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Emergency Medicine Workforce in Ireland 2024-2038

An expert stakeholder informed review.

HSE
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Training & Planning

RCSI ROYAL COLLEGE OF SURGEONS IN IRELAND

IRISH ASSOCIATION FOR EMERGENCY MEDICINE

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Foreword: Medical Director, NDTP

It is my pleasure to welcome the publication of this review of the specialist training requirements for Emergency Medicine. The report is a collaboration between NDTP, the National Emergency Medicine Programme, and the Irish Association for Emergency Medicine. I would like to thank all who contributed; without whose input this report could not have been prepared.

The primary aim of this report is to develop a roadmap for the expansion of the Emergency Medicine specialty training programme across both Core and Advanced Specialty Training in Emergency Medicine (CSTEM and ASTEM, respectively) in line with anticipated future demand for Consultants in Emergency Medicine. Health care demand is expanding exponentially with population expansion, demographic aging, healthcare reform, and a range of other factors. Our goal is to ensure that the domestic training pipeline is sufficient to meet future demand for consultants in a sustainable manner.

It is anticipated that the consultant workforce in Emergency Medicine will need to almost double in size by 2038. This was determined by assessing attendance records for Emergency Departments across Ireland in conjunction with projected population and demographic changes, as well as configuration of the pathway for unscheduled and emergency care with the National Trauma Networks, Sláintecare, and HSE Health Regions. The training pipeline for Consultants in Emergency Medicine is not capable of servicing this demand in its present configuration.

This report recommends increasing CSTEM intake from current levels 30 per annum to 40 per annum by 2028 and increasing ASTEM intake from current levels of 16 per annum to 30 per annum by 2034. Furthermore, substantial efforts should be made to retain more individuals who have completed CSTEM within the Emergency Medicine training pathway, as currently approximately 50% of trainees leave Emergency Medicine training on completion of CSTEM.

The proposed expansion of both stages of the training programme are contingent on identifying suitable new training posts in clinical sites across Ireland, as well as conversion of existing non-training NCHD posts to training posts. NDTP is committed to working closely with the national clinical and training programmes to ensure that these recommendations can be achieved and output of trained specialists in Emergency Medicine is substantially increased.

Prof Anthony O'Regan

Medical Director, National Doctors Training & Planning

Foreword: National Emergency Medicine Programme

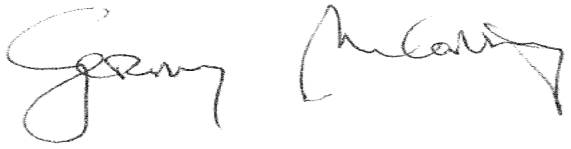
Emergency Medicine (EM) plays a vital role in the healthcare system, providing rapid and life-saving care to patients in urgent situations. As the complexity of healthcare delivery increases and the demands on emergency services evolve, it is crucial that we have a well-prepared, well-staffed, and resilient medical workforce. The Medical Workforce Plan for Emergency Medicine is a comprehensive roadmap to address current workforce gaps, anticipate future needs, and ensure that the emergency medicine specialty in Ireland is aligned with the growing and changing population.

This report is the result of extensive collaboration between key stakeholders, including clinical experts, workforce planners, and national leadership bodies. It provides an informed and detailed overview of the current status of the EM workforce, including consultant demographics, training capacities, and future demand projections, while offering strategic recommendations for scaling up specialist training. The underlying goal is to align with international standards and to ensure that Ireland's emergency departments are equipped to deliver the best care possible, now and into the future.

By 2038, the EM consultant workforce needs to expand significantly to meet rising demand, particularly in response to demographic shifts such as an aging population. The insights and recommendations outlined here aim to support this expansion by increasing specialist training capacity, enhancing recruitment efforts, and ensuring a sustainable pipeline of emergency medicine professionals.

This plan is not only a testament to the commitment of healthcare leaders to prepare for the future, but also a call to action as we strive to deliver a consultant-delivered, patient-centred emergency care model across Ireland. It is my hope that this document will guide our next steps in building a workforce capable of meeting these objectives.

Dr Gerry McCarthy



National Clinical Lead (2015-2024), National Emergency Medicine Programme

Executive Summary

Aim

The aim of this report is to outline expert-informed future demand for Consultants in Emergency Medicine (EM) in Ireland and to make recommendations on the required specialist training programme intake on an annual basis to meet consultant demand by 2038. [1] This exercise follows the methodology established in previous specialty reviews by National Doctors Training & Planning (NDTP). [2]

Demand estimates and supply roadmaps were established in collaboration with clinical and training leads within the national Emergency Medicine Programme (EMP). This document is intended to complement ongoing work within the EMP in their recommendations for the delivery of high-quality emergency care in Ireland.

This report is a dynamic document which will require regular review and refinement of demand estimates and recommendations to ensure that they are aligned with future service demand and configuration. Numerous elements of the Irish medical system are in flux, substantially impacting the configuration of the EM workforce and care delivery pathways. These elements include establishment of the HSE Health Regions (HRs), the National Trauma Networks, pivoting to a consultant-delivered EM service, public-only consultant contracts, and increased demand for flexible working arrangements.

Baseline Workforce

Data used to inform the current baseline status of the Consultant in EM workforce was sourced from the NDTP Doctors Integrated Management E-system (DIME), correct as of 1st June, 2024. [3] Further data validation was performed through consultation with clinical experts and the relevant postgraduate training body for EM. An overview of the Consultant in EM workforce in HSE-funded services is presented in Table 1 below. Whole Time Equivalent (WTE) is the preferred method for quantifying the workforce, as this accurately captures the capacity of the workforce to deliver care.

Table 1: Detailed characteristics of HSE consultant workforce in EM. [3]

Emergency Medicine	WTE	WTE Rate	% Over 55 Years	% Fulltime	% Permanent	% Temporary	% Locum	% Agency	% General Register	% Vacant >18m
Total	**182.1**	**88.7%**	**22.2%**	**84.8%**	**83%**	**11%**	**4.8%**	**0.9%**	**7.2%**	**4%**

A locum doctor works on a temporary basis to cover staff absences (maternity, illness, holiday etc.) or to meet service needs. Reasons for locum cover include when there is a permanent consultant post pending but not yet filled, a requirement for an additional temporary post, when a permanent post is difficult to fill and when there is a need for back-fill for a national or clinical director role.

In addition to the publicly funded workforce, 9 WTE consultants were found to be working in EM in the private sector. These were included in the baseline workforce for statistical modelling of the future workforce as outlined in the Methodology section which follows.

The geographic distribution of the Consultant in EM workforce by HR as of June 1st, 2024, is shown in Table 2. This breaks the workforce down by hospital type and also shows the ratio of consultants per 100k population. Greater analysis and discussion of the current configuration of the consultant workforce and of population ratios are presented later in this document.

Table 2: Regional distribution of Consultants in EM workforce (WTE) by hospital acuity level in publicly funded EDs, June 2024. [3]

Health Region	Model 4	Model 3	Model 2	Specialist Paediatric	Other*	Total	Consultants/100k**
Dublin & Northeast	18.55	17.76	0.46			36.8	2.99
Dublin & Midlands	16.49	15.53				32.0	2.79
Dublin & Southeast	14.92	11.92	0.54		0.47	27.9	2.77
South-Southwest	14.67	7.29	0.46		0.50	22.9	2.99
Midwest	11.64		0.36			12.0	2.82
West-Northwest	5.14	21.70	0.36			27.2	3.50
CHI				21.34		21.3	1.99‡
National Ambulance Service					2.03	2.0	
Total	**81.4**	**74.2**	**2.2**	**21.3**	**3.0**	**182.1**	**3.57**

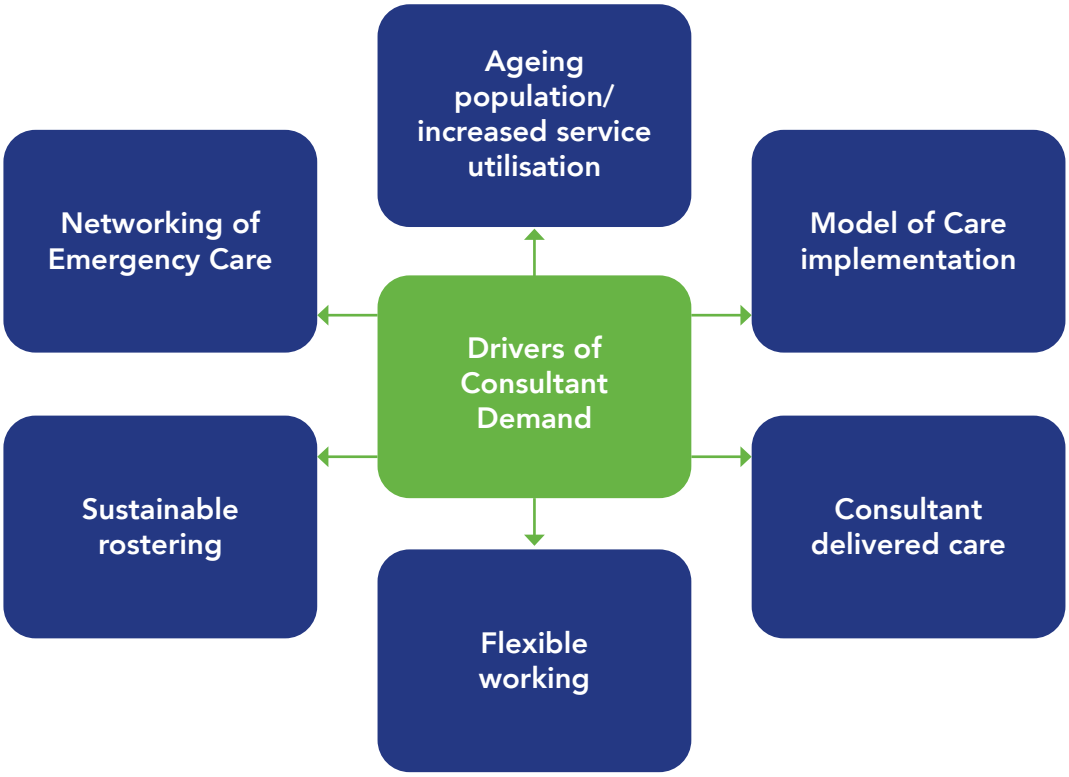
**"Other" locations includes academic institutions and the National Ambulance Service.*
***Consultant/population ratios were determined using the population for each HR as recorded by the Health Intelligence Unit of the HSE. [4]*
‡The ratio for CHI was determined using the national paediatric population, i.e. the national population U16 years of age.

Future Demand

There are many drivers which impact future demand for Consultants in EM, as outlined in Figure 1. Quantification of consultant demand was carried out in conjunction with the EMP to be aligned with planned reorganisation of the delivery of emergency care in public hospitals. It was estimated that, by 2038, there will be a demand for 311 WTE consultants in public EDs. This value represents only demand for adult/mixed services, with demand for specialised paediatric emergency care considered separately, as outlined later in the report. This figure was arrived at through analysis of historic patient attendance data and recommendations from the Royal College of Emergency Medicine (RCEM), in addition to anticipated future development of networks of Emergency Care and staffing arrangements. [5]

When accounting for paediatric emergency care and also the private sector, the total demand for Consultants in EM in 2038 was determined to be 335 WTE. Detailed discussion of how demand estimates were quantified is presented later in this report.

Figure 1: Main drivers of demand for Consultants in EM in Ireland.



Key Recommendations

The primary recommendation of this report is the expansion of all levels of the training programme for EM. The consultant workforce in EM is required to almost double in size over the next 15 years. This will only be achieved with significantly increased output from the training programme in Ireland. Even with increased training output, it will be necessary to hire consultants from outside of the domestic training programmes to meet immediate unmet demand and service expansion targets while the training programme expands in capacity.

Intake at Core Specialist Training in Emergency Medicine (CSTEM) will need to increase from current levels of 30 per annum to 40 over the next 5 years. Advanced Specialist Training in Emergency Medicine (ASTEM) will need to increase annual intake from current levels of 16-18 to 30 over the next ten years. Additionally, retention rates of trainees between these training stages will need to improve substantially, as many trainees currently leave EM training after CSTEM to pursue other training in specialties within the Irish health system.

Fundamental to increasing training capacity will be the conversion of Non-Training Scheme Doctors (NTSDs) to training posts. EM has a substantial dependence on non-training doctors compared to other medical specialties in the Irish health system. NDTP is continuously working with training bodies and clinical sites to identify NTSD posts which can be converted to training posts.

The roadmap outlined in this report will see the Consultant EM workforce reach recommended levels in 2038. This will bring the workforce in line with international peers in terms of consultant/population and consultant/patient ratios. However, continuous monitoring of workforce recruitment numbers will be necessary as service configuration and delivery of emergency care develops and matures with the implementation of numerous ongoing changes to the landscape of EM in Ireland and the broader healthcare system.

1. Introduction

This report is the culmination of a collaboration between HSE NDTP and the EMP. [1] Within its medical workforce planning remit, NDTP is tasked with estimating and recommending the number of postgraduate trainees required annually for each medical specialty. To this end, NDTP works with specialty stakeholders including national clinical programmes, postgraduate training bodies, and others to estimate the demand for consultants across the Irish healthcare system, both public and private.

This information then feeds into the medical education and training role of NDTP via the commissioning of medical training required to meet workforce needs, ensuring that the training content and delivery is responsive to the changing needs of the Irish healthcare systems, and supporting the retention of doctors upon completion of their training. More recently, NDTP has used workforce planning reports to inform and influence consultant recruitments and retention initiatives across the health service.

The key objective of this report is to outline expert-informed demand projections for Consultants in EM and to inform training intake numbers (across all levels of EM training) to meet consultant demand by 2038. This document updates the plan previously set out by NDTP in 2017 to reflect the networking of Emergency Care that has been set out by the EMP. [6]

Workforce planning is an inexact science and estimated requirements for demand and supply are based on the best available data, expert opinion, as well as policy and other related developments relevant to the health service at the time that the workforce plan document is prepared. Where data is not readily available in this exercise, assumptions have been made and clearly outlined. For example, the data which is available for the private sector lacks considerable detail, when compared to that which is available for HSE-funded service. Additionally, one of the key documents used to inform this report is the Model of Care (MoC) for EM, which is currently still in the approval process in the HSE and may undergo changes before being published and adopted. The impacts of this are discussed in greater detail in the following sections.

1.1. Methodology

The approach taken in this workforce plan for EM is broadly based on the methodological framework "NDTP Health Workforce Planning: A stepwise Approach". [2] This forms the basis for all NDTP workforce plans across all specialties. However, as all specialties are unique in delivery of service and quantification of demand, this framework is adjusted accordingly.

A multi-method approach to workforce planning for EM was used to include:

1. A review of EM in Ireland.
2. A quantitative review of the Irish EM workforce across public and private sectors to establish the baseline current workforce and related demographic variables.
3. A review of policy documents to ensure the workforce plan is aligned with policy and strategy for the specialty.
4. Stakeholder consultation to establish expert-informed baseline assumptions and scenarios to be used in modelling exercises.
5. Quantitative simulation modelling of supply and demand statistics to establish the recommended annual increase in the supply of the consultant and trainee workforce numbers to meet the demand for consultants by 2038.

2. Review of Emergency Medicine Service in Ireland

EM is a specialty which involves the delivery of Unscheduled and Emergency Care (UEC) in hospital EDs and Injury Units (IUs). In 2023 there were 27 24/7 EDs and associated satellite units in Ireland, with over 1.5 million patient attendances. Patients are assessed rapidly to ascertain the severity of their condition and triaged to prioritise those in need of most urgent care. EM specialists are trained to treat a diverse range of medical conditions, often in time-critical circumstances with little warning and incomplete data available. Staffing in EDs uses blended Multidisciplinary Teams (MDTs) comprising medical, nursing, and other health and social care professionals. This report considers the medical workforce within the ED environment.

2.1. Emergency Medicine Model of Care

The EMP has developed a revised MoC for the specialty, to replace the previous document published in 2012. [7] This document proposes restructuring of the care pathway within EM across four pillars, summarised below. While much of the content of this MoC is beyond the scope of this report, Pillars 1 and 3 significantly impact on the staffing requirements of EDs, including consultants.

Pillar 1: Organisation of Emergency Care	Pillar 2: ED Patient Pathway	Pillar 3: Infrastructure	Pillar 4: Values, Measures & Improvements
• Developing Networks of Emergency Care • Patient Participation • Pre-hospital EM • Paediatric EM • EM and the Older Person	• Key Specialty & Service Interfaces	• Multidisciplinary Teams • Academic EM • Health Information Systems • Physical Infrastructure	• Value-based Emergency Care • A Systems Improvement Approach to Emergency Care • Clinical Guidelines • Green Emergency Care

Within the pillars outlined above, there are two strands of recommendations from the MoC which directly impact on the consultant workforce requirements in EDs. Firstly, optimisation of processes of care within each ED, and secondly; recommendations around the required number of 24/7/365 EDs nationwide. Future UEC service delivery categorises EDs in a networked system according to the National Trauma Strategy. [8] Two regional networks are centred on Major Trauma Centres (MTCs) located in Dublin and Cork (Mater Misericordiae and Cork University Hospitals, respectively), with Trauma Units (TUs), TUs with Specialist Services (TUSSs), Local Emergency Hospitals (LEHs), and IUs distributed around the country within each network. The TUs and TUSSs are currently undergoing accreditation, and, when this phase has been completed, will facilitate a national network optimised for delivery of care to victims of physical injury on a 24/7/365 basis, further supported by LEHs and IUs with some operating on a 12/7 basis. Patients will be referred to the appropriate ED according to the severity of the injury, with more complex care being provided in the MTCs, TUSSs, and TUs.

EDs are classified by size according to the number of patient attendances per annum. The RCEM recommends 1 WTE consultant per 3,600-4,000 annual patient attendances in an ED. [5] This information is summarised in Table 3 below. In the Irish context, 5 EDs are classified as "medium", while 3 are considered "large", with the two MTCs falling in the latter category. Achieving the recommended consultant staffing levels will allow the EMP to optimise the process of care within EDs by designating specific areas and duties to multiple consultants on duty at a given time. Allocation of consultant resources at clinical site level is beyond the scope of this report.

Table 3: Classification of EDs and the corresponding recommended staffing levels. [5]

ED Classification	Attendances per Annum	Staffing Levels (WTE)
Medium	60,000-100,000	18-25
Large	>100,000	25-36

The regionalisation of the HSE and the appointment of Regional Executive Officers (REOs), the implementation of which is contemporaneous to the development of this workforce plan, will further facilitate the organisation of emergency care in a coherent networked manner, with all levels of complexity of UEC appropriately catered for across the country. [9]

2.2. Emergency Medicine Specialist Training Programme

Upon completion of the Intern year, Non-Consultant Hospital Doctors (NCHDs) can undertake specialist training in EM comprising a three-year programme in Core Specialist Training in Emergency Medicine (CSTEM), followed by a four-year programme in Advanced Specialist Training in Emergency Medicine (ASTEM). [10] Upon completion of ASTEM, candidates are awarded the Certificate of Successful Completion of Specialist Training (CSCST) and are eligible for consultant posts in EM. Many individuals will spend time in overseas fellowships at post-CSCST stage in order to gain further expertise prior to taking up consultant posts. EM training in Ireland is under the auspices of the Irish Committee for Emergency Medicine Training (ICEMT) of the Royal College of Surgeons in Ireland (RCSI). It follows the training curriculum of RCEM and is recognised by the RCEM and Irish Association for Emergency Medicine (IAEM), the professional bodies for EM physicians in the UK and Ireland, respectively. [11]

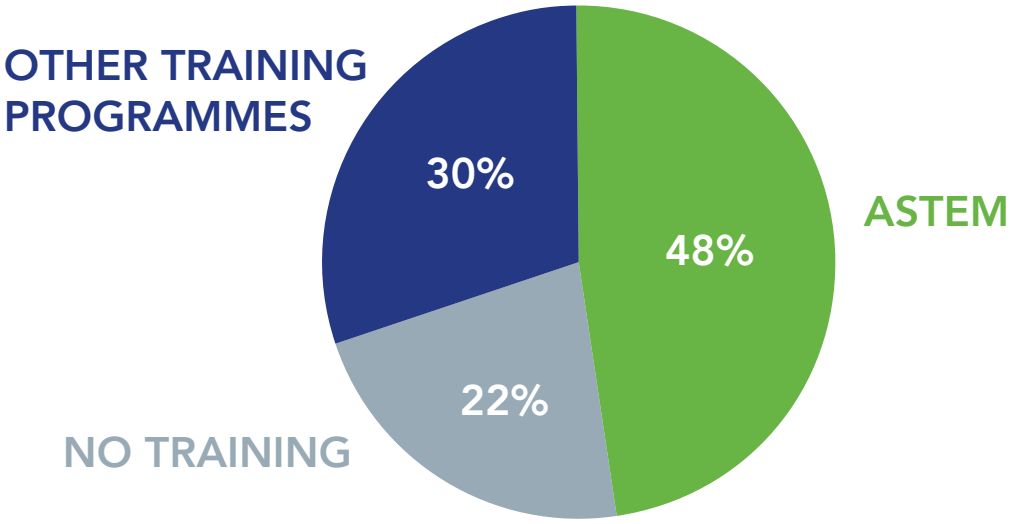
As of July 2024, the EM trainee workforce is as shown in Table 4. Internal NDTP analysis indicates that, according to the cohorts graduating 2017-2020, only 48% of CSTEM graduates continued to ASTEM. [12] A significant number of CSTEM graduates progress to specialty training programmes in other specialties (30%), while others do not do any further training (22%), see Figure 2. Trainee numbers in recent years indicate 58% retention (approximately 28 CSTEM trainees per year supporting 16 ASTEM trainees).

A consequence of the mid-training attrition is that substantiative increases in ASTEM intake must be preceded by an increased intake in CSTEM to ensure an adequate supply of eligible individuals. This has already been recognised by the ICEMT, resulting in additional training rotations being identified; with CSTEM intake in July 2024 increasing to 30 from a previous level of 26 and plans to expand further beyond this value. ASTEM intake for 2024 has been approved for 18 with 16 individuals confirmed in post. Projected training numbers are discussed in greater detail later in this report.

Table 4: Breakdown of EM trainee workforce as of July 2024.

Training Stage	CSTEM				ASTEM				
Training Year	Approved intake	Year 1	Year 2	Year 3	Approved intake	Year 1	Year 2	Year 3	Year 4
Headcount	30	30	27	26	18	16	14	14	20

Figure 2: Destination of CSTEM graduates for the cohorts graduating 2017-2020. [12]



NDTP analysis of CSTEM cohorts graduating 2016-2019 indicated that 76% of CSCST graduates in EM took up a consultant post (either public or private) by 2023, i.e. within 5 years of being awarded CSCST. [12, 13] The remainder are assumed to be working abroad. The EMP recommends and anticipates a substantial expansion in the number of consultant posts in the next number of years, which should act as a driver to ensure that CSCST graduates in EM take up consultant posts within Ireland. Additionally, the competitive nature of the Public Only Consultants Contract 2023 (POCC 23) for consultant employment contracts is expected to act as a secondary driver in retaining Irish qualified specialists in Ireland going forward. A small number of CSCST graduates in EM are expected to complete post-CSCST fellowships specialising in Paediatric EM (PEM) and go on to work in exclusive paediatric EDs, as discussed in the following section.

2.3. Paediatric Emergency Medicine

Within the Greater Dublin Region, UEC for children is provided at EDs in dedicated Paediatric EDs (PEDs) in Children's Health Ireland (CHI) sites and, in the near future, the National Children's Hospital (NCH), which is due to open its doors to patients in 2026. Outside of Dublin, UEC for children is provided at "mixed" adult EDs and a handful of adjacent but separate PEDs. While this report is not concerned with the demand for exclusive Consultants in PEM, some consideration must be given to this to account for all demands to the EM training pathway.

Consultants working in PEM posts can complete specialty training through either the Paediatrics or EM training programmes. [14, 15] When training through the EM pathway, trainees will complete PEM rotations across CSTEM and ASTEM, and subsequently complete a post-CSCST fellowship to further specialise in PEM.

Recent documentation from CHI outlines comprehensive workforce requirements for the NCH. This specifies a total workforce requirement for 40 WTE Consultants in PEM. Achieving this requires an extra 16.5 WTE Consultants in PEM to enter the workforce in the coming years. [16] For the purposes of outlining demand on the EM training programme, it is assumed that 9 WTE of this PEM requirement for PEDs will be supplied through EM CSCST graduates, the remainder are assumed to be Paediatrics CSCSTs who have completed the requisite post-CSCST training. To account for this supply of EM CSCSTs to PEM, 9 WTE is added to the demand for adult EM services. Further detail on how PEM is handled in supply modelling is discussed below.

3. Review of the Emergency Medicine Workforce in Ireland

A quantitative review of the consultant, trainee, and non-training scheme doctor workforce was carried out using data from the following sources:

- NDTP Doctors Integrated Management E-system. [3]
  A database of all doctors employed in the public health system in Ireland, receiving data from the postgraduate medical training bodies, the Irish Medical Council (IMC), and all clinical sites.
- IMC Annual Retention Application Form (ARAF). [17]
  Captures information on registration of specialist doctors such as where they obtained their primary medical degree, as well as high level data on the private sector.
- Royal College of Surgeons in Ireland. [10]
  The postgraduate training body which delivers the CSTEM and ASTEM programmes.

The accuracy of DIME is dependent on clinical sites regularly updating details of their medical workforce. As this is a live system where data can be updated retrospectively, variances can exist between publicly available figures depending on the date for which the workforce report is run and the date in which it was accessed. All DIME data for the consultant workforce used in this report is correct as of 1st June, 2024, and was accessed on 7th July, 2024, to allow retrospective corrections and updates to have been made prior to this. Data on trainees is for the training year running from July 2024 to July 2025. Private sector data (IMC ARAF) is correct to April 2023. Although this is not as recent as the data available for the publicly funded workforce, this is the most up-to-date private sector data available to NDTP at the time of preparing this report.

This section of the report outlines the demographic breakdown of the EM workforce as of 1st June, 2024, in both Headcount (HC) and WTE, as indicated. WTE is the preferred means of quantifying the consultant workforce as it accounts for those who work less than full time and accurately captures those who have commitments across several clinical sites, giving an accurate metric of the capacity of the health system.

3.1. Demographics of the Emergency Medicine Workforce

Table 5 below details the demographics of the consultant and NCHD workforces in EM. These parameters are used as the inputs for the statistical supply model which underpins all projections in this report. Of the 207 Consultants in EM working in the HSE, approx. 68% are men and 32% are women, with women working with slightly lower WTE rates than men on average; 86% and 89% WTE, respectively. Table 6 shows a detailed breakdown of the characteristics of the consultant workforce, with 85% on permanent fulltime contracts. The current ASTEM cohort shows a gender balance of 61-39% male-female, indicating the feminisation of the consultant workforce in coming years.

EM has the highest proportion of NTSDs to consultants across all specialties within the HSE, and this number grew by 13% over the course 2022-2023. [18] As it is clear HSE policy to move towards a consultant-delivered health system, the expansion of the NTSD cohort is a concerning issue which ideally will be addressed by conversion of some of these posts to training posts and expansion of the consultant numbers. The rapid expansion in NTSDs is generally reflective of recruitment in individual clinical sites to meet immediate demand or service gaps. The ongoing strategic restructuring of the EMP at national and regional level should address such immediate staffing shortfalls and the UEC pathway outlined in the MoC should reduce the reliance on NTSDs in EM in the future.

Table 5: Workforce data underpinning input parameters for modelling supply of Consultants in EM to 2038.

Variable	Value	Source
Consultant HSE funded services (HC)	207	DIME, June 2024
Consultant HSE funded services (WTE)	182.1	DIME, June 2024
WTE rate HSE funded services	89% (male) 86% (female) 88.7% (average)	DIME, June 2024
Gender balance HSE funded services	68.2% male, 31.8% female	DIME, June 2024
Expected retirements by 2038 (HC)	101 (retirement age 62) 77 (retirement age 65)	DIME, June 2024
Exclusive private sector consultants	15 (HC), 9 (WTE) (100% male)	IMC, 2023
CSTEM Years 1-3 (HC)	84	RCSI, July 2024
ASTEM Years 1-4 (HC)	64	RCSI, July 2024
Gender balance ASTEM	61% male, 39% female	RCSI, July 2024
NTSDs	540	DIME, June 2024

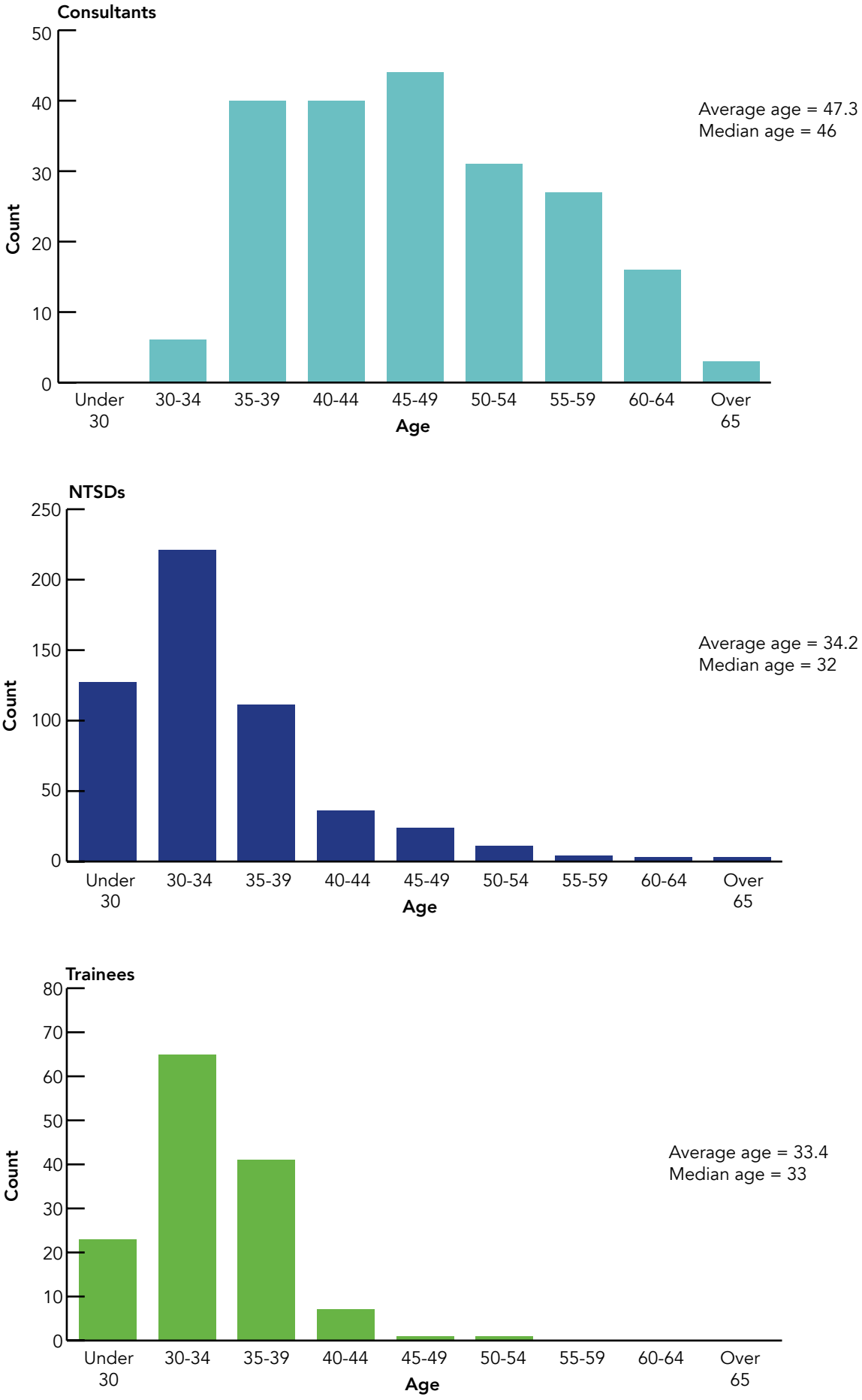
Table 6: Detailed characteristics of HSE Consultant in EM workforce. [3]

Emergency Medicine	HC	WTE	WTE Rate	% Over 55 Years	% Fulltime	% Permanent	% Temporary	% Locum	% Agency	% General Register	% Vacant >18m
Total	207	182.1	88.7%	22.2%	84.8%	83%	11%	4.8%	0.9%	7.2%	4%

A locum doctor works on a temporary basis to cover staff absences (maternity, illness, holiday etc.) or to meet service needs. Reasons for locum cover include when there is a permanent consultant post pending but not yet filled, a requirement for an additional temporary post, when a permanent post is difficult to fill and when there is a need for back-fill for a national or clinical director role.

The age profile of the public EM workforce is illustrated in Figure 3, separated by consultants, NTSDs, and trainees. The age profile of trainees and NTSDs is very similar, as highlighted in the selected summary statistics for each cohort included in Figure 3.

Figure 3: Age profile of EM medical workforce, separated by consultants, NTSDs, and trainees. [3]



3.2. Location of Consultants in Emergency Medicine

The hospital types in which Consultants in EM currently work are outlined in Table 7, indicating that the vast majority are located in Model 4 and Model 3 hospitals, with sessional commitments in Model 2 hospitals that operate IUs. This will likely change as the MoC is implemented in coming years. With the continued implementation of the national Trauma Networks, EMP recommends that Consultants based in LEHs be offered a sessional commitment to adjacent MTCs or TUs. A comparison of the consultant and NCHD EM workforce as a ratio per 100k population by HR is presented in Table 8.

Table 7: Regional distribution of Consultants in EM workforce (WTE) by hospital acuity level in publicly funded EDs, June 2024. [3]

Health Region	Model 4	Model 3	Model 2	Specialist Paediatric	Other*	Total
HSE Dublin & Northeast	18.55	17.76	0.46			36.8
HSE Dublin & Midlands	16.49	15.53				32.0
HSE Dublin & Southeast	14.92	11.92	0.54		0.47	27.9
HSE South-Southwest	14.67	7.29	0.46		0.50	22.9
HSE Midwest	11.64		0.36			12.0
HSE West & Northwest	5.14	21.70	0.36			27.2
CHI				21.34		21.3
National Ambulance Service					2.03	2.0
Total	**81.4**	**74.2**	**2.2**	**21.3**	**3.0**	**182.1**

**"Other" locations include academic institutions and the National Ambulance Service.*

Table 8: Public EM workforce population ratios by Health Region, June 2024. [3, 4, 19]

Health Region	Consultants/100k	NTSDs/100k	Trainees/100k
HSE Dublin & Northeast	2.99	9.76	2.93
HSE Dublin & Midlands	2.79	7.05	2.44
HSE Dublin & Southeast	2.77	10.32	1.79
HSE South-Southwest	2.99	9.14	1.17
HSE Midwest	2.82	8.92	2.58
HSE West & Northwest	3.50	13.00	2.19
CHI*	1.99	2.42	1.77
Total	**3.57**	**10.08**	**2.58**

**CHI ratio calculated from national paediatric (U16) population.*

3.3. International Peer Comparison

An international comparison of the ratio of Consultants in EM per 100k population was carried out to provide further context to the composition of the Consultant EM workforce. This is summarised below in Table 9. It is immediately apparent that Ireland has a lower ratio of Consultants in EM per capita than our peers, significantly so in some cases, even when the private sector is accounted for. Furthermore, it is evident that Ireland has a disproportionate reliance on NTSDs compared to the other jurisdictions summarised here, with a substantially lower proportion of trainee NCHDs

on specialist training programmes compared to the UK nations. This information is also presented in Figure 4, visually demonstrating the disparity in consultants and NCHDs per capita between Ireland and other peer nations.

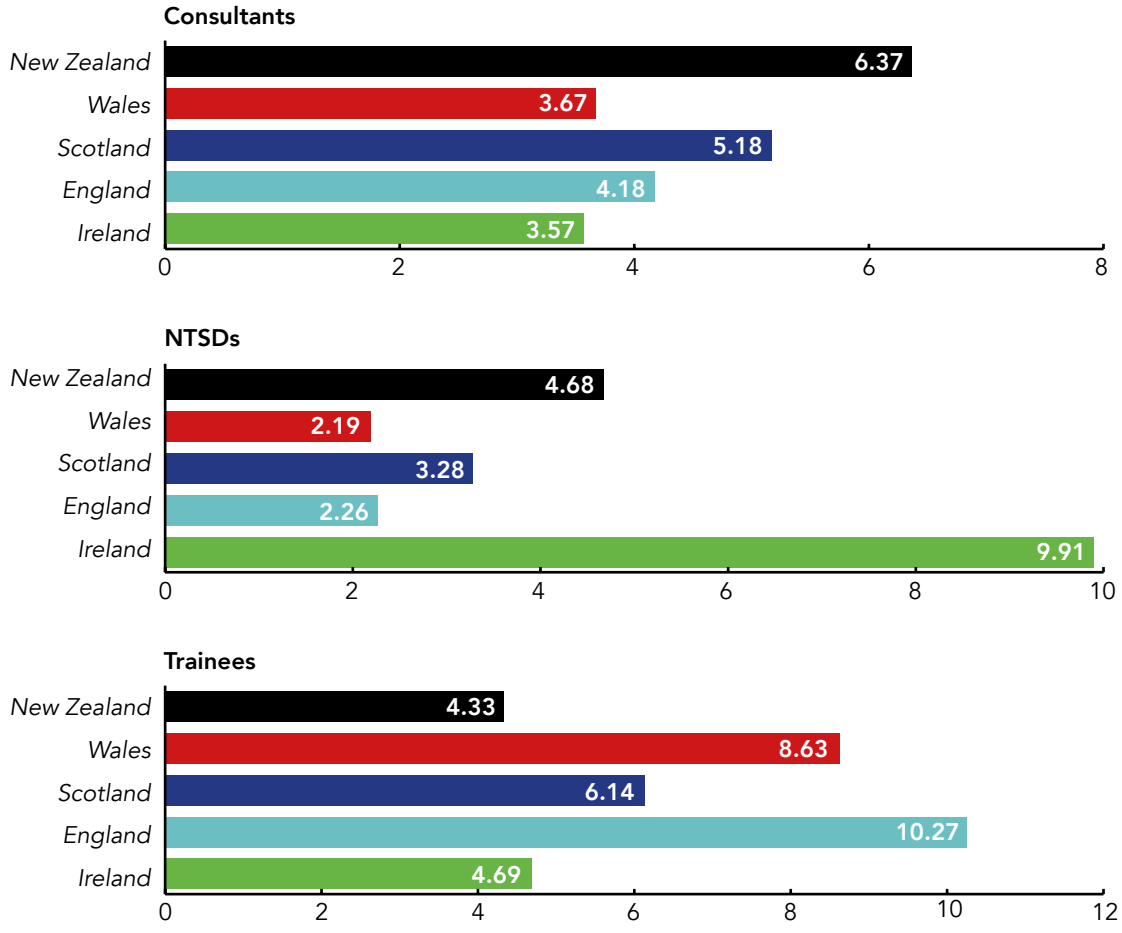
It is imperative that NTSD posts are converted to training posts, as this will ensure the supply of trainees to the training pipeline which is the desired source of new entrants into the consultant workforce. Additionally, this is consistent with the objectives set out by Sláintecare regarding moving towards a consultant-delivered health system. [20] This is also in compliance with the WHO Code on ethical recruitment in healthcare and underpins the development of a sustainable consultant workforce. [21]

Table 9: International peer comparison of the EM workforce per 100k population. WTE or HC as indicated.

Role	Ireland [3, 19]	England [22, 23]	Scotland [24, 25]	Wales [22, 26]	New Zealand [27, 28]
	WTE				HC
Consultants (public)	3.40	4.18	5.18	3.67	
Consultants (public + private)	3.57				6.37
Trainees	4.69	10.27	6.14	8.63	4.33
NTSDs	9.91	2.26	3.28	2.19	4.68

Note that population ratios presented here are for all EM services, including dedicated PEM services.

Figure 4: Population ratios for consultants, NTSDs, and trainees per 100k population.




Dr. Dejan Janevski

4. Modelling Supply

Statistical modelling of the consultant workforce was performed using a stock-flow model to project the supply of consultants to 2038. Input parameters were derived from workforce statistics correct as of June 1st, 2024 (Table 5), while various assumptions were derived from internal NDTP research and consultation with the relevant stakeholders (Table 10). A schematic of the supply model is outlined in Figure 5 below.

As outlined previously, consultants working exclusively in PEDs sites are not considered in this exercise and, consequently, 21.34 WTE was removed from the baseline workforce to ensure that the projected workforce reflects only consultants working in adult or mixed EDs (see Table 7).

The high mid-training attrition rate in EM necessitates that any significant increase in ASTEM must be preceded an increase in CSTEM to ensure supply of eligible candidates into ASTEM. Thus, training capacity is modelled from the point of CSTEM intake, with individuals assumed on average to spend 3 years in CSTEM, 4 years in ASTEM, and 2 years post-CSCST before being appointed to a consultant post. Consequently, an individual starting CSTEM in 2025 is assumed to become a consultant in 2034.

In the supply modelling of this report, the mid-training retention rate is initially assumed to be 55%; just over half of CSTEM graduates progress to ASTEM. This retention rate is assumed to increase annually by 2% to a maximum of 75% by 2034 and remain static beyond this. This reflects recent observations by the EM training programme that mid-training retention is showing signs of improvement, and their on-going efforts to improve this further. Furthermore, a small number of trainees may enter ASTEM without having formally completed CSTEM, increasing the pool of eligible candidates for ASTEM. This side-entry pathway may be possible if a candidate has completed the CSTEM competencies through rotations outside of the formal CSTEM programme.

As outlined above, post-CSCST retention to consultant posts is approx. 75% in EM . [12] Thus, a post-CSCST attrition rate of 25% was assumed in supply modelling, with this reducing by 1.5% annually to 15% by 2032, whereafter it remains static.

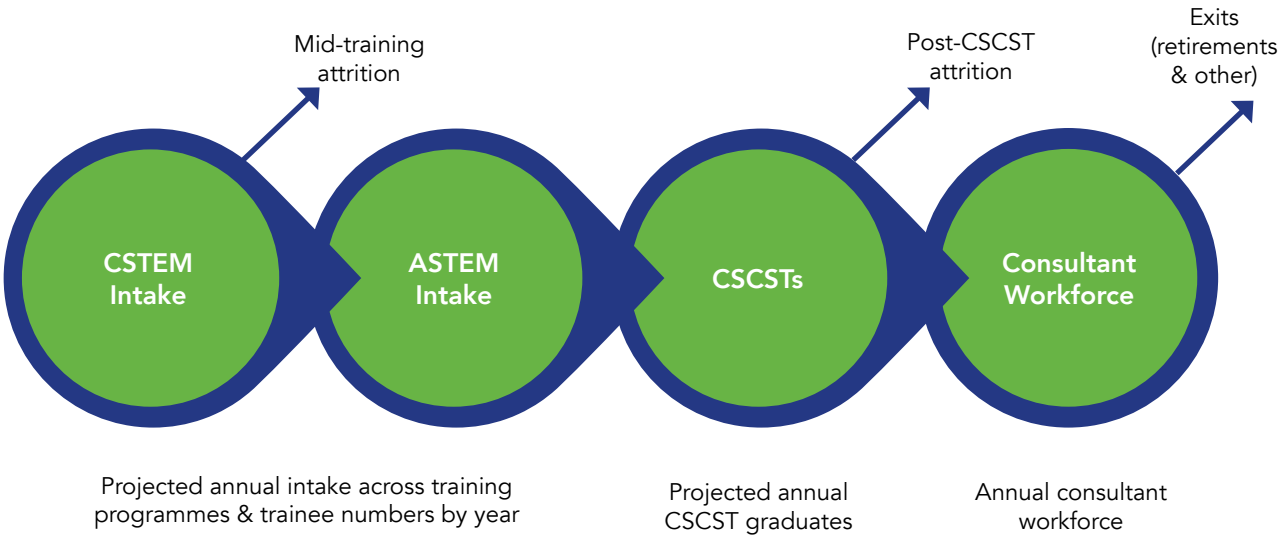
Increased demands for Less Than Full Time (LTFT) working practices are anticipated in the future. Currently the average WTE rate of Consultants in EM is 88.7%, with the different male and female rates (89% and 86%, respectively) accounted for during modelling. In order to account for increased LTFT working practices in the future, the male and female WTE rates are assumed to reduce annually by 0.1% from their current values. Internal NDTP analysis indicates that the median age of retirement of consultants from permanent posts is approx. 62. [29] Accordingly, this value is assumed to be the age of retirement in this exercise. New entrants to the training programme are assumed to follow the current gender split of 60% male, 40% female.

Although the primary focus of this work is consultant supply to HSE-funded consultant posts, total population needs must be considered, not just those using public services. As such, the private sector must be accounted for in modelling. As there are no exclusive private PEDs, all private consultants are assumed to work exclusively in adult care. Accordingly, the national workforce at the beginning of the projection period is considered to be the combined public (excluding PEM) and private workforces. The private sector is estimated as reported by the IMC (Table 5). As of the latest data available, the capacity of the private sector (WTE) is approximately 5.6% of that of the public sector, giving a total public + private workforce (excluding PEM) of 169.8 WTE. This value is taken as the starting point for modelling supply of consultants.

Table 10: Assumptions underpinning statistical modelling of consultant supply to 2038.

Assumption	Value	Source
Baseline workforce (excluding PEM in CHI)	169.8 WTE	NDTP internal analysis + assumption
Attrition rate CSTEM-ASTEM	Initially 45%, decreasing 2% per year to minimum of 25% by 3034	NDTP internal analysis + assumption
Attrition rate post-CSCST to consultant post	Initially 25%, decreasing 1.5% per year to minimum of 15% by 2032	NPDT internal analysis + assumption
Age of retirement	62	Assumed
Non-retirement exits	0.5% (male) 0.8% (female)	Derived-NDTP
Years between CSCST and consultant post	2	Derived-NDTP
Gender balance trainee intake & consultant recruited outside training pipeline	60/40% - male/female	Assumed
Flexible working	WTE to reduce annually by 0.1%	Derived-NDTP
Private sector assumptions	Private sector capacity remains at 5.6% of total public sector throughout projection period.	Derived-NDTP

Figure 5: Supply model schematic.



5. Estimating Demand for Emergency Medicine Consultants

5.1. Aligning Demand with Model of Care for Emergency Medicine

As outlined above, the RCEM recommends a WTE requirement for Consultants in EM according to the number of annual patient attendances to an ED. This is aggregated to a national total demand which defines the targets for this workforce plan. There are two demand scenarios considered in this report. The first projects current patient attendances by ED with projected demographic aging to estimate future patient attendances. No changes to the delivery of UEC in EDs is considered. The second scenario considers demand driven by demographic aging in conjunction with planned networking of the EM service in accordance with the draft MoC. These are outlined in greater detail as follows.

As of June 2024, the estimated WTE of the private sector was approx. 5.6% of the total WTE of the public sector, when excluding workload in exclusive PEDs. For the purpose of this exercise, it is assumed that the private sector activity will grow at the same rate as the public sector and remain 5.6% of the public sector activity for the duration of the projection period. To that end, the total Consultant in EM demand (including the private sector) to 2038 is considered to be 105.6% of the demand projected for public-only consultants in adult/mixed EDs.

5.1.1. Demand Due to Demographic Aging

Projected national demographic changes to 2038 are summarised in Table 11 clearly highlighting the expected substantial increase in the older adult population. 2022 values are based on summary results of national Census 2022, while 2038 values are based on scenario M2 population projections published by the Central Statistics Office. [19, 30]

Table 11: Projected demographic changes in Ireland 2022-2038. [19, 30]

Demographic Group	2022 Value	2038 Value	Average Annual Growth Rate
0-15	1,084,577	889,281	-1.23%
16-30	943,146	1,107,636	1.01%
31-45	1,147,588	1,157,372	0.05%
46-60	1,010,442	1,259,042	1.38%
61-75	698,167	1,006,719	2.31%
76-85	230,174	399,674	3.51%
Over 85	69,872	161,426	5.37%
Total	**5,183,966**	**5,981,150**	**0.90%**
Births	57,450	50,771	-0.78%
Deaths	35,477	46,527	1.71%

Baseline patient attendances in EDs were established through analysis of the Patient Experience Times dataset for 2023. [31] This information was combined with current and projected demographic data for each clinical site, allowing individual ED attendances to be projected to 2038. [4] This is summarised by HR shown in Table 12. These projected attendances were translated into a WTE requirement according to the RCEM guideline of 1 WTE per 4,000 attendances, with the resulting aggregate Regional WTE shown in the final column of Table 12. Note: patient attendance data from PEDs in Dublin have been excluded from these calculations, as Consultants in PEM will provide UEC in these sites, as outlined above, and are not considered in utilisation projections by HR.

Table 12: Patient Attendances at publicly funded EDs for 2023 (actual) and 2038 (projected) per HR.

Health Region	2023 Attendances (actual)*	2038 Attendances (projected)	WTE Demand 2038
HSE Dublin & Northeast	343,425	427,472	106.85
HSE Dublin & Midlands	268,397	345,198	86.3
HSE Dublin & Southeast	148,332	175,129	43.78
HSE Southwest	259,109	297,708	74.42
HSE Midwest	79,999	90,540	22.64
HSE West & Northwest	241,476	271,645	67.91
Total	**1,340,738**	**1,607,692**	**401.9**

**Patient attendances for PEDs have been removed from 2023 figures.*

Considerations of demographic aging alone results in a demand for Consultants in EM in HSE-funded services of approx. 402 WTE. Of particular note is that this value represents services in EM being provided in the same manner as they currently are today. No provision is made for proposed future networking of the service. Accounting for the private sector, the national demand increases to approximately 425 WTE. Supplying this demand target would require the consultant workforce more than doubling in size in the next 15 years.

5.1.2. Demand Due to Demographic Aging and Networking of the Emergency Care

As outlined above, the current development of the MoC for EM aims to significantly improve the care pathway for patients through a number of pillars. Pillar 1 involves reorganisation of the programme in line with the National Trauma Strategy with MTCs, TUs, LEHs, and IUs. Pillar 2 seeks to improve the infrastructure through MDTs and health information systems. The MDTs involve enhanced integration of Advanced Nursing Practitioners, physiotherapists, and other Health & Social Care Professionals within the ED environment. With this planned networking, the consultant workforce required to service the projected demand for 2038 is 311 WTE. This increases to 320 WTE when including 9 WTE demand for Consultants in PEM. Accounting for the private sector, the total value is increased to approx. 338 WTE. This value is taken as the WTE demand for Consultants in EM in 2038 for this report.

6. Supply of Emergency Medicine Consultants

6.1. Baseline

This exercise provides a baseline against which any recommendations to training or recruitment patterns can be measured. This scenario assumes that intake into ASTEM will remain steady at current levels of 16 per annum with no additional recruitment of consultants from outside of the national training programme. All previously stated assumptions around attrition rates, gender balance, etc remain. Under these conditions, the WTE demand for 2038 will never be met, with total workforce in adult/mixed EDs reaching approx. 237 WTE by 2038. The corresponding consultant/population ratio (in WTE) will reach approx. 4/100k.

Table 13: Baseline supply projection. No change to ASTEM intake.

Year	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038
HST intake (July)	16	16	16	16	16	16	16	16	16						
Consultant Supply (WTE) (Year-end)	168.4	175.7	184.4	192.4	196.4	200.6	204.3	208.1	212.1	217.7	223.3	228.8	231.7	234.5	237.3

In light of this, it will be necessary to both increase training capacity and directly recruit consultants from outside the domestic training programme. The latter approach involves recruiting individuals who have completed specialty training and been awarded CSCST outside of the Irish training programme, regardless of their nationality. This would ideally not be required; however, this is necessitated by the magnitude of the required workforce increase and practical restrictions to how quickly training output can increase. Short term expansion demand of the Consultants in EM workforce will predominantly be met through recruitment from outside of the Irish training system while the training programme ramps up in capacity. In the longer term, the demand for Consultants in EM will be sustainably serviced by domestic CSCST graduates.

6.2. Expansion of the Emergency Medicine Consultant Workforce

6.2.1. Increased Training Capacity

In this scenario, CSTEM intake is initially 30 in 2024, building to 40 by 2028. Any increase in CSTEM above 40 would require a minimum of 5 new training rotations in addition to present levels. This may not be straightforward, given the difficulty in securing appropriate rotations in non-EM posts such as anaesthesiology. ASTEM intake is initially 16 in 2024, building to 28 per year by 2034.

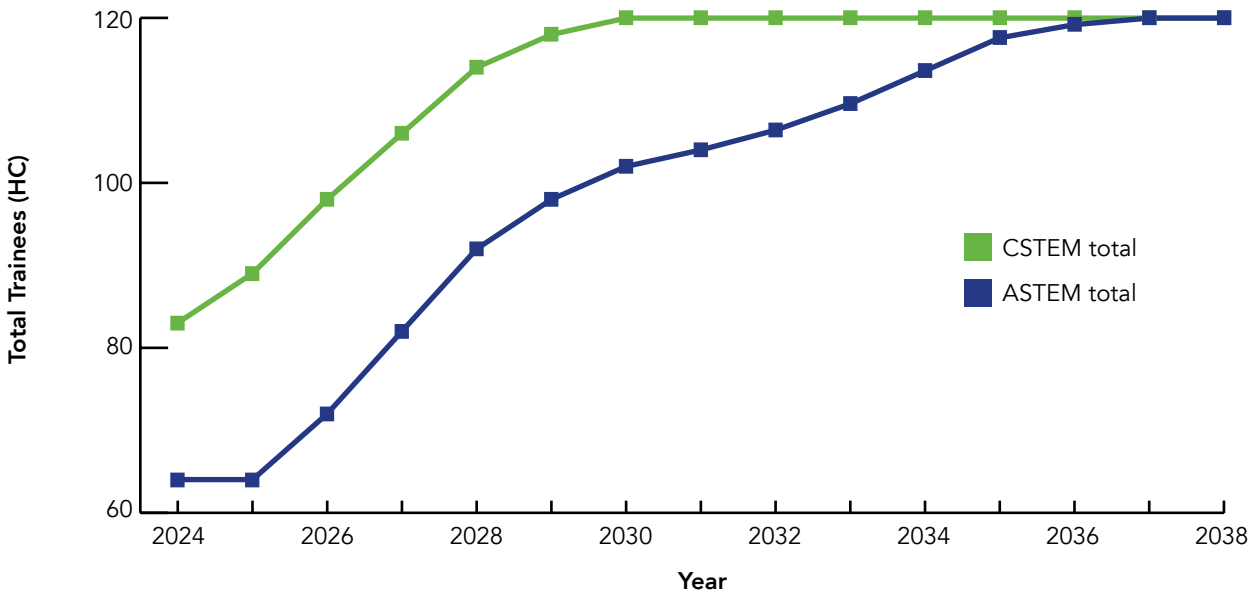
The projected intake at both training levels is shown in Table 14. The corresponding total number of trainees in the system annually is illustrated in Figure 6. This highlights the initial increase in CSTEM followed by ASTEM, before settling at sustainable rates thereafter. CSTEM will reach a sustainable total of 120 trainees across all three CSTEM years by 2030 (currently 83), while ASTEM will reach a steady 120 total trainees across all 4 years by 2037 (currently 64). The exact values presented here for any given year are an approximation and some year-to-year variation can be expected. Nonetheless, the general profile of the expansion of the training programme across the entire projection period will follow that presented here.

The scale of expansion of both training programmes will depend on conversion of existing NTSD posts to training posts across the EMP. As this will require identification of further potential training posts across several clinical sites, it is expected that it will take a few years to expand both programmes to their increased capacity, which is reflected in the gradual increase in training numbers here.

Table 14: Projected annual training intake at CSTEM and ASTEM level for expanded training scenario.

Year	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038
CSTEM intake (HC)	30	32	36	38	40	40	40	40	40	40	40	40	40	40	40
ASTEM intake (HC)	16	20	22	24	26	26	26	26	28	29	30	30	30	30	30

Figure 6: Projected annual total trainee numbers in the expanded training scenario.



6.2.2. International Recruitment of Emergency Medicine Consultants

Recruitment of consultants from outside of the domestic training programme will be required to satisfy immediate demand before the increased training output is achieved. These consultants are referred to as "Category E" by the IMC; consultants who were not awarded CSCST on completion of an Irish specialty training programme but are eligible for consultant posts. [32] These consultants either completed training and achieved CSCST abroad or are deemed eligible by the IMC for specialist registration through equivalent competence.

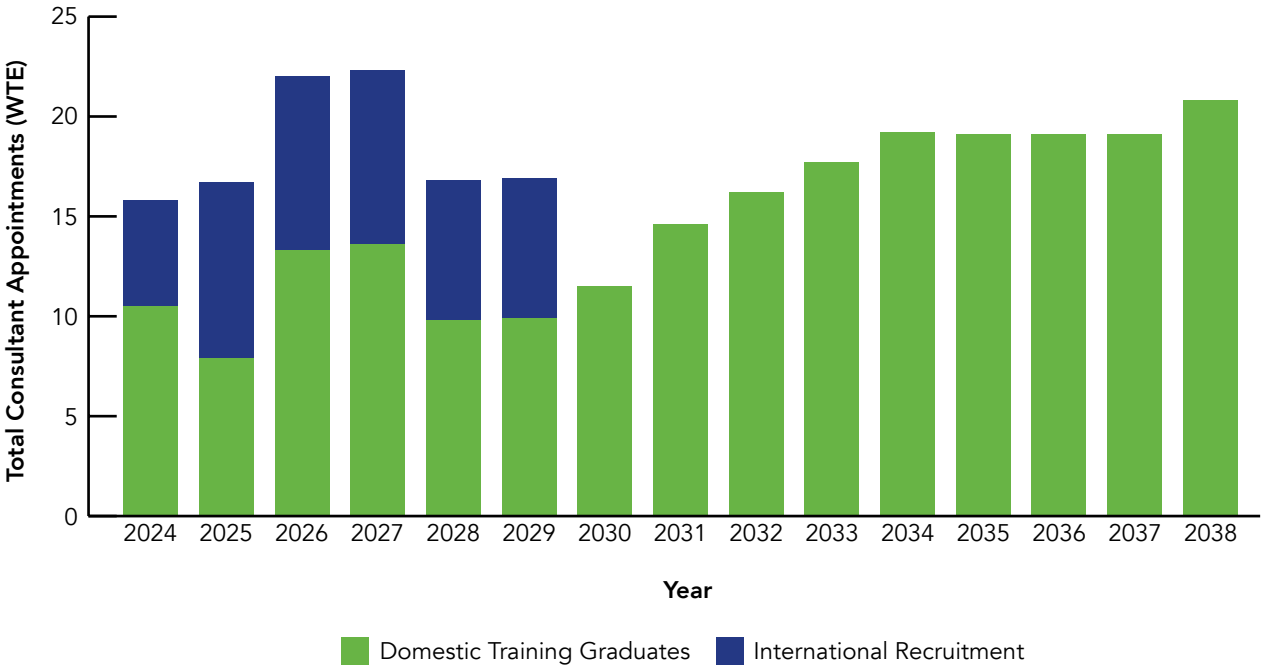
Approximately 50-55 such consultants will need to be recruited into new posts up to 2030, as shown in Table 15, to satisfy immediate consultant demand due to service expansion. Beyond this point, the demand for consultants will be matched by the output of the expanded training programme. This is illustrated in Figure 7. In 2023, 15 consultants were appointed to posts in EM

having been trained outside of the Irish system. It is assumed that this represents the absolute maximum number of consultants recruited in this manner in a given year and the annual international recruitment pattern up to 2030 presented here is reflective of this. The total number of consultants recruited from outside the Irish training programme demonstrates the scale of service expansion required in the short term. The specific number of consultants recruited annually is subject to a number of factors, such as availability of suitable candidates and pace of recruitment processes. Thus, the annual number of consultants recruited from overseas as presented here is subject to change, even if the overall total remains broadly the same.

Table 15: Proposed annual recruitment pattern of Consultants in EM from outside of the Irish training pipeline.

Year	2024	2025	2026	2027	2028	2029
Consultants appointed to posts from outside Irish Training Programme (HC)	6	10	10	10	8	8

Figure 7: Projected annual appointments to consultant posts (WTE) from domestic graduates or international recruitment.



A summary of this supply scenario encompassing immediate recruitment and increased training intake is presented in Table 16. The bottom row indicates the projected national total workforce in adult/mixed EDs (in WTE) at the end of each year.

Table 16: Overall supply projection accounting for trainee intake and recruitment from outside of the domestic EM training programme.

Year	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038
CSTEM intake (HC)	30	32	36	38	40	40	40	40	40	40	40	40	40	40	40
ASTEM intake (HC)	16	20	22	24	26	26	26	26	26	27	28	29	30	30	30
International recruitment (HC)	6	10	10	10	8	8									
Consutant Supply (WTE) (Year-end)	182.6	198.7	216.0	232.5	243.2	254.0	257.3	263.7	271.7	282.7	295.2	307.5	317.1	326.5	337.7

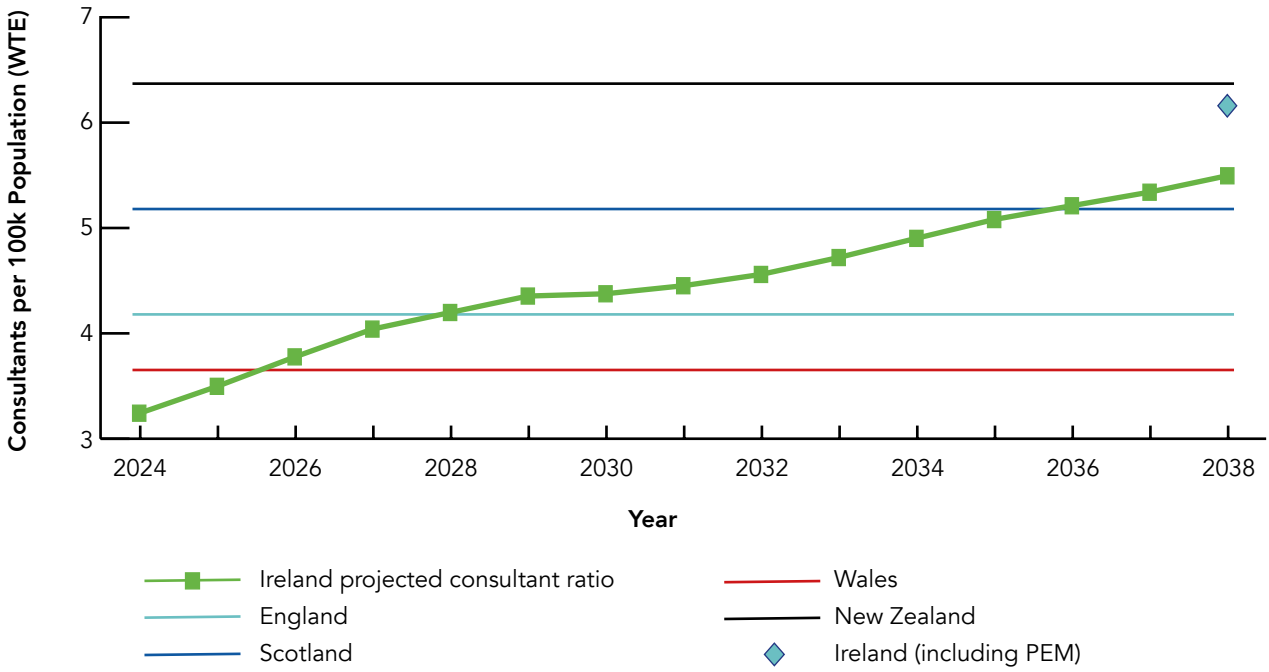
6.2.3. Trainee/Consultant Ratios

The ratio of trainees per consultant will initially increase from current levels of 0.8 trainees/consultant as the training programmes increase in capacity, reaching a maximum of approx. 0.85 trainees per consultant from 2028-2031. Beyond this, the training programmes will remain steady in capacity while the consultant workforce continues to increase, resulting in the trainee/consultant ratio decreasing to 0.7 by 2038. Critically, the trainee/consultant ratio is not projected to rise above 1 trainee per consultant at any stage.

6.2.4. Consultant/Population Ratio

The year-on-year consultant/population ratio in this scenario is presented in Figure 8 below, determined according the modelled workforce growth profile discussed above in conjunction with CSO national population projections (scenario M2). [19] This shows that by the end of the projection period, the ratio of Consultants in EM per 100k total population will increase to approx. 5.7/100k, when excluding consultants working exclusively in PEM. If PEM in CHI sites is considered, the 2038 consultant/population ratio increases to approx. 6.1/100k, as marked on the graph. A comparison with the consultant/population ratio for the older adult population is shown in the appendix. Also included on Figure 8 are the current population ratios in comparable international jurisdictions taken from Table 9, showing that the workforce expansion outlined here will bring Ireland more in line with other countries in terms of Consultants in EM per 100k population.

Figure 8: Projected annual consultant/population ratios.



The current comparison international population ratios from Table 9 are included as reference values. Note, the annual projected Irish population ratio is for UEC in adult/mixed EDs only (PEM excluded), international comparisons are for all EM services. The ratio for total Irish EM services (PEM included) is shown for 2038.

6.2.5. Detailed Supply Summary

A detailed summary of the supply model for this scenario is shown in Table 17, below. This summary breaks projected total recruitment by replacement and expansion demand, entrants to the workforce by CSCST graduates or international recruitment, as well as providing annual metrics around average WTE rate, feminisation rate, and estimated headcount. Note that slight variations may arise if, for example, there are fluctuations in the recruitment of overseas consultants, trainee intake, or gender balance compared to the profile presented here. The final workforce will be met, regardless of slight variations on an annual basis.

Table 17: Detailed supply summary.

	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038
Replacement Posts (WTE)	2.9	4.5	4.6	5.6	5.7	5.8	7.9	7.9	8.0	6.3	6.4	6.5	9.2	9.2	9.3
New Posts (WTE)	12.9	12.2	17.5	16.7	11.0	11.1	3.6	6.7	8.3	11.4	12.8	12.6	9.9	9.9	11.5
Total Recruitment (WTE)	15.8	16.6	22.1	22.3	16.7	16.9	11.5	14.6	16.2	17.7	19.2	19.1	19.1	19.1	20.8
Domestic Graduates (WTE)	10.5	7.9	13.3	13.6	9.8	9.9	11.5	14.6	16.2	17.7	19.2	19.1	19.1	19.1	20.8
International recruitment (WTE)	5.3	8.8	8.7	8.7	7.0	7.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Consultant Supply (@ year-end) (WTE)	**182.6**	**198.7**	**216.0**	**232.5**	**243.2**	**254.0**	**257.3**	**263.7**	**271.7**	**282.7**	**295.2**	**307.5**	**317.1**	**326.5**	**337.7**
Percent female	27%	27%	29%	31%	31%	32%	33%	33%	34%	35%	36%	36%	37%	37%	38%
Estimated Headcount	212	226	246	265	278	291	295	303	312	325	340	355	366	378	391

7. Geographic Distribution of Consultants in 2038

The projected geographic distribution of Consultants in EM by HR in 2038 is shown in Table 18 below. The Regional workforce (in WTE) is aligned with the nationally networked configuration set out by the EMP in the draft MoC. The specific commitments by clinical site will be established with the MoC, and individual consultants will likely have clinical commitments across multiple sites. This information is visualised in the Appendix section of this document, showing the relative increase in consultants per capita across the HRs. As the MoC is currently being assessed, the specifics are subject to change before formal adoption. In the case that the future regional distribution of the workforce per the MoC differs from that presented in this document, the national total is expected to stay largely the same. Thus, the roadmap around expansion of the training programme and workforce will be valid, regardless of readjustments to the specific workforce geographic distribution. As is standard practice with these workforce planning documents, this will be reviewed in three to five years when the EMP has published and adopted the new MoC, and a firmer grasp on consultant workforce commitments by specific ED sites will be available.

Table 18: Current (2024) and projected (2038) Consultants in EM per HR (WTE) across public and private sectors.

Health Region	Consultant workforce 2024 (WTE)	Consultants per 100k population 2024 (WTE)	Recommended consultant workforce 2038 (WTE)	Consultants per 100k population 2038 (WTE)
HSE Dublin & Northeast	36.8	2.99	95	6.85
HSE Dublin & Midlands	32.0	2.79	45	3.39
HSE Dublin & Southeast	27.9	2.77	35	3.14
HSE Southwest	22.9	2.99	64	7.62
HSE Midwest	12.0	2.82	23	4.94
HSE West-Northwest	27.2	3.50	49	5.79
CHI	21.3	1.99	40*	4.5
National Ambulance Service	2.0	0.04		
Private	9.0	0.17	18	0.3
Total (including PEM)	**191.1**	**3.57**	**369**	**6.17**
Total (excluding PEM)	**169.8**	**3.4**	**329**	**5.5**

**The future workforce of Consultants in PEM is based on projected staffing demands outlined by CHI and has been determined outside of this collaboration between the EMP and NDTP. [16]*

It should be noted that the consultant workforce in each HR is not currently forecast to grow by the same proportion to 2038. This is reflective of the planned distribution of MTCs and TUs/TUSSs. In particular, the workforce in the Dublin & Northeast and Southwest regions will grow at a substantially greater rate than other regions. This is due to the two MTCs located in the Mater Misericordiae and Cork University Hospitals, respectively, resulting in some consolidation of resources. In practice, individual consultants will likely have sessional commitments across multiple EDs, so the figures presented here are subject to change and serve a simple guideline. Furthermore, no detailed discussion regarding Consultants in PEM is made here, as the exact disposition of Consultants in PEM working in PEDs is beyond the scope of this document. This is discussed in other publications directly concerned with Paediatrics and CHI workforce planning.

8. Conclusions and Recommendations

- The Consultant in EM workforce is expected to expand significantly in coming years in accordance with the draft MoC for EM which sets out to improve delivery of care in EDs. This will set out workforce requirements according to projected patient demand and how UEC is organised at a national level.

- At present, the Irish health system has a lower number of Consultants in EM per capita than comparable international peers, and an over-reliance on NTSDs. Moving to a consultant-delivered service, meeting changing demographic demand, and bringing staffing levels up to international levels requires the Consultants in EM workforce to increase by approx. 80% in size over the next 15 years.

- Meeting these staffing requirements presents a significant challenge, as the domestic training pipeline for Consultants in EM is not currently equipped to service this demand. In addition to current overall capacity restrictions, a substantial number of trainees currently move to other specialties within the Irish healthcare system midway through their training pathway, a feature unique to EM.

- The projections outlined here detail how the training capacity needs to be expanded over the next 10-15 years. Annual intake CSTEM should increase to 40 over the next 5 years, while ASTEM intake should increase to 30 per annum over the next 10 years.

- It will be necessary to recruit 50-55 additional Consultants in EM from outside of the Irish training programme in the next 5-6 years to meet immediate expansion demand in the workforce while the training output capacity gradually increases. Beyond this, the demand for Consultants in EM will be met sustainably by the domestic training pipeline.

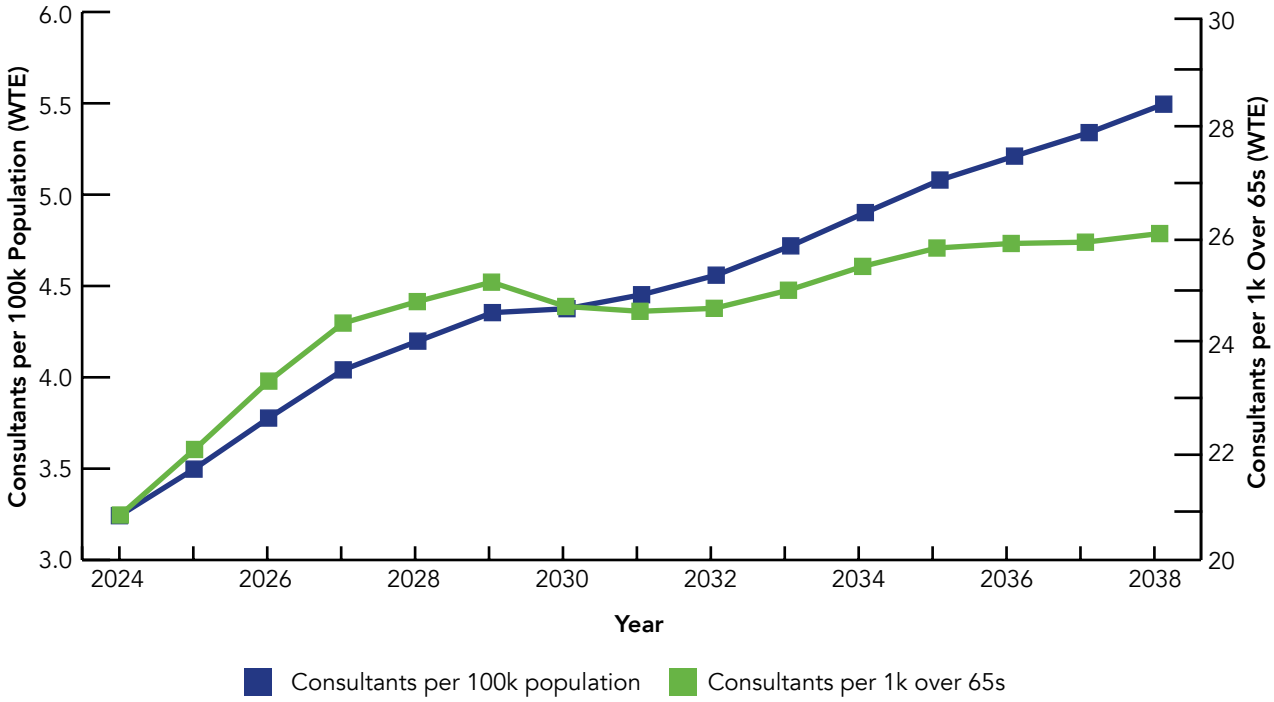
- The specific configuration of the Consultants in EM workforce in the future will be outlined by the MoC. As this is under assessment, the specifics are liable to change following the publication of this report. The expansion of the EM training programme will be required regardless of this. Following the publication of the EM MoC and corresponding networking of services, as well as other associated service developments across other elements of the health system such as CHI and the Trauma Networks, this workforce plan will be reviewed and revised to ensure that the training and workforce roadmap to 2038 are aligned with service requirements.

9. Appendix

9.1. Further Population Ratios

The consultant/population ratio for the older adult population (people aged 65 years and older) is shown below in Figure 9, with the corresponding ratio for the entire population included for comparison. While the consultant/population ratio for the total population will continue to increase over the course of the projection period, the rate of increase of the corresponding ratio for the older adult population will decrease in the latter half, despite the increasing workforce. This is reflective of the aging national demographics over the next few decades, as outlined in Table 11.

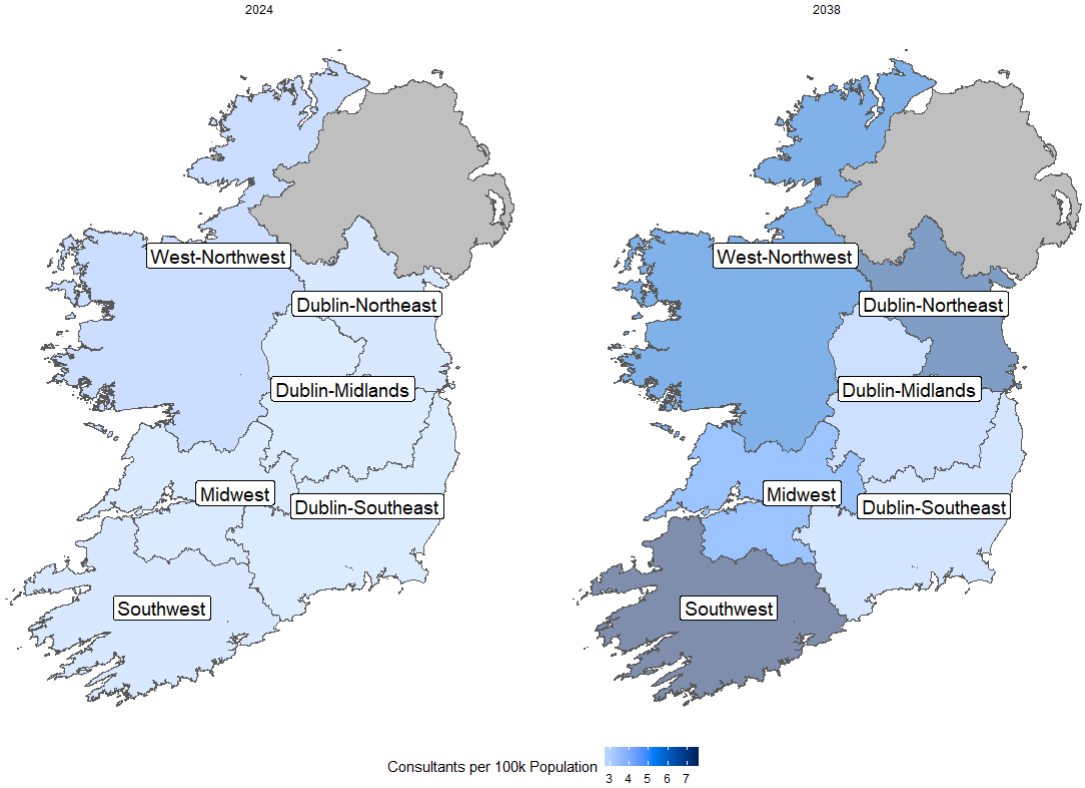
Figure 9: Projected annual consultant/population ratios for overall and older adult populations. [19]



9.2. Geographic Workforce Distribution

The information presented in Table 18 is visualised on a map of Ireland in Figure 10 below. This demonstrates the increasing population ratio of Consultants in EM across all HRs, with those containing the two MTCs expected to increase substantially.

Figure 10: Consultants in EM per 100k population in 2024 (actual) and 2038 (projected) per HR.



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