in *Section 10.1* and includes:

- Policy formulation.
- Legislation and regulation.
- Monitoring financial and service activity.
- Evaluating outcomes.

The Group recommends allocating dedicated resources for the development, evaluation and dissemination of national policy in relation to postgraduate medical education, training and research. This requirement should be met from within the Department's existing resources.

HSE Medical Education and Training Unit (HSE-MET)

The HSE will need to assess the level of resource requirements needed to administer and implement the medical education and training functions allocated to it by the Government Decision on foot of the *Report of the National Task Force on Medical Staffing (see Section 1.4)* plus the recommendations in this Report. Consideration of the types of structures required is being progressed within the HSE but no cost can be attributed to the setting up of such structures at this time.

Protected Time

Many of the recommendations refer to protected time. This is required to safeguard training time of both trainers and trainees within the working week and to ensure that high quality training can be delivered in a 48 hour working week as prescribed in the EWTD.

For consultant/specialist trainers, protected time is required to ensure that trainees receive training appropriate to their training programme. Some consultants/specialists may also have a mentoring role, managerial role or require more time for research. The amount of time required and the numbers of trainers will depend on the specialty, the hospital and the move to consultants working in teams, noting that the same consultants who teach postgraduates also teach undergraduate medical students, often simultaneously. The governance, funding and accountability structure needs to ensure that value for money is achieved. There may also be a case for sporadic payments to consultants/specialists who contribute periodically to training but are not involved on a weekly basis.

A range of indicative costs per annum is calculated below taking into account the lowest and the highest rates of pay at 1st June 2005. These figures represent the cost of the loss of service provided by specialists during these periods.

In addition there is considerable potential for Specialist Registrars to provide training for interns and SHOs. SpRs are often highly regarded by the more junior trainees.

Protected Time for Trainers – Indicative Costs						
Rate of pay at 1st June 2005	1 session* per week for 500 consultants	1 session per week for 1000 consultants	2 sessions per week for 500 consultants	2 sessions per week for 1000 consultants	3 sessions per week for 500 consultants	3 sessions per week for 1000 consultants
€131,300 (€194 per session)	€5,044,000	€10,088,000	€10,088,000	€20,176,000	€15,123,000	€30,246,000
€167,878 (€247 per session)	€6,422,000	€12,844,000	€12,844,000	€25,688,000	€19,266,000	€38,532,000
NOTE: If it is determined that more consultants/dedicated time will be required, the costs will increase on a pro-rata basis. These figures are intended to be indicative, and are based on June 2005 costs.						

*A session is taken to mean three working hours

The level of protected time required will have to be determined in the appropriate forum. Protected sessions may be required to address a wide range of training situations, for example formal didactic training, conference/seminar attendance, personal CME/CPD, examination/assessment supervision, mentoring/career advice, training involving other disciplines to facilitate multidisciplinary team working, etc.

The appropriate level of dedicated time for each such situation will need to be determined in the appropriate forum. If it is determined that more dedicated time will be required, the costs will increase on a pro-rata basis.

For the NCHD (trainee), protected time would similarly apply to a wider range of situations depending on the specialty and grade e.g. formal didactic training, journal clubs, attendance at conferences, seminars, examinations, mentoring sessions etc, CME/CPD, training of undergraduates and/or junior NCHDs, etc. The appropriate level of dedicated time for each such situation will need to be determined in the appropriate forum. Most NCHDs at SpR/Senior Registrar level already have the equivalent of a half or full day rostered at different stages throughout their week for their training programmes so no additional cost will be required for those NCHDs. In future, the number of NCHDs will be reduced in line with Government policy.

The appropriate level of dedicated time for each such situation will need to be determined in the appropriate forum. If it is determined that more dedicated time will be required, the costs will increase on a pro-rata basis.

Protected Time for Trainees – Indicative Costs					
Rate of pay at 1st June 2005	Half day per week for 1000 NCHDs	Full day per week for 1000 NCHDs	Half day per week for 2000 NCHDs	Full day per week for 2000 NCHDs	Half day per week for 3000 NCHDs
€35,858 1st point of House Officer scale	€3,585,800	€7,171,600	€7,171,600	€14,343,200	€10,757,400
€74,472 last point of Senior Registrar scale	€7,447,200	€14,894,400	€14,894,400	€29,788,800	€22,341,600
NOTE: If it is determined that more NCHDs/dedicated time will be required, the costs will increase on a pro-rata basis. These figures are intended to be indicative, and are based on June 2005 costs.					

The additional cost of protected time for trainees who are not currently accommodated could be between €3.5 million and €30 million per annum (depending on the level of protected time, grade and number of NCHDs).

Information Systems and ICT infrastructure

It has been agreed that significant investment is required to improve the ICT infrastructure in the health service. The HSE has a budget for this and will be developing the framework across all areas over the next number of years. No additional cost is factored in arising from the MET Group recommendations.

The recommendations in this Report are for specific information systems, particularly relating to medical education and training. These include the development of information systems on trainees and the posts they occupy, the matching scheme for all NCHDs and the generic inspection system. Some of this work is underway but will need to be further developed and implemented. There is also an annual cost for administration, maintenance and future development.

The information systems will cost approximately €500,000 to develop plus administration, maintenance and further development of approximately €200,000 per year. The HSE already have financial systems which should be able to include a specific programme for funding allocation to medical education and training within their current budget.

Re-entry and Time-limited Schemes for Entry onto the Register of Medical Specialists

Currently, 5 Training Bodies are developing and operating such schemes at a cost of between €20,000 and €70,000 each. Once-off funding for development of these schemes is required. The trainee pays a fee to attend these courses which should cover the running costs. The cost for the remaining 8 Training Bodies to develop such schemes at an average cost of €40,000 each is €320,000.

Flexible Training Scheme

The PGMDB estimated that 25 flexible training posts (the equivalent of 12.5 full time posts) would cost €1,029,000 in 2005 (average of €41,000 per flexible trainee). The PGMDB already funds 20 posts. However, supernumerary posts cannot be created indefinitely. Therefore, it is recommended that the **additional** posts be increased to 30 (15 full time equivalent posts) over three years in tandem with **existing** posts being offered as shareable between 2 flexible trainees. After this period the scheme should be reviewed. It is considered that 5% of the complement of NCHDs in flexible training (current level in UK) would be an appropriate medium-long term target.

Expansion of Flexible Training Scheme – Indicative Costs			
Average pay per flexible trainee	Year 1 increase of 4 posts to 24 posts (12 full time)	Year 2 increase of 4 posts to 28 posts (14 full time)	Year 3 increase of 2 posts to 30 posts (15 full time)
€41,000	+ €164,000	+ €164,000	+ €82,000

Cost in Year 1 = €820,000 already allocated
+ €164,000 = €984,000
Cost in Year 2 = €1,148,000
Cost in Year 3 = €1,230,000.

It is also recommended that an information campaign be undertaken to promote the Flexible Training Scheme. This would cost approx. €50,000.

Competency-based Training

The RCSI is developing a competency-based approach to training with the Royal Colleges in the UK. The RCPI is developing a system and has been given €50,000 towards the costs involved.

Cost of once-off grant to assist remaining 11 Training Bodies to develop competency-based training at €50,000 each = €550,000.

Commissioning Studies and Building an Evidence Base

The Career Tracking Study cost €70,000 in 2004. It is recommended that this study be repeated at regular intervals (perhaps every 5 years) and that follow-up studies or other such studies across a range of core areas be commissioned to provide an evidence base for planning and evaluation of policy. These studies will cost €80,000 – €100,000 per year.

In Section 8 above on the research environment, it is recommended that further graduate medical education analysis be undertaken to ensure that the medical education and training policies being followed produce the desired results (evidence-based approach).

In total, it is recommended that funding should be provided to carry out 2 studies per year over 5 years at €75,000 each at a cost of €150,000 per annum (€750,000 in total).

It is also recommended that an analysis be undertaken as a matter of urgency to determine the current and future costs of postgraduate medical education and training in Ireland. A similar study on undergraduate medical education cost €125,000.

Career Advice, Mentoring and Outreach Facilities

Information should be made available to all NCHDs that will help to inform their career choices, will guide them when they need personal assistance and will forge a link with doctors abroad who may be considering a return home. The information could include future vacancies - consultant or training, occupational health contacts, diary of events, etc. This information should be available to all NCHDs whether the

NCHD is in a larger teaching hospital, a smaller rural hospital or abroad. This could possibly be done via information on a website, seminars, mail shots, etc. The development of this facility should be a once-off cost of approx. €175,000 and ongoing support of €50,000.

It is also recommended that the existing once-off administrative support for the Intern Co-ordinators Network be increased and made ongoing as it is an important vehicle for the development of Interns. It is recommended that €40,000 per year be allocated toward administrative support.

Development of Generic Modules

It is recommended throughout the Report that modules be developed that can be delivered across specialties and possibly to other health care workers. €40,000 is estimated as the cost of developing a module on a once-off basis. If 2 modules were to be developed per year for 4 years, the cost would be €80,000 per annum in Years 1 - 4.

There is usually a grant of approx. €500 per capita toward the running cost of each module. If approx. 1/4 of the complement of SpRs (200 trainees) were to be subsidised for 2 modules per year over the 4 years, the cost would be €200,000 per annum.

Training Abroad in Demand-led Specialty

The Report recommends that funding should be made available for doctors to train abroad in a specialty/sub-specialty in which shortages may occur in the Irish health service. It is recommended that a pilot programme be established and that four NCHDs per year be sponsored for such training, for up to 4 years, providing they return to practise in Ireland within a specified time and for a specified period.

Funded Training Abroad – Indicative Costs				
Students	Year 1	Year 2	Year 3	Year 4 onwards
4 per annum at a rate of €75,000 p.a (7th point on the Senior Registrar scale)	€300,000	€300,000	€300,000	€300,000
		€300,000	€300,000	€300,000
			€300,000	€300,000
				€300,000
Total	€300,000	€600,000	€900,000	€1,200,000

The cost would be €300,000 for the 1st year rising to a steady €1,200,000 from the 4th year onwards. The pilot should be reviewed on an annual basis, with a full cost-benefit analysis before the end of Year 4 with a view to deciding on an expansion of the programme.

On-site and Off-site Facilities

On-site training facilities, particularly in hospital settings should meet the minimum standards agreed by the HSE, employers, Training Bodies and/or Medical Council. There should be lecture rooms, library facilities, IT and internet access, video-conferencing facilities, etc. The development of the ICT infrastructure by the HSE should assist the improvement of facilities. In 2005, the Department of Health and Children allocated €1.5 million to the upgrade of training facilities on hospital sites. As part of the work of the Local Implementation Groups, an audit of facilities is to be undertaken. The audit should take into account common-user facilities which span the needs of undergraduate and postgraduate and can facilitate CME/CPD and training of other disciplines to ensure value for money is achieved.

It is recommended that a further €8 million per year for the next 3 years and €6 million for the following 2 years be allocated for this purpose.

It is also recommended in the "Training Principles" that there will be more demand for off-site facilities when the EWTD is fully implemented. The development of skills laboratories and simulators will be very important, not just for those already in training but for those who wish to retrain. A further €2 million per year for 3 years should be allocated for this purpose. Another €2.5 million per year for 5 years should be set aside for capital developments which will improve medical education and training. It is suggested that these skills laboratories be distributed geographically to ensure optimum access for trainees throughout the regions.

Funded Research Posts

Research should be an integral part of the training of doctors. It is also important when it comes to the calibre of doctors attracted to Ireland or retained in Ireland. There are four types of research training recommended in the Report:

1. Non-clinical generic research modules on research methodologies: the funding for this would come from the "Development of Generic Modules" above.
2. Masters in research: the fees for this are approx. €1,500 per year and could be paid by the doctor themselves from their NCHD training grant.

3. A defined period of paid research training leading to e.g. MD, PhD: the number of scholarships is to be agreed. The table opposite gives a range of between 20 and 50 scholarships per year for up to 2 years.

   The figures are based on an overall annual cost per scholarship of €80,000.

   The cost per annum could range from a steady €3,200,000 p.a. to fund 20 students to €8,000,000 p.a. for 50 students.

Research Scholarships – Indicative Costs		
Students	Year 1	Year 2 onwards
20 per annum	€1,600,000	€1,600,000
		€1,600,000
Total for 20 p.a.	€1,600,000	€3,200,000
50 per annum	€4,000,000	€4,000,000
		€4,000,000
Total for 50 p.a.	€4,000,000	€8,000,000

4. Fellowships to undertake a 3 year PhD programme: the number of fellowships is to be agreed. The table opposite is based on 5 fellowships per year for 3 years.

   The figures are based on an overall annual cost per fellowship of €80,600.

PHD Fellowships – Indicative Costs			
Students	Year 1	Year 2	Year 3 onwards
5 per annum	€403,000	€403,000	€403,000
		€403,000	€403,000
			€403,000
Total	€403,000	€806,000	€1,209,000

10.3 Action Plan

The envisaged actions required to implement the recommendations in this report are set out beneath:

Year	Organisation	Action / Timescales[28]
2006	*Department of Health and Children*	Q1-Q2 1. Prepare legislation for allocation of appropriate medical education and training functions to the HSE and Medical Council (Recommendations 1 & 58) 2. Identify a section with responsibility for medical education, training and research policies (Recommendation 1) 3. Establish liaison with Department of Education and Science for national strategies/policies (Recommendations 43 & 56)
	Health Service Executive	Q1-Q2 1. Devise implementation plan for HSE functions arising from this Report 2. Establish interim group with stakeholders (Recommendation 57) 3. Revise procedures for appointing NCHDs to include training criteria in line with Government policy and agree targets for phasing out NCHD posts with limited training value and begin development of a system to ensure explicit approval of all training posts (Recommendation 19) 4. Establish immediate workforce requirements, including interns, general practitioners and specialists and communicate to Training Bodies [with Depts of Health & Children and Finance] (Recommendation 53) 5. Specify the training status of NCHD post(s) in all advertisements as recommended in the Report of the National Task Force on Medical Staffing (Recommendation 18) 6. Begin to provide the required training of other healthcare workers to support change in roles (Recommendation 36) 7. Continue to develop ICT on trainees and training posts (Recommendations 53 & 61) 8. Promote best practice HR policies, including antidiscrimination, ethical recruitment, family-friendly policies (Recommendations 14, 26 & 28)

[28] Q1: January - March; Q2: April - June; Q3: July – September; Q4: October - December

Year	Organisation	Action / Timescales
2006	*Health Service Executive (continued)*	9. Work with Training Bodies and Medical Council to facilitate time-limited schemes for entry onto Register of Medical Specialists (Recommendation 30) 10. Continue to support the Intern Coordinators and Tutors Network (Recommendation 54) 11. Begin to consider working and training in multidisciplinary teams (Recommendation 33) 12. Establish requirements and secure funding for postgraduate medical education and training, including Flexible Training Strategy (incl. Recommendation 11)
		Q3-Q4 13. Commence implementing policy on consultant-team provided service (Recommendation 18) 14. Continue to define NCHD duties and begin appropriate skill mix assignments [with local employers] (Recommendation 38) 15. Devise mechanisms to ensure trainees and trainers are delivering their training commitments [with Training Bodies and Medical Council] (Recommendations 4 & 39) 16. Assess needs and develop training facilities on clinical sites to agreed standard [with local employers and Training Bodies] (Recommendation 36) 17. Extend protected time to flexible trainer and trainees (Recommendation 11) 18. Ensure equal opportunities exist for flexible trainees (Recommendation 11) 19. Publish report with projected vacancies for specialists (Recommendation 21) 20. Examine position of long-term registrars and begin to address issues (Recommendation 31) 21. Incorporate "Training Principles" into new working arrangements (Recommendation 36)

Year	Organisation	Action / Timescales
2006	*Health Service Executive (continued)*	22. Continue to fund agreed increase in GP trainees (Recommendation 47) 23. Put in place financial system for funding postgraduate medical education and training (Recommendation 64)
	Medical Council	Q1-Q2 1. Set out a 3-year (2006-2008) strategy identifying plans and targets for the delivery of the Council's responsibilities in postgraduate medical education (Recommendation 8) 2. Consult and engage with stakeholders regarding implementation of 2006-2008 strategy 3. Work with Training Bodies and the HSE to facilitate time-limited schemes for entry onto Register of Medical Specialists (Recommendation 30) 4. Continue to define and publicise mission and outcome objectives (Recommendation 8) 5. Engage with health service managers to ensure postgraduate medical education and training requirements are met (Recommendation 8) 6. Consider implications of designating Intern Year as the first year of postgraduate training (Recommendation 55) 7. Continue to streamline and set high standards for the medical education and training sector (Recommendation 8)
		Q3-Q4 8. Devise mechanisms to ensure trainees and trainers are delivering their training commitments [with Training Bodies and HSE] (Recommendations 4 & 39) 9. Consider the role of universities/third level institutions in CME/CPD (Recommendation 45)
	Training Bodies	Q1-Q2 1. Assign lead responsibility for medical education and training to a consultant in each consultant team (Recommendation 6)

Year	Organisation	Action / Timescales
2006	*Training Bodies (continued)*	2. Assign each trainee to a designated trainer (Recommendation 6) 3. Put in place systems to provide feedback to employers after inspections (Recommendation 7) 4. Begin to develop training programmes using competency-based methodologies (Recommendation 10)
		Q3-Q4 5. Devise time-limited schemes for entry onto the Register of Medical Specialists [with HSE and Medical Council] (Recommendation 30) 6. Begin to develop and deliver generic multidisciplinary skills training modules to include modules on doctors' health, management, leadership, governance and consider multidisciplinary delivery (Recommendations 3, 35 & 42) 7. Devise mechanisms to ensure trainees and trainers are delivering their training commitments [with Medical Council and HSE] (Recommendations 4 & 39) 8. Develop training facilities on clinical sites and assess during generic inspections [with HSE and local employers] (Recommendations 10 & 36) 9. Develop methods of retaining links with graduates and trainees abroad (Recommendation 25) 10. Consider reciprocal arrangements or exchanges with sites abroad (Recommendation 25) 11. Explore further centres of excellence in other countries (Recommendation 25) 12. Devise reentry or retraining schemes for those returning after long absences (Recommendations 29 & 42) 13. Develop confidentiality protocols (Recommendation 42) 14. Promote and implement Flexible Training Strategy [with local employers] (Recommendation 13) 15. Establish over-arching body for common processes/funding (Recommendation 60) 16. Ensure that GME research underpins the reform process (Recommendation 52)

Year	Organisation	Action / Timescales
2006	*Local employers*	1. Define NCHD duties and begin to ensure appropriate skill mix [with HSE] (Recommendation 38) 2. Develop training facilities on clinical sites to agreed standard and consider multidisciplinary use [with HSE and Training Bodies] (Recommendations 34, 35, 36) 3. Promote and implement Flexible Training Strategy [with Training Bodies] (Recommendation 13) 4. Put systems in place to consider feedback from inspections (Recommendation 7)
	Universities/ third level institutions	1. Evaluate role in postgraduate medical education and training [with Training Bodies] (Recommendations 46 & 49)
2007	*Department of Health and Children*	1. On-going medical education, training and research policy development to include: a. Graduate retention issues (Recommendation 9) b. International migration patterns (Recommendation 15) c. Role of private sector in medical education and training (Recommendation 20) d. Multidisciplinary training and working (Recommendation 32) e. Role of universities (Recommendation 43) f. Ensure that GME research underpins the reform process (Recommendation 52)
	Health Service Executive	Q1-Q2 1. Establish robust national training structure within the HSE with implementation group (HSE-MET) (Recommendations 2 & 48) 2. Revise workforce planning estimates, including specialist training requirements and interns and communicate to Training Bodies [with Dept of Finance] (Recommendation 59) 3. Continue to build on the training requirement element of NCHD appointments [with HSE-MET] in line with Government policy and agreed targets for phasing out posts with limited training value (Recommendation 19)

Year	Organisation	Action / Timescales
2007	*Health Service Executive (continued)*	4. Create no new NCHD posts without being part of recognised training programme, in line with Government policy and agreed targets for phasing out posts with limited training value (Recommendation 18) 5. Devise a comprehensive recruitment and retention plan (Recommendations 16 & 47) 6. Continue the required training of other healthcare workers to support change in roles (Recommendation 36) 7. Put in place transparent recruitment procedures for NCHDs and allocation of intern positions (Recommendation 17)
		Q3-Q4 8. Continue to address the issues relating to long-term registrars (Recommendation 31) 9. Establish occupational health structure to include all NCHDs (Recommendation 40) 10. Establish a scheme for trainees to study abroad in service-dictated specialty/subspecialty & provide funding for training abroad [with HSE-MET and Training Bodies] (Recommendation 24) 11. Establish a scheme for research scholarships & fellowships and provide funding for agreed number (Recommendation 50) 12. Continue to develop training facilities on clinical sites including primary care [with local employers and Training Bodies] (Recommendation 36) 13. With DoHC begin to appoint appropriate numbers of academic clinicians and clinical scientists (Recommendation 51) 14. Ensure GME research underpins the reform process (Recommendation 52)
	HSE-MET	Q1-Q2 1. Establish the current cost of postgraduate medical education and training (Recommendation 63) 2. Strengthen the system for ensuring explicit approval for all training posts (Recommendation 19)

Year	Organisation	Action / Timescales
2007	*HSE-MET (continued)*	3. Undertake information campaign on Flexible Training Strategy (Recommendation 12) 4. Make available to findings of the CTS and commission other relevant studies (Recommendation 27) 5. Establish a mentoring network and career advice structure (Recommendations 22, 41 & 49) 6. Promote integration of undergraduate and postgraduate training (Recommendation 44) 7. Provide a forum for regulators, providers and other relevant parties to contribute to the development and delivery of modules (Recommendation 44) 8. Develop a matching scheme for all NCHDs [with HSE and Training Bodies] (Recommendation 17) 9. Promote multidisciplinary use of on-site and off-site training facilities (Recommendation 34) 10. Ensure GME research underpins reforms (Recommendation 52)
		Q3-Q4 11. Use feedback from EWTD implementation groups as evidence for policies on level of protected time, etc. (Recommendation 37) 12. Review "Training Principles" (Recommendation 37) 13. Ensure occupational health structures are available to all NCHDs (Recommendation 41) 14. Ensure educational need of general practice are taken into account in the new health service structures (Recommendation 48) 15. Facilitate training in non hospital based settings (Recommendation 48) 16. Secure funding for postgraduate medical education and training and revise budget for next year [with HSE]

Year	Organisation	Action / Timescales
2007	*Training Bodies*	1. Publish numbers to be accepted onto each training programme in a timely manner (Recommendation 23) 2. Recognise research as a core competence (Recommendation 49) 3. Consider amount of credit given for periods of research for specific candidates (Recommendation 49) 4. Begin to streamline training programmes and allow flexibility for academic study and research (Recommendation 10)
	Medical Council	1. Review strategy and engage with stakeholders on implementation (Recommendation 8) 2. Ensure Graduate Medical Education (GME) research underpins the reform process (Recommendation 52)
2008	*Health Service Executive*	1. Revise workforce planning estimates, including interns and primary care and communicate to Training Bodies [with DoHC and Dept of Finance] 2. Intensify phasing out of existing NCHD posts with limited training value in line with Government policy and agreed targets 3. Continue to increase consultant numbers and decrease NCHD numbers [with DoHC and Dept of Finance] 4. Secure funding for postgraduate medical education and training and revise budget for next year [with HSE-MET] 5. Implement the matching scheme for all NCHDs [with HSE-MET]
	HSE-MET	1. Ensure that GME research underpins the ongoing reforms (Recommendation 52) 2. Evaluate Flexible Training Strategy (Recommendation 12) 3. Secure funding for postgraduate medical education and training and revise budget for next year [with HSE]
	Medical Council	1. Review strategy and engage with stakeholders on implementation (Recommendation 8) 2. Ensure that GME research underpins reform (Recommendation 52)

Appendices

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APPENDIX A

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APPENDIX B

Postgraduate Training Bodies Recognised by the Medical Council in Ireland

In relation to each recognised specialty, the Medical Council currently recognises the following bodies in Ireland for the purpose of granting evidence of satisfactory completion of specialist training:

The College of Anaesthetists
22 Merrion Square North, Dublin 2
Tel: 01-6614412

The Irish Committee on Higher Medical Training
Royal College of Physicians of Ireland, 2nd Floor, International House, 20-22 Hatch Street Lower, Dublin 2
Tel: 01-6616677

The Irish College of General Practitioners
4-5 Lincoln Place, Dublin 2
Tel: 01-6763705

The Institute of Obstetricians and Gynaecologists
Royal College of Physicians of Ireland, 2nd Floor, International House, 20-22 Hatch Street Lower, Dublin 2
Tel: 01-6616677

The Faculty of Occupational Medicine
Royal College of Physicians of Ireland, 2nd Floor, International House, 20-22 Hatch Street Lower, Dublin 2
Tel: 01-6616677

The Irish College of Ophthalmologists
121 St. Stephen's Green, Dublin 2
Tel: 01-4027777

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The Faculty of Paediatrics
Royal College of Physicians of Ireland, 2nd Floor, International House, 20-22 Hatch Street Lower, Dublin 2
Tel: 01-6616677

The Faculty of Pathology
Royal College of Physicians of Ireland, 2nd Floor, International House, 20-22 Hatch Street Lower, Dublin 2
Tel: 01-6616677

The Faculty of Public Health Medicine
Royal College of Physicians of Ireland, 2nd Floor, International House, 20-22 Hatch Street Lower, Dublin 2
Tel: 01-6616677

The Irish Psychiatric Training Committee
Corrigan House, Fenian Street, Dublin 2
Tel: 01-6763875

The Faculty of Radiologists
Royal College of Surgeons in Ireland, 123 St. Stephen's Green, Dublin 2
Tel: 01-4022139

The Royal College of Surgeons in Ireland
123 St Stephen's Green, Dublin 2
Tel: 01-4022743

The Faculty of Sports and Exercise Medicine, RCPI and RCSI
Royal College of Surgeons in Ireland, 121 St. Stephen's Green, Dublin 2
Tel: 01-4022780

APPENDIX C

Interim Report: Medical Education and Training in a 58 Hour Working Week

Informal Recommendations of the Medical Education and Training Group to the Minister for Health and Children on quality medical education and training as the maximum average on-site on-call working week for NCHDs reduces to 58 hours (August 2004)

1. INTRODUCTION AND SUMMARY OF RECOMMENDATIONS

1.1 Introduction

Over the last two years the Medical Education and Training (MET) Group has consulted widely with all the stakeholders in medical education and training through a series of meetings, Interim Report on Postgraduate training for Non-Consultant Hospital Doctors (NCHD) 2002, written submissions, questionnaires and a major national seminar in January 2004. All stakeholders now share the government's vision for postgraduate medical education and training which is that:

The postgraduate education and training environment will be attractive to all medical graduates, and deliver high quality schemes that will result in a sufficient number of fully trained, competent doctors to deliver a patient-centered health service in this country.

A central issue which has been addressed in the course of consultation to date is how best to address change and assure quality in medical education and training in the context of complying with the European Working Time Directive (EWTD) and the wider Health Reform Programme. This includes the Hanly Report, which sets out specific medical education and training recommendations and identifies issues to be addressed in a further report by the MET Group. Training must be needs-based and timely.

The required working hours reductions under the Directive are phased so that average working hours (on-site on-call) for NCHDs may not exceed 58 hours by 1 August 2004, 56 hours by 1 August 2007 and 48 hours by 1 August 2009.

The first step is to provide a framework for training in the context of the August 2004 deadline for introducing a maximum average of 58 hours on-site on-call per week. This document focuses on the steps which the MET Group views as essential to ensuring compliance with the Directive on the one hand and safeguarding quality training on the other while maintaining safe service delivery.

1.2 Summary of Recommendations

Immediate Steps

1. Each training body should draft training principles to be included in EWTD-compliant rosters.

2. Progress discussions between medical training bodies and employing authorities to agree mutually-acceptable training principles and arrangements for implementation by 1 August 2004.

3. Management representation to be added to membership of MET Group.

4. Agree and put in place interim structures (pending allocation of integrated medical education and training functions to Health Service Executive (HSE)) to drive and manage medical education and training reform and the implementation of the EWTD.

Other Short-term Steps
(for completion before 1 August 2004)

5. Training compliant rosters to be devised based on the principles and arrangements agreed by MET Group. (see No. 2 above)

6. Introduce further skill mix initiatives to re-allocate inappropriate NCHD duties to appropriate grades of staff.

7. In consultation with the training bodies, outline the type and duration of training which may take place outside on-site on-call hours.

8. Training bodies to be requested to devise innovative assessment / retraining / re-entry schemes.

9. Initiate discussions between stakeholders with a view to agreement in principle on quality assurance (QA) measures for training.

10. Identify minimum data recording requirements to be in place by 1 August and agree measures for implementation.

11. Identify resources required in 2004.

12. Insofar as is practical, begin to address the issues identified below under the heading "Short-Medium Term Steps (for completion within approximately 12 months)".

Short-Medium Term Steps (for completion within approximately 12 months)

13. Agree detail of proposed medical education and training functions & structures to be established, including structures to manage the interface between service and training on an ongoing basis so as to ensure the quality of both training and patient care.

14. Assign lead responsibility for educational governance to a designated consultant in each consultant group or team when established.

15. Agree timescale and begin to implement phased reallocation of inappropriate duties to appropriate grades of staff as a matter of urgency (see No. 6 above).

16. Commence implementation of the recommendations on QA at No. 9 above.

17. Agree and circulate timeframe for phasing out all non-training NCHD posts in consultation with all key stakeholders.

18. Identify other data requirements for workforce planning, resourcing, training needs and regulating the numbers of doctors in training.

19. Identify resources required in 2005.

Medium-Long Term Steps

The MET Group will provide further recommendations to the Minister for Health and Children with regard to the 56 hour week, 48 hour week and other medium-long term medical education and training issues.

These recommendations will be made in the context of

a wider reform programme which will include increased bed capacity, increased consultant numbers, reorganisation of acute hospitals, review of ancillary professions, restructuring primary care, ambulance services and continuing care. The issues to be developed include:

- Ensuring that the established training structure at No. 13 above reflects the functions recommended in the Hanly Report;
- Significant progress in the phasing out of all non-training NCHD posts;
- Identify barriers to graduate retention and devise strategies to address same;
- Competence-based training and other innovations;
- On-going Quality Assurance and standards;
- International training opportunities;
- Academic research;
- Monitoring the implications of workforce planning for numbers of doctors in training;
- Identification and quantification of on-going resource requirements;
- Role of universities in postgraduate education.

2. DETAILED RECOMMENDATIONS

2.1 Immediate Steps

1. **Each training body to draft training principles and where possible, sample rosters to be included in EWTD-compliant rosters.**

From the 1st August 2004, all doctors in training will be subject to the European Working Time Directive (EWTD). In order to comply with the shorter working week, new rosters must be devised which take account of all the provisions of the Directive. This is a complex exercise for the employers as they must include the required rest breaks, compensatory rest, on-site on-call, off-site on-call and training. The training bodies and the employing authorities have been briefed on how the EWTD is to be applied and the meaning of "working time" under the Directive.

All stakeholders must work in partnership to proactively manage, and thus avoid any possible adverse effects of implementing the 58 hour week on education and training. This has been done in other countries on a phased basis without compromising training or patient care, e.g. in Denmark and Finland.

It should be borne in mind that training opportunities will be available both outside and within core and rostered hours. However, care must be taken that artificial distinctions are not made between training and service as medical education and training is a vocational, apprenticeship-based model and the two elements are and will remain intertwined. The training principles to be incorporated into the rosters should include any release programs (day or half day), hand-over rounds, off-site training commitments and any other curricular requirements.

Sample rosters for resident on-call Senior House Officer (SHO) surgical trainees and Higher Specialist Registrars (SpR) have been devised by the Royal College of Surgeons in Ireland (RCSI) and training recommendations have been submitted to the MET Group by the Irish Committee on Higher Medical Training, Royal College of Physicians of Ireland (ICHMT, RCPI). These have been very helpful and give an indication of the training principles that need to be incorporated into any new rosters for NCHDs. It is not possible to recommend a standard roster for training which will suit all specialties and hospitals. Much of the detail will have to be developed and agreed at local level mindful of the principles prescribed by the training bodies.

The MET Group recommends that each specialist training body should prepare similar rosters for their specialties or at minimum, identify the principles that are considered necessary for their training programmes. The secretariat of the MET group is available to facilitate this process.

2. Initiation of dialogue between training bodies and employing authorities aimed at agreeing mutually-acceptable training principles and arrangements for implementation by 1 August 2004.

Currently, the employing authorities are drawing up EWTD-compliant rosters. Efforts are being made to accommodate the appropriate training time. The work of the MET Group will provide guidance to the employers and the training bodies on measures that are needed to ensure that training requirements are addressed.

In the interest of medical education and training, the training bodies should now outline their requirements and input them into the manpower planning process. It is imperative that agreement can be reached on the balance between training and service in the new rosters. In preliminary discussions with the MET Group, the employers and training bodies have had similar views on how this can be achieved and therefore, it is necessary for all stakeholders to continue this dialogue as a matter of urgency.

Pending the establishment of the structures referred to at No. 13 below to drive medical education and training reform and to manage the training/service interface, the MET Group recommends that an informal process be initiated in which employers and training bodies can discuss the training principles and service requirements of new rosters and come to an agreement on incorporating both elements in new EWTD-compliant rosters.

3. Add management perspective to membership of MET Group

Training organisations and health service managers do not have many opportunities to exchange views in relation to medical education and training. Both groups are trying to achieve the same thing - a quality health service with education and training of highest standard - but the understanding of each other's issues can only be reached through discussion.

Originally, the MET Group was a Project Group of the National Task Force on Medical Staffing. At that time, all of the MET Group's recommendations were discussed at the steering group level whose members included Director of Planning, ERHA; IR Executive, HSEA; Medical Manpower Manager, Beaumont Hospital; CEO, WHB; CEO, St. Vincent's Hospital; and HR Director, SEHB. The Medical Stakeholders Group and the Interagency Forum also facilitate the exchange of views. However, the MET Group itself includes no specific management perspective.

It would be valuable for the views of the training organisations to be taken into account by managers and vice versa.

It is therefore recommended that Mr. John Bulfin, National Coordinator, NCHD Hours Reduction be appointed to the MET Group by the Minister.

4. Agree and put in place interim structures (pending allocation of integrated medical education and training functions to Health Service Executive (HSE)) to drive and manage medical education and training reform and the implementation of the EWTD

It is critical that medical education and training is safeguarded and developed, particularly during this period of major change. A move toward a structure containing the training functions, as described in the Hanly Report and agreed by the Government, must be made. A single, authoritative, national, statutory structure to promote and oversee medical education and training will be required to ensure that:

- medical education and training is provided in accordance with integrated strategies and plans;

- service pressures do not override training requirements or impact on the quality of that training;
- sufficient numbers of doctors must be on the roster to assure quality service and medical education and training;
- all doctors in training are in genuine structured training posts;
- the numbers of NCHDs do not increase;
- sufficient numbers of doctors are being trained for projected future requirements of the health service;
- all the stakeholders liaise with each other, have a shared understanding of the issues and are kept informed of any reforms that will impact on medical education and training.

At local level, each consultant group/team should have an individual consultant within that group/team charged with responsibility for educational governance. Each trainee should have a designated consultant trainer.

The MET Group recommends that the Interim Health Service Executive (HSE) make immediate provision for the establishment of a single, authoritative education and training structure representative of the MET Group, the Department of Health and Children, the training bodies, the employers, the Medical Council, Medical Schools, Health Research Board, trainees and the public interest. This training structure should establish priorities, co-ordinate funding, liaise with the stakeholders and monitor the impact on training in the Phase I regions and under the new rostering arrangements.

2.2 Other short-term steps - for completion before 1 August 2004

5. Employing authorities and training bodies to agree rosters

Final agreement on the rosters can only take place in the context of industrial relation (IR) issues being resolved. The agreement reached will have to reflect the training bodies' views on the levels of protected time for trainers and trainees, on-site and off-site training, etc.

The MET Group recommends that agreed rosters should:

- be based on agreed principles and arrangements (see No. 2 above)
- include provision for protected training time for trainer and trainee and handover rounds
- take into account that while there are learning opportunities at almost every point during the working day, care must be taken to ensure that only appropriate periods are designated as training/non-working time;
- only appropriate periods of non-working time off-site should be designated as training time and should be aligned to curricula and year of training, e.g. training in non-clinical competencies, skills laboratories, course work;
- provide for trainers and trainees being on duty together as much as possible, and for trainee rosters to ensure exposure to the full spectrum of their specialty's workload (e.g. extended hours cover, 24-hour cover where appropriate);
- insofar as is possible, ensure all rostered and core working hours are scheduled to maximise the learning opportunities;
- support a flexible training strategy.

6. Negotiate and agree reallocation of inappropriate NCHD duties to appropriate grades of staff

Currently, NCHDs perform duties which can easily and safely be done by other grades, e.g. cannulation and blood cultures. Agreement should be reached to reassign these inappropriate functions as soon as the relevant and appropriately trained staff are in place. However, this should be done on a phased basis while retaining patient-care activities with the highest training value.

The MET Group recommends that the recommendations contained in the Report of the Steering Group on NCHD Working Hours should be implemented as a matter of urgency.

7. Consider the type and duration of training which may take place outside on-site on-call hours

Many of the training bodies have suggested that, in addition to study and exam leave, a proportion of training can and should take place outside of working hours. Examples include:
o Release programmes
o Conference Leave
o E-Learning
o Reading up procedures
o Attending lectures
o Research
o Skill enhancement in laboratories
o Acquiring skills of a non- clinical nature e.g. management, clinical governance, communications and IT

The doctor in training should be made aware of what the commitment will be and it should only be a small proportion of the overall training requirement.

The MET Group recommends that each of the training bodies prepare guidelines on the type and duration of training which it would require outside of rostered hours for each specialty, sub-specialty and grade and provide each NCHD with the appropriate details.

8. Training bodies to be requested to devise innovative assessment / retraining /re-entry schemes to facilitate entry to the Specialist Register for experienced doctors who may face barriers to accessing structured training within the existing training and assessment framework

There are several categories of doctors who may not have completed training or find it difficult for other reasons to qualify for entry onto the Specialist Register. These doctors include those who have left training due to family or personal reasons, those who have remained in a particular training post for a long time, those who have not graduated from an Irish medical school, etc.

Many of the doctors who face barriers to accessing structured training make a significant and continuing contribution to Ireland's Health Service. In recognition of the contribution that these doctors have made, innovative schemes should be available for a period of time to accommodate their training needs without compromising the quality of training or service. This will be a necessary step in phasing out training posts which are not recognised by a training body and decreasing the numbers of NCHDs as the numbers of consultants rise.

Schemes should also be devised to assist doctors to re-enter the workplace if they so wish.

The MET Group recommends that the needs of the doctors who fall into these categories be defined and that each training body devise innovative schemes, including entry criteria, to address these requirements.

9. Initiate discussions between stakeholders with a view to agreement in principle on quality assurance (QA) measures

The health system has begun a process of major reform. The aim is to deliver a service of the highest quality - a service that meets the highest national and international standards. To provide such a top quality service, doctors must be trained to the highest standards. To

ensure that the standards are continuously improved, additional quality assurance measures must be put in place. The Medical Council has a major role to play in QA.

The MET Group recommends that all stakeholders produce proposals on the type of measures and/or systems that should be put in place to ensure that medical education and training is of the highest standard and continues to be so. It will be a matter for the central training structure to determine what measures should be implemented, monitored and reviewed on an ongoing basis.

10. Identify minimum data recording requirements to be in place by 1 August and agree measures for implementation

The main obstacle in addressing the medical education and training issue is the lack of information. More accurate and comprehensive data needs to be recorded centrally and the quality of the data must be improved. Standardised definitions and terminology should be used by all stakeholders.

Initial discussions suggest that it would be necessary to record the following data, possibly in a web-based database which is easily accessible by each hospital, training body and by primary health centres:

For each trainee:
o Training number
o Specialty
o Grade
o Location
o Time in post
o Qualifications held

For each post:
o A unique identifier
o WTE trainees filling the post
o Specialty/sub-specialty
o Grade
o Location
o If approved by a Training Body:
- Medical Council post number
- Training body that approved post
- Date and duration of approval
- If the post is attached to a training scheme

For each specialty:
o Approved trainers
o Trainer/trainee ratio
o Flexible training data requirements

In the long term, the Shared Services Centre of the HSE will facilitate common data definitions and centrally accessible information.

The MET Group recommends that all stakeholders agree standardised definitions, e.g. "training post" and agree the information that should be recorded centrally.

11. Insofar as is practical, begin to address the issues identified below under the heading "Short-Medium Term Steps (for completion within approx. 12 months)"

The issues for completion in the short-medium term are those which preferably would be implemented by the August deadline but in practical terms may take longer. These items should be seen as urgent and where possible should commence ahead of 1st August.

12. Identify any resources required in 2004

There will be resource implications for implementation, both funding and staff. For example, in reallocating NCHD duties to other grades, the requirement for extra staff in other grades and/or extra training is likely. Similarly, the re-configuration of training provision may require additional funding. These requirements will have to be identified, prioritised and costed.

C

2.3 Short-medium term steps - for completion within approx. 12 months

13. Agree detail of proposed medical education and training functions & structures to be established

It has been agreed by government that the current fragmentation in the coordination, management, regulation, inspection, control and funding of postgraduate medical training must be addressed by incorporating the medical education and training functions recommended in the Hanly Report within the envisaged new structures on a statutory basis:

- o formal allocation of a budget for postgraduate training
- o the control of all NCHD posts[28] through a requirement for explicit approval by the training authority, based on training criteria, to be provided for a specified time, e.g. 3 or 5 years, as a condition for the creation or replacement of those posts and for the release of funding to the employing authorities for those posts;
- o aligning the number of medical training programmes and the number of trainees to, at a minimum, meet estimated specialist[29] staffing needs of the health service on an on-going basis;
- o coordinating, in collaboration with the postgraduate training bodies and the Medical Council, the provision and accreditation of specialty training programmes and training posts;
- o collaborating with the postgraduate training bodies and other MET agencies, to achieve agreed efficiencies and value for money improvements through greater standardisation and co-ordination in areas such as recruitment processes, hospital inspections, processes of assessment, shared information systems, data collection and publications (e.g. common procedures, entry requirements and guidelines);
- o responsibility and accountability for strategic development of medical education in Ireland, including the flexible training strategy discussed in the Hanly Report;
- o independent evaluation and supervision of all aspects of medical education and training, including undertaking or commissioning appropriate studies, reports, reviews, etc;
- o ensuring that there is a systematic mentoring system and career guidance for all doctors in training at every level of training;
- o ensuring and commissioning, if necessary, a continuing programme of research and development of the educational methods employed;
- o ensuring that all doctors in training are exposed to research principles and methodologies;
- o ensuring that opportunities exist for those undertaking approved academic research to compete for appropriately funded and supported educational contracts/agreements, which should continue to include proper provision for insurance liability;
- o in consultation with the employers, the Medical Council and training bodies, to facilitate the policy and strategy in relation to Continuing Professional Development (CPD), including Continuing Medical Education (CME) and Competence Assurance (CA);
- o ensuring that non-statutory funding, from whatever source, complies with the highest ethical and quality standards in postgraduate medical education and training; and
- o setting minimum entry criteria for training posts on the advice of the training bodies.

The functions have been agreed but the structure to carry out those functions is not as clear. All stakeholders must be represented. Legislation to establish the HSE and its agencies will be drafted shortly and therefore, the medical education and training aspect must be determined.

The MET Group recommends that discussions take place with the Department of Health and Children, the Interim HSE and the other stakeholders in the Reform Programme to expedite agreement on structures and draft legislation as recommended in the Hanly Report.

[28] Reference to NCHD posts in this section is in the context that all NCHD posts will be training posts.

[29] The term specialists which is used in this section includes hospital consultants, general practitioners, and the specialties of public health medicine and occupational medicine.

14. Agree timescale and begin the phase reallocation of inappropriate NCHD duties to appropriate grades of staff

The duties inappropriate to the NCHD and the resource needs of other grades will have been determined at No. 6 above. The process of reallocating the duties should begin in this period.

The MET Group recommends that
- *o NCHDs have a revised written description of their duties outlining roles and responsibilities;*
- *o sufficient numbers of staff at other grades be appointed or provision for medical and nursing students to perform such duties in a "part-time working" capacity;*
- *o other grades be properly resourced to undertake the duties for which the NCHDs will no longer be responsible;*
- *o a planned timescale is agreed.*

15. Assign lead responsibility for educational governance to a designated consultant in each consultant group or team when established

It is important that responsibility for medical education and training is filtered down to local level. This will require a consultant from each group or team to take responsibility for educational governance and ensure the appropriate trainer/trainee ratios as prescribed by the training bodies. It will be necessary that the time required to undertake these extra duties will be permitted in the working hours of that consultant.

The MET group recommends that a) each group or team of consultants nominates a consultant to take the lead in educational governance and that the time commitment is protected and b) the recommendations in the Hanly Report on protected time for trainers is implemented.

16. Commence implementation of the recommendations on QA

All the relevant stakeholders will have made proposals on the types of measures and/or systems that are required to maintain high quality medical education and training (see No. 9 above).

The MET Group recommends that implementation of those proposals begins.

17. Agree and circulate timeframe for phasing out all non-training NCHD posts in consultation with all key stakeholders

All doctors in training should be in genuine, approved, structured training posts. As this is not currently the case, implementation must be phased in over an agreed period. A number of matters must be addressed, e.g.
- o how to define a genuine training post;
- o how to ensure that all trainees are in genuine training posts;
- o how to phase out posts that do not have training body recognition;
- o how to facilitate doctors in self-directed training to become eligible for recognition (see No. 8 above);
- o what timescale is practical and workable;
- o what the resource implications are.

The MET Group in consultation with all the relevant stakeholders, including the postgraduate training bodies, Medical Council, trainees and employing authorities, will prepare a discussion document on this issue for submission to the Minister.

18. Identify other data requirements for workforce planning, resourcing, training needs and regulating the numbers of doctors in training

The basic data required by each of the stakeholders will have been identified at No. 10 above. As the new health service begins to evolve, other requirements may become apparent. More specific information may be required for workforce and training planning.

Resourcing of medical education and training may call for an analysis of other types of data. As the Shared Services Centre comes on stream, it may be possible to access the data available across the health service for different purposes. This matter should be followed up by the HSE in due course.

The MET Group recommends that the data requirements for and from each of the stakeholders be revisited regularly throughout the change process and that the group liaise with the HSE in relation to the developing the Shared Services Centre.

19. Identify any resources required in 2005

Resource implications arise from many of the short/medium term steps. These must be identified, prioritised and costed.

3. MEDIUM-LONG TERM RECOMMENDATIONS

The MET Group will provide further recommendations to the Minister for Health and Children with regard to the 56 hour week, 48 hour week and other medium-long term medical education and training issues.

These recommendations will be made in the context of a wider reform programme which will include increased bed capacity, increased consultant numbers, reorganisation of acute hospitals, review of ancillary professions, restructuring primary care, ambulance services and continuing care. The issues to be developed include:

- Ensuring that the established training structure at No. 13 above reflects the functions recommended in the Hanly Report;
- Implementation of the phasing out of all non-training NCHD posts;
- Identify barriers to graduate retention;
- Competence-based training and other innovations;
- On-going Quality Assurance and standards;
- International training opportunities;
- Academic research;
- Monitoring the implications of workforce planning for numbers of doctors in training;
- Identification of on-going resource requirements;
- Role of universities in postgraduate education.

The MET Group's detailed recommendations for each stage will include prioritisation of issues and costing of the various elements.

APPENDIX D

Training Principles to be Incorporated into New Working Arrangements for Doctors in Training

July 2004

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Introduction

The National Task Force on Medical Staffing was established in February 2002 by the Minister for Health and Children. The Report (Hanly) was published in October 2003. At the launch of the report the Minister invited the Medical Education and Training (MET) group, chaired by Dr. Jane Buttimer, to remain in place in order to complete their work. The new terms of reference and membership are at Appendix I.

The implementation of the European Working Time Directive (EWTD) from the 1st of August this year will require changes in the work practices of all doctors in training. The MET group has set out to identify a series of training principles which, when incorporated into new EWTD-compliant rosters, will ensure that the quality of medical education and training is not adversely affected by such changes, but rather can be enhanced.

The need for coherent well structured recommendations on the future delivery of medical education and training was highlighted at the National Seminar on Postgraduate Medical Education and Training held in January 2004. While the Report of the National Task Force on Medical Staffing (Hanly) sets out a way forward for medical education and training, detailed short to medium term recommendations were needed.

These principles have also been informed by informal and formal contacts with the employers and training bodies and submissions to the MET group over the last two years. The principles were discussed at a number of meetings with the MET group, with the Medical Council and with individual training bodies. A discussion document was compiled and circulated. Comments were invited from all of the training bodies with a template for response. The combined responses are set out in the documents attached.

It is envisaged that all the principles identified will be incorporated into the work practices of doctors in training, on a phased basis, beginning with the first phase of implementation of the EWTD on 1st August. Some of the principles are dependant on the implementation of the recommendations of the Hanly Report and should be incorporated as those recommendations are rolled out.

If we are to retain our medical graduates and continue to attract highly trained doctors from other jurisdictions, postgraduate medical education and training in Ireland must be attractive from both a national and international perspective. Most importantly, the continued provision of high quality, safe hospital services is dependant on the availability of highly trained doctors.

Our priority is the provision of safe patient care. We must therefore ensure that the quality of medical education and training is improved rather than compromised by the ongoing reform process.

The MET group wish to thank the training bodies and the Medical Council for their assistance with and contributions to the preparation of these training principles.

Part I - General Principles

All stakeholders including employers, policy makers, training bodies and trainees must, in so far as possible, put in place mechanisms whereby the vision of postgraduate education and training can be met. The vision is that:

The postgraduate education and training environment will be attractive to all medical graduates, and deliver high quality schemes that will result in a sufficient number of fully trained, competent doctors to deliver a patient-centred health service in this country.

The principles outlined below underpin this vision and are based on the agreement that

- educational and training opportunities in the workplace should be exploited and maximised;

- o an artificial barrier must not be created between service and training;
- o because of the various working patterns between units and specialties there can be no one template roster;
- o it is imperative that the training of NCHDs is of sufficient quality to safeguard the standards and continuity of patient care;
- o the "prescription" as outlined in the Hanly Report will be implemented in full.

- Maximising Training Opportunities

1. Educational and training opportunities in the workplace should be exploited and maximised.

2. To maximise learning opportunities in a context of reduced hours, duties should be performed by the most appropriate member of the multi-disciplinary team.

3. Trainees should have access to state-of-the-art educational and training facilities including:
   - o electronic learning systems;
   - o broadband internet access;
   - o global access to web based journals;
   - o a well stocked library and/or a virtual library;
   - o videoconferencing;
   - o educational resource centres including simulator training and clinical skills laboratories;
   - o web-based curriculum for training;
   - o lecture theatres, workrooms etc.

Where such facilities are already in place for any one discipline, spare capacity should, where possible, be shared with other disciplines in line with best value for money approaches. This would also enhance the development of a multi disciplinary working and training culture.

4. Where applicable, flexible training should be accommodated.

- Governance and Managing Change

5. An educational governance system at national, regional and local levels should be in place as soon as possible.

6. On an ongoing basis throughout the forthcoming period of major health service reform, the recognised specialist training bodies and the Medical Council should engage closely with health service managers at national, regional and local levels in order to ensure that appropriate training principles are reflected in NCHD working arrangements and that the quality of both training and patient care is fully protected.

7. For each training body offering higher specialist training within a hospital or group, one of the designated trainers should take the lead in co-ordinating the training activities, liaising with an identified individual from the hospital management to ensure that postgraduate training requirements are being met. A lead consultant trainer should also be available in respect of basic specialist training. Such appointments have the potential to achieve and maintain a correct balance between service and training throughout the period of postgraduate education. Details of the range and responsibilities of the role, the likely sessional commitment, the financial and other resources necessary need to be determined.

8. The inspectorial process by the training bodies and Medical Council will routinely review specialties at individual sites from the educational and training perspective, make recommendations in a timely and co-ordinated manner to the employing authorities, who, where possible will take corrective action. Then, if not possible to arrange service duties to allow for training to continue, the training body will withdraw recognition.

9. "Working Time" in EU and Irish law, as interpreted by the European Court of Justice (ref Jaeger ruling para 63) means "when the doctors are required to be

present at the place determined by the employer and to be *available to the employer* in order to be able to provide their services immediately in case of need". In this context, time spent training at the behest of the training body rather than the employer does not count as working time for the purposes of the EWTD but may count as paid time.

10. The quality of medical education and training can be enhanced by improved clinical practice, e.g. patients admitted to appropriate wards and improved information systems.

- Curriculum

11. The training bodies should provide employers as well as designated consultant trainers with details of the curricula and duration of training for each specialty at each level.

12. All training posts should provide the trainee with adequate opportunities to gain the experience to meet the needs of the curriculum.

13. The delivery and assessment of training should, where possible, be competence-based. Training must be delivered within the relevant curricula and appropriate timeframes.

14. Each trainee should have a set of educational goals, log book and regular performance appraisal.

- Trainer and Trainee Roles

15. Time, though it may be utilised mainly or even exclusively for an educational purpose (e.g. "protected", study leave) and lies outside the definition of "working" time, can still be included as part of a contract of paid employment. Each NCHD should have a job description outlining his/her role and responsibility and education and training commitments, including any role in teaching other medical students, nurses, and health and social care professionals. This job description will be subject to negotiation and agreement by the relevant stakeholders.

16. Employers should facilitate protected training time for designated trainers and trainees in recognised training posts.

17. In practice, NCHDs receive education and training from the team of trainers, including other NCHDs, consultants and various healthcare professionals. Each NCHD should also have a designated trainer/ mentor, i.e. consultant who has a commitment to teaching and training, and whose name is on the appropriate specialist register.

18. All designated trainers should participate in a recognised teaching course.

19. Teaching in individual units where appropriate should be in block with a very significant training input by consultants. All non-emergency work should, where possible, be avoided during these teaching blocks.

20. The more senior NCHDs will be expected to teach other medical students and/ or nursing and health and social care professionals. NCHDs must be consulted with a view to organising such time in the most appropriate manner.

- Training Principles in Rosters

21. The primary consideration in constructing rosters is the provision of safe care for patients as agreed by the relevant local medical body (see Item 7)

22. Rosters must be compiled to reflect the training needs and agreed principles. (In addition to the principles below, management should, when devising rosters, pay particular attention to principles 1, 2, 4, 9, 12, 16, 19 and 20 above).

23. Rosters should in so far as possible be structured in such a way that the trainee is provided with the opportunity to follow patients in their journey through the hospital system e.g. through structuring in formal opportunities to see and/or review the patients involved during subsequent periods on duty. In the future this should be facilitated by electronic patient records.

24. Trainees' rosters should be structured to preserve the maximum possible association and contact with their designated trainers, as long as this is consistent with being exposed to the full spectrum of experience necessary for training in the specialty concerned, including extended hours and/or night work where appropriate.

25. NCHDs should not be rostered for acute on-call and elective duties simultaneously, where possible.

26. Rosters should facilitate scheduled on and off site education and training activities.

Principles relating to each Training Body

1. Rostered hours should maximise educational exposure to:
   - o inpatient-centred activities, especially those defined in the curricula as having a high training value, and appropriate to the grade and specialty of the trainee;
   - o a broad range of conditions and procedures and adequate throughput of case material, in order to provide the widest experience available;
   - o experience in initial assessment, investigation and management of patients including outpatients, with particular reference to ensuring continuity of care, in a team working context;
   - o the full range of procedures identified in the relevant curriculum for the specialty;
   - o those generic skills expected of all practising doctors.

2. Rostered hours should also include the necessary formal training time.

3. Rosters where possible should facilitate essential off-site education and training, which would not normally be considered working time.

The following is a summary of the recommendations from the specialist training bodies:

1. Royal College of Surgeons in Ireland

The Royal College of Surgeons in Ireland have submitted the following documents which are attached in full at Appendix II :

1. European Working Time Directive : A Discussion Document from the Royal College of Surgeons in Ireland

2. General Criteria for Recognition of Basic Training Posts by the Royal College of Surgeons in Ireland

3. Letter to John Bulfin, National Co-ordinator for Implementation of EWTD re the delivery of teaching and training within Surgery and the European Working Time Directive

2. Royal College of Physicians of Ireland

Training in specialties which are predominately elective can be more easily accommodated into the EWTD-compliant rosters.
Teams required to provide 24/7 acute care, with an inpatient load of approx. 12-15 admissions per day and an outpatient load of 5 – 6 clinics per week, need a minimum of 9 doctors on the rota for acute medicine and related specialties.
Assuming improved trainer: trainee ratios, the more doctors on the rota, the more flexibility there should be to structure training effectively.
Protected time should be a minimum of 4 hours per week.

		Y = Yes			
Activity	**Time**	**Onsite**	**Offsite****	**BST***	**HST***
Research meetings	As appropriate	Y	Y	Y	Y
In-patient consults	As appropriate	Y	Y	Y	Y
Out-patient clinics	As appropriate	Y	Y	Y	Y
Procedural sessions, e.g. endoscopies	As appropriate	Y	Y	Y	Y
Ward rounds and case conferences	As appropriate	Y	Y	Y	Y
Departmental tutorials and seminars	As appropriate	Y	Y	Y	Y
X-ray and pathology meetings where appropriate	As appropriate	Y	Y	Y	Y
Grand rounds and CPCs	As appropriate	Y	Y	Y	Y
Post call rounds/ extended handover time	Minimum of 1.5 hours	Y	Y	Y	Y
Journal clubs	As appropriate	Y	Y	Y	Y
Administrative experience in the management of the ward and the operation of the unit	As appropriate	Y	Y	Y	Y
Appropriate study leave	As appropriate	Y	Y	Y	Y
Audit, e.g. morbidity and mortality conferences	As appropriate	Y	Y	Y	Y

The appropriate time will be specialty and post specific, and should be identified in each trainers' training plan as designed for each trainee in each training post.

* BST includes Basic Surgical Training, General Professional Training etc
* HST includes Higher Specialist Training/Higher Surgical Training
** Offsite can be within a group of hospitals or a region.

3. College of Anaesthetists, RCSI

For training purposes, 50%-75% of hours worked should be between 8:00 and 18:00, the remainder between 18:00 and 8:00. Out of hours work and presence in the hospital during daytime hours are complementary and both essential for training. Need 8 on a rota to facilitate this in practical terms.
Trainees should have 220 hours per year of protected training time (including study leave) within the 58 hour week. Junior trainees should spend 3 hrs per week of these in structured didactic teaching. Senior trainees should have more flexibility and may use the time for other training activities, e.g. research.
Emphasis on well structured rotations with some choice for trainees. Tutor system for educational organisation and governance.
See also "Specialist Training in Anaesthesia" and "Guidelines for Training in Anaesthesia in relation to EWTD" from the College of Anaesthetics.

		Y = Yes			
Activity	**Time**	**Onsite**	**Offsite**	**BST***	**HST***
Continuity of care (ICU, pre-op assessment)		Y		Y	Y
Outpatient clinics (pain, pre-op)		Y		Y	Y
Procedural sessions, e.g. theatre, PainTx		Y		Y	Y
Ward rounds and case conferences (ICU)		Y		Y	Y
Departmental tutorials and seminars		Y		Y	Y
Grand rounds		Y	Y	Y	Y
Post call rounds/ extended handover time	0.5 hr in theatre, 1 hr in ICU	Y		Y	Y
Journal clubs		Y	Y	Y	Y
Administrative experience in theatre/ICU management		Y			Y
Core topic study days			Y	Y	Y
Practical skills courses, e.g. regional, fibre-optic, etc.			Y	Y	Y
Anaesthesia simulator			Y	Y	Y
Management courses			Y		Y
Anaesthesia MSc.			Y		Y
Day/half-day release			Y	Y	Y
Audit, e.g. morbidity and mortality conferences		Y		Y	Y

* BST includes Basic Surgical Training, General Professional Training etc
* HST includes Higher Specialist Training/Higher Surgical Training

4. Faculty of Radiology, RCSI

The following rotations are required at BRT[30] level:
1 month neuroradiology, 2 months paediatric radiology and 3 months regional hospital (variable)
See also publications below from the Faculty of Radiology:
A. The items which will be considered during a visit
B. Training Programme in diagnostic Radiology
C. Regulations relating to the training, education and examination of candidates

		Y = Yes			
Activity	**Time**	**Onsite**	**Offsite**	**BST***	**HST***
1st Yr formal lectures	2 half days per week		Y	Y	
2nd – 4th Yr formal lectures	1 half day per week		Y	Y	
Structured Study	3 hours per week		Y		Y
Clinical radiological conferences	5 – 10 hours per week depending on hosp	Y		Y	Y
Obstetrics course	2 weeks per BRT		Y	Y	
AFIP course	Once per BRT (6 weeks)		Y	Y	
Lectures by visiting professors from abroad	1 week twice yearly		Y	Y	
Local faculty meetings	1 week per year	Y		Y	Y
1st Yr release course	2 x 2 days per year		Y	Y	
Appropriate study leave			Y	Y	Y
Audit & research		Y	Y	Y	Y

* BST includes Basic Surgical Training, General Professional Training etc
* HST includes Higher Specialist Training/Higher Surgical Training

[30] BRT is Basic Radiology Training

5. Faculty of Paediatrics, RCPI

Trainees must have adequate exposure to each aspect of paediatric care in the hospital setting including: o Acute on-call work for neonates and general paediatrics out-of-hours and during the working day; o Consultant-led ward rounds; o Consultant-let out-patients clinics and ward work; o Organised early hand-over rounds; o Completion of an audit project in each post; Three monthly clinical peer review of difficult cases	
Activity	**Time**
Day-time on-call	8 hours per week
Out-of-hours on-call	16 hours per week
Ward work and audit	8 hours per week
Consultant-led outpatient clinics/ interdisciplinary meetings	6 hours per week
Consultant-led ward rounds	6 hours per week
Dedicated training time	4 hours per week
Appropriate study leave	7-8 days per year for HST* trainees in years 1 and 2

* BST includes Basic Surgical Training, General Professional Training etc
* HST includes Higher Specialist Training/Higher Surgical Training

6. Institute of Obstetricians and Gynaecologists, RCPI

Training in Obstetrics and Gynaecology requires time in hospital during daytime hours and at least one overnight call per week, both for BST and HST. While trainees will inevitably receive training from a number of consultants, rosters should preserve exposure of the trainee to the designated trainer, where possible.
Learning opportunities are maximised and psychological stress reduced by a weekly timetable which combines a variety of clinical activities rather than a prolonged exposure to labour ward activity.
Obstetric units approved for BST have a min. of 3 permanent consultants and 1000 deliveries per yr;
Obstetric units approved for HST have a min. of 4 permanent consultants with a min. of 3000 births per yr.
Hospitals recognised for HST offer a number of sub-specialties or special skills modules.
High intensity gynaecology posts in general hospitals are also recognised for BST & HST.

		Y = Yes			
Activity	**Time**	**Onsite**	**Offsite**	**BST***	**HST***
Research meetings	1 hr per week	Y		Y	Y
Perinatal mortality meetings	2 hrs per month	Y		Y	Y
Journal club	1 hr per week	Y		Y	Y
SPR study days	8 hrs per month		Y		Y
Basic Surgical Skills course	2 days per yr		Y	Y	
ALSO course	2 days per yr		Y		Y
Administrative experience	1 hr per week	Y			Y
Study leave for specific exams or recognised courses	As appropriate		Y	Y	Y
Obstetrics					
Labour ward	24 hours per week minimum	Y		Y	Y
Antenatal ward rounds	1 hour per day	Y		Y	Y
Antenatal clinics	3 hrs per week (min.)	Y		Y	Y
Specialist antenatal clinic	As appropriate	Y			Y
Gynaecology					
Gynaecology operating list	6 hrs per week (min.)	Y		Y	Y
Gynaecology ward rounds	Article I. Half hour per day	Y		Y	Y
Gynaecology clinic	3 hrs per week (minimum)	Y		Y	Y

During HST trainees acquire a portfolio of special skills requiring 3 – 6 hours per week					
Activity	**Time**	**Onsite**	**Offsite**	**BST***	**HST***
Obstetric ultrasound		Y	Y		Y
Gynaecological ultrasound		Y	Y		Y
Colposcopy		Y	Y		Y
Uro-gynaecology		Y	Y		Y
Infertility		Y	Y		Y
Out-patient hysteroscopy		Y	Y		Y
Minimal access surgery		Y	Y		Y
Maternal medicine		Y	Y		

* BST includes Basic Surgical Training, General Professional Training etc
* HST includes Higher Specialist Training/Higher Surgical Training

7. Irish College of General Practitioners

Out-of-hours experience is essential for GP training Close liaison with local GP Training Programme Directing Teams in relation to all aspects of GP training recommended	
Activity	**Time**
Research methodology and application	
Appropriate study leave	
Half-day release (release course teaching based on problem based learning requiring the majority of trainees to be present. GP trainees therefore need to be rostered off at the same time to attend the release course)	Mandatory 0.5 day per week for first 2 years
Full-day release	Mandatory 1 day per week for 3rd and 4th years
Audit	

8. Faculty of Occupational Medicine, RCPI

Trainees in Occupational Medicine normally work a 9 -5, Mon to Fri week as standard and therefore, will be compliant with the EWTD.	
Activity	**Time**
Employment Health Advisers clinic on-site	1.5 days per week
Employment Health Advisers clinic off-site	1 day per week
Health Board Occupational Health Department clinic	1.5 days per week
Out-patient attendance	0.5 days per week
Research activity	0.5 days per week

9. Irish Psychiatric Training Committee Trainees

Regional IPTC MRCPsych. Academic programme for GPT Academic programmes for senior registrars	
Activity	**Time**
Case conferences	
Journal clubs	
Grand rounds	
Personal supervision with educational supervisor	1 hour
Supervision of group and individual psychotherapy classes	
Research days	
Special interest sessions	

10. Faculty of Public Health Medicine, RCPI

The submission from the Faculty of Public Health Medicine concluded that they are EWTD compliant as they do not have NCHDs working on-call.

11. Faculty of Pathology, RCPI

The response from the Faculty of Pathology addressed issues relevant to Part I – General Principles.

Appendix I

Medical Education and Training Group

Terms of Reference

'Having regard to section 3.4.3 of the Report of the National Task Force on Medical Staffing, to examine and report to the Minister for Health and Children on the measures required to:

1. Accommodate NCHD training in all postgraduate training programmes within a 48-hour working week;
2. Facilitate NCHDs in addressing any skills deficits which may hinder entry to the specialist register;
3. Safeguard both training and service delivery during the transition to a 48-hour working week;
4. Identify the barriers to improving graduate retention;
5. Address obstacles to the conduct of academic health research; and
6. Improve access to international training opportunities for Irish doctors in training.

The Group is also asked to consider and make recommendations on:

7. Issues relating to competence-based specialist training;
8. The role of the university sector in postgraduate medical education and training; and
9. The implications of the draft EU Directive on the recognition of professional qualifications as it relates to medical practitioners.

The Group will

10. Engage closely with the appropriate section of the Department of Health and Children to assist it in accommodating the integrated education and training functions proposed by the Task Force within the structures announced by the Government in June 2003 following publication of the Brennan and Prospectus Reports.

The Group will, where appropriate, liaise on other relevant issues with the Department of Health and Children, the Working Group on Undergraduate Medical Education and Training and the Primary Care Task Force.

The Group will undertake any other tasks that may be agreed between the Group and the Minister.'

Membership

CHAIR: Dr. Jane Buttimer
Medical Director Education and Training

Dr. Ruth Barrington
Chief Executive Officer, Health Research Board

Dr. Richard Brennan
Chairperson, Irish College of General Practitioners
(Dr Margaret O'Riordan, Irish College of General Practitioners)

Prof. Gerard Bury
President, Medical Council

Mr. Bernard Carey
Director, Personnel Management and Development, Department of Health and Children

Prof. Anthony Clare
Consultant General Adult Psychiatrist, St. Patrick's Hospital, Dublin

Dr. Deborah Condell
Consultant Histopathologist, Cavan Monaghan General Hospital

Dr. Patricia Fitzsimons
Consultant Radiologist, Sligo General Hospital

Mr. John Gloster
Chief Officer, Postgraduate Medical and Dental Board

Mr. Fergal Costello
Head of Policy and Planning, Higher Education Authority

Mr. Asam Ishtiaq
Senior Registrar, Dept. of Surgery, University College Hospital, Galway

Prof. Gerry Loftus
Consultant Paediatrician, University College Hospital Galway

Mr. Tommie Martin
Chief Executive, Comhairle na nOspidéal, Corrigan House, Fenian Street, Dublin 2

Dr. Eilis McGovern
Consultant Cardio-thoracic Surgeon, St. James's Hospital, Dublin

Prof. T.J. McKenna
Consultant Physician in Endocrinology and Diabetes Mellitus, St. Vincent's University Hospital, Dublin

Mr. Larry O'Reilly
Principal Officer, Department of Health and Children

Mr. Fergal Lynch
Principal Officer, Department of Health and Children

Ms. Mary McKeon
Principal Officer, Department of Finance

Dr. Mick Molloy
Clinical Fellow (Emergency Medicine), St. Vincent's University Hospital, Dublin (nominated by the Irish Medical Organisation)

Mr. Pawan Rajpal
Consultant General Surgeon, Cavan/Monaghan General Hospital (nominated by the Irish Hospital Consultant's Association)

Prof. Arthur Tanner
Dean of Postgraduate Studies, Royal College of Surgeons in Ireland

Dr. Cillian Twomey
Consultant Physician in Geriatric Medicine, Cork University Hospital

APPENDIX II

Documents from The Royal College of Surgeons in Ireland

- European Working Time Directive: A Discussion Document from the Royal College of Surgeons in Ireland
- General Criteria for Recognition of Basic Training Posts by the Royal College of Surgeons in Ireland
- Letter to John Bulfin, National Co-ordinator for Implementation of EWTD re the delivery of teaching and training within Surgery and the European Working Time Directive

EUROPEAN WORKING TIME DIRECTIVE: A DISCUSSION DOCUMENT FROM THE ROYAL COLLEGE OF SURGEONS IN IRELAND

Time Scale

The European Working Time Directive (EWTD) applies to employed workers in the European Community. Doctors in training will only be exempt from the requirements of the Directive until August 2004, when the limit on weekly hours of work will be 58 hours with the application of defined rest periods. By 2009, 48 hours becomes the limit together with specified hours of rest. Presently, senior doctors may opt out of the Directive's requirements. The Royal College of Surgeons in Ireland is concerned that the serious implications of the directive have not been fully appreciated.

RCSI Working Party on the European Working Time Directive

RCSI established a Working Party on the European Working Time Directive (EWTD and asked it to produce a sample roster that would conform to the new EWTD and to identify how within these restricted hours surgical trainees may be offered learning opportunities. A sample roster was designed to work in a unit consisting of a team of at least three Consultant Surgeons. The roster also contains one period of time spent outside of the working environment i.e. the hospital per fortnight acquiring knowledge and skills. It is our view that this time will not be included within the confines of the EWTD. It was the conclusion of the Working Party that the Royal College of Surgeons in Ireland could continue to maintain high standards of surgical training through the aegis of its own teaching environment and through that traditional environment of consultant led teaching within the hospitals resulting in adequate learning opportunities to produce a confident surgeon. This revised approach to learning and teaching will be underpinned by the following:

Making shift patterns work

- Shift working patterns have for many years been criticised due to the inherent weakness of a perceived lack of continuity in patient care. Therefore, on this sample roster, all handover periods commence (or end) with a handover round. Within the concept of team working, all members of this surgical team, from Consultant through to Junior SHO, need to be au fait with the management of all patients under the care of the team.
- New teaching methods will have to be taught to the teachers. RCSI must, therefore, be at the forefront in introducing courses, seminars and discussion groups that will involve all Consultants, who express an interest in being in teaching. There is an implied recognition that not all consultants need or wish to be trainers.
- Different specialties will need to work out new pathways to facilitate their trainees. The pathway to

completion of training maybe directed through greater or lesser exposure to generic training with a variable time point for induction to specialist specific skills.

- The EWTD will inevitably affect service delivery. This was outwith the brief of the Working Party, but it is our belief that many of the traditional aspects of an SHO's role will need to be taken over by other paramedical or medical staff. Patterns of work and ways of providing the service will need more staff.

- Each Consultant team will need an individual within that team charged with responsibility for educational governance. It would be their responsibility to ensure that service pressures, and the impact of policies, such as the EWTD, do not compromise the education, training and continuing professional development of all members of the team.

- Junior trainees may no longer be single institute based. If the signalled changes in healthcare reform take place in Ireland, as suggested, surgical trainees may have to follow the patients for their elective surgical training. Surgical training involving emergency care would take place in the major referral hospital and the care and management of elective surgical patients would be delivered in adjoining hospital units. A consequence of this is that the trainee may no longer be assigned to an individual consultant, but within a group of consultants working as a team. Patients in the future may well have their care provided by "the team of surgeons" rather than have the individualised care by a specific consultant.

- It will be more difficult to provide the opportunities for large group teaching activities, if trainees are working shifts. Trainers will need to continually optimise the potential to structure learning within clinical settings. Learners will need to recognise that at almost every point during the working day there are learning opportunities to be exploited.

- Concepts will have to change! Consider, for example, whether the time-honoured presumption that a business ward round does not involve teaching and hence differentiating between a business round and a teaching round. If the lessons of the business round are succinctly drawn out at the end of the round, does this then become a teaching round? What is the difference between a business round and a teaching round? Perhaps only the name! There is always an opportunity for teaching on almost any aspect of a clinical encounter, be it in the consulting room, in the outpatients, at the bedside or elsewhere in a clinic or operating theatre. This can be lengthy or brief, and may embrace clinical, scientific, psychological, social, ethical or any other domain of medicine.

- There is no place now for the acquisition of the most basic technical skills to be acquired by learning on patients. We must ensure that we have the necessary Basic Surgical Skills and laboratories to teach the rudimentary elements of surgery. It is important to note that time spent in educational activities off site are not counted within the EWTD.

The Royal College of Surgeons in London have released a policy statement on this subject. I believe RCSI should endorse this statement and in particular with regards Ireland emphasise the following points.

Implication for surgery in Ireland

The progressive application of the Directive over the next few years will have profound effects on the delivery and continuity of acute surgical care and the training of tomorrow's surgeons. The RCSI recognises that the Directive is intended to benefit both patients and surgeons and the College believes, both intuitively and with some evidence, that the performance of tired surgeons may endanger patients and, indeed, their own health.

The view of the RCSI

The RCSI feels that it is now timely to make a definitive policy statement bearing in mind that its implementation is only one year away. The RCSI understands the require-

ment to adhere to European Law and realises that a legal relaxation of the explicit rest requirements cannot be achieved in the short term. The College encourages surgeons to look for ways of maintaining safe acute surgical care and safeguarding the training of future surgeons.

What needs to be done

The College believes that:

I. The EWTD is the most important agent for change, in the way in which we train for and practice medicine. It is the major reality that will bring the changes recommended and published in the past by numerous commissions and reports to reform the healthcare service in Ireland, but, for a variety of reasons including patient and political sensitivities, never implemented. Viewed positively the EWTD is a window of opportunity to reform the working of our healthcare system; to improve access for patients to emergency and elective services in all disciplines; to revitalise the teaching and training of young doctors for the betterment of the community they serve. The EWTD is being progressively implemented and no derogation will be granted, so for the first time the imperative for change in the healthcare system at all levels is driven by a piece of legislation that is already becoming a daily reality. As a College we welcome the introduction of the EWTD as an opportunity to introduce service and medical education changes of the highest standard.

II. The impact of the EWTD will be most serious in the small district hospital, but will impact also on larger hospitals.

III. Reconfiguration and redesign of the acute service is inevitable and includes the networking of surgical services. Patient access for local services remains a priority for all involved. The College recognises the political sensitivities of service redesign and reconfiguration.

IV. The College will support the innovative compliant rotas for surgeons that are sensitive to training needs and the quality of life of trainees. Nevertheless, the design of appropriate rotas in small hospitals involved in acute care as currently pertains will be virtually impossible.

V. The Department of Health & Children (DOHC) must be committed to funding an increase in the numbers of doctors in higher surgical training (HST). The EWTD implementation will require more consultant surgeons to provide a safe and effective acute service.

VI. The job plans of consultant surgeons must allow protected teaching and training time in outpatient departments, at the bedside and in the operating theatre. Training future surgeons is an essential part of the service, both now and in the future.

VII. Non-medical members of the surgical team must urgently undergo quality assured training. Their training must allow them to acquire the competencies needed to provide supportive surgical care at night.

Despite a positive approach to the EWTD The Royal College of Surgeons in Ireland remains concerned that the time frame as applied to doctors in training, could compromise safety of surgical care and the training of surgeons. The implementation of the suggestions set out above will go some way towards addressing these concerns.

These documents have been drawn up in an attempt to help liberate learning in the context of a modern healthcare system that includes conforming to the requirements of the EWTD. The Working Party has identified practical learning strategies that can be used within a clinical learning environment throughout the day. The Working Party has largely dealt with educational aspects and does not attempt to describe the service changes that may be required in any depth, but it does appreciate that many changes in the current structure of services will have to occur in parallel with the training changes necessary to conform with the EWTD.

1 December 2003

LEARNING OPPORTUNITIES

Situation	Learning Strategy
Ward Round • Business / daily ward round • Formal ward round	• Bedside Teaching • Discussion • Question / answer • Demonstration • Opportunistic / Experiential teaching • Teaching others • Peer learning • e-learning (where available)
Outpatient Clinic	• Structured Observation • Opportunistic teaching • Question / answer • Demonstration • 1-1 teaching / coaching • Discussion • Experiential • Problem based learning
Special units e.g. endoscopy	• Demonstration • Structured Observation • Experiential • Question / answer • Problem-based learning • Team teaching
Theatre	• Demonstration • Structured Observation • Experiential • Question / answer • Team teaching
On-the-job independent working Opportunistic	• Experiential • Reflective analysis • Discussion (learning from patients and relatives)

LEARNING OPPORTUNITIES (CONT.)

Situation	Learning Strategy
X-ray / pathology meeting	• Case study / case meetings • Discussion • Question / answer • Problem-based learning
CPC / Grand round Multi-professional opportunities	• Case study / case meetings • Lecture • Discussion • Question / answer
Audit Meeting Multi-professional opportunities	• Learning from audit • Project work • Discussion • Case study (analysis) • Significant incident analysis
M & M Meeting Multi-professional opportunities	• Case study • Case debriefing • Significant incident analysis • Discussion • Project work

03.07.03

SAMPLE ROSTER

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Hours
Doctor 1	**7am-1pm** Hand-over rounds. X-ray/pathology meeting OPD	**7am-5pm** Hand-over rounds. CPC/Grand rounds OPD Endoscopy	**7am-8pm** Hand-over rounds. Audit meeting Theatre Rounds & hand-over	**7am-8pm** Hand-over rounds. M & M meeting Theatre Minor ops. Rounds & hand-over	**7am-8pm** Hand-over rounds. Theatre Rounds & hand-over	**OFF**	**OFF**	**55**
Doctor 2	**7pm-8am (Nights)** Hand-over rounds Management of emergencies Rounds & hand-over	**7pm-8am (Nights)** Hand-over rounds Management of emergencies Rounds & hand-over	**7pm-8am (Nights)** Management of emergencies Management of emergencies Rounds & hand-over	**7pm-8am (Nights)** Hand-over rounds Management of emergencies Rounds & hand-over	**OFF**	**OFF**	**OFF**	**52**
Doctor 3	**7am-8pm** Hand-over rounds X-ray/pathology meeting Theatre Rounds & hand-over	**7am-8pm** Hand-over rounds CPC/Grand rounds Theatre Rounds & hand-over	**OFF**	**9am-5pm** Learning (operative skills, theory of surgery, communication skills, personal learning, BeST, etc.) OFF SITE	**7pm-8am (Nights)** Hand-over rounds Management of emergencies Rounds & hand-over	**7pm-8am (Nights)** Hand-over rounds Management of emergencies Rounds & hand-over	**7pm-8am** Hand-over rounds Management of emergencies Rounds & hand-over	**65**

D

SAMPLE ROSTER (CONT.)

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Hours
Doctor 4	**OFF**	**9am-5pm** Learning (operative skills, theory of surgery, communication skills, personal learning, BeST, etc.) OFF SITE	**7am-1pm** Hand-over rounds Audit meeting OPD	**7am-1pm** Hand-over rounds M & M meeting OPD	**7am-5pm** Hand-over rounds Theatre	**7am-8pm** Hand-over rounds Management of emergencies Rounds & hand-over	**7am-8pm** Hand-over rounds Management of emergencies Rounds & hand-over	**56**
Doctor 5	**Study leave**	**Holidays**	**Exams etc.**					
Total hours (4 weeks)								**228**

Based on a team of 3 Consultant Surgeons. **At least** one trainee in theatre and OPD each working day. 5 weeks holiday/leave in 6 months. Average 57 hours per week. Each trainee attends on average one OPD session and two theatre sessions per week.

01.12.03

GENERAL CRITERIA FOR RECOGNITION OF BASIC TRAINING POSTS BY THE ROYAL COLLEGE OF SURGEONS IN IRELAND

I. The post must be in the grade of senior house officer or equivalent.

II. All posts must be in a hospital offering the trainee adequate clinical opportunities for training, through working with consultants who have a commitment to teaching and training, and whose names are on the appropriate specialist register. The unit in which the trainee works must have at least two such consultants, whose combined sessional commitment amounts to at least one whole time equivalent. In the case of individual subspecialties, it may be acceptable to have one consultant, as long as the SHO post forms part of an appropriate wider department. The ratio of consultant to trainee may vary from hospital to hospital depending on circumstances. The ideal ratio is 1 trainer to 1 trainee, with a maximum of 1 trainer to 2 trainees.

III. There must be adequate throughput to offer wide experience across a broad range of conditions and procedures within the specialty. The Individual Training Plan and record of procedures ensure that both trainee and trainer are aware of what is expected from them during each six month period of training.

IV. The post must provide the trainee with experience in the initial assessment, investigation and treatment of a wide range of surgical conditions and in continuing care.

V. The trainee's weekly timetable must provide a balanced programme in accordance with the College Handbook on Basic Surgical Training. As an absolute minimum the programme should include at least two notional half days in theatre, at least one outpatient clinic, and at least one notional half day of protected study time. The programme should provide for formal teaching sessions including ward rounds and departmental seminars, and it should offer some administrative experience in the management of the ward and the operation of the unit.

VI. The trainee should be given opportunity in clinics to investigate and diagnose new patients, and to recommend admissions in consultation with senior colleagues.

VII. The trainee must be given, under supervision, progressive responsibility to perform operative procedures with appropriate assistance from senior members of the team. The experience gained, both as operator and assistant, must be in accordance with the guidelines in the Individual Training Plan (RCSI). The trainee must maintain a log-book of operative experience for regular inspection by consultants and as part of the entry requirements to the AFRCSI Examination.

VIII. The post must provide the trainee with formal educational opportunities. These should include departmental tutorials and case conferences, and X-Ray and pathology meetings where appropriate.

IX. A minimum level of audit is required. Audit may be thought of as review of practice. The most obvious example is morbidity and mortality conferences. These must be comprehensive in that all relevant cases are brought for discussion, i.e., it is non-selective. All of the surgical team, from interns to consultants, must be involved, and a record of attendance will be kept for inspection by the inspection team.

X. The trainee must be allowed prescribed protected study time.

XI. There must be ready access to a library stocked with contemporary surgical textbooks and major journals and also adequate provision within the unit of

"bench books" – reference copies of key publications.

XII. The post should provide opportunities to teach medical students and/or nursing and paramedical staff.

XIII. All units must be located within a hospital offering access to a full range of supporting services including haematology, microbiology, biochemistry, blood transfusion, (intensive care), pathology and radiodiagnosis. There should also be an adjacent general medical unit or adequate alternative arrangements for consultation on medical problems in surgical patients.

XIV. Adequate residential accommodation and sustenance must be available if required during the trainee's period on duty.

XV. Any significant change to the arrangements as set out on the application form seeking recognition of a post must be notified to the College immediately.

LETTER TO JOHN BULFIN, NATIONAL CO-ORDINATOR FOR IMPLEMENTATION OF EWTD RE: THE DELIVERY OF TEACHING AND TRAINING WITHIN SURGERY AND THE EWTD

Mr John Bulfin
National Co-ordinator for Implementation of EWTD
Health Service Employers Agency
63-64 Adelaide Road
Dublin 2

cc Mr Andrew Condon, Acute Hospitals Divisions, Department of Health and Children.
Mr Michael Kelly, Secretary General, Department of Health and Children.
Mr Fintan Hourihan, Irish Medical Organisation IMO House.
Dr Jane Buttimer, Medical Director Postgraduate Education and Training, Department of Health and Children.

27 May 2004

European Working Time Directive

Dear John

The Royal College of Surgeons in Ireland (RCSI) has recently issued guidelines on how teaching and training in Surgery can be delivered in the light of changes imposed upon us by reduced working hours for NCHDs. RCSI is of the view that the principles implicit in the European Working Time Directive (EWTD) are in the best interests of trainees and ultimately the patients. These principles will, however, require a different approach to the delivery of teaching and training within Surgery.

The EWTD will inevitably require a change in rostering for surgical trainees. We do not believe that "one size fits all" and, therefore, it is our view that different grades of trainee and different subspecialties of Surgery will require different approaches to rostering. We have already published a sample roster for trainees who must spend their time on site while on call. This roster includes implicit and explicit training opportunities. It is our view that this roster is applicable in the main to NCHDs at the Basic Surgical Training (BST) level.

As regards higher surgical trainees, also known as Senior Specialist Registrars in Surgery (SpRs), we believe that they represent a group who have already gained considerable clinical experience in the acquisition of their surgical skills. The aim of training at Higher Surgical Training (HST) level is to create a Consultant, who is "fit for purpose" in this country. Differentiating "service provision" from "training" is therefore somewhat artificial as both issues are inextricably linked. Equally, as emergency management of surgical patients is distinct from, although obviously related to, experience gained in elective settings, there is considerable educational benefit to the trainee in being "on call" for their specialty discipline. For these reasons, it is essential that the working hours of a higher surgical trainee are concentrated around the time of maximal departmental activity. Until infrastructure and changes in the number of Consultants are otherwise established, the majority of HST working hours must therefore be rostered between the hours of 7am and 8pm. We believe there to be much merit in the concept espoused in the United Kingdom of the "hospital at night", but this will require major infrastructural changes within our hospitals. Until then, and in accordance with NCEPOD recommendations, emergency operations should be facilitated during periods of full hospital activity and out of hours operating should be kept to a minimum. This will, of course, require the provision of dedicated emergency theatres during the working day.

In consultation with higher surgical trainees in all the subspecialty disciplines of surgery, we would like to make the following recommendations regarding rosters and training opportunities.

The Concept of Surgical Training

It is well accepted that responsible surgical practice requires elements of clinical knowledge and technical skill which are acquired through both study and experience. While much training in the basic technical aspects of surgical practice, including basic dexterity skill acquisition, can be performed outside of the operating theatre, advanced technical skill, surgical responsibility and appropriate judgement in the performance of surgical procedures, as well as the ability to adapt to unforeseen or unusual intraoperative circumstances, are acquired largely through experience and practice. Through clinical experience a deeper understanding of theory emerges which leads to an intuitive understanding as to 'on whom, how and when' to operate. The experienced trained surgeon evolves thus from the combination of personal tuition and mentorship. A failure to recognise, and safeguard, these basic tenets would undermines the delivery of high quality surgical practice nationally. Indeed, the imposition of restrictive work practice in the United Kingdom has already had a devastating effect both on the quality and quantity of surgical care provision as well as on the morale of a generation of surgical trainees and consultants.

Suggested references:

(1) *"An EWTD-compliant SpR rotation" Ann RCS, Bulletin, May 04 (164-6)*
(2) *"No more time to train the surgeons" Br Med J 2004; 328: 418-419.*

The Higher Surgical Trainee

As much as the specialty of surgery deserves distinct consideration with regard to the implications of the EWTD, so too does the HST. The HST, or senior specialist registrar, is a non-consultant hospital doctor who is at an advanced stage of surgical training and is therefore considerably and directly involved in the provision of patient care. Additionally, as well as being intrinsically involved in the training of both junior members of medical staff and students, the HST, as a visible and easily accessible member of a hospital's surgical staff, represents an advisor and role model for junior doctors with surgical aspirations.

The HST is also, obviously, a vital part of the mentor: apprentice relationship that currently exists between consultant and trainee. The quality of this relationship is rightly valued by all surgical training bodies and envied by other disciplines. In addition to advancing their own training, this partnership allows the HST to aid and support their consultant practically while in turn learning responsibility in clinical practice. The HST shares responsibility for implementation of individual surgical departmental management and research projects i.e., arrangement of undergraduate and postgraduate education, co-coordination of meetings and regular clinical audit presentations, as is now practiced in most units nationwide.

To focus EWTD implementation entirely on training issues to the exclusion of the other roles of the HST serves only to diminish one of the great traditional strengths of Irish surgery. Furthermore, in artificially distinguishing "work" from "training" as a means of allowing activities to be excluded from working hour calculation only reinvents old and now discarded systems of work practice. Thus, the opportunity to improve upon traditional systems would be lost.
For these reasons, the unique role and activity of the HST should be recognized in the introduction of EWTD-compliant rosters in that HSTs should be not only facilitated but in fact encouraged to be present at the core of surgical departmental activity in their hospitals.

Future manpower requirements

The purpose of surgical training is to provide consultants who are "fit for purpose". If the desires of the Department of Health to provide a consultant-delivered service are to be realized and the required expansion in consultant numbers that this entails is to be facilitated,

there is currently a great need in the short-term to allow HSTs to continue to intensively train. It is essential, therefore, that EWTD compliant rosters hold training requirements at their core. As the health service develops toward larger designated acute centres of high activity, sufficient caseload and case mix can indeed be experienced in a more restricted time frame. Injudicious expansion of trainee numbers to allow immediate EWTD compliance is ultimately a counterproductive step as it will dilute available training opportunities, create new difficulties in how best to preserve continuity of patient care and undermine the recommendations of previous expert groups to move away from the undue reliance of the current Irish hospital system on junior doctors. As a principle therefore, we submit that, with regard to EWTD-compliant rosters, the working time of the HST should be concentrated around the time of maximal surgical departmental activity.

Elective surgical service provision and training

Until the resources to provide full outpatient and day ward facilities as well as operating theatre services at night time and weekends are made available ('hospital at night'), the HST should be present as required between 7am and 77 pm Monday to Friday. In order to provide an adequate level of patient throughput, sufficient to allow both maintenance of service delivery and appropriate elective caseload for training purposes, day ward and operating theatre efficiency requires to be maximized. Day wards should therefore open between 7 am and 7 pm and turnover their bed usage twice daily; while operating theatre commencement time punctuality needs to be improved and the standard operating day extended. Portering and paramedical services such as phlebotomy and laboratory analysis should also be prioritised towards facilitating the surgical timetable. Equally, emergency surgical admissions should be prioritized and fast-tracked through the Accident and Emergency system.

Emergency service provision and training

Provision of a number of dedicated acute surgical theatres per major hospital with an extended working day would allow the vast majority of operating at night to be avoided (a point consistent with NCEPOD recommendations) and therefore would alleviate the 'need' for surgical specialists to be on-site 'out of hours' for prolonged periods of time other than for the management of true surgical emergencies. For example, the requirement of the HST for emergency operative experience could be facilitated by appointing one HST in each of the disciplines of general surgery and orthopaedics to acute surgery theatres and to be available exclusively for emergency work for an extended period of time (e.g. 8.00-20.00 hrs). The emergency work of other subspecialties (e.g. ENT, plastics etc) could be facilitated in acute surgery theatres or as appropriate on subsequent elective lists.

HSTs would then not be required to be in-house on call at night-time (after 7pm) as HSTs in a hospital (or region) could rotate their emergency cover duties on a rotational basis. Thus in a team with 7 HSTs, with one permanently absent at any one time, the remaining five weeks (working 7 am to 7 pm = 55 hr week) would be spent working with their designated surgical team without interruption by emergency workload. Finally it should be recognized that on-site cover for surgical patients later at night, not requiring critical decisions or surgical intervention should be capably managed by basic surgical trainees (in consultation with off-site senior surgical colleagues).

It is therefore unnecessary for senior surgical staff (consultants or HSTs) to remain on-site all night with current hospital structures and to do so would be an inefficient use of manpower and expertise at a period of relative inactivity. HSTs should be available on rostered standby off-site for "life and limb threatening" emergent cases that require urgent review and/or operation. Surgical cross-specialty cover is possible at more junior levels, but cross-cover of subspecialties at more senior levels makes a mockery of the concept and benefits of specialization and specialist training.

EWTD compliance

Such a system as detailed above allows for 11 hours of rest time following a rostered shift, saving for extraordinary call-outs which would be compensated for during the remainder of the week and averaging a 58 hour working week over a six week period. It does however require a degree of horizontal cooperation between HSTs, and a concentration of HSTs (7 to allow for study and annual leave) in an acute surgical referral centre (whether a single hospital, or a shared-call rotation between hospitals).

This proposal is consistent with the recommendations of the Hanly report into reform of the Irish health service. It requires that HSTs pursuing a specific specialization continue to train and provide service generally. This is consistent with the continuing need in the Irish health care systems to have consultants who are capable of doing general on-call in addition to their specialist role. This reformed system would however allow the HST to continue to be involved in all aspects of their department's activities (including teaching of junior staff and multidisciplinary conferences) during their off-call week without artificially excluding these activities from their "working week" Lastly, it requires that consultant-cover (perhaps alternating) be available for the emergency theatre and that the consultant on call works with HSTs in the spirit of a team based approach.

Accident and Emergency Care

Implementation of this system requires expansion of the role of A&E services, and includes early assessment of emergency patients by senior diagnosticians, facilities for expediting surgical patient investigations and early access to inpatient beds to those likely to require operation. Furthermore, A&E departments should take full responsibility for the initial care of critical injured patients rather than depending on multidisciplinary trauma teams. Directed specialty care should be sought after initial stabilization of the patient.

Emergency Medicine as a specialty already functions successfully on a shift-work system as the majority of its workload does not depend greatly on continuity of patient care but instead aims to either appropriately manage and then discharge the patient or, alternatively, handover to specialist care. This fundamental difference between this discipline and surgical services should allow considerable and reciprocal support systems to be developed between these separate but complementary departments. Basic and intermediate level trainees are currently encouraged to rotate through A&E departments. This should become mandatory but their appointment on a surgical scheme should be a point of distinction allowing them to focus their attention on acute surgical or trauma cases. Furthermore, junior surgical trainees in emergency departments should be encouraged to attend and assist at operations of the patients in whose triage they were involved.

Paramedical support services

As outlined above, paramedical services need to be extended both in number and availability. Radiological reports and films should be more easily available through the provision of extra clerical staff and systems underlying the ordering of tests needs to be streamlined.

(a) IT development and support

The development of digital imaging networks may allow additional off-site support to become available for acute referrals from A&E, and other sources, where required (e.g. incorporation of radiological or neurosurgical expertise). In addition, in keeping with RCSI's pioneering role in the developing e-Learning integrated electronic teaching and clinical activity monitoring, we would encourage development of uniform national hospital IT systems. It is currently unclear why different institutions vary so much in the systems utilised. Much time is wasted in retraining junior medical staff, every time they rotate to a different site. In addition to access to academic literature search services, access to electronic

texts and journals, should be arranged countrywide for all trainees of all grades. Logistical PDA based support, for clinical work, and activity logs could also be further developed and utilisation of plug in PDA textbooks would provide better access to information. Such packages could be devised by the training bodies and RCSI and would not require major capital outlay.

Basic surgical training

On the wider issue of Basic Surgical Training a move towards a greater degree of shift-work type rosters seems likely. However, this would have the advantage of allowing pursuance of higher academic degrees and research to be incorporated in parallel to clinical work and training during BST. This could obviate the current need to abscond from clinical training for a period of up to two years to achieve academic honours. Additionally, greater amounts of free time at this level could be well spent involved in out-of-hours training on bench models and simulators, a move that will greatly be facilitated by the development of our National Surgical Skills Centre. Although restricted working time may require the length of BST to be extended to three or four years (with perhaps discrimination into junior and senior basic trainees) the advantage to this would be a seamless transition to HST and could be facilitated without the need for the period of time spent in uncertainty inherent in the current system. Furthermore, incorporation of this "lost tribe" into the ranks of the BST would allow surgical services to continue to be effectively staffed without huge increases in the numbers appointed to training schemes.

Competency based certification

Moves towards judging progression through training schemes and, ultimately, certification of completion of training by means of competency based assessment rather than the current 'time-based' system will be welcomed by surgical trainees. We continue to support the principle that specialist certification be granted on the basis of certified training rotation, assessed competency and successful completion of intercollegiate examination (where appropriate).

In summary, therefore, we recommend the following.

On-call rostering

The majority of higher surgical training programmes do not require mandatory on-site on-call for training purposes. Practices where this exists are in general solely providing a service that could be performed by other disciplines already rostered in house. It may be appropriate for some of the higher surgical specialities to adopt in-house on-call rosters on a shift-based system (e.g. Cardiothoracic, Neurosurgery etc) on an exceptional basis. However, cross-cover between subspecialties at HST level is not in the best interest of either patient or trainee.

Off-site call is not Working Time

We believe that all off-site on-call time should not be included or accounted as "Working Time". This corresponds to the recent European Court findings in the Jaeger and SiMAP cases. This policy should be maintained independently of any remuneration issues and would significantly reduce "Working Time" calculations towards required EWTD levels. We, furthermore, suggest that the reference period for averaging working time be increased to 26 weeks so that, during a 6 month block, study leave, conference leave, training days and exam leave can be included to reduce the overall average "Working Time".

Work Practices

Currently, the majority of evening and night-time surgery is performed on cases not classified as limb or life threatening emergencies. The surgery is often performed to clear, or prevent, a backlog of cases. This practice is contrary to the recommendations of the

NCEPOD report whereby all late operating and night time procedures should only be performed if absolutely mandatory. We therefore suggest a few strategies to reduce this necessity.

- Commence Operating Lists Earlier

The Royal College of Anaesthesia has suggested fundamental changes to regular working days during the daytime hours between 8am and 10pm with theatre lists commencing at 8am. Such recommendations should be adopted.

- Keep all available theatres running longer.

Workplace staffing practices in many institutions ensure that theatres close as soon as scheduled lists are completed. This is done to reduce the requirement for theatre nursing and ancillary staff. If theatres could continue to be utilised for longer periods, e.g. 8.00-20.00hrs, it would virtually eliminate the need for out-of-hours surgery. The benefit of this for patient care, higher intensity of surgical training and more efficient use of resources is clearly evident. However, although we do recognise that there will be difficulties in implementing this, we would see this as a first step towards providing 24 / 7 healthcare as envisaged in the Hanly report. Other possibilities include the early extension of the normal working week to 6 days out of 7.

- In addition to improved utilisation of current resources as a means of reducing out-of-hours work, we believe that the in-house Emergency Department staff could provide overnight management of relatively non-urgent cases with the off-site higher surgical trainees taking over further management in the morning. Of course, off-site higher surgical trainees would respond immediately to lead in the management of emergency situations that threaten life or limb. Furthermore, all on-call HSTs would need to remain in-house during daytime hours when hospital activities continue to be at their maximum.
- Finally, compulsory "Rest Periods" immediately following rostered working time may adversely affect continuity of care for patients. Time off in compensation for hours worked on call should instead be taken at the soonest convenient time. The College therefore is seeking written assurances from the Department of Health and Children and the H.S.E.A ensuring that no higher surgical trainee would be prevented by hospital authorities / risk managers from attending morning rounds or conferences after completing 13 hours of continuous "working time".

It is essential that surgeons (both consultants and trainees) take a lead role in the development of new work practises in this challenging new era. Newly devised rosters should not be based solely on increased higher surgical trainee numbers but should act to maintain current caseload and case-mix in more efficient manners. We would envisage that this can enhance training as the intensity of clinical and operative experience during "working time" would be increased and late night "service work" would be diminished for the benefit of both trainee and patient.

How should we adapt current work practices towards EWTD compliance?

In general, most SpRs in Surgery are almost compliant in their work practices, if their on call duties are performed on an off site basis. On call service provision by HSTs, therefore, could be continued in a similar fashion to that which currently obtains, if working time outside of these activities can be minimised. In particular, relief through delegation or deferral of elective non-essential duties during the "day on call" will allow the work performed on that day to be interspersed with frequent rest periods. This practice will alleviate the need to take obligatory, prolonged compensatory rest at the expense of being absent from the vital activities (as opposed to the non-essential duties) of a surgical department. In the unusual event of prolonged continuous presence in house when on call being mandated, however, the HST will obviously be required to take a compensatory rest period at the earliest convenient opportunity.

This will require each surgical department to examine their weekly schedules and determine what the activities that require attendance of the HST are. On call rostering will have to be planned in order to allow the HST attend these activities. An example of this is that the HST should not be on call at a time they have has a planned single or twin operating list with the Consultant.

Much of the time spent on site on call at present is inefficient and is caused either by an overrun of elective operating lists or lack of suitable anaesthetic expertise. Working time means any period during which the doctor is working at the employer's disposal, and at a place determined by the employer. It is the view of RCSI, therefore, that time spent in the hospital building in pursuit of self-directed educational activity, such as writing up a thesis, studying evidence based medicine in a journal, etc., would not be deemed working time despite the fact that the doctor might be "on call".

It is obvious from the above that there will be different requirements for rosters within different departments and different specialties. It is preferable, therefore, that surgical departments, after close consultations with HSTs and the approval of RCSI take a lead role in all rostering issues. Furthermore, we would propose that a central national review forum should be established with broad membership representation in order to allow examination of individual and / or departmental difficulties with EWTD compliance.

Finally, might we suggest how some rosters could be organised?

Suggested HST 1–in-4, Offsite call

Week	Mon	Tues	Wed	Thur	Fri	Sat	Sun	Hours
1	B	A	A/T	A	B	C	C	78
2	A	A	A/T	B	A	-	-	50
3	A	A/T	B	A	A	-	-	50
4	A	B	A/T	A	A	-	-	50

Average working week 57 hours

A = 07.00-18.00=11- 1 hour (rest/food) =10 hours

A/T= 07.00-13.00=6 hrs working time and afternoon training time -not included in working time

B = on call week night, 07.00 to 12.00 on site, then off-site rest / study period allows response acute trauma referral, allowing 8-9 hours accumulated time onsite, and 11 hours accumulated rest, over the full 24 hour period.

C = extended weekend day on-call , typically fragmented on-site day e.g. 08.30- 13.30, 4.5 hours for rounds and OR with a rest break, then later on-site working time will average 5-7 hours, typical total 10-12 hours on-site with 12-14 hours offsite accumulated rest.

The potential problems lie in the length of on call on the week nights, too long spent on-site, the required rest period of a minimum 11 hours. There is no bar to off-site call in terms of hours.

One solution, as we see it, is to build in an off-site period earlier in the SpR on-call day. The SpR may be studying, resting, doing research or any activity but clinical work (this can be shared with the rest of the team, it is a 'bleep free' period.

Suggested HST 1–in-6 Offsite call

Week	Mon	Tues	Wed	Thur	Fri	Sat	Sun	Hours
1	A	A	A/T	A	B	C	C	75
2	A	A	A/T	A	A	-	-	46
3	A	A	A/T	B	A	-	-	49
4	A	A/T	B	A	A	-	-	49
5	A	B	A/T	A	A	-	-	49
6	B	A	A/T	A	A	-	-	49

Using formula as above for **ABC** and **A/T**

Averaged working weekly hours = **53 hrs**

Suggested HST 1–in-6 Offsite call (with leave included)

Effectively this is a roster with 5 Registrars onsite

Week	Mon	Tues	Wed	Thur	Fri	Sat	Sun	Hours
1	A	A	A/T	A	B	C	C	75
2	A	A	A/T	B	A	-	-	49
3	L	L	L	L	L	-	-	39L
4	A	A/T	B	A	A	-	-	49
5	A	B	A/T	A	A	-	-	49
6	B	A	A/T	A	A	-	-	49

Using formula as above for **ABC** and **A/T**

If the leave L is included in effective working time
Averaged working weekly hours = **51.6 hrs**
If the leave is excluded in effective working time
Averaged working weekly hours = **45.1 hrs**

SAMPLE ROSTER A:

(Based on a 1 in 4 rotation)

Week	Mon	Tues	Wed	Thur	Fri	Sat	Sun	Hours
1	B	A	A/T	A	B	C	C	78
2	A	A	A/T	B	A	-	-	50
3	A	A	B	A	A	-	-	54
4	A	B	A/T	A	A	-	-	50

Average working week 58 hours

A = 07.00-18.00=11- 1 hour (rest/food) =10 hours

A/T = 07.00-13.00=6 hrs working time and afternoon training time -not included in working time

B = on call week night 07.00 to 21.00 or 22.00 = approximately 13 hours onsite (allowing time for rest/food)

C = extended weekend day on-call , typically on site 08.30- 13.30, 5 hours for rounds and OR , then later on-site working time will average 5-7 hours, total 10-12 hours on-site with 12-14 hours offsite.

The potential problems lie in the length of on call on the week nights, too long spent on-site, the required rest period of a minimum 11 hours. There is no bar to off-site call in terms of hours. Also, if the rota goes to 1 in 3, or 1 in 2, it clearly requires more nights on call and therefore will exceed 58 hours. Effectively 1 registrar is excluded from the rota by annual leave/ study leave for 16 to 20 weeks every 26 months.

SAMPLE ROSTER B:

(1–in-6 Offsite call)
(Annual leave included- effectively a roster with 5 working registrars)

Week	Mon	Tues	Wed	Thur	Fri	Sat	Sun	Hours
1	A	A	A/T	A	B	C	C	75
2	A	A	A/T	B	A	-	-	49
3	L	L	L	L	L	-	-	39L
4	A	A/T	B	A	A	-	-	49
5	A	B	A/T	A	A	-	-	49
6	B	A	A/T	A	A	-	-	49

Using formula as above for ABC and A/T
If the leave L is included in effective working time, averaged working weekly hours = 51.6 hrs.
If the leave is excluded in effective working time, averaged working weekly hours = 45.1 hrs.

SAMPLE ROSTER C:

(1:6 Rota)
(One day protected Study/Research per Week not included in hours calculation).
Conferences not included in working time calculations (4 hours per week). Three weeks annual leave per six months +/- study leave. Time spent in hospital on call will count towards 48 hours but will be offset by 44 hour core week and averaging including leave periods.

	Mon	Tues	Wed	Thur	Fri	Sat	Sun
WEEK 1	7-7 On call	7-7	9-5 Research	7-7	7-7		On call
WEEK 2	7-7	7-7 On call	9-5 Research	7-7	7-7		
WEEK 3	7-7	7-7	9-5 Research On call	7-7	9-5 Research		
WEEK 4	7-7	7-7	9-5 Research	7-7 On call	7-7		
WEEK 5	7-7	7-7	9-5 Research	7-7	7-7 On call		
WEEK 6	7-7	7-7	9-5 Research	7-7	7-7	On call	
WEEK 7	Leave	Leave	Leave	Leave	Leave		

Sample rostered working week for the Senior Specialist Registrar in a General Surgical or Orthopaedic Department.

<table>
<tr><th>Time</th><th>Monday</th><th>Tuesday</th><th>Wednesday</th><th>Thursday</th><th>Friday</th></tr>
<tr><td>7.00</td><td>Handover Ward Round</td><td>Handover Ward Round</td><td>Handover Ward Round</td><td>Handover Ward Round</td><td>Handover Ward Round</td></tr>
<tr><td>7.30</td><td>X-ray conference</td><td rowspan="6">Trauma Operating theatre</td><td>Case conference</td><td rowspan="6">Elective Operating theatre</td><td rowspan="3">Outpatients clinic</td></tr>
<tr><td>8.30</td><td rowspan="4">Outpatients clinic</td><td rowspan="5">Outpatients clinic</td></tr>
<tr><td>10.30</td></tr>
<tr><td>11.30</td></tr>
<tr><td>12.00</td></tr>
<tr><td>12.30</td><td>Lunch</td></tr>
<tr><td>13.30</td><td rowspan="2">Research
Off-site on call</td><td rowspan="2">TRAINING-Core curriculum</td><td rowspan="2">Outpatients clinic</td></tr>
<tr><td>15.00</td></tr>
<tr><td>17.30</td><td>Handover Ward Round
Off-site on call</td><td>Handover Ward Round</td><td>Handover Ward Round</td><td>Handover Ward Round</td><td rowspan="2">Handover Ward Round
Off duty</td></tr>
<tr><td>17.30-07.00</td><td>Off duty</td><td>Off duty</td><td>Off duty</td></tr>
</table>

Essential activity *Non-essential activity* Available for emergency
Weekly working time = 47 hours (weekend on-call will increase the averaged hours/week)
If time spent in-house on call on exceeds 11 hours, compensatory rest will have to be allowed at the expense of time spent performing non-essential departmental activity

In the event that increased theatre time comes available, lists can be staffed by surgeons working a, rostered long days (07.00-20.00), the benefit of this would be to reduce requirement for further activity, and on-site time late at night. Other options for reducing effective working hours could include rostering in increased training time T and Study days; there is much scope for creating such rosters. Indeed any rosters suggested above can be easily altered according to individual departmental needs. We do suggest however, that the underlying principles (as outlined in the preceding document) along with a genuine enthusiasm for work practise reform are fundamental necessity, for such rosters to work.

Finally these daily work sheets (see over) suggest how 3 HSTs could cover a surgical department.

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
7.00	Handover Round	Handover Round	Handover Round	Handover Round	Handover Round	Standby	
8.00	Operating theatre	*Ward duties*	X-ray conf	**Operating theatre**	**Outpatients clinic**		
9.00			*Ward duties*				
10.00						Handover Round	
11.00							
12.00							
13.00		Standby	Pathology conference		*Ward duties*		
14.00			**Outpatients clinic**				
15.00							
16.00	Handover Round			Standby	Handover Round		
17.00		Handover Round	Handover Round	Handover Round			
18.00		Standby		Standby			

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
7.00	Handover Round	Handover Round	Handover Round	Handover Round	Handover Round		Standby
8.00	Operating theatre	*Ward duties*	**X-ray conf**	**Operating theatre**	**Outpatients clinic**		
9.00			*Ward duties*				
10.00						Handover Round	
11.00						Standby	
12.00							
13.00			Path conf		*Ward duties*		
14.00			**Outpatients clinic**				
15.00							
16.00	Standby	Handover Round			Handover Round		
17.00	Handover Round		Handover Round	Handover Round			
18.00	Standby						

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
7.00	Handover Round	Handover Round	Handover Round	Handover Round	Handover Round	Standby	
8.00	Operating theatre	*Ward duties*	**X-ray conf**	**Operating theatre**	**Outpatients clinic**		
9.00			Standby				
10.00						Handover Round	
11.00							
12.00							
13.00			Path conf		*Ward duties*		
14.00			**Outpatients Clinic**				
15.00							
16.00	Handover Round			Handover Round	Handover Round		
17.00		Handover Round	Handover Round		Standby		
18.00			Standby				

Should you require any clarification on any points raised in this document do not hesitate to contact me

Kind regards

Yours sincerely

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W Arthur Tanner MD, FRCSI, FRCSEd, FFSEM.

APPENDIX E

National Task Force on Medical Staffing

Flexible Training Strategy
July 2003

CONTENTS

Acknowledgements

The Medical Education and Training Project Group of the National Task Force on Medical Staffing wishes to acknowledge the assistance of the Postgraduate Medical and Dental Board and its Director of Flexible Training, Dr. W.T. Blunnie.

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The Group would also like to thank Ms. Siobhán Doyle of the Task Force secretariat who provided substantial assistance in the literature retrieval.

Executive Summary

1. The Flexible Training Strategy, while endorsing flexible/part-time options recognises that the preferred option for the majority of doctors-in-training and consultants is most likely to continue to be full-time training and work. This may become increasingly attractive when the forty-eight hour week is implemented. However, given the increasing interest in balancing work/life commitments, the need to retain graduates and the increasing number of female graduates there is a need for better access to flexible/part-time training and work in Ireland. The Task Force considers that this can best be delivered by the commitment of all stakeholders to a Flexible Training Strategy (para 1.1).

2. The aim of the Flexible Training Strategy is the provision of an adequate number of flexible training posts to facilitate doctors-in-training in Ireland who have a requirement for part-time training, where compatible with service needs. There should, in turn, be a number of flexible permanent posts in order to provide career opportunities for doctors with these requirements. By enhancing the work/life environment, more doctors will be encouraged to remain in the health care sector (para 1.2).

3. Prior to the establishment of the Postgraduate Medical and Dental Board (PGMDB) Flexible Hours Scheme, the options for flexible training in Ireland were negligible apart from the Public Health Medicine specialty. The Task Force recommends a major increase in the proportion of training posts that are flexible / part-time and highlights the need for a strategy to drive the change (para 1.1).

4. The Strategy refers to the requirements for flexible training under European law EU Directive EC 93/16/EEC 2 and defines a flexible trainee as a doctor in training who works less than full time but at least 50% of the full time hours. Flexible training can be one post shared by two people, or one person occupying part of a post (para 1.3).

5. The need for flexible training and work is substantiated in the Strategy by the following:
   - Implications for having a large number of female graduates (56% in the period 1997 – 2001) (para 2.1.1).
   - The international trend for the workforce's desire to balance work/life commitments (para 2.1.3).
   - Some doctors have special needs (para 2.1.3).
   - An anticipated increase in the number of specialists* (para 2.1.4).
   - Potential losses of specialists* to other Health Care systems (para 2.2.2)

6. The national and international experience is reviewed. This includes policies and practices in various countries, the criteria for acceptance on flexible training programmes and the barriers experienced (para 2.2). Substantial efforts will need to be made at all levels of specialist training to meet the goal.

   Ireland has a relatively small number of flexible trainees in comparison to countries such as UK, Australia, New Zealand, Sweden and Switzerland (para. 2.2.4, para. 2.6.5). As a direct result of the PGMDB scheme

* The term "specialist" as used throughout this document includes consultants, general practitioners, public health and occupational medical specialists.

2.4% of the total number of SpR/SnR are in flexible training in the country as at 1st January, 2003. At present, this scheme only applies to Higher Specialist Training but should be extended to all grades (para 2.6.6).

7. The Strategy identifies the need for
   - Leadership and commitment to the Flexible Training Strategy at national, regional and local level (para 3.1).
   - Unified national, regional and local policies where the government, employers and training bodies are committed to the success of the scheme at internship, initial and higher specialist training level[10,21,22] (para 3.1).
   - A significant cultural and attitudinal change amongst all stakeholders (para 3.1).
   - On-going incremental increase in the funding of the Postgraduate Medical and Dental Board flexible training scheme to enable the development of flexible training in line with the strategy (para 3.2).
   - More detailed tracking and monitoring of graduates who are in specialist training /work so that the benefits of flexible training / working can be quantified.
   - Specific responsibilities for each of the main stakeholders (para 3.2 - 3.5)
   - A structure to facilitate specialists who have completed flexible training and awaiting appointment to a flexible specialist* post (para 3.7.1)
   - Flexible specialist* posts (para 3.7.2)
   - Retraining facilitated for doctors who wish to re-enter the workforce (para 3.7.2)

8. The Task Force recommends that, given the rising trend in the percentage of women medical graduates and the anticipated expansion in the specialist* workforce, it is urgent that a flexible training / work strategy is adopted and implemented. This should be phased in, and together with the service implications, be closely monitored (para 3.8)

National Task Force on Medical Staffing

FLEXIBLE TRAINING STRATEGY

1. Background and Goal of Flexible Training Strategy

1.1 Introduction

The strategy set out in this document for developing further a more flexible medical training and working environment was prepared by the Task Force's Medical Education and Training (MET) Project Group and is endorsed by the National Task Force on Medical Staffing. In August 2002, the MET Group, in its Interim Report1 to the Task Force, recommended a major increase in the proportion of training posts that are flexible / part-time and identified some of the central issues which need to be addressed including:

- A need for a strategy for flexible / part-time training including career progression and other family friendly practices
- A change of culture to enable the development of flexible /part-time training and working
- A reduction in the high attrition rate of doctors
- Identifying the policy and plans of the major stakeholders on flexible working and training
- Identifying the extent of flexibility currently evident in the workforce
- The need to establish an understanding of the issues surrounding vocational choice, medical training and current workforce flexibility from the doctors' perspective.

Given the increasing emphasis on work-life balance and the rising trend in female medical graduates, it is essential that policies and plans are in place in order to retain medical graduates in the system and optimise their career potential. While acknowledging that full time training/work will remain the choice of the majority of doctors, some will want or need to train and work in a more flexible environment. Full-time trainees/con-

* The term "specialist" as used throughout this document includes consultants, general practitioners, public health and occupational medical specialists.

sultants should not be treated less favourably than those those who opt for flexible/part-time training and working.

Prior to the introduction of the Postgraduate Medical and Dental Board (PGMDB) Flexible Training Scheme, the options for flexible training in Ireland were practically non-existent, except in Public Health Medicine. The Report of the National Task Force on Medical Staffing (June 2003) endorses the PGMDB's approach in having identical entry criteria for full-time and flexible training programmes.

The goal of this strategy is to make part-time, flexible training, job-sharing and other family friendly practices a legitimate and accessible option for all doctors. It identifies the key issues which need to be addressed by the stakeholders and highlights the major cultural shift required to implement the strategy.

The Task Force Report recommends that
- The Flexible Training Strategy be adopted and adequately resourced, and be implemented by all stakeholders
- An adequate number of flexible training/working posts should be developed to facilitate doctors in training who have a requirement for part-time training/working, taking account of service needs
- A retraining/re-entry system be developed
- The Flexible Training Strategy should be phased in and, together with the implications for services and the introduction of a 48-hour week, should be closely monitored.

1.2 Aim

The aim of the Flexible Training Strategy is the provision of an adequate number of flexible training posts to facilitate doctors-in-training in Ireland who have a requirement for part-time training, taking account of service needs. There should, in turn, be a number of flexible permanent posts in order to provide career opportunities for doctors with these requirements. By enhancing the work/life environment, more doctors will be encouraged to remain in the health care sector. All medical graduates who wish to work in Ireland should have the prospect of a career with a quality work/life environment. Flexible training and work are key ingredients.

The objectives are to:
- Retain doctors who are unable to train full-time by enabling them to train on a half time basis at minimum
- Maintain a balance between flexible arrangements and service needs.

Fundamental to the achievement of these objectives are the provision of:
- Organised training slots to accommodate flexible training
- A structure to facilitate specialists who have completed flexible training and awaiting appointment to a flexible permanent post
- Flexible specialist posts
- Retraining facilitated for doctors who wish to re-enter the workforce
- Definition of flexible training

1.3 Legislation

European law EU Directive EC 93/16/EEC[2] does not require member states to provide part-time opportunities, but lays down conditions to which part-time training must comply. It places the obligation on the competent authorities (Medical Council) to ensure that the total duration and quality of part-time training of specialists are not less than those of full-time trainees. It must constitute at least 50% of the weekly programme of trainees in full time training for all specialties. A trainee must demonstrate that they have "well founded reasons" which prevent them from training full time. Doctors working less that 50% full time cannot be accredited for training, but allowances could be made to allow career breaks etc.

1.4 Definition

It is essential that there is a clear working definition of what constitutes flexible training. In all circumstances the duration and quality of training must comply with European Law. A suggested definition is as follows:

A flexible trainee is a doctor in training who works less than full time but at least 50% of the full-time hours. Flexible training can be one post shared by two people or one person occupying part of a post.

2. Irish and International Perspectives

2.1 Trends in Ireland

2.1.1 Several emerging trends have been identified over the last decade in medical training and practice.

The PGMDB have collated data from various sources, which depicts the current situation and trends 4. An extract from the Fourth Report shows that

- 62% of Irish medical undergraduates at 1 January, 2002 were female [Table 1] as compared to 57% in 1996, 51% in 1990 and 45% in 1984
- 56% of new Irish medical graduates in the period 1997 – 2001 were female, compared with 51% in 1991/96 and 47% in 1986/90
- 53% of Irish non-consultant hospital doctors on 1 October, 2002 were female. Just 69 female Irish nationals were employed on 1 October, 2002 in the 624.5 posts available as registrars and house officers in the surgical specialties [Table 2]
- at 1 January, 2002 23% of Hospital Consultants were female; the percentage varied considerably between the specialties e.g. 48% and 36% of Psychiatrists and Pathologists respectively were female, as were 35% of Paediatricians and 29% of Anaesthetists. The corresponding percentages in the other hospitals specialties were much lower viz. Accident and Emergency 10%, Radiology 18%, Obstetrics and Gynaecology 15%, Medicine 14% and Surgery 4% [Table 3]. 59 of the 178 temporary consultants in post as 1 January, 2002 were female
- 28 (29%) of the 97 doctors who commenced consultant practice during 2000 were female; the corresponding percentages for the years 1990-1999 ranged from 18% to 44% with the median being 25% and the mean being 27%
- at least 23% of General Practitioners are female (66% of the persons who commenced General Practice Specialist Training on 1 July, 2001 were female; the percentage female intake in each of the five preceding years ranged from 64 to 74%, with an average of 70%)".

2.1.2 The Comhairle Report on Consultant Staffing 20015 shows that while males traditionally occupied the consultant posts in certain specialities, the percentage of females in all specialities is rising. However the percentage of women in consultant posts is still low relative to their numbers at the more junior levels of the workforce.[6]

2.1.3 Working patterns and family requirements are in many ways incompatible with current training schemes. Internationally there is evidence of a change in young doctors (male and female) attitudes to work.[7,8] Job sharing and flexible training can provide an ideal solution for men or women who wish to train and work part-time, combining family commitments or other interests with their career.[6,7,8,9,10,11] Now, with more than half our new graduates being women, the demand for these posts will rise. Some doctors may have other special needs e.g. doctors with a disability and doctors who may have to care for an elderly or disabled relative.[10,11,16,22]

2.1.4 It is likely that there will be a need for substantial increases in the number of specialists* for the provision of a consultant provided service as envisaged by the Forum Report[12], by the National Task Force on Medical Staffing and the anticipated outcome of the Primary Health Care

Table 1- Undergraduates in Irish Medical Schools in January, 2002

Origin	Female		Male		Total
	No	%	No	%	No
Republic of Ireland	1,147	62	703	38	1,850
Northern Ireland	56	50.45	55	49.55	111
Elsewhere	815	43.4	1,063	56.6	1,878
Totals	**2,018**	**52.57**	**1,821**	**47.43**	**3,839**

Table 2- Male/Female Ratios[4]

Grade	Nationals		Non-Nationals		Totals	
	M	F	M	F	M	F
Sen./Sp. Registrars	52	48	85	15	59	41
Registrars	49	51	87	13	76	24
House Officers	44	56	81	19	65	35
Interns	47	53	61	39	51	49
All Grades	**47**	**53**	**83**	**17**	**66**	**34**

Table 3- Male/Female distribution of Permanent Consultants at 1st January 2002[6]

Specialty	Male No / (%)	Female No / (%)	Total
Accident and Emergency	18 / (90%)	2 / (10%)	20
Anaesthesia	156 / (71%)	63 / (29%)	219
Medicine	218 / (86%)	36 / (14%)	254
Obstetrics and Gynaecology	72 / (85%)	13 / (15%)	85
Paediatrics	51 / (65%)	27 / (35%)	78
Pathology	79 / (64%)	44 / (36%)	123
Psychiatry	105 / (52%)	98 / (48%)	203
Radiology	107 / (82%)	23 / (18%)	130
Surgery	270 / (96%)	12 / (4%)	282
Total	**1,076 / (77%)**	**318 / (23%)**	**1,394**

Strategy Group. It is therefore essential that, in so far as possible, graduates are retained in the system and that the potential of all available doctors is optimised.

2.2 International

2.2.1 The Annual Survey of Flexible Training in the United Kingdom in 2002 showed that[13]

- The overall percentage of flexible trainees (all grades) had risen to 5.03%
- The specialties of Paediatrics, Psychiatry and Anaesthetics had the highest numbers of flexible Specialist Registrars (SpRs)
- The specialties of General Psychiatry, Obstetrics and Gynaecology and General Practice had the highest number of flexible Senior House Officers (SHO)
- There were 150 flexible SpRs with their Certificate of Specialist Training (CCST) in the UK. Nine deaneries were finding that they were needing to extend the "period of grace" of flexible trainees, as they were unable to find consultant posts
- In the majority of deaneries, it was rare for flexible SpRs to convert to full-time training. A relatively large number did so in North and South Thames
- In September 2001 there were 98 trainees in the UK waiting solely for deanery flexible funding.

2.2.2 The recent UK Royal College of Physicians Report highlights that many female doctors cease to practice hospital medicine as the demands of family and home become incompatible with their work. The report highlights the shortage of doctors in the UK to meet the needs of the 10-year plan. They make a number of recommendations, which apply, to men as well as women. These include a recommendation for more flexible working arrangements and for an increase in part-time opportunities and shared consultant appointments, taking full account of the requirements of the post and the need for continuing medical education.[14]

2.2.3 The British Medical Association recently undertook an international study of the extent and availability of flexible training.[15] The results are reproduced here with the kind permission of Ms Sarah Carney of the BMA. The results show that flexible/part-time working is organised in many countries in an ad hoc manner with the practicalities being worked out at a hospital or programme director level, even in EU countries, which are all governed by Council Directive 93/16/EEC.[2]

2.2.4 The percentage of flexible/part-time trainees in the total junior doctor populations in other countries is variable. Australia, New Zealand, Sweden, and Switzerland and the UK report similar percentages. However many countries either have no data or a negligible number of flexible/part-time trainees. See Appendix 3.

2.2.5 A Training and Workplace Flexibility Project is currently being undertaken in Australia. Through this it is hoped to draw up an agreed strategy for part-time work with the medical colleges, hospitals, government and health administrations.

2.2.6 The reasons for the variations and the identified similarities in the schemes are discussed in Appendix 3. The variations relate to the provision of childcare facilities, working hours for full time doctors, supply and demand factors, attitudes and organisation. The similarities relate to demographics, training time and specialty issues.

2.3 Criteria for Acceptance on Flexible Training

The main criteria for acceptance for flexible training in countries where such exist are:

- Child care commitments
- Other family commitments
- Health reasons
- Other major commitments

2.4 Barriers

Experience in other countries shows that there are many barriers to the smooth operation of flexible training schemes.[8,16] From discussions to date it is unlikely that the experience in Ireland is any different. The barriers experienced include:

- Attitudes amongst some employers, training bodies and trainers. This may be reflected in the composition and decisions of interview panels
- The resulting lack of policies, strategies and plans
- The length of time it takes to complete training
- Complex procedures
- Uncertain funding
- The lack of accurate mentoring and advice
- The perception that flexible trainees may lack commitment
- Uncertainty surrounding job contracts and job descriptions
- Uncertainty regarding career prospects
- Variations in the commitment between the specialties e.g. internationally the specialties of public health medicine, psychiatry, paediatrics and general practice have most commonly introduced part-time/flexible training, while other specialities are less inclined to do so
- Flexible posts not integrated in the teams and seen as an "add on".[17]

2.5 Current Irish position

Various recommendations and commitments to flexible /part-time training have been made over the years but there has been little tangible success.[20] In 2002 the Medical Manpower Forum acknowledged that women are significantly under represented at consultant level in Irish hospitals and that there are obstacles to career progression in the paths of women doctors.[12]

2.6 The PGMBD Scheme

2.6.1 In 2002, the Postgraduate Medical and Dental Board (PGMDB) launched a pilot scheme to facilitate Senior/Specialist Registrars who wish to train flexibly.[4] A guide to flexible training is available on the PGMDB's web site (www.pgmdb.ie). The PGMDB has laid down the procedures regarding the application process. Entry is through competition and is judged on merit alone.

2.6.2 The equivalent of ten full time salaries was made available for flexible posts. If the demand is sufficient and the training posts are educationally approved, the PGMDB intend to seek funding to expand the scheme. The process of appointment to accredited higher training programmes is the same for both full time and flexible trainees. The scheme is designed to include supernumerary posts/job sharing and or partnerships in existing posts.

2.6.3 All training bodies have nominated a mentor to liaise with trainees who wish to train flexibly. The scheme is explained in full detail in Appendix 4.

2.6.4 The PGMDB provided the following overview of the scheme to date.[18]

2.6.4.1 *Structure of the scheme*

This scheme is intended for those doctors who would otherwise be lost to the system because of commitments outside work, the care of an elderly relative, for example. There has been much interest in the scheme and to-date ten appointments have been made, with an additional three to take up post in January 2003.

2.6.4.2 *Implementation of the scheme*

From the start, the pilot scheme has been a cross specialty initiative. Two posts were allocated each to Anaesthetics, Obstetrics and Gynaecology, Medicine, Paediatrics, Pathology, Psychiatry, Public Health Medicine, Radiology and Surgery. Two posts were held in reserve. There are a total of twenty part-time posts. These twenty posts may be additional to complement. A trainee can only move into a part-time post once it has been established that his/her current full-time post will not be left vacant. The PGMDB is the fund holder for this scheme. The PGMDB on a monthly basis pays hospitals that employ a flexible trainee under the auspices of this scheme. A part-time post will only be funded if the relevant training body educationally approves it. One year in a flexible post has the same educational recognition as six months in a full-time post.

2.6.4.3 *Experience to date*

Flexible trainees have been appointed in Paediatrics, Obstetrics and Gynaecology, Anaesthesia, Medicine, Pathology, Psychiatry and Occupational Medicine. Paediatrics and Obstetrics and Gynaecology are over subscribed.

2.6.5 Before the introduction of the flexible scheme by the Postgraduate Medical and Dental Board there were only 7 doctors in flexible training posts, five of which were in Public Health Medicine, one in Anaesthesia and one in Occupational Medicine (see MET Survey of the Training Bodies)[20]

2.6.6 In 2002, the PGMDB appointed a part-time Director of Flexible Training (Dr. William P. Blunnie). Dr. Blunnie in his presentation to the MET Group and subsequent discussions recommends that particular emphasis is required on the following in the Strategy[19]:

Flexible training

- Should extend to all grades – internship, senior house officer, registrar, specialist/senior registrar
- Should be better supported by all specialities, particularly within surgical disciplines
- Training bodies should align their current approved posts and then fill a portion of them on a job sharing basis
- In the current culture he advises applicants not to declare their desire to train flexibly until after interview and formal appointment to a SpR/SnR training programme.

2.7 The Challenge

Ireland has a relatively small number of flexible trainees in comparison to countries such as UK, Australia, New Zealand, Sweden and Switzerland. However, as a direct result of the PGMDB scheme on 1st January, 2003, there were 14 SpR/SnR training flexibly, which is 2.4% of the total number of SpR/SnR in the country. Given the rising trend in the percentage of women medical graduates, and the anticipated expansion in the specialist* workforce it is urgent that a flexible training / work strategy, building on the PGMDB pilot scheme, is adopted and implemented.

3. Key Issues - Stakeholders

The following are the key issues that need to be considered with and addressed by the stakeholders:

3.1 Framework

Leadership and commitment to flexible training is required at national, regional and local level. Constant flux militates against the scheme and leads to uncertainty about the viability of the training programme amongst the trainees and trainers and other stakeholders. There is need for unified national, regional and local policies where the government, employers and training bodies

are committed to the success of the scheme at internship, initial and higher specialist training level.[10,21,22] Significant cultural and attitudinal changes amongst all stakeholders is required. Flexible training must take cognisance of the EU Directive[2]. The following are suggested responsibilities which each of the main stakeholders should consider.

3.2 Department of Health and Children

- The Minister for Health and Children to formally adopt the training strategy and promote the development of targets for all training grades
- The 10-year target should be that all who have a requirement for flexible training should be able to avail of flexible training posts, taking into account service needs. This to be phased in gradually and systematically evaluated. (Experience in the UK suggests that a critical mass of at least 6-7% is required)
- There needs to be on going incremental increase in the funding of the Postgraduate Medical and Dental Board flexible training scheme to enable the development of the strategy.

  The current scheme is costing €716,000 and would cost an additional €45,000 for each extra SpR added to it. However, once the scheme has overcome the constraints and the Strategy adopted future posts would not be supernumerary but would be subsumed into the allotted training posts with a slight adjustment in the cost, depending on the type of flexible training available, e.g. 2 doctors-in-training attending for 3 days a week each will cost proportionately more than 2 doctors-in-training attending for 2.5 days a week each. These costs will need to be closely monitored as the scheme expands.

3.3 The Postgraduate Medical and Dental Board-Central Training Authority

Should ensure that:

- The targets are set for all grades and specialties and agreed with the training bodies
- Central funding is applied to all posts whether in the community, hospital or voluntary sectors
- The posts are funded in "perpetuity" so that there is no uncertainty
- Guidance and detailed policies on flexible training schemes to ensure fairness and universality of access are disseminated widely
- Flexible posts are accurately defined and recorded on a routine basis, targets met and continuous improvements are introduced based on findings
- An information system is introduced to enable careful monitoring. This should include:

  (a) The numbers of flexible training posts by grade, speciality, gender
  (b) The number who achieve a specialist* post, whether part-time or full-time and the number who do not. In the latter group the reasons should be ascertained
  (c) The number of flexible to full time conversions (and vice versa) and the year of training in which the conversion was undertaken
  (d) Satisfaction of the relevant parties.

3.4 The Health Service Employing Authority and Employers

Should ensure that:

- There is an explicit commitment to the policy/ strategy of flexible training and work
- Doctors in full time and flexible training posts have equitable contracts (relative to the % of contract held e.g. 50%, 60%), job descriptions, including issues such as study leave, maternity leave, holidays, pensions

- Interview panels should be advised against discrimination and there should be guidelines on the composition of panels
- Flexible training is available for all those who wish to train less that full time
- Flexible posts are accurately defined and recorded on a routine basis
- Flexible posts are an integral part of all training schemes and not supernumerary posts
- Flexible trainees are not forced into formal job shares i.e. one job shared between two people
- A flexible training /work plan is submitted to the Department of Health and Children and the Central Training Authority
- Innovative flexible arrangements in place at local level to meet the needs of trainees are included in the plan (e.g. rotation flexibility)
- The implementation of the plan is reported on in the annual service/business plan to the Department of Health and Children
- Childcare facilities are appropriate to the needs of flexible trainees and include hospital crèches with extended opening times and children vouchers for out-of hours work
- There is an increase in the number of specialist* posts available to doctors who wish to work less than full time for well founded reasons
- Care is taken that so that pay issues do not compromise the employment of flexible trainees
- The application and recruitment process is transparent. The flexible trainee should undergo the same competitive process as all other trainees.

3.5 The Training Bodies

Should ensure that:

- The implications of the EU Directive on Flexible education and training considered and addressed where necessary[2]
- Consideration is given to competency based accreditation rather than duration of training
- Flexible training posts rather that fixed job shares are offered to the trainees
- Flexible trainees have the right to equivalent opportunities to full-time trainees
- Clear policies and guidelines are provided to the trainees and trainers on the training requirements for flexible trainees, application procedures, availability of posts, funding, entry criteria, study leave rules etc.
- The trainers ensure that the flexible trainee is treated equally to the full time trainee
- The application and recruitment process is transparent. The flexible trainee should undergo the same competitive process as all other trainees
- The recommendation of the PGMDB that these posts should not be seen as an "easy entry" to the higher specialists training schemes is implemented.

3.6 Mentoring System

A mentoring system has been recommended in the Interim Report for all trainees.[1] This should begin in medical school, followed throughout a doctor's career (particularly in the early stages) to provide much better career guidance. This system should take account of the special needs that the flexible trainees may have e.g. the duration of training, how to move back to the full time posts, how to be competitive for consultant posts. The mentor should also be able to assist in resolving any difficulties that the trainee encounters with the flexible training scheme.

3.7 Workforce Planning

3.7.1 Those who have undertaken flexible training may also wish to have a flexible / part-time job. Currently there are 24 job sharing / permanent part-time posts. Planning the future medical workforce should take account of the output of the flexible training scheme and the career aspirations of those doctors. There is the danger that those undertaking flexible training and want flexible working condition may be trapped in "career posts". To counteract this pitfall, mecha-

* The term *"specialist"* as used throughout this document includes consultants, general practitioners, public health and occupational medical specialists.

nisms need to be put in place for the continued employment of these doctors while they wait for an available flexible/part-time post if that is their wish. This issue needs to be addressed urgently by the Department of Health and Children, Comhairle na nOspidéal and Employing Authorities. A review of the operation of flexible/part-time specialists should be considered.

3.7.2 The Task Force recommends the following[14]:

- The number of part-time posts and job shares should be increased – at present the number is limited, partly by funding and partly by organisation
- There should also be a facility to work a reduced number of sessions – this would encourage doctors who have left to return if flexible working arrangements allowed them to look after their family and other commitments
- A re-entry /retraining scheme should be introduced
- A retainer system, similar to that in the U.K. should be explored
- Pension rights for part-time workers and those who have career breaks should be reviewed
- More part-time academic posts (lecturer and senior lecturer) should be created, and research grants should be available for doctors working either part-time or without a fixed-term contract, although some contracts may not be suitable for part-time
- There should be a process to return to full-time work after flexible working.

3.8 Conclusion

The Strategy sets out the need for a flexible training strategy and considers the barriers which may exist at present. It also identifies the key issues, which need to be addressed by the major stakeholders i.e. the Department of Health and Children, the Postgraduate Medical and Dental Board/the Central Training Authority, the Health Service Employing Authority and Employers and the Training bodies.

The Task Force recommends that the Flexible Training Strategy is urgently implemented and funded accordingly. It also recommends that the Strategy should be phased in, and, together with the service implications, be closely monitored.

Appendix 1

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Appendix 2

COPMeD Birmingham Meeting

Conference of Postgraduate Medical Deans of the United Kingdom (COPMeD)

Flexible Training Sub-group

Annual Survey – September 2001

Summary:

- The overall % of flexible trainees (all grades) had risen to 5.03%
- The SW Deanery had the highest numbers of flexible SpRs (13%)
- The specialties of paediatrics, psychiatry and anaesthetics had the highest numbers of flexible SpRs
- The old Thames deaneries (now London and KSS) had the highest % of flexible SHOs
- The specialties of general psychiatry, obstetrics and gynaecology and general practice had the highest number of flexible SHOs.
- 5% of flexible trainees were male
- There were 150 flexible SpRs with their CCST in the UK. 9 deaneries were finding that they were needing to extend the "period of grace" of flexible trainees, as they were unable to find consultant posts
- In the majority of deaneries, it was rare for flexible SpRs to convert to full-time training. A relatively large number did so in N and S Thames
- In September 2001 there were 98 trainees in the UK waiting solely for deanery flexible funding

Appendix 3

BMA International Survey on Flexible Training

Numbers of part-time trainees

The percentage of flexible/part-time trainees in the total junior doctor populations in other countries is variable. Australia, New Zealand, Sweden, and Switzerland report similar percentages to the UK. However many countries have no data or an estimated negligible percentage of flexible/part-time trainees.

Country	Do any doctors in training in your country train part time?	How is this arranged?	No of flexible or part-time trainees as percentage of total junior doctors
Austria	Yes	Governed by Council Directive 93/16/EEC. Part-time working is only granted in the case of pregnancy-maternity.	negligible
Australia	Yes	Part-time work normally takes place after the intern year, but it is often difficult to arrange. Job-sharing for RMOs does exist in public hospitals, but is unusual and has to be arranged by the doctors themselves. When it comes to vocational training with a medical college, the availability of part-time training differs a lot according to the discipline or college. Colleges do not offer part-time training places: each trainee must negotiate his/her own part-time arrangements with the college and with the hospital or supervising practice.	6.3 %
Belgium	Yes	Governed by Council Directive 93/16/EEC. In specialist training, it is not permitted other than in very exceptional circumstances. In general practice doctors in training can set up their own practice in order to complete their training.	No data: 'part-time training is avoided'

Country	Do any doctors in training in your country train part time?	How is this arranged?	No of flexible or part-time trainees as percentage of total junior doctors
Belgium	Yes	Governed by Council Directive 93/16/EEC. In specialist training, it is not permitted other than in very exceptional circumstances. In general practice doctors in training can set up their own practice in order to complete their training.	No data: 'part-time training is avoided'
Canada	Yes	There is a six month maternity and paternity leave, leave to look after an aging parent, but the time off must be made up. Any other cases would be on an individual basis and worked out between the resident and program director i.e. it might be feasible for a family medicine or psychiatric resident but doubtful whether a surgical resident would be permitted to train part time.	No data
Finland	Yes	Governed by Council Directive 93/16/EEC. The training period is increased proportionately to number of basic hours worked.	No data
Germany	Yes	Governed by Council Directive 93/16/EEC. Consent to train part time must be obtained from the medical board. When he/she applies they must indicate the duration of part-time training and the reasons why he/she wants to do part-time training.	No data
Netherlands	Yes	Governed by Council Directive 93/16/EEC. In addition junior doctors have to be full time in the first and last year of his/her training.	No data

Country	Do any doctors in training in your country train part time?	How is this arranged?	No of flexible or part-time trainees as percentage of total junior doctors
New Zealand	Yes	The majority of part time RMOs job share, working one week on and one week off (or longer) rather than day or part days. Training time is increased by the proportion of the work performed. For other part-time working arrangements specific jobs must be created.	5-10%
Switzerland	Yes	Dependent on the hospital and the senior consultant.	< 9%
Sweden	Yes	Governed by Council Directive 93/16/EEC. Training time is increased by the proportion of the work performed.	2–4%
UK	Yes	Governed by Council Directive 93/16/EEC.	5%

Arrangements for part-time training

Where it is available, flexible/part-time working is organised in many countries in an ad hoc manner with the practicalities of it being worked out at a hospital or programme director level, even in European countries which are all governed by Council Directive 93/16/EEC

Reasons for the variation

The following possible influences were highlighted from the information obtained:

- *Childcare facilities* – for example, the Scandinavian countries are well known for being ahead in their thinking and facilitation of childcare provision
- *Working hours for full-time junior* doctors – for example, in Finland and Germany full-timers work approximately 38 hours a week
- *Over or undersupply of junior doctors* – for example, in Germany there is an excess of doctors competing for posts; whereas in New Zealand it is suggested that a scheme is not needed as all junior doctors are treated well due to them being in such demand
- *Attitudes* – for example, the Netherlands reports that 'trainers are not very pleased if the junior doctor wants to have his/her training part time'; Belgium reports that 'It is avoided' and ' In specialist training, it is not permitted other than in very exceptional circumstances'
- *Organisation* – there are many factors that make direct comparison between different countries'

provision of part-time working invalid. For example, the way that junior doctors are trained and managed are very different between countries, and many of the reasons cited for training flexibly in the UK are not issues for doctors in other countries.

Similarities

The following similarities were discovered:

- *Demographic* reasons – Australia and Germany mirrored the UK in having a future population of 50 per cent female doctors

- *Training time* – of note is that the UK's response to training time is mirrored by other countries i.e. where a reduction in hours is permitted, training time is increased by the proportion of the work performed (Finland, New Zealand, Sweden). So if the junior doctor is working half time, the training time will be doubled

- *Specialty issues* – other common issues lie in part time opportunities within specialities. Both Canada and Australia reported that part-time working was easier to organise in psychiatry and general practice, than in surgery!

Specific examples

Australia was the most interested in the issues with current work being carried out on flexible working options with the Training and Workplace Flexibility Project. The project explores the different work patterns of men and women in the medical profession; changing attitudes to work; and policy and practice relating to flexible working. The hope, ultimately, is to draw up an agreed strategy with the medical colleges, hospitals and the respective governments and health administrations on addressing part-time working issues.

New Zealand reported that they found job-share was preferable to part-time working i.e. two junior doctors perform the duties of one. They found that handover/communication was better with consistent people involved. It also allowed run (team/firm) allocations to continue uninterrupted through the training period. The job-share partners tended to work week on week off (or longer) rather than days or part days.

Appendix 4

PGMDB Flexible Training Scheme for Senior/Specialist Registrars

INTRODUCTION

Many doctors (male and female) are seeking different working arrangements, often because of domestic responsibilities. The purpose of flexible (part-time) training is to retain within the health service doctors who might otherwise leave because they are unable to train on a full time basis.

APPLYING TO ENTER THE SENIOR OR SPECIALIST REGISTRAR GRADE

The process for appointment to a training post is the same for both full-time and flexible applicants. Entry is through the same competition and is on merit alone.[31] Once candidates are notified that they have been selected for training they may apply to the Postgraduate Medical and Dental Board (PGMDB) to be considered for flexible training. For a trainee to commence training in a part- time capacity funding, educational approval, hours of work and the agreement of a Hospital/ Health Board to accept a flexible trainee have to be organised.

The PGMDB's Director of Flexible Training will ascertain whether an individual's request for flexible training is based on well founded individual reasons. Having established eligibility the PGMDB's Director of Flexible Training will determine the feasibility of acceding to the request. This will depend on:

- The specialty the trainee has chosen
- The stage of training
- The presence of other flexible trainees enhancing the possibility of job-sharing or partnership arrangements
- The availability of resources, where having exhausted other possibilities, the Director decides to establish a supernumerary post
- Suitable educational approval for the supernumerary post

PART- TIME/FLEXIBLE TRAINING PLACEMENTS

The scheme will encompass a variety of part-time training options including job sharing, job partnerships and flexible supernumerary posts.

Job-Shares: A job-share can be created by dividing a training placement between two trainees.

Job-Partnerships: Job partnerships can be arranged by the PGMDB. Using flexible training funds for an additional session, each partner works 60% of full-time. This allows each partner to fulfil the duties of half of a full-time post and for both to attend protected teaching sessions and audit, with time for a formal hand-over of responsibilities. Part of the extra time can be used for additional training sessions or for service needs. Trainees eligible for flexible training may be placed in job partnerships.

Flexible Supernumerary Posts: New training opportunities are created by supernumerary placements additional to the existing complement of trainees. Supernumerary posts are needed when a trainee needs specific specialist training and cannot be paired with a suitable partner in a job-share. These posts are funded by the PGMDB.

FUNDING - GENERAL

The PGMDB has limited funds available for flexible training and priority will be given to those with a definite need for the opportunity to train flexibly.

If funding is identified for a supernumerary flexible training post the PGMDB will fund 100% of the basic

salary cost including the employer's PRSI contribution and costs relating to indemnity and training allowances/grants. The payment will be based on 50% of a full-time post calculated at the mid-point of the senior or specialist registrar salary scale.

EDUCATIONAL APPROVAL

All training programmes/placements (whole-time or part-time) require educational approval from the relevant Training Body. Some of these programmes may include flexible training placements which have been approved already. In others, educational approval will need to be obtained for the individual part-time placement/programme.

IMMEDIATE PROPOSALS

Funding has been made available by the Department to the Board to enable 20 additional senior or specialist registrars to be appointed, on a part-time basis. It is the Board's intention that all of these posts should, if possible, be filled as close as possible to 1 July, 2002. It is the Board's wish, subject to demand from trainees, that the posts should be spread over many specialties and for this reason has adopted a draft distribution of two part-time specialist registrar posts in each of the following specialty groups: anaesthetics, obstetrics/gynaecology the medical specialties (excluding public health medicine), paediatrics, pathology, psychiatry, radiology, surgical specialties, public health medicine together with two posts held in reserve. That distribution should be seen as indicative of the Board's intentions, should suitable applicants from all specialty groups present themselves This proposed distribution is not "set in stone" and if insufficient suitable applicants come forward in the immediate future to fill the posts in accordance with it the Board's intention would be to transfer very quickly, with the Comhairle's approval, any unfilled posts to specialties in respect of which suitable applications from trainees have been received.

One criticism in the past of efforts to introduce flexible training arrangements has been the absence of agreed schemes and the slowness with which decisions were made or sometimes not made. It is the Board's earnest hope that the pilot scheme will enable decisions to be taken quickly. Obviously it is impossible to be precise at this point as to what the initial demand will be among trainees in the different specialties. The indicative allocation of posts among the different specialties should be seen as an initial desired framework and model but which must be capable of being revised speedily if the demand from trainees in some specialties falls short of the proposed indicative allocation. The Comhairle's approval to the 20 posts on the basis proposed has been sought now so as to obviate a need to make up to 20 individual applications over the coming months.

The training bodies are aware, and have welcomed, the Board's proposals.

Postgraduate Medical and Dental Board
26 April, 2002

P.S.: This scheme is designed to increase the availability of part-time training. It will supplement any existing scheme/facilities.

31 Those candidates who wish to train part-time do not declare this desire to the interview board

APPENDIX F

World Federation of Medical Education (WFME) Standards*

The WFME standards aspire to international relevance but recognise the need to ensure sensitivity for the needs of individual countries. WFME recommends the following set of global standards in postgraduate medical education structured according to 9 areas and 38 sub-areas.

Areas defined as broad components in the structure process and outcome of postgraduate medical and education and training cover:

- Mission and Outcomes
- Training Process
- Assessment of Trainees
- Trainees
- Staffing
- Training Settings and Educational Resources
- Evaluation of Training Process
- Governance and Administration
- Continuous Renewal

The WFME includes the following as competencies relevant to postgraduate training:

- Patient care that is appropriate, effective and compassionate for dealing with health problems and health promotion
- Medical knowledge in the basic biomedical, clinical, behavioural and clinical sciences, medical ethics and medical jurisprudence and application of such knowledge in patient care
- Interpersonal and communication skills that ensure effective information exchange with individual patients and their families and teamwork with other health professions, the scientific community and the public
- Appraisal and utilisation of new scientific knowledge to continuously update and improve clinical practice
- Function as supervisor, trainer and teacher in relation to colleagues, medical students and other health professions
- Capability to be a scholar contributing to development and research in the chosen field of medicine
- Professionalism
- Interest and ability to act as an advocate for the patient
- Knowledge of public health and health
- Policy issues and awareness and responsiveness to the larger context of the health care system, including e.g. the organisation of health care, partnership with health care providers and managers, practice of cost-effective health care, health economics and resource allocations.
- Ability to understand health care and identify and carry out system-based improvement of care.

* http://www.sund.ku.dk/wfme/Activities/WFME%20Postgraduate.pdf *(website: www.wfme.org)*

APPENDIX G

Intern Co-ordinators and Tutors Network: Terms of Reference

1. To develop, in consultation with the relevant post-graduate Training Bodies a set of standards for the education and training of interns.

2. To develop systems for the implementation of these standards in clinical sites.

3. To develop systems for the monitoring of the implementation of standards.

4. To encourage innovation in the enhancement of intern education and training

5. To develop the essential infrastructure to allow this setting implementation and monitoring of standards by the network on an on-going basis.

6. To establish formal links in reporting structures with the country's five Medical Schools, with the Medical Council, with the Department of Health and Children and with other relevant statutory bodies.

7. To publicise the on-going activities of the network, so that the relevant organisations and individuals are kept informed.

8. To encourage Inter Representative Groups within the five Medical Schools. (The Chairman of each University Intern Representative Group will be invited to the Annual Intern Co-ordinators and Tutors Network Annual General Meeting). A member of the Intern Representative Group will represent Intern "interests" on the Network.

9. To co-opt as appropriate, members with special expertise to attend Network meetings.

APPENDIX H

Membership and Functions of the European Working Time Directive National Implementation Group

The Labour Relations Commission (LRC) put forward a proposal on the ongoing negotiations in regard to the European Working Time Directive on 7 February 2005. The LRC recommendations regarding the membership and functions of the European Working Time Directive National Implementation Group were:

Membership

The indicative membership of the National Implementation Group will be as follows; the Department of Health and Children (2), the Health Service Executive/Employers (5), IHCA (2), the Postgraduate Medical and Dental Board (1), the Medical Council (1), medical training colleges (4), the Irish Medical Organisation (6), nursing (2) and representatives of other relevant healthcare professions (1). The Group will be chaired by an independent Chairperson nominated by the Commission.

The Group will have a joint secretariat, i.e. Joint Honorary Secretaries - one of whom shall be nominated by the IMO. Their function will be to agree the agenda papers and meeting dates with the Chairperson.

Appropriate arrangements will be made for designated NCHDs to attend meetings of the implementation Body.

Functions

The primary consideration of the National Implementation Group is the continued provision of safe, high quality care to patients coupled with the provision of appropriate training to NCHDs during the EWTD implementation period. The National Implementation Group will:

a) Coordinate the work of the existing Local Implementation Groups and help them plan and support the implementation of the EWTD in line with the following three reports:
   - The Report of the National Joint Study Group on the working hours of non-consultant hospital doctors.
   - The Report of the National Task Force on Medical Staffing.
   - Training principles issued by the Medical Education & Training Group.

b) Issue of agreed guidance to health employers and other parties on issues related to the implementation of the European Working Time Directive.

c) Assist in the development and evaluation of local implementation plans.

d) Initiate such research or data gathering exercises as are considered necessary.

e) Be responsible for communication with all national stakeholders on progress in the EWTD implementation process.

f) Review of the operation of the Body six months after the implementation of the Directive.

APPENDIX I

Career Tracking Study

A Career Tracking Study entitled "Factors affecting Career Choices and Retention of Irish Medical Graduates" commissioned by the MET Group, and undertaken by the Department of Public Health Medicine and Epidemiology, University College Dublin, is published on the CD accompanying this Report.

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