NATIONAL DOCTORS TRAINING & PLANNING

ROYAL COLLEGE OF SURGEONS IN IRELAND

MODEL 4

MODEL 3 HOSPITALS - CONSULTANT RECRUITMENT & RETENTION REPORT

MODEL 2

MODEL 1

Contents

List of tables

Forewords

Foreword by the Chief Clinical Officer

The distribution of our population continues to change, presenting new challenges as we try to meet the expectations of patients who live further from urban centres. As some treatments become more complex, specialist services cannot be available in every hospital and county, but must be consolidated within a smaller number of Model 4 centres where we can secure the best outcomes and provide specialist care. The greater proportion of healthcare, however, will always take place in the community and in more general Model 3 hospitals.

To deliver this care, we must be able to attract and retain appropriately qualified and skilled medical specialists (consultants). We know that it is difficult to recruit consultants to Model 3 hospitals, which are often trying to compete with their Model 4 counterparts. This report highlights that such difficulty is also exacerbated by delays in the recruitment process for consultants. Recruitment timelines in the voluntary hospital sector, where recruitment is undertaken locally, are shown to be quicker and more efficient.

Crucially, this report aligns with the emerging role of Model 3 hospitals and broader structural reform as outlined in Government policy and other reports, including Sláintecare[1], Securing the Future of Small Hospitals[2], and Surgery for Ireland[3]. The report also aligns with the ambition for the medical workforce as outlined in the recently published NCHD Taskforce Report[4].

The data produced and presented on the Model 3 consultant workforce demonstrates clearly, and in stark terms for the first time, the challenges facing Model 3 hospitals in the successful recruitment and retention of consultants. The report highlights the challenges that these hospitals face now and in the future. If we do not undertake measures to improve the recruitment of consultants for Model 3 hospitals, it will undoubtedly impact negatively on our ability to deliver safe and effective patient care in the medium term. I am therefore pleased to see that the report makes several key recommendations to mitigate these impending challenges.

NDTP, led by Professor Brian Kinirons, has produced this report in conjunction with colleagues from the Royal College of Surgeons of Ireland. Once implemented, the recommendations will address the challenges of consultant recruitment at Model 3 hospitals in the years to come.

Dr Colm Henry
Chief Clinical Officer
Health Service Executive

1 *Sláintecare* (gov.ie)
2 *Securing the Future of Smaller Hospitals: A Framework for Development*, 2013 (lenus.ie)
3 *Surgery for Ireland report*, 2023 (rcsi.ie)
4 *National Taskforce on the NCHD Workforce - Interim Recommendations Report*, 2023 (Department of Health)

Foreword by the NDTP Medical Director

This Model 3 report shines a light on the fragility of the Model 3 network. Evidence of this is clear in the fact that the Model 3 network has more non-permanent posts and more consultants with general registration than the Model 4 network. This report highlights that challenges in the recruitment and retention of consultants to this sector stretch across all specialities and all sites.

It is clear to me that, unless we actively encourage recruitment, the Model 3 network will be challenged in service delivery in the near future. A service delivery crisis is inevitable unless Model 3 hospital posts are made more attractive. The Model 3 consultant workforce is senior, with one-third of the workforce over 55 years of age. This has obvious implications for future recruitment.

I would like to acknowledge the work and commitment of both the operation and steering groups that made this report possible. On our site visits around the Model 3 network, I have been impressed with the ambition shown at multiple sites to deliver a high-quality service. Those whose task it is to recruit and provide this service know, more than most, the challenges that await.

Prof Brian Kinirons,
Medical Director,
National Doctors Training and Planning (NDTP)

NDTP NATIONAL DOCTORS TRAINING & PLANNING

Foreword from the RCSI Council

The Model 3 hospital report project has its origins in RCSI research from 2014, published in 2017 in the Irish Journal of Medical Science (Mealy et al). It showed an impending surgical workforce crisis in Model 3 hospitals, which deliver about 50% of general surgical activity nationally. One in four consultant surgeons in Model 3 hospitals were not in a permanent position, 54% had not trained in Ireland, and 22% were due to retire in the following five years.

I approached Prof Kinirons, in NDTP, who felt the issues would be replicated in other specialties. The data gathered and validated by NDTP has corroborated this prediction. As co-sponsors of the project, RCSI warmly welcomes this report which has used the latest data and covered all consultants in Model 3 hospitals to reach strong recommendations that address the key issues.

It is now incumbent on us all to work towards implementation in the short - and medium - term.

Mr. Paddy Kenny,
Council Member, Royal College of Surgeons in Ireland (RCSI) & Joint Clinical Lead for National Clinical Programme for Trauma and Orthopaedic Surgery

ROYAL COLLEGE OF SURGEONS IN IRELAND

Executive Summary

The future of Model 3 hospitals in Ireland is precariously balanced due to the challenges in the recruitment and retention of consultants for this sector.

The primary role of Model 3 hospitals in Ireland is outlined in Government policy and reports, including *Sláintecare*[5], *Securing the Future of Small Hospitals*[6], and the *National Acute Medicines Programme*[7]. A publication from the RCSI, *What is the future of General Surgery in Model 3 hospitals?*[8], described a crisis in general surgery consultant workforce in Model 3 hospitals.

This Model 3 hospital project was established by NDTP, in association with RCSI, to investigate challenges in the recruitment and retention of consultants across all specialties in Model 3 hospitals and to make recommendations to address the issues identified. A steering group including representatives of the key stakeholders was established to oversee the project.

This report demonstrates a consultant recruitment crisis across every specialty in the Model 3 network. As Model 3 hospitals are essential to the roll out of the new Health Regions structures, the provision of adequate medical staffing will be key to the delivery of this new model of care. The project team analysed the Doctors Integrated Management E-System (DIME) data relating to consultants working in Model 3 hospitals to identify areas of concern in the staffing profile of such hospitals. The team visited 10 Model 3 hospitals and met with senior management teams (SMTs), Medical Manpower Managers, and clinicians – including permanent consultants, locum consultants, NCHDs on a recognised training scheme, and NCHDs not on a recognised training scheme – to explore their insights into recruitment and retention challenges. Additionally, non-consultant hospital doctors (NCHDs) were surveyed[9].

Data analysis

The fragility of the future provision of medical services was starkly outlined in the initial data analysis. This identified marked differences between Model 3 and Model 4 hospitals across several key parameters. In Model 3 hospitals, 24% of consultants are in locum posts, 7% are not on the specialist division of the Medical Council of Ireland register, 7% are in non-approved posts, and 33% are over the age of 55 years. These numbers are significantly higher than in Model 4 hospitals and demonstrate the recruitment challenges facing Model 3 hospitals.

The differences in the baseline data analysis are summarised below.

Table 1: Summary consultant characteristics by model in public acute services in Ireland – January 2022

Hospital model	Consultants employed (headcount)	Non-approved*	Non-permanent	General registration	Posts vacant > 12 months	Aged 56 to 65	Aged 66 or over	Full-time**	Female
Model 4	1,667	2%	12%	1%	1%	21%	2%	97%	35%
Model 3	**807**	**7%**	**24%**	**7%**	**1%**	**28%**	**5%**	**97%**	**32%**

** Not Approved by CAAC ** Full-time is >0.9WTE*

5 *Sláintecare* (gov.ie)
6 *Securing the Future of Smaller Hospitals: A Framework for Development*, 2013 (lenus.ie)
7 *Report of the National Acute Medicine Programme*, 2010 (hse.ie)
8 *What is the future for General Surgery in Model 3 Hospitals?*, Mealy et al, 2017 (researchgate.net)
9 Final NCHD survey response total was 220 of which 155 or 77% were on recognised training schemes

A summary of the findings and recommendations is outlined:

Strengthening the consultant workforce

- **Robust consultant workforce plan**
  Future demand for consultant posts at Model 3 hospitals was reviewed by the project team, with input from the NDTP medical workforce planning team. Analysis showed an estimated recruitment need for 1,005 Model 3 hospital consultant posts in the next 10 years. This will be a major challenge and highlights the urgent need to quickly implement the recommendations in this report.

- **Addressing consultant workload**
  Consultant posts at Model 3 hospitals require a higher degree of regular in-person out-of-hours attendance when on-call, and a workload associated with unscheduled care. This can be compounded by more onerous rotas. These work-life balance issues make Model 3 posts less attractive.

- **Improving consultant recruitment and attraction**
  The recruitment process for the employment of consultants in statutory hospitals is slow, as previously outlined in the 2016 Keane report[10]. The reasons are multifaceted and include geographical and Model 4 versus Model 3 considerations. Despite some recent improvements to reduce the time taken to recruit consultants, the process remains significantly slower than that used in voluntary hospitals, where recruitment is undertaken locally. Model 3 hospital management views this as a barrier to the recruitment of consultants and has stated that potential consultants are lost because of this delay. This needs to be urgently addressed.

  Clinicians were clear that consultant posts, as currently structured, do not appeal to candidates, whose expectations are for greater work-life balance. The workload in posts may be onerous, with a high frequency of on-call rota commitments and with the associated burden of unscheduled care. Other challenges are that Model 3 hospitals rely significantly more on trainees in the early years of their training and doctors who are not on a recognised training scheme than Model 4 hospitals; infrastructure with poor facilities for the delivery of efficient and up-to-date clinical care added to the burden for clinicians; and the appointment of new consultants to posts without a multi-disciplinary team, office space, or clinical facilities is frequent practice. Only 6% of current trainees express an interest in working in a Model 3 hospital.

  Challenges in recruitment to specific specialties (for example, radiology, obstetrics and gynaecology, or emergency medicine) need further exploration. Specific solutions within these specialties are outside the terms of this project. Radiology, in particular, was highlighted as a challenge as radiology trainees do not rotate to Model 3 hospitals. Access to on-call radiology services is curtailed in many Model 3 hospitals due to the difficulty of filling posts. This has an impact on all services in terms of delivery and recruitment.

10 *Towards Successful Consultant Recruitment, Appointment and Retention*, Keane, 2016 (hse.ie)

- **Investing in education and training**
  The importance of having medical students, trainees, and an educationally focused culture was emphasised at all meetings, noting the impact on morale and quality of patient care. Training for the needs of the population and for the care delivered by Model 3 hospitals was highlighted repeatedly. Senior management and consultants at Model 3 hospitals state that they require more generalist trained consultants to deliver the care needs of their patients. However, the NCHD survey showed that trainees were more likely to choose to work at Model 4 hospitals as consultants, and their training is increasingly focused on sub-specialisation which is predominantly associated with posts at Model 4 hospitals. It is worth noting that a third of consultant posts are at Model 3 hospitals. This is a challenge for both the recruitment process and the expectations of trainees achieving their *Certificate of Satisfactory Completion of Specialist Training* (CSCST).

- **Improving on-site infrastructure**
  The team observed poor or absent educational facilities at many of the Model 3 hospitals visited, compounded by a difficulty finding protectewd time for teaching and education. Although some Model 3 hospitals had excellent educational facilities and well-organised educational supports, this should be standard.

- **Reinforcing links with Model 4**
  A joint appointment with a Model 4 hospital improves the possibility of recruiting to the Model 3 hospital. However, the configuration of joint appointments needs to be considered carefully to ensure the Model 3 commitment is realised. A strong academic and educational link with Model 4 hospitals is needed to improve the attractiveness of Model 3 consultant posts and enhance patient care.

  Hospital groups must clearly define, and quickly implement, care pathways that ensure immediate transfer when required and the repatriation of patients if care needs indicate.

- **Implementation**
  Given the current problems in the recruitment and retention of consultants at Model 3 hospitals, and the impact this has on service delivery, a proposal to commence implementation at a small number of initial sites is outlined.

1. Introduction

The population of Ireland is growing, and people are living longer but often with chronic and more complex medical conditions. This increases the demand for healthcare professionals, including doctors. The public is entitled to the same high standard of medical care across Ireland, regardless of their location.

Outside of main urban areas, Model 3 hospitals play a pivotal role in providing access to high-quality and timely healthcare. They provide elective and general medical and surgical services. They also treat unscheduled patients through acute medical assessment units (AMAU), emergency departments (ED), and intensive care units (category 1 or 2 ICU) and may cater for some specialist services such as obstetrics, gynaecology, or paediatrics. To differentiate, Model 4 hospitals will also have a category 3 or 3S ICU and accept tertiary patient referrals[11]. Model 4 hospitals are larger in size in terms of bed numbers and provide a wider range of sub-specialties.

There are 17 Model 3 hospitals in Ireland, split across five hospital groups[12]. Each hospital group has at least one Model 4 hospital, as listed below:

Table 2: Model 3 and Model 4 hospitals, by group

Hospitals group (HG)	Model 4 hospital	Model 3 hospital
Ireland East (IE) HG	1. Mater Misericordiae University Hospital, Dublin 2. St Vincent's University Hospital, Dublin	1. Midlands Regional Hospital, Mullingar 2. Our Lady's Hospital, Navan 3. St Luke's General Hospital, Kilkenny 4. Wexford General Hospital
Dublin Midlands (DM) HG	3. St James's Hospital, Dublin 4. Tallaght University Hospital, Dublin	5. Midlands Regional Hospital, Portlaoise 6. Midlands Regional Hospital, Tullamore 7. Naas General Hospital
Royal College of Surgeons Ireland (RCSI) HG	5. Beaumont Hospital, Dublin	8. Cavan General & Monaghan Hospitals 9. Connolly Hospital, Dublin 10. Our Lady of Lourdes Hospital, Drogheda
South / South West (SSW) HG	6. Cork University Hospital 7. University Hospital Waterford	11. University Hospital Kerry, Tralee 12. Mercy University Hospital, Cork 13. Tipperary University Hospital, Clonmel
Saolta HG	8. University Hospital Galway	14. Letterkenny University Hospital 15. Mayo University Hospital, Castlebar 16. Portiuncula University Hospital, Ballinasloe 17. Sligo University Hospital
University of Limerick (UL) HG	9. University Hospital Limerick	N/A

11 Definition distilled from the Report of the National Acute Medicine Programme, 2010 (hse.ie) by comparing each model as reformatted in the Glossary section

12 The full list of all hospitals - Models 1, 2, 3, and 4 as well as specialist (children, maternity and other) - across all seven hospital groups are listed in the Glossary section

While there has been substantial growth in the number of consultants employed in Ireland over recent years, recruitment and retention of consultants remains a national challenge. This is especially the case in Model 3 hospitals. A paper published by the Royal College of Surgeons Ireland (RCSI), *What is the future of general surgery in Model 3 hospitals?*[13], examined general surgery activity and consultant staffing to inform future workforce and service planning requirements.

The paper demonstrated that 25% of consultant surgeons in the Model 3 network are in locum posts and that 54% have not undergone formal surgical training in Ireland. Over one-third of all consultant surgeons working in these hospitals at the time of publication were 55 years old or over. The report concluded that there is a general surgery consultant workforce crisis. This Model 3 project expands on the work undertaken by RCSI in relation to surgery, with a review of the wider consultant medical workforce within the Model 3 network.

An expert steering group, representative of all the relevant stakeholders, was established in January 2022 to oversee the project. The role of the steering group was to provide strategic direction and leadership throughout the project. The group met five times in 2022, including an in-person workshop in September 2022, to review project output as it progressed and provide valuable input to the NDTP project team. The members of the steering group are listed in Appendix 1, along with dates of its meetings.

The main aims of the project were to:

i. Undertake a baseline study of the current consultant medical workforce in the Model 3 hospital network, across all specialities[14].

ii. Quantify the medical workforce requirements in 2022 and predict the future workforce requirements over the next 10 years to 2032.

iii. Develop a range of recommendations to address Model 3 consultant workforce issues and reach required consultant staffing levels.

The project was co-sponsored by National Doctors Training Planning (NDTP) and the Royal College of Surgeons Ireland (RCSI).

13 *What is the future for General Surgery in Model 3 Hospitals?*, Mealy et al, 2017 (researchgate.net)

14 Model 2 and Model 4 hospitals or those doctors working in community health organisations (CHOs) are not included within scope of this report.

2. Methodology

Under the leadership of the project steering group, national data on the consultant medical workforce was gathered, primarily through NDTP's Doctors Integrated Management E-System (DIME). The data was then subject to a direct validation exercise with the relevant Model 3 hospital.

To achieve the aim of developing a set of recommendations, consultation with stakeholders was carried out through a combination of site visits, semi-structured interviews, and a survey.

National data

Baseline consultant data was sourced from DIME on 31st January 2022.

DIME is a quadripartite system which encompasses National Doctors Training & Planning, the Medical Council of Ireland, postgraduate medical training bodies, and clinical sites. DIME records the registration, training, and employment details of non-consultant hospital doctors (NCHDs). It also provides a database of consultant posts approved by the Consultant Applications Advisory Committee (CAAC) and the employment details of the consultants who occupy all posts. The bespoke nature of DIME means it provides a central source of data on the medical workforce in all HSE-funded public and voluntary services. It also includes the key workforce demographics and characteristics relevant to this report.

Resignations and retirements of consultants from the publicly funded hospital system were estimated by identifying employed consultants who are not listed on DIME in the subsequent year. Similarly, appointments of new consultants were estimated by identifying employed consultants who were not listed on DIME in the previous year.

At the time of the baseline survey, there was an estimated 99% compliance rate on DIME (it is dependent on clinical sites inputting details on their consultant workforce) and therefore there may be variances with data held by clinical sites.

Data for the number of interns shown in this report has been provided by the Medical Intern Unit within NDTP. Data for the number of doctors in specialist training programmes has been provided directly by postgraduate medical training bodies and correlated with DIME data.

Data validation

All Model 3 hospital Medical Manpower Managers (MMMs) were provided with an extract of the consultant data for their hospital as extracted from DIME on 31st January 2022. Between February and May 2022, the NDTP project team held meetings with HR or MMM leads for each of the 17 Model 3 hospitals (see table below). The primary purpose of these meetings was to validate the DIME data. During these meetings, views were sought from these key stakeholders on the current challenges facing their site in relation to the recruitment and retention of consultants.

Map of Model 3 hospital sites

Site visits

Members of the NDTP operational group, including the clinical advisor and the project manager, visited a representative sample of Model 3 hospitals across the country. They met with a wide range of stakeholders, including senior management, Medical Manpower Managers, one or more permanent and locum consultant(s), and NCHDs (both those enrolled on a training programme and those not) to discuss recruitment and retention challenges.

A semi-structured interview was conducted, which focused on aspects negatively impacting recruitment and retention at Model 3 sites. The topics for the meetings were developed by the clinical advisor with stakeholder engagement and informed by the data analysis, then shared with the site in advance of the visits. These topics included:

- data on the key characteristics of the consultant workforce for the hospital site
- consultant recruitment and retention issues for the hospital site
- links with their hospital group and Model 4 hospitals or other sites
- the recruitment process itself

- current NCHD recruitment experience for the hospital site
- consultant, locum, and NCHD experiences at the hospital site
- other items, including suggestions for improvements in recruitment and retention

The project team visited 10 of the 17 Model 3 hospitals selected (see table below). The main criterion for the choice of these sites was geographic, selecting two sites from each hospital group.

Table 3: Model 3 hospital meetings and site visits

Hospitals group (HG)	Model 3 hospital	Meeting date	Site visit date
Ireland East (IE) HG	1. Midlands Regional Hospital, Mullingar	26 Apr 2022	*
	2. Our Lady's Hospital, Navan	06 May 2022	14 Jul 2022
	3. St Luke's General Hospital, Kilkenny	01 Apr 2022	23 May 2022
	4. Wexford General Hospital	10 Mar 2022	*
Dublin Midlands (DM) HG	5. Midlands Regional Hospital, Portlaoise	06 May 2022	*
	6. Midlands Regional Hospital, Tullamore	25 Mar 2022	11 May 2022
	7. Naas General Hospital	09 May 2022	27 Jun 2022
Royal College of Surgeons Ireland (RCSI) HG	8. Cavan General & Monaghan Hospital[15]	17 May 2022	14 Sep 2022
	9. Connolly Hospital, Dublin	18 May 2022	*
	10. Our Lady of Lourdes Hospital, Drogheda	20 Apr 2022	06 Jul 2022
South / South West (SSW) HG	11. University Hospital Kerry, Tralee	19 Apr 2022	24 May 2022
	12. Mercy University Hospital, Cork	28 Feb 2022	*
	13. Tipperary University Hospital, Clonmel	28 Apr 2022	03 Jun 2022
Saolta HG	14. Letterkenny University Hospital	01 Apr 2022	20 Jun 2022
	15. Mayo University Hospital, Castlebar	29 Mar 2022	*
	16. Portiuncula University Hospital, Ballinasloe	30 Mar 2022	27 Jun 2022
	17. Sligo University Hospital	10 May 2022	*

*not selected for site visit

Non-consultant hospital doctor (NCHD) survey

As today's NCHDs are the consultant workforce of the future, it was important to seek the views of this stakeholder group. To achieve this, an online survey of NCHDs was undertaken. The objective of the survey was to ascertain the experiences of NCHDs to date as well as their future career plans, in the context of working at a Model 3 hospital.

The survey was developed by NDTP's National Lead NCHD, in consultation with the NDTP operational group, and shared with the steering group. It was then created on Google Forms by the project team and shared with NCHDs. At the time of the survey, there were 5,735 NCHDs working at Model 3 and Model 4 hospitals. The survey was emailed to NCHDs using the network of 75 NDTP Lead NCHDs[16] across the country and received 220 responses. This response is equivalent to a confidence level of 85% which is within ±5% of the surveyed value[17].

15 Cavan General & Monaghan Hospital are managed as one entity

16 Lead NCHDs is a range of initiatives taken at national level to address a deficit in NCHD representation at an executive level across the country. The NDTP National Lead NCHD role was introduced in 2016. The programme is evaluated each year to ensure adequate representation for trainees. Further information can be found here https://www.hse.ie/eng/staff/leadership-education-development/met/leadnchd/

17 Source: Sample Size Calculator (www.calculator.net/sample-size-calculator.html)

3. Findings

Aim 1: baseline study of the current consultant medical workforce in the Model 3 hospital network, across all specialties

A review was undertaken of the current configuration of the consultant medical workforce in publicly funded health services, as of January 2022. This review included a comparative analysis of the following key characteristics of the consultant workforce:

- Consultants employed
- Consultants in posts not approved by CAAC[18]
- Consultants employed on a non-permanent basis
- Consultants registered on the general division of the Medical Council register
- Posts vacant for over 12 months
- Consultant posts filled by an incumbent aged 56 to 65
- Consultant posts filled by an incumbent aged 66 or over
- Full-time posts
- Gender breakdown

Table 4: Summary consultant workforce characteristics, by hospital model – January 2022[19]

Hospital model	Consultants employed (headcount)	Not approved by CAAC %	Non-permanent %	General register %	Posts vacant > 12 months %	Aged 56 to 65 %	Aged 66 or over %	Full-time* %	Female %
Model 4	1,667	2%	12%	1%	1%	21%	2%	97%	35%
Model 3	**807**	**7%**	**24%**	**7%**	**1%**	**28%**	**5%**	**97%**	**32%**
Model 2	98	5%	23%	4%	2%	31%	3%	100%	26%
Specialist/ other	473	3%	4%	1%	1%	22%	2%	94%	54%
Total acute services	3,045	4%	14%	3%	1%	23%	3%	97%	37%

** Full-time is >0.9WTE*

18 Consultant posts are regulated nationally. Posts are considered for recommendation by the Consultant Applications Advisory Committee (CAAC). Recommendations made by CAAC are then submitted to the National Director of Human Resources and, if a post is approved, a Letter of Approval (LoA) is issued. Posts which are not approved are posts which have not been through this process.

19 An analysis of DIME data extracted in July 2022 noted no material change in the characteristics above.

Model 3 Hospitals Report

Table 5: Summary consultant workforce characteristics, by Model 3 hospital – January 2022

Hospital group	Model 3 principal clinical site	Consultants employed	Not approved %	Non-permanent %	General registration %	Posts vacant > 12 months %	Aged 56 to 65 %	Aged 66 or over %	Full- time* %	Female %
RCSI	Our Lady of Lourdes Hospital, Drogheda	103	6%	21%	2%	0%	19%	3%	97%	43%
Saolta	Sligo University Hospital	80	5%	20%	8%	1%	24%	5%	98%	43%
Saolta	Letterkenny University Hospital	70	1%	27%	7%	0%	31%	7%	100%	26%
RCSI	Connolly Hospital, Dublin	63	0%	13%	0%	3%	16%	2%	94%	38%
Dublin Midlands	Midlands Regional Hospital, Tullamore	54	4%	24%	7%	0%	31%	6%	98%	37%
South / South West	Mercy University Hospital	51	8%	12%	0%	0%	22%	4%	96%	29%
Saolta	Mayo University Hospital	51	14%	27%	4%	0%	20%	6%	94%	39%
South / South West	University Hospital Kerry	45	4%	20%	9%	0%	42%	7%	100%	22%
RCSI	Cavan General & Monahan Hospitals	41	10%	34%	20%	2%	39%	10%	100%	10%
Ireland East	Midlands Regional Hospital, Mullingar	41	7%	34%	10%	0%	27%	7%	95%	27%
Ireland East	St Luke's General Hospital, Carlow/Kilkenny	38	18%	26%	5%	0%	32%	8%	100%	21%
Ireland East	Wexford General Hospital	34	9%	24%	3%	0%	38%	9%	100%	21%
South / South West	Tipperary University Hospital, Clonmel	34	6%	35%	26%	0%	32%	6%	97%	32%
Saolta	Portiuncula University Hospital, Ballinasloe	33	6%	24%	6%	0%	24%	3%	91%	36%
Dublin Midlands	Midlands Regional Hospital, Portlaoise	28	4%	25%	11%	0%	39%	7%	100%	32%
Dublin Midlands	Naas General Hospital	26	15%	27%	8%	4%	42%	0%	92%	31%
Ireland East	Our Lady's Hospital, Navan	15	7%	20%	7%	0%	20%	13%	100%	13%
	Model 3 hospital Totals	**807**	**7%**	**24%**	**7%**	**1%**	**28%**	**5%**	**97%**	**32%**
	Model 4 hospital Totals	**1,667**	**2%**	**12%**	**1%**	**1%**	**21%**	**2%**	**97%**	**35%**
	Model 2 Hospital Totals	**98**	**5%**	**23%**	**4%**	**2%**	**31%**	**3%**	**100%**	**26%**
	Specialist/Other Totals	**473**	**3%**	**4%**	**1%**	**1%**	**22%**	**2%**	**94%**	**54%**
	Acute Services Totals	**3,045**	**4%**	**14%**	**3%**	**1%**	**23%**	**3%**	**97%**	**37%**

** Full-time is >0.9WTE*

4. Analysis

Consultant data comparing hospital models (Model 3 versus Model 4) reveals significant differences in the profile of the consultant workforce. Further examination of the data shows variations in the key characteristics of the consultant workforce within the Model 3 network. This demonstrates that certain Model 3 hospitals are facing greater challenges than others. To highlight this, we looked at four key metrics.

Non-permanent tenure

At 24%, the percentage of consultants with non-permanent contracts at Model 3 hospitals is twice that of Model 4 hospitals (12%). This variance is significant and should be regarded as a risk to the sustainability of the workforce at Model 3 hospitals.
Non-permanent contracts are mainly for a combination of fixed-term and specified purpose locum consultants, employed directly by the hospital or through an agency. There are, however, a number of long-term locum or temporary appointments where the appointee has obtained a contract of indefinite duration (CID), which is equivalent to a permanent contract. It should also be recognised that within any health service there will continue to be a requirement for locum consultant posts to fill short-term vacancies for reasons such as recent retirement, maternity leave, sick leave, and secondments to leadership or national roles.

It is notable that the levels of non-permanent consultants in the Mercy University Hospital (Cork) and Connolly Hospital (Dublin) are just 12% and 13% respectively. This is in line with the Model 4 average of 12%. All other Model 3 hospitals that have a 20% or more non-permanent consultant rate are located outside of large cities. The highest non-permanent rates (over 33%) are found in South Tipperary University Hospital, Cavan General Hospital, and Midland Regional Hospital Mullingar.

Table 6: Non-permanent consultants, by selected hospital model – January 2022

Hospital model	Consultants employed	Non-permanent %
Model 4	1,667	12%
Model 3	**807**	**24%**

General registration with the Medical Council

In 2008, the HSE amended its essential qualifications for consultant appointments, requiring specialist registration with the Medical Council of Ireland for all consultants employed by the HSE. However, our data shows that the percentage of consultants with general registration at Model 3 hospitals is significantly higher than at Model 4 hospitals, at 7% and 1% respectively. When reviewing the number of consultants on the general division of the Medical Council register, we see variations across the Model 3 network ranging from 0% to 26%. Mercy University Hospital and Connolly Hospital are the only Model 3 hospitals that have no consultants in this category.

The table below shows that there are 72 consultants employed by acute hospitals[20] who do not have specialist registration with the Medical Council. This equates to 3% of the total acute hospital consultant population. Of the 72 consultants, 55 are employed within the Model 3 hospital network, or 7% of their workforce, compared to 17 consultants employed by a Model 4 hospital, representing 1% of their workforce. This finding is of significant concern, as it shows there is a large cohort of consultants employed who do not meet the minimum criterion for appointment.

Table 7: Consultant registration status, by hospital model – January 2022

Hospital model	Specialist registration	General registration	Filled	General registration %
Model 4	1,650	17	1,667	1%
Model 3	**752**	**55**	**807**	**7%**

Age profile

The data on age profile demonstrates an urgent need to plan for impending vacancies due to retirement. Model 3 hospitals will come under increasing pressure to recruit and replace retiring consultants just to maintain the current level of services.

The age profile of consultants at Model 3 hospitals is notably older than at Model 4 hospitals, with those aged from 56 to 65 at 28% (versus 21%) and those aged 66 or over at 5% (versus 2%). In total, the consultant workforce over the age of 56 at Model 3 hospitals when compared to Model 4 hospitals stands at 33% versus 23%.

Ranging from 18% to 49% between sites, there is a wide variation in the percentage of consultants at Model 3 hospitals aged 56 and over. A small number of hospitals – for example, Connolly, Our Lady of Lourdes Drogheda, Mayo University Hospital, and Mercy University Hospital – are broadly in line with the Model 4 average, however the remainder show a significantly older consultant population. Notably, nearly half the consultants in University Hospital Kerry, Wexford General Hospital, Cavan General Hospital, and St. Luke's General Hospital Kilkenny are over 56 years old.

Table 8: Consultant age profile, by model – January 2022

Hospital model	Consultant age range				
	56 to 65	66 or over	Total	56 to 65 %	66 or over %
Model 4	342	26	1,667	21%	2%
Model 3	**224**	**44**	**807**	**28%**	**5%**

20 Analysis excludes consultants working in mental health services in the community

Consultant posts not approved by the Consultant Applications Advisory Committee (CAAC)

Applications for new and replacement consultant posts are considered for recommendation by CAAC. Recommendations made by CAAC are then submitted to the National Director of Human Resources and, if a post is approved, a Letter of Approval (LoA) is issued. It is HSE policy that recruitment for a consultant post cannot commence without an LoA. However, the system does contain a small number of consultant posts that have progressed without national approval.

The percentage of consultants at Model 3 hospitals in posts not approved ranges from 0% to 18%. The Model 3 average of 7% not approved posts is significantly higher than the Model 4 average of 2%.

Table 9:Consultant posts approval status – January 2022

Hospital Model	Approved	Not approved	Filled	Not approved %
Model 4	1,626	41	1667	2%
Model 3	**754**	**53**	**807**	**7%**

Consultant posts not approved are generally temporary in their nature and likely not attractive to those seeking permanent employment. In total, there are 53 consultant posts not approved within the Model 3 network. Of these 53 posts, 85% are non-permanent.

Table 10: Consultant posts not approved by CAAC, analysis by tenure – January 2022

Number of Model 3 hospitals	Permanent	Non-permanent	Total
17	8	45	53

5. Projections for the consultant workforce

Aim 2: Quantify the medical workforce requirements in 2022 and predict the future workforce requirements over the next 10 years to 2032

Demand for health care continues to increase year on year. A range of factors are driving increased demand, including population growth of 1% per year and an increase in the number of people over the age of 65 of 3% per year (CSO, 2018). A future projection of consultant supply and demand to 2032 for Model 3 hospitals was undertaken.

The approach taken was as follows:

- Model 3 consultants on 22nd July 2022 taken as the current baseline.
- Projected by year from 2022 to 2032.
- Based on a 5% per annum demand growth rate.

Table 11: 10-year projection and recruitment requirements for Model 3 consultants

Model 3 consultants	Number	Supply requirement
Consultant workforce in July 2022	809	
Vacancies in July 2022	119	119
10-year projections to 2032 Growth in workforce @ 5% per annum	584	584
Projected consultant workforce 2032	1,512	
This represents an 87% increase in the consultant workforce in Model 3 hospitals by 2032		
Attrition		
Exits due to retirements		234
Exits other than retirements @ 1% per annum		68
Total recruitment requirement to 2032		**1,005**

The above projection shows that there will be a recruitment demand for 1,005 consultants over the next 10 years. This will result in a projected 1,512 consultants employed, equating to a net increase of 87% on the current Model 3 consultant workforce of 809. To put this in context, data shows that the average increase in consultants employed by Model 3 hospitals over the past four years was 37 per annum.

6. Findings from stakeholder groups

Aim 3: Develop a range of recommendations to address Model 3 consultant workforce issues and reach the required consultant staffing levels

To achieve the aim of developing a set of recommendations, consultation with stakeholders was carried out through a combination of site visits with semi-structured interviews and a survey. From consultation meetings with various stakeholders and the results of the NCHD survey, common themes affecting the recruitment and retention of Model 3 consultants were identified. These included:

Workload

A significant number of consultations highlighted the view that the workload of a Model 3 consultant has a negative impact on quality of life, and this adversely affects the ability to attract consultants to work at Model 3 hospitals.

> **Medical NCHD recruitment and retention was a huge issue which massively affected the work-life balance and stress levels of NCHDs and consultants within medicine.**
>
> **—(NCHD)**

Key areas raised included the frequency of on-call rotas and the lack of opportunity to redistribute patients to the relevant specialties when compared to colleagues at Model 4 sites.

> **Patients are not discharged from ED but distributed to consultants [...] 80% go to the medical team on call [...] patients with GP letters are sent directly to the medical team without triage.**
>
> **—(Consultant)**

Consultants highlighted that this is further exacerbated by having fewer training NCHDs within their sites when compared to Model 4 hospitals and that generally the trainees within the Model 3 hospitals are at an earlier of stage of their training programme. The junior nature of trainees often led to more consultant supervision being required. Analysis of training rotations and consultation with postgraduate training bodies support this view when it comes to the allocation of higher specialist trainees. This view was supported by junior trainees, who often felt unsupported and expected to function at a more responsible level in a Model 3 hospital than in a Model 4 hospital.

> **I was forced to upskill very quickly, which was good for my training but it was at times extremely stressful.**
>
> **—(Trainee)**

Challenges working within the hospital, as well as within the hospital group, were raised. These included difficulties accessing diagnostics, including radiology and access to subspecialist care or advice within the hospital.

> **While many Model 3 hospitals do a lot of things well, there are occasional shortcomings in the service on offer, for example difficulty accessing out-of-hours diagnostic imaging or poorly structured pathways for the acutely unwell patient with complex and not so complex care needs.**

The lack of certain subspecialties in a Model 3 hospital is very frustrating and challenging.
—(NCHDs)

The transfer of patients with serious illnesses who require subspecialist intervention in a Model 4 hospital within the hospital group was cited as a particular difficulty, due to problems with the referral pathways. Consultants felt that the workload from unscheduled care could be better supported with earlier specialist input from within the hospital group.

Managing the patient who needs Model 4 specialist intervention where transfer is delayed for days adds significantly to the stress and workload of a consultant in a Model 3.
—(Consultant)

However, there were some positive views of the transfer of patients and in contrast some sites had a supportive network.

Good network, a no-refusal transfer and repatriation policy with the hospital group's maternity hospital.
—(Consultant)

Addressing these workload factors should support more consultant-delivered care and a structured reduction in the employment of doctors who are not on a recognised training scheme, as envisaged by *Sláintecare*.

Incentives

As noted Model 3 hospitals have a dis-proportionate level of temporary consultants often because these posts are perceived as less attractive posts. Therefore, it has been raised on site visits (citing the UK[21] as an example) and in the NCHD survey as to whether any incentives could be offered to fill posts which are difficult to recruit. However, any change to financial pay measures is beyond the remit of this report, so the recommendations focus on flexibilities and innovate recruitment approaches.

Specialities that are most difficult to appoint

The three specialities identified by the sites as the most difficult to recruit or retain consultants in the Model 3 network were:

Specialty	Sites reporting
Radiology	10 of 17 (59%)
Obstetrics and gynaecology	10 of 17 (59%)
Emergency medicine	7 of 17 (41%)

21 The Targeted Enhanced Recruitment Scheme is an initiative that will offer a one off payment of £20,000 to GP Specialty Trainees committed to working in a select number of training locations in England that either have a past history of under-recruitment or are in under-doctored or deprived areas.

Sites noted that they often had difficulties sourcing candidates and frequently needed to re-advertise. It was noted that the radiology training programme does not rotate trainees through Model 3 hospitals. This was seen as a disadvantage when trying to recruit graduates from Irish training schemes.

> **In radiology, we had permanent vacancies which had to be re-advertised three or four times.**
>
> **Obstetrics and gynaecology posts are frequently re-advertised as no candidates were recruited.**
>
> **—(Medical Manpower Managers)**

This broadly correlates with recent data for Model 3 consultant vacancies and non-permanent (temporary) filled posts by medical discipline, as outlined below.

Table 12: Rank of Model 3 consultant vacancies, by medical discipline

Medical discipline	Filled	Vacant	Total	% of posts vacant
Emergency medicine	**52**	**29**	**81**	**36%**
Medicine	237	54	291	18%
Obstetrics and gynaecology	**61**	**10**	**71**	**13%**
Radiology	**92**	**11**	**103**	**11%**
Pathology	51	5	56	9%
Paediatrics	60	5	65	8%
Anaesthesiology	122	9	131	7%
Surgery	120	8	128	6%
Total	**795**	**131**	**926**	**14%**

Source: DIME, March 2023

Table 13: Rank of Model 3 consultant posts filled temporarily, by medical discipline

Medical discipline	Permanent	Temporary	Filled total	% Filled temporarily
Emergency medicine	**37**	**15**	**52**	**29%**
Obstetrics and gynaecology	**49**	**12**	**61**	**20%**
Paediatrics	49	11	60	18%
Medicine	196	41	237	17%
Radiology	**77**	**15**	**92**	**16%**
Pathology	44	7	51	14%
Surgery	104	16	120	13%
Anaesthesiology	106	16	122	13%
Total	**662**	**133**	**795**	**17%**

Source: DIME, March 2023

Infrastructure

Deficiencies in infrastructure were highlighted during several site visits as another disincentive for consultants. Examples given included:

- older in-patient wards and out-patient departments
- restricted consultation spaces, meeting spaces, and administrative office spaces
- poor educational or training facilities

Information technology infrastructure and services were also compared negatively to Model 4 hospitals. Examples of where technology is lacking were electronic prescribing, electronic dictation, software systems to manage appointments, and Wi-Fi accessibility.

> **Lack of consultants' room in the hospital for confidential discussion of cases.**
>
> **Frustration with poor infrastructure (lack of work space, IT issues, and limited lab diagnostics capacity).**
>
> **—(Consultants)**

General division NCHDs

Model 3 hospitals show a higher reliance on NCHDs who have general registration with the Medical Council than Model 4 hospitals. This is reflected in the table below, which shows that 60% of NCHDs at Model 3 hospitals are not on recognised specialist training schemes, compared to just 36% at Model 4 hospitals. This equates to an average of 1.9 not on a recognised specialist training scheme NCHDs per consultant at Model 3 hospitals versus only 0.8 at Model 4 hospitals.

Table 14: Numbers and ratios of NCHDs on recognised training schemes or not at Model 3 and Model 4 hospitals – December 2022

Hospital Model	Consultants	Total NCHDs	Recognised training scheme NCHDs	Interns	Not on recognised training scheme NCHDs	Total NCHDs per consultant	Recognised training scheme NCHDs per consultant	Not on recognised training scheme NCHDs per consultant
Model 4	1,577	3,427	2,182	518	1,245	2.2	1.4	0.8
			64%		36%			
Model 3	**742**	**2,330**	**926**	**203**	**1,404**	**3.1**	**1.2**	**1.9**
			40%		**60%**			

Source: Draft NDTP Workforce Planning Report 2022

Several sites raised concerns that Model 3 hospitals are unable to retain these doctors as many of them are leaving to work in the United Kingdom, where they can access higher specialist training. This was echoed by consultants, NCHDs, and Medical Manpower Managers. The UK has made a number of changes to remove barriers for international medical graduates (IMGs), such as removing the cap on its Foundation Programme and healthcare worker visas. Over the last five years, this has led to an increase of 40% in IMGs studying in the UK[22]. In addition, NCHDs not

22 The state of medical education and practice in the UK: The workforce report 2022 (gmc-uk.org)

enrolled on training schemes are migrating to Model 4 hospitals. The loss of these doctors, many of whom are very experienced, is further compounding the workforce challenges of the Model 3 consultant.

Education and training

By their nature, Model 3 hospitals are more generalist in the services delivered. During the site visits, consultants expressed their view that postgraduate training schemes are often too specialist in their focus and are training consultants more for specialist roles at Model 4 hospitals, meaning that graduates from postgraduate training programmes were less interested in roles at Model 3 hospitals. In particular, a need was expressed for general medicine and general surgery consultants.

A number of medical colleges have recognised the need to address this. The Imrie report, for example, recommended that the RCPI, "*Maintain and strengthen a commitment for generalism. The College can strengthen its already enviable commitment to generalism in training and in practice by ensuring consistent, high-quality, high-intensity General Internal Medicine training, while maintaining generalist training in Paediatrics and Obstetrics and Gynaecology.*"[23]

Half of all NCHDs surveyed feel they would have less opportunity to undertake research or academic work in a Model 3 hospital, and that this would influence their decision to work there. 90% of NCHDs surveyed felt that protected time for educational activity and teaching would encourage them to apply for a permanent consultant post in this sector.

Lack of formal teaching and supervision at Model 3 hospitals was frequently brought up by the NCHDs surveyed. Poor education delivery appears to be confounded by a number of factors at Model 3 hospitals.

> **Formal teaching was reduced due to a lack of filled permanent consultant posts and a lack of NCHDs, leading to increased clinical workload.**
>
> **Over-reliance of locums at consultant and NCHD level at Model 3 hospitals is poor for training. Teams were managed by locum consultants who would change every few weeks.**
>
> **I would be happy to work in either a Model 3 or 4 hospital once there is a good department in place with scope to establish and improve a service and the opportunity to undertake research.**
>
> **—(NCHDs)**

Recruitment process

Many of the Model 3 hospitals expressed a clear view that the consultant recruitment process is long and complex, with multiple stakeholders. This negatively impacts their ability to recruit permanent consultants when compared to the localised recruitment control enjoyed by voluntary hospitals. Delays correlate with the high percentage of temporary and locum consultants.

23 Training 21st Century Clinical Leaders, A review of the Royal College of Physicians of Ireland training programmes by Professor Kevin Imrie, July 2014 (rcpi-live-cdn.s3.amazonaws.com)

Currently, the majority of the Model 3 hospitals use the Public Appointments Service to recruit permanent consultants. The Mercy University Hospital in Cork is the only voluntary Model 3 hospital and therefore it conducts its own local recruitment. The recruitment process is significantly shorter and less complex in terms of the number of steps and stakeholders involved. An exercise was conducted to review the length of time needed to permanently fill consultant posts approved by CAAC in 2021. The duration is calculated using the date of CAAC approval and the date of the post being filled on a permanent basis, as recorded in DIME.

Table 15 outlines the number of posts filled permanently at 6-month, 12-month, and 18-month intervals. The table looks at the 511 posts approved by CAAC in 2021. The data shows that it is considerably slower to permanently fill posts at Model 3 hospitals. There were 104 posts at Model 3 hospitals approved by CAAC in 2021, of which 38% had been permanently filled after 18 months, with a further 41% filled on a non-permanent basis. A comparison of voluntary Model 4 hospitals (86%) and statutory Model 4 hospitals (48%) highlights the variation in the rate at which consultant posts are permanently filled across sites after 18 months.

The voluntary hospital network consists of five large Dublin sites and the statutory Model 4 network consist of 4 large regional sites (Cork, Limerick, Galway, and Waterford). All statutory Model 4 sites have a lower fill rate than the voluntary hospitals. There are potentially a range of reasons, including geography and recruitment processes, which may be driving the large differences between the sites.

Table 15: Percentage of posts permanently filled at 6, 12, and 18 months after CAAC approval [24]

Duration	Total	Model 3	Model 4 voluntary	Model 4 statutory
At 6 months	16%	6%	24%	6%
At 12 months	36%	14%	58%	17%
At 18 months	64%	38%	86%	48%

Source: Draft NDTP Workforce Planning Report 2022, June 2023

Joint appointments

Stakeholders highlighted the importance of joint appointments, although referenced some challenges that can be associated with these. Joint appointments with a Model 4 hospital seem to be more attractive when recruiting a permanent consultant for a Model 3 site. Current DIME data would support this view, as it shows that 17% of consultants with their principal commitment to a Model 3 hospital have a joint appointment with a Model 4 site. 10% of Model 4 consultants have a joint appointment with a Model 3 hospital (source: DIME, March 2023).

> **I was appointed to a Model 3 hospital on a joint appointment with an 11-hour commitment to the Model 4 where I had an OPD clinic, peer meetings, and research opportunities and with a full team was working very well.**
>
> **—(Consultant)**

Joint appointments with just one day a week at a Model 3 hospital are limited in the service and support they provide to the Model 3 hospital. Often, this commitment is net of travel time,

24 The Kaplan–Meier estimator is used to calculate the rate at which CAAC approved posts are filled.

which in some geographic locations can be substantial. Joint appointments with the minor commitment to the Model 4 hospital were preferred by the Model 3 hospitals.

The NCHD survey showed that 89% of NCHDs feel they would have fewer opportunities to maintain or enhance their skills as a consultant in a Model 3 hospital, whilst 77% of NCHDs feel they would have less exposure to complex patient care as a consultant at a Model 3 hospital. The survey also found that this would influence 56% of them not to work as a consultant in a Model 3 hospital. NCHDs highlighted that to maintain their skills, the option of a joint consultant appointment would be attractive to them.

> **From an anaesthesia point of view, and as someone with an interest in ICU, a joint appointment between a Model 3 and Model 4 ICU would be very appealing, as the intensity of work between the hospitals can be very different. It would also work to improve access to ICU from Model 3 to Model 4 units.**
>
> **—(NCHD)**

NCHD survey

As part of this report, it was important to seek the views of the current NCHD cohort, in particular training NCHDs, to determine their views on working at a Model 3 hospital. There were 220 responses received. The survey shows that 88.1% of the respondents have worked in a Model 3 hospital. In Section 2 of the survey, Your Career Plans, the question was asked, "Do you have a preference for working in a particular model of hospital?" While 47% indicated a preference for a consultant post at a Model 4 site, it is notable that 23% stated they would prefer to work at a Model 3 hospital, either exclusively or via a joint appointment with a Model 4 hospital (7.5% and 15.3% respectively). 30% of respondents were unsure.

Table 16: NCHD hospital model preference

Do you have a preference for working in a particular model of hospital?	Training NCHDs	%	All NCHDs	%
Yes, I would prefer to work in a Model 4 hospital	89	54%	100	45%
Yes, I would prefer a joint appointment within both a Model 3 and a Model 4 hospital	20	12%	34	15%
Yes, I would prefer to work in a Model 3 hospital	10	6%	19	9%
No/unsure	47	28%	67	30%
Total	**166**	**100%**	**220**	**100%**

Reasons cited for the 45% preference for Model 4 versus 9% preference for Model 3 included:

- Access to services, specialties, diagnostics, and investigations
- Availability of research, academic, and innovation opportunities
- The experience or seniority level of NCHDs
- Involvement in complex care and sub-specialisation
- The resources and supports available, including colleagues
- On-call frequency

The responses of NCHDs are in line with the views expressed by stakeholders during the site visit process. When the responses of NCHDs on the general division of the Medical Council register are extracted from the data, the percentage of doctors in training expressing an interest in working in a Model 3 hospital reduces to 6%. This is broadly in line with the findings in the general surgery Model 3 report, which found that 3% of surgical trainees expressed a preference for a consultant appointment in a Model 3 hospital[25].

However, whilst the survey focuses on the intentions of NCHDs, it is important to track the actual percentage of graduates from Irish postgraduate training programmes who are now working at Model 3 sites. A review of the 2016 to 2018 cohort of doctors who received a Certificate of Satisfactory Completion of Specialist Training (CSCST) and worked in the Irish publicly funded healthcare system in 2022 showed that, in fact, 13% were principally employed by Model 3 hospitals. 54% were principally employed by Model 4 hospitals, with the remainder at mental health, specialist, and other public healthcare sites. In addition, a further 8% are principally employed by other hospitals with a commitment to a Model 3 hospital. A detailed breakdown of the survey and responses are outlined in Appendix 2.

25 What is the future for General Surgery in Model 3 Hospitals?, Mealy et al, 2017 (researchgate.net)

7. Recommendations

Given the current crisis in consultant staffing in the Model 3 network, as clearly outlined in this report, and having regard to the Terms of Reference, the following recommendations in relation to recruitment and retention of consultants at Model 3 hospitals are provided.

Theme A: Strengthening the Consultant Workforce

i. Robust Consultant Workflorce Plan

Findings Summary:

There are currently over 100 vacant consultant posts at Model 3 hospitals. Demand projections show that over 1,000 consultants will need to be recruited in the next 10 years.

Recommendations:

1. Develop annual plans and priorities at hospital group (HG) or Health Region level for consultant post expansion in the Model 3 network to meet the target for 2032. Plans need to take into account the required resources and infrastructure to support new consultant posts. Plans should be costed and aligned with taskforce targets[26].

Responsibility[27]:

HG/Health Region CD & HR, Model 3 MMM

26 National Taskforce on the NCHD Workforce, 2022-2023

27 Hospital group (HG), Health Region, Clinical Director (CD), human resources (HR), Medical Manpower Manager (MMM), senior management team (SMT), Chief Academic Officer (CAO), education and training (E&T), Training Lead (TL), postgraduate training bodies (PGTBs)

ii. Addressing consultant workload

Findings Summary:

Many consultant posts at Model 3 hospitals require a higher degree of in-person out-of-hours attendance when on-call, plus a workload associated with unscheduled care. This can be compounded by more onerous rotas. These work-life balance issues make Model 3 posts less attractive.

Recommendations:

2. Model 3 hospitals must identify consultant posts (filled and vacant) that require a high degree of out-of-hours attendance. The on-call rotas for the identified posts should be critically assessed with a view to reducing the onerous workload. Sites should explore the possibility of hospital group/Health Region rotas or hospital clusters in a defined area if possible (subject to geography and speciality).

3. Following review where sites are unable to address the onerous workload or reduce the frequency of on-call rotas, Model 3 hospitals, in conjunction with the hospital group or Health Region, should prioritise the appropriate business case or application for additional consultants.

Responsibility:

Model 3 CD, Model 3 SMT, HG/Health Region

iii. Improving consultant recruitment and attraction

Findings Summary:

The time taken to fill a consultant post is considerably longer at Model 3 statutory hospitals. The reasons are multifaceted and include geographic location, voluntary versus statutory, and Model 3 versus Model 4 considerations.

Recommendations:

4. Give statutory hospitals more control of recruitment within their hospital group or Health Region. A more localised recruitment model, similar to that of voluntary hospitals, is recommended as the data clearly demonstrates that this model is much more efficient. This model must maintain appropriate recruitment and governance standards, with central reporting and planning.

5. Model 3 hospitals should implement a monitoring and review process of potential retirements and commence the consultant replacement process pre-emptively. NDTP should engage with National Human Resources (HR) and the Consultant Applications Advisory Committee to streamline the application process for replacement consultant posts.

6. NDTP should engage with National Human Resources (HR) and the Consultant Applications Advisory Committee to streamline the application process for replacement consultant posts.

Responsibility:

HG/Health Region HR, Model 3 MMM, NDTP, National HR

iii. Improving consultant recruitment and attraction (contd.)

Findings Summary:

Only 6% of trainees express an interest in working in a Model 3 hospital.

Recommendations:

7. All Model 3 hospital consultant posts should have a formal relationship with the hospital group or Health Region, facilitating the maintenance of skills in complex case management and promoting educational and academic research opportunities.

8. Model 3 hospitals should promote and establish flexible working opportunities to address lifestyle factors and make posts more attractive to all applicants.

9. Support should be provided by hospitals to any consultants relocating for work – including support with accommodation, employment opportunities for partners, finding local schools, community supports, etc.

10. Promote the benefits of working in a Model 3 hospital and be innovative in making posts more attractive. For example, leverage the new POCC[28] contract to attract trained doctors back to Ireland.

11. Targeted recruitment campaigns should be aimed at trainees in the last year of higher specialist training.

12. A formal policy or process on proleptic appointments should be considered for Model 3 hospitals.

Responsibility:

HG/Health Region HR, Model 3 MMM

28 For details on the Public Only Consultant-Contract (POCC), 2023 refer to https://www.hse.ie/eng/staff/resources/hr-circulars/ hr-circular-008-2023-public-only-consultant-contract-2023.html

Findings Summary:

Difficulty in recruiting to specialties within Model 3 hospitals, particularly in radiology, obstetrics and gynaecology, and emergency medicine. Radiology trainees do not rotate to Model 3 hospitals. Radiology services are being outsourced to the private sector in a number of Model 3 hospitals.

Recommendations:

13. Conduct a quantitative and qualitative analysis of the applicant pool for these posts to identify why they are unattractive and highlight what practical steps should be taken to address this.

14. Extend radiology training rotations to Model 3 hospitals with the Faculty of Radiologists.

15. Given the demand for radiology services, hospitals should invest in growing their radiology capacity as the long-term sustainable solution for scheduled and unscheduled care.

Responsibility:

Model 3 CD, NDTP, Faculty of Radiology, HG/Health Region, Model 3 MMM

Theme B: Investing in Education and Training

Findings Summary:

In comparison to Model 4 hospitals, there is a higher proportion of doctors not on a recognised training scheme and of relatively junior trainees.

Recommendations:

16. Where doctors are not on a recognised training scheme, this should be evaluated with a view to converting to a recognised training scheme post. Such posts should be proactively identified to postgraduate training bodies, particularly at registrar level. Postgraduate training bodies can determine if these posts would be suitable for training.

17. Model 3 hospitals and consultant trainers should work in collaboration with postgraduate training bodies to make specialist registrar posts educationally appropriate for more senior trainees.

18. Provide a career pathway such as recognition of prior learning to facilitate the eligibility of NCHDs on the general division to compete for higher specialist training posts.

19. Model 3 hospitals should work closely with medical schools and the intern network to identify teaching and training opportunities for medical students and interns which match the curriculum from each sector. This would enhance the experience of these groups.

20. Hospitals that do not have interns assigned or trainees in a number of specialties must work with the relevant training bodies or regulator to meet the requirements to have these posts recognised for training and assigned to their hospital.

21. NDTP and the Forum of Irish Postgraduate Training Bodies should further engage on the issue of generalist training programmes, which may be more suitable for the Model 3 network.

Responsibility:

NDTP, Forum PGTBs, HG/Health Region CAO, CD E&T/TL

Theme C: Improving Site Infrastructure

Findings Summary:

There are issues of poor educational facilities, older wards and outpatient departments, lack of office space, and poor ICT.

Recommendations:

22. Identify immediate deficits that are impacting training and/or accreditation – and by extension the ability to provide suitable learning environments – to attract trainees and qualified consultants interested in training. Plans should be costed and aligned with the taskforce report on minimum standards for training.

23. Identify all options within the site to address deficits. This should include consideration of suitable modular, re-purposed, or leased spaces in the short term.

24. Develop medium- to long-term plans and appropriate business cases to address other infrastructural deficits.

Responsibility:

Model 3 SMT, HG/Health Region SMT, HSE Estates

Theme D: Reinforcing Links to Model 4

Findings Summary:

Joint appointments with only one day per week at a Model 3 hospital do not provide an optimal benefit to the hospital's delivery of care.

While 6% of trainees expressed a preference for Model 3 hospitals only, 12% of trainees would consider a joint appointment between a Model 3 and Model 4 hospital.

Recommendations:

25. Joint appointments should have a minimum of two days per week commitment to the Model 3 hospital.

26. CAAC to consider this as a minimum requirement when considering joint appointment applications.

Responsibility:

Model 3 CD, HG/Health Region HR, Model 3 MMM, NDTP

Findings Summary:

Transfers between Model 3 and Model 4 hospitals can be delayed.

Recommendations:

27. Hospital groups and Health Regions should critically review existing care pathways to implement efficient bi-directional transfer of patients, in all specialties.

Responsibility:

HG/Health Region CD

8. Implementation

Given the current problems in the recruitment and retention of consultants at Model 3 hospitals and the impacts outlined above, it is imperative that swift action is taken to implement the recommendations of this report. Therefore, it is proposed that:

- A Model 3 initial implementation project is established as soon as possible, with a group providing oversight for a period of at least 18 months.
- Led by NDTP, it should:
    - Agree the selection of initial sites from the 17 Model 3 hospitals, using objective selection criteria.
    - Ensure appropriate clinical leadership and project management support is put in place.
    - Assess and evaluate initial implementation.
    - Monitor progress against recommendations and relevant key performance indictors (KPIs).

These actions will maintain the momentum generated while producing this report and optimise the chances of achieving improvements for patients and staff in Model 3 hospitals. They will also mitigate the risk of more adverse scenarios arising should the current trend in recruitment continue as outlined in the projections.

The implementation of this report will not happen in isolation and due consideration should be given to the existing and evolving role of Model 3 hospital, as outlined in Government policy and reports, including *Sláintecare*[29], *Securing the Future of Small Hospitals*[30], and *Surgery for Ireland*[31]. The rollout of the Health Regions model will impact current hospital groups and community healthcare organisations (CHOs).[32] This should facilitate some of the recommendations, such as a more networked approach to consultant recruitment, joint appointments, rotas, education and training, infrastructure improvements, and the bi-directional transfers of patients between hospitals of all models and the community.

Any implementation would be subject to appropriate corporate and clinical governance with the respective Health Region in the initial sites selected.

Other principles to be considered in the implementation plan include:

- Recommendations may not be a 'one size fits all' approach;
- How to strengthen links between undergraduate medical colleges and model 3 hospitals;
- In examining areas to implement in the initial sites try to leverage the expansion of GP training, given it has a shorter specialist training period (4 years) and is spread across the country so should be a good fit with the model 3 hospitals geographically.

29 Sláintecare (gov.ie)
30 Securing the Future of Smaller Hospitals: A Framework for Development, 2013 (lenus.ie)
31 Surgery for Ireland report, 2023 (rcsi.ie)
32 See in Glossary & Abbreviations table Model 3 and other hospitals by Hospital Group and Health Region

References

1. Sláintecare Implementation Strategy & Action Plan gov.ie/en/campaigns/slaintecare-implementation-strategy/

2. Securing the Future of Smaller Hospitals: A Framework for Development, 2013 lenus.ie/bitstream/handle/10147/623977/SecuringSmallerHospitals.pdf

3. Report of the National Acute Medicine Programme, 2010 hse.ie/eng/about/who/cspd/ncps/acute-medicine/report%20of%20the%20national%20acute%20medicine%20programme.pdf

4. What is the future for General Surgery in Model 3 hospitals?, Mealy et al, 2017 researchgate.net/publication/312118030_What_is_the_future_for_General_Surgery_in_Model_3_Hospitals

5. Towards Successful Consultant Recruitment, Appointment and Retention, Keane, 2016 hse.ie/eng/staff/leadership-education-development/met/consultantapplications/doc1/successful-consultant-recruitment-appointment-and-retention-report-and-guidance-document-pdf.pdf

6. The state of medical education and practice in the UK: The workforce report 2022 gmc-uk.org/-/media/documents/workforce-report-2022---full-report_pdf-94540077.pdf

7. Training 21st Century Clinical Leaders, A review of the Royal College of Physicians of Ireland training programmes by Professor Kevin Imrie, July 2014 rcpi-live-cdn.s3.amazonaws.com/wp-content/uploads/2016/01/Training-21st-Century-Clinical-Leaders.pdf

8. Medical Workforce Report 2021-2022, NDTP hse.ie/eng/staff/leadership-education-development/met/ndtp-workforce-report-2021-2023.pdf

9. National Adult Critical Capacity Census Report 2021 hse.ie/eng/about/who/cspd/ncps/critical-care/national-adult-critical-capacity-census-report-2021.pdf

10. A Trauma System for Ireland: Report of the Trauma Steering Group, 2018 assets.gov.ie/10116/70fd408b9ddd47f581d8e50f7f10d7c6.pdf

11. Strategic Review of Medical Training and Career Structure, MacCraith, 2014. radiology.ie/images/uploads/2012/01/McCraith_Final_Report_300614_FINAL1.pdf

12. Medical Education in Ireland: A New Direction, Fottrell, 2006 assets.gov.ie/46983/e02f7ad57b1f44cba0336f838e11c306.pdf

13. Preparing Ireland's doctors to meet the health needs of the 21st century: report of the Postgraduate Medical Education and Training Group, Buttimer, 2006 lenus.ie/bitstream/handle/10147/42920/2677.pdf

14. Report of the National Task Force on Medical Staffing, Hanly, 2003 gov.ie/en/publication/8736d0-report-of-the-national-task-force-on-medical-staffing-hanly-report

15. Surgery for Ireland report, RCSI, 2023 rcsi.com/dublin/-/media/feature/media/download-document/surgery/practice/publications-and-guidelines/reports/report-of-the-short-life-working-group-on-the-provision-of-emergency-surgery.pdf

16. National Taskforce on the NCHD Workforce – Interim Recommendations Report, Department of Health, 2023 gov.ie/en/publication/73674-national-taskforce-on-the-nchd-workforce-interim-recommendations-report/

Glossary & Abbreviations

Hospital model characteristics[33]

Model 1 hospital characteristics (sub-set)

1. This hospital will be a community or district hospital, with sub-acute in-patient beds.
2. This hospital will not have an ED, ICU, high dependency unit (HDU), coronary care unit (CCU), or AMU/AMAU/MAU. Patients requiring a higher level of care will be transferred to an ISA Model 2, 3, or 4 hospital.

Model 2 hospital characteristics (sub-set)

1. This hospital will provide in-patient and out-patient care for differentiated, low-risk medical patients who are not likely to need resuscitation.
2. This hospital will have a daytime MAU.
3. This hospital will not have an ICU. If necessary, patients will be transferred to the associated Model 3 or 4 hospital.

Model 3 hospital characteristics

1. This hospital will admit undifferentiated acute medical patients.
2. The hospital will have a category 1 or 2 ICU and may have an HDU.
3. This hospital will have an AMAU, which will open on a 12-to-24-hour basis every day of the year (where the AMAU is closed at night, medical patients will be managed by the on-call senior medical doctor in the 24-hour ED).
4. There will be an ED on-site and there may be a clinical decision unit (CDU) on-site as part of the ED service.
5. There will be guaranteed bi-directional patient flow for appropriate medical in-patients between hospital Models 1, 2, and 4. There will be bi-directional flow of critical care patients between hospital Models 3 and 4.
6. There will be streaming to appropriate specialty units or wards as per protocols.
7. Where a patient requires category 3 or 3S ICU care, the regional critical care retrieval team will effect safe transfer.
8. All hospitals must have a person trained and responsible for infection prevention and control on-site plus formal access to advice from a consultant microbiologist or infectious disease physician.
9. The medication needs and supplies for patients in Model 1 and Model 2 hospitals will be coordinated through the Model 3 hospital.

Model 4 hospital characteristics

1. This hospital will admit undifferentiated acute medical patients, including tertiary referred patients.
2. There will be a category 3 or 3S ICU on-site.
3. There will be an AMU present which is open on a continuous basis (24 hours, every day of the year).
4. There will be an ED, including a CDU, on-site.
5. There will be guaranteed bi-directional patient flow for appropriate medical in-patients between hospital Models 1, 2, and 3. There will be bi-directional flow of critical care patients between hospital Models 3 and 4.
6. There will be streaming to appropriate specialty units or wards as per locally agreed protocols.
7. Where a patient becomes critically ill in a Model 1, 2, or 3 hospital, the regional critical care retrieval team will effect safe transfer to a Model 4 hospital. Retrieval between Model 4 hospitals will be required for national specialty transfers. Remote critical care retrieval will include continued resuscitation, stabilisation, and safe transport by the retrieval team.
8. All hospitals must have a person trained and responsible for infection prevention and control on-site plus formal access to advice from a consultant microbiologist or infectious disease physician.

33 Extracted from the Report of the National Acute Medicine Programme, 2010 (hse.ie) and reformatted for comparative purposes

Model 3 Hospitals Report

Model 3 and other hospitals by hospital group and Health Regions[34]

Hospital group (HG)	Model 4 hospital	Model 3 hospital	Model 2 Hospital	Other/specialist hospital	Health Region
Royal College of Surgeons Ireland (RCSI) HG	Beaumont Hospital, Dublin	Cavan General & Monaghan Hospitals Connolly Hospital, Dublin Our Lady of Lourdes Hospital, Drogheda	Louth County Hospital, Dundalk	Rotunda Hospital (Maternity)	A. Dublin North Central, North West Dublin, North Dublin, Meath, Louth, Cavan/ Monaghan B. Dublin South City, Dublin, South West, Dublin West, Kildare/West Wicklow, Laois/ Offaly, Longford/Westmeath C. Dublin (South East), Dun Laoghaire, Wicklow, Wexford, Carlow/Kilkenny, Waterford, South Tipperary D. West Cork, Cork South Lee, Cork North Lee, North Cork, Kerry
Ireland East (IE) HG	Mater Misericordiae University Hospital St Vincent's University Hospital, Dublin	Our Lady's Hospital, Navan Midlands Regional Hospital, Mullingar St Luke's General Hospital, Kilkenny Wexford General Hospital	St Columcille's Hospital St Michael's Hospital, Dun Laoghaire	Cappagh National Orthopaedic Hospital National Maternity Hospital, Dublin Royal Victoria Eye & Ear Hospital	
Dublin Midlands (DM) HG	St James's Hospital, Dublin Tallaght University Hospital, Dublin	Midlands Regional Hospital, Portlaoise Midlands Regional Hospital, Tullamore Naas General Hospital	N/A	Coombe Women & Infants University Hospital St Luke's, Rathgar (Radiation Oncology)	
South / South West (SSW) HG	University Hospital Waterford Cork University Hospital	Tipperary University Hospital, Clonmel University Hospital Kerry, Tralee Mercy University Hospital, Cork	Bantry General Hospital Mallow General Hospital South Infirmary Victoria University Hospital, Cork	Kilcreene Orthopaedic Hospital, Kilkenny Cork University Maternity Hospital	
University of Limerick (UL) HG	University Hospital Limerick	N/A	Ennis Hospital Nenagh Hospital St John's Hospital, Limerick	University Maternity Hospital Limerick Croom Orthopaedic Hospital, Limerick	E. Limerick, Clare, North Tipperary/East Limerick
Saolta HG	University Hospital Galway	Letterkenny University Hospital Mayo University Hospital, Castlebar Portiuncula University Hospital, Ballinasloe Sligo University Hospital	Roscommon University Hospital	N/A	F. Galway, Roscommon, Mayo, Sligo/Leitrim, Donegal
Children's Hospital Ireland (CHI) HG	N/A	N/A	N/A	CHI at Temple Street CHI at Crumlin CHI at Tallaght CHI at Connolly	N/A

34 See Sláintecare Health Regions (gov.ie)

Glossary

Abbreviation	Description
AMAU	Acute medical assessment unit – treats patients referred by their injury unit or GP for a wide variety of medical complaints
CAAC	Consultants Applications Advisory Committee
CSCST	Certificate of Satisfactory Completion of Specialist Training
DIME	Doctors Integrated Management E-System
DM HG	Dublin Midlands Hospital Group
DoH	Department of Health
ED	Emergency department
GP	A doctor in general practice (primary care)
HG / Health Regions	Hospital group network in Ireland (migrating to the Health Regions model)
HIPE	Hospital In-Patient Enquiry System
HR SS-HSE	HSE Human Resources Shared Services
HSE	Health Service Executive
ICU	Intensive care unit
IE HG	Ireland East Hospital Group
IU	Injury unit – a locally based service designed to treat injuries of lesser severity that are unlikely to need admission to hospital
NHS	National Health Service of the United Kingdom
PA	Programmed activity – a UK NHS term for a block of time, usually equivalent to four hours, in which contractual duties are performed
PAS	Public Appointment Service
RCSI HG	Royal College of Surgeons Ireland Hospital Group
SC	Sláintecare
SMT	Senior management team
SSW HG	South / South West Hospital Group
NCHDs	Non-consultant hospital doctors
NDTP	National Doctors Training & Planning
NI	Northern Ireland
NRS-HSE	National Recruitment Service, HSE
UK	United Kingdom (England, Scotland, Wales, and Northern Ireland)

Appendix 1: Model 3 Project Steering Group

The group consisted of the following representatives:

Organisation/ representative	Name	Title
NDTP	Operational Group	
	Prof Brian Kinirons (Chair)	Medical Director, National Doctors Training and Planning (NDTP)
	Mr Eddie Staddon	General Manager
	Dr Consilia Walsh	Clinical Advisor
	Ms Roisin Morris	Medical Workforce Planning Lead
	Mr Michael Morgan	Senior Project Manager
NCHD	Dr Caroline Herron (to June 2022)	NDTP National Lead NCHD
	Dr Jennifer Finnegan (from July 2022	NDTP National Lead NCHD
RCSI	Other members	
	Mr Paddy Kenny (Co-Sponsor)	Consultant Orthopaedic Surgeon
	Mr Des Toomey	Consultant General & Colorectal Sugeon
National HR	Ms Mary Doran	General Manager, National HR Shared Services, HSE
	Ms Eithne Fox (from April 2023)	Assistant National Director Recruitment, Reform and Resourcing, HSE
RCPI	Prof Anthony O'Regan	Chair IOM
Forum of PGMTBs	Mr Ken Mealy	Chair of the Forum
Medical Council	Dr Suzanne Crowe	President, MCI
HSE Acute Operations	Ms Ann Cosgrave	COO, Saolta Hospital Group
Model 3 HR	Ms Martha Saba	Medical Manpower Manager, Sligo University Hospital
CAI	Dr Michelle Duggan	CAI HSE Liaison Committee
NCAGL	Mr Michael O'Connor	National Clinical Advisors and Group Leads (NCAGL), Acute Hospitals
CD	Prof Conor Deasy (from March 2022)	Consultant in Emergency Medicine, CUH
Department of Health	Ms Breda Rafter	Principal Officer, Strategic Workforce, DOH

The operational group worked closely on a week-by-week basis.

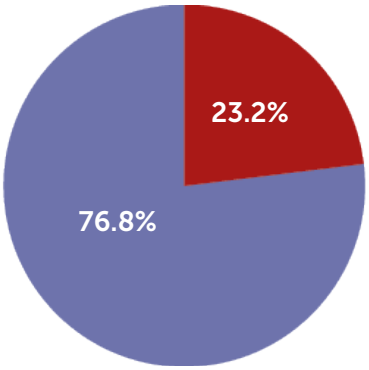
The full steering group met on six occasions as follows:

1. 12 January 2022
2. 23 March 2022
3. 2 June 2022
4. 28 September 2022 (workshop)
5. 7 December 2022
6. 26 April 2023

Appendix 2: NCHD Survey Responses

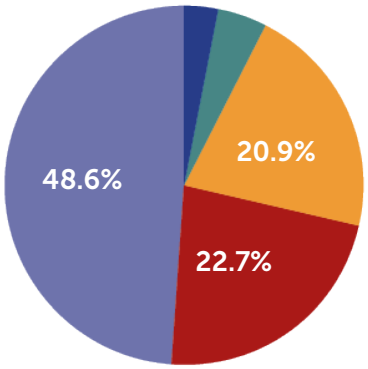
Section 1 of 4: About You

Q1: Did you graduate from an Irish Medical School? (220 responses)



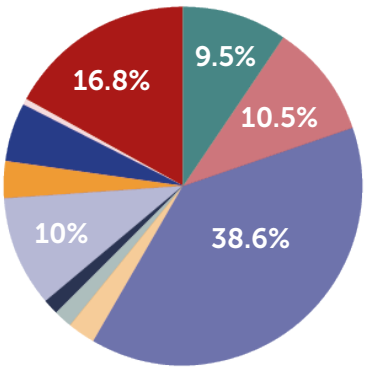
- Yes (76.8%)
- No (23.2%)

Q2: Which grade do you currently work at? (220 responses)



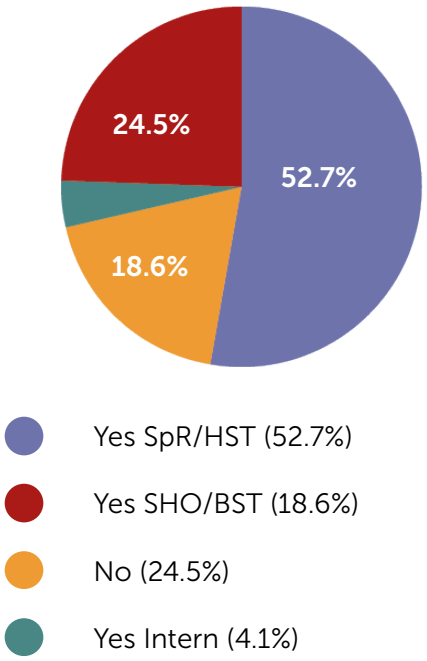
- SpR (48.6%)
- SHO (22.7%)
- Registrar (20.9%)
- Intern (4.5%)
- Fellow (3.2%)

Q3: What is your specialty? (220 responses)



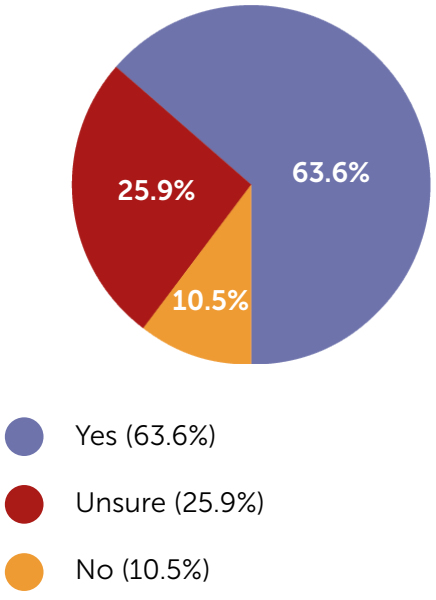
- Anasthesioogy (9.5%)
- Emergency Medicine (10.5%)
- Medicine (38.6%)
- General/Intern (2.3%)
- Obstetrics/Gynacology (1.8%)
- Ophthalmology (1.4%)
- Paediatrics (10%)
- Pathology (3.2%)
- Psychiatry (5.5%)
- Radiology (0.5%)
- Surgery (16.8%)

Q4: Are you on a training scheme? If yes, are you at SHO/BST level, SpR/HST level: (220 responses)

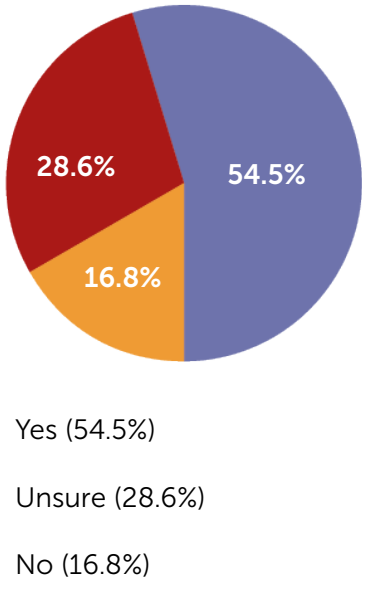


Section 2 of 4: Your Career Plans

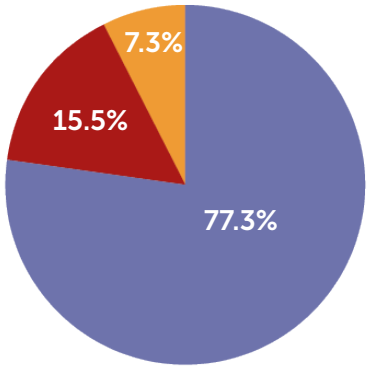
Q5: Do you plan to work in Ireland as a permanent consultant upon completion of your training scheme? *(220 responses)*



Q6: Do you plan to return to Ireland to take up a consultant post after a period abroad? *(220 responses)*

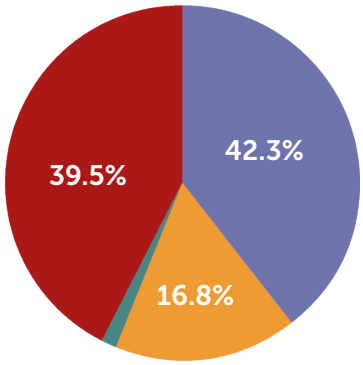


Q7: How do you plan to work?
(220 responses)



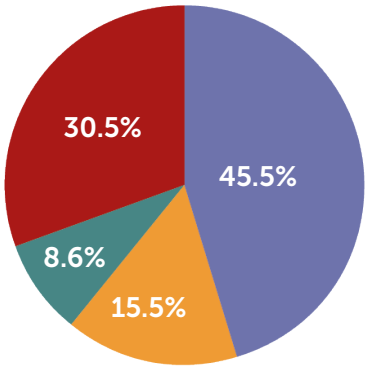
- Full-time (77.3%)
- Less than full-time (LTFT) (15.5%)
- Unsure (7.3%)

Q8: Do you have a preference for working in the private or public sector?
(220 responses)



- I would like to work in both the public and private sector (42.3%)
- Yes, I want to work fully in the public sector (39.5%)
- No preference/unsure (16.8%)
- Yes, I want to work fully in the private sector (1.4%)

Q9: Do you have a preference for working in a particular model of hospital?
(220 responses)

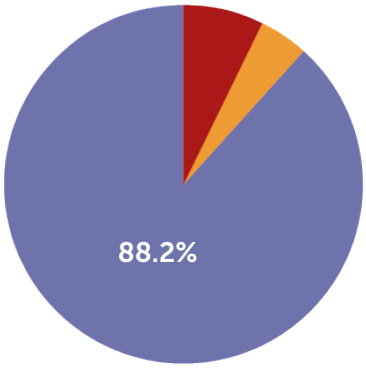


- Yes, I would prefer to work in a model 4 hospital (45.5%)
- No/unsure (30.5%)
- Yes, I would prefer to work in a joint appointment within both a model 3 and model 4 hospital (15.5%)
- Yes, I would prefer to work in a model 3 hospital (8.6%)

Q10: Why do you have a prefereence for working in a particular model hospital? (Optional free text - 102 responses)

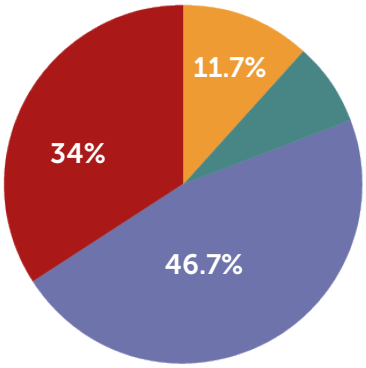
Section 3 of 4: Your Experience in Model 3 Hospitals

Q11: Have you worked as a doctor in a model 3 hospital? *(220 responses)*



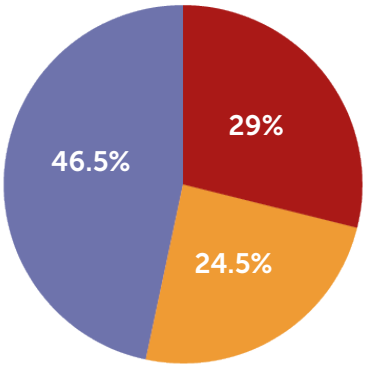
- Yes (88.2%)
- No, my training does not rotate through model 3 hospitals (7.3%)
- No (4.5%)

Q12: If yes, do you think that the education and training you received in a model 3 hospital was comparable to model 4 hospitals? *(197 responses)*



- No, I felt the training I received in a model 3 hospital was worse (46.7%)
- Yes (34%)
- No (11.7%)
- No, I felt the training I received in a model 3 hospital was better (7.6%)

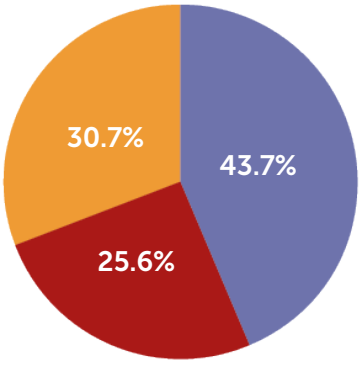
Q.13: Overall, do you think your experience in a model 3 hospital was positive or negative?
(200 responses)



- Positive (46.5%)
- Neutral (29%)
- Negative (24.5%)

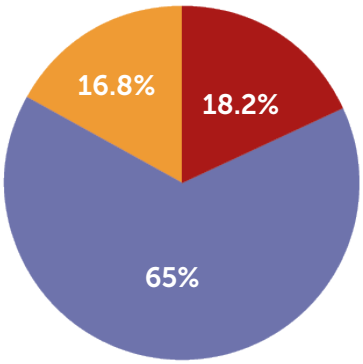
Q14: Free text to give further details of your experience, if you wish; e.g., what was better or distinct from model 4 experience, supervision, case mix, facilities, support structures, educational opportunities?
(106 responses)

Q15: Did rotating through a model 3 hospital on your training scheme make you more or less likely to apply for a permanent consultant position in a model 3 hospital? *(199 responses)*



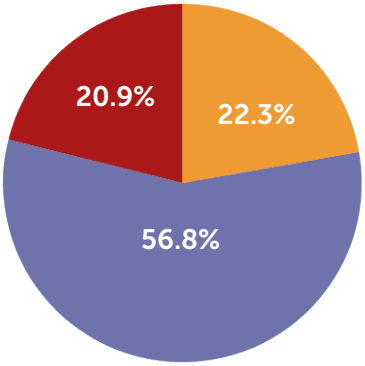
- Less likely to work in a model 3 hospital as a consultant (43.7%)
- More likely to work in a model 3 hospital (25.6%)
- Neither/unsure (30.7%)

Q16: Do you think there are fewer opportunities to enhance/maintain skills as a consultant in a model 3 hospital? *(220 responses)*



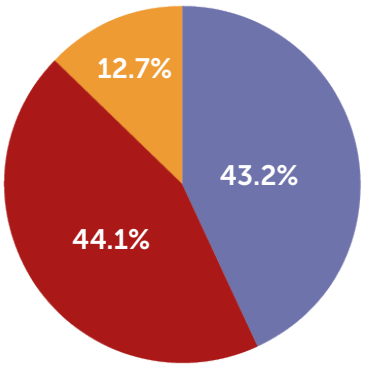
- Yes, and would influence my decision to work in model 3 (65%)
- Yes, but would not influence decision to work in model 3 (18.2%)
- No (16.8%)

Q17: Do you think you would have less exposure to complex patient care as a consultant in a model 3 hospital? *(220 responses)*



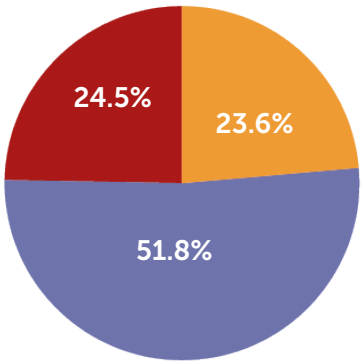
- Yes - and would influence decision to work in model 3 (56.8%)
- Yes - but would not influence decision to work in model 3 (20.9%)
- No (22.3%)

Q18: Are you concerned about the future of model 3 hospitals in terms of job security? *(220 responses)*



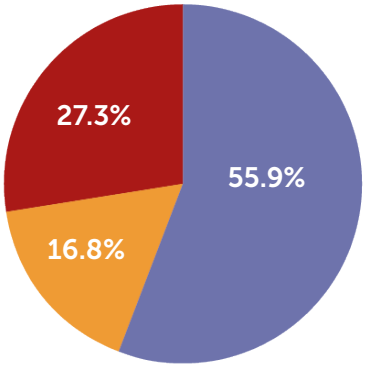
- No (43.2%)
- Yes - and would influence decision to work in model 3 (44.1%)
- Yes - but would not influence decision to work in model 3 (12.7%)

Q19: Do you think you would have less opportunity to undertake research/ academic work as a consultant in a model 3 hospital? *(220 responses)*



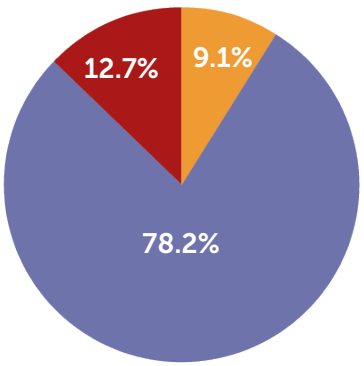
- Yes, and would influence my decision to work in model 3 (51.8%)
- Yes, but would not influence decision to work in model 3 (24.5%)
- No (23.6%)

Q20: Do you think you would have less opportunity to undertake private practice as a consultant in a model 3 hospital? *(220 responses)*



- No (55.9%)
- Yes, but would not influence decision to work in model 3 (27.3%)
- Yes, and would influence my decision to work in model 3 (16.8%)

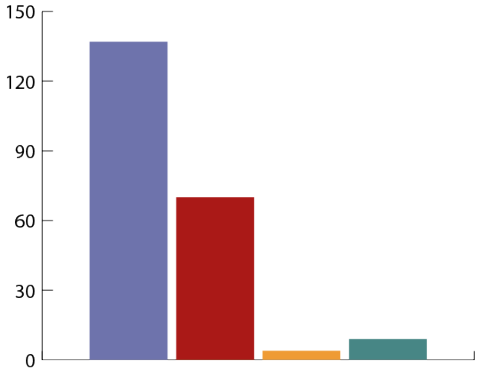
Q21: Do you think there are less resources and supports in place for consultants, in model 3 hospitals? (e.g. clinical supports such as experienced colleagues or non-clinical supports such as administrative support) *(220 responses)*



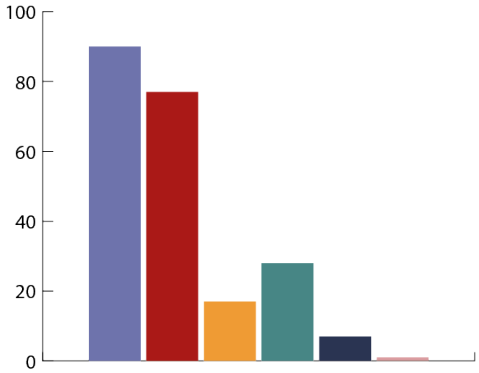
- Yes, and would influence my decision to work in model 3 (78.2%)
- Yes, but would not influence decision to work in model 3 (12.7%)
- No (9.1%)

Q22: On the scale below please rate how important each of the following aspects of working life are to you, when considering applying for a permanent consultant post:

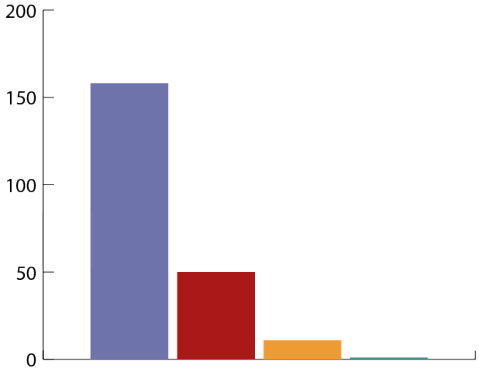
Very important | Important | Neutral | Less important | Not important | Not applicable



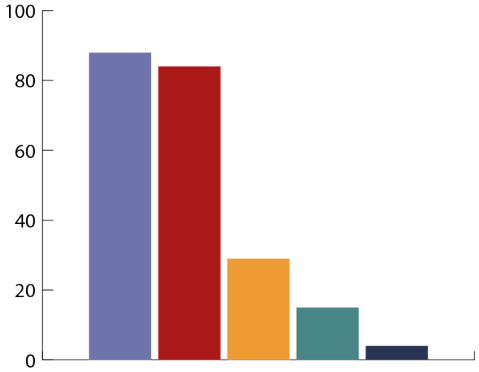
22.1 The geographical location of the post



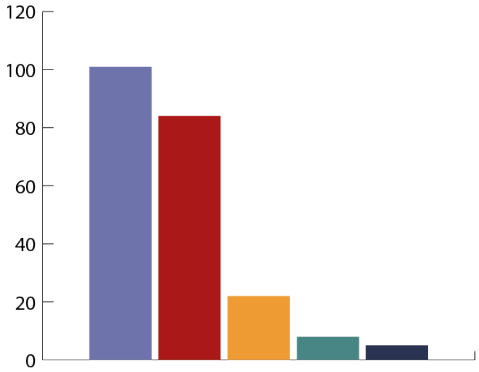
22.2 Available transport links



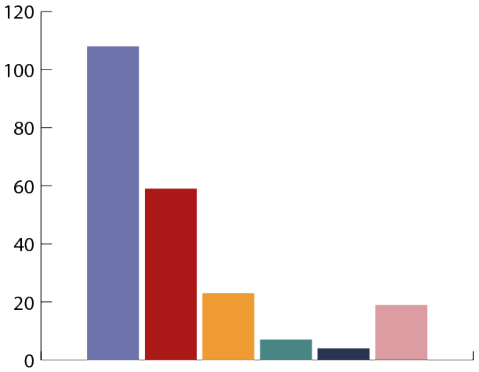
22.3 Work life balance



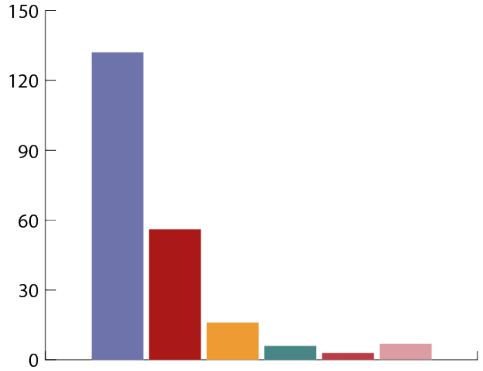
22.4 Cost of living



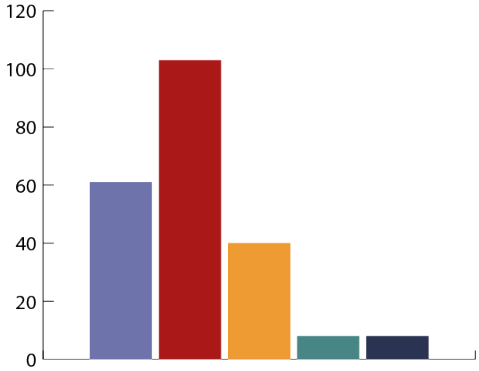
22.5 Availability/cost of appropriate housing nearby



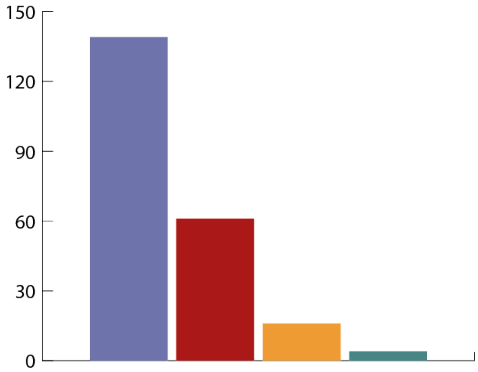
22.6 Availability of schools for your children



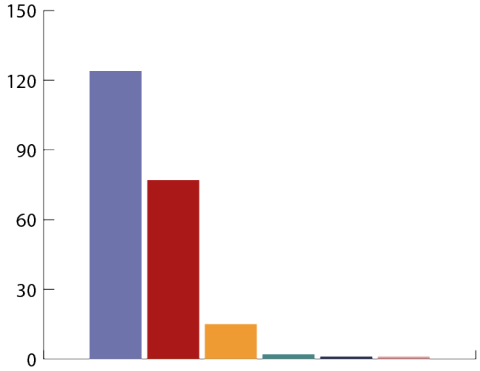
22.7 Availability of employment for your partner



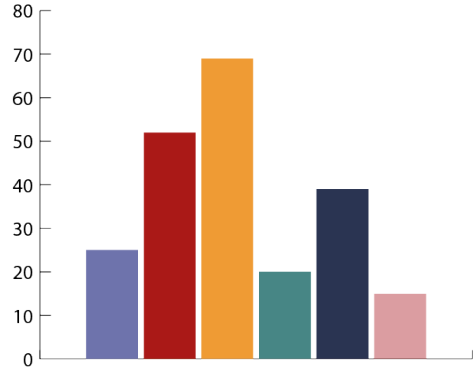
22.8 Social life, sports clubs, societies, amenities, entertainment



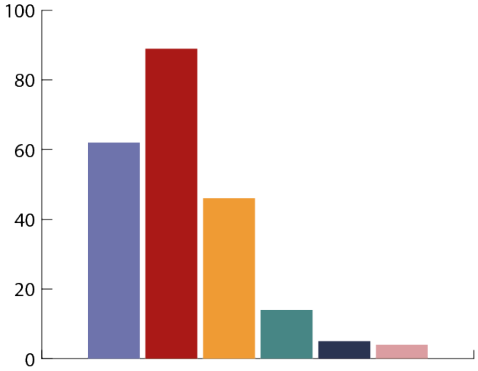
22.9 Permanent consultant colleagues/ support network



22.10 The frequency of on call / out of hours work



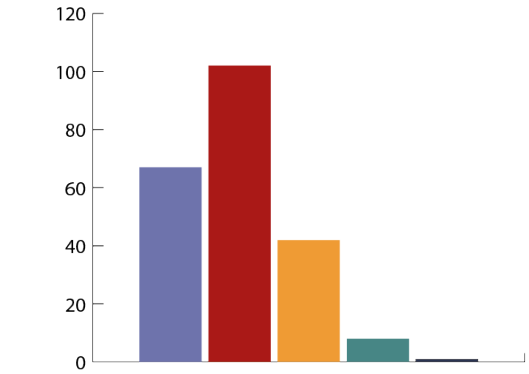
22.11 The availability of private work



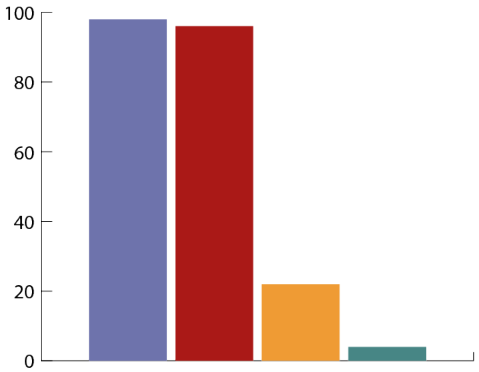
22.12 Research/ Academic opportunities

Q23: On the scale below please rate how desirable you would consider each of the incentives are, to encourage you to apply for a permanent consultant post in a model 3 hospital:

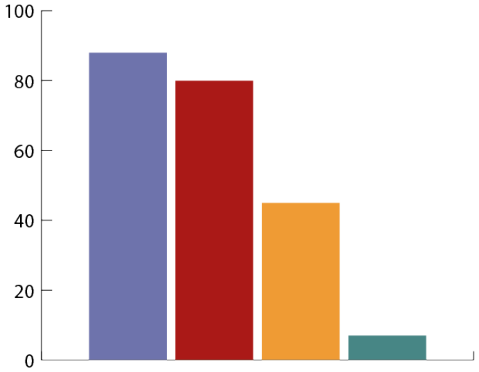
Very desirable | Desirable | Neutral | Undesirable | Very undesirable | Not applicable



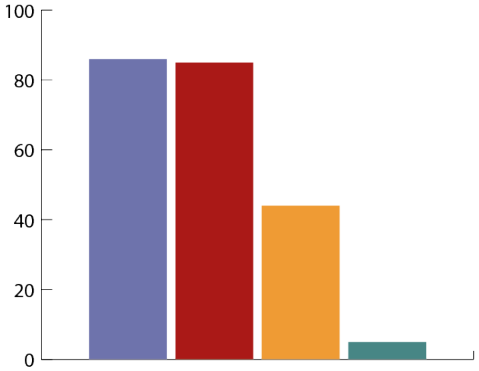
23.1 Recruitment bonus



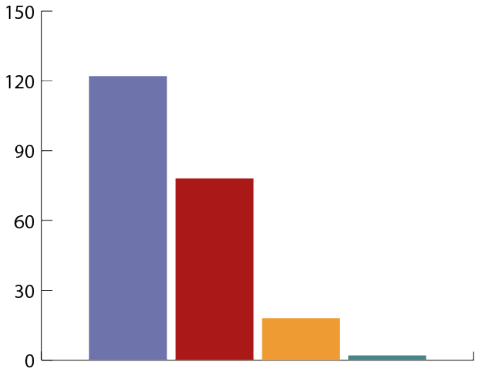
23.2 Increased starting salary/ higher point on current consultant salary scale



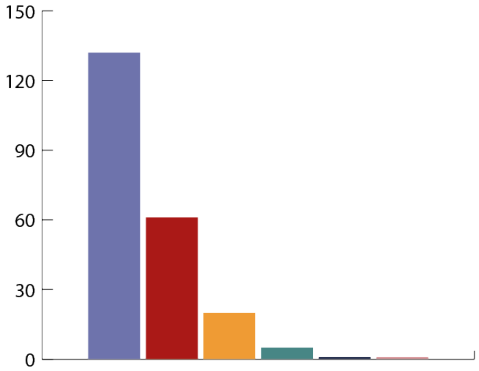
23.3 Alternative salary scale (to reflect the difference in working environment, case mix, emergency work etc.)



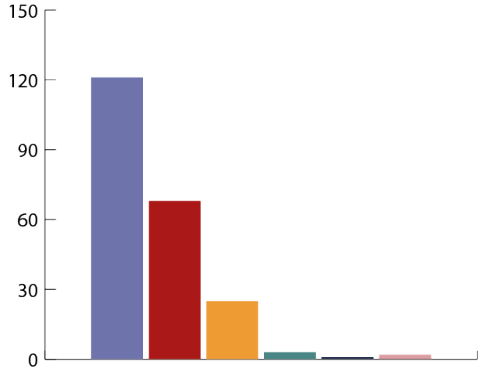
23.4 Retention bonus



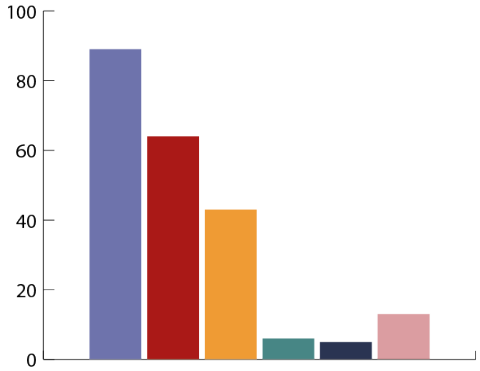
23.5 Remuneration for additional on-call work



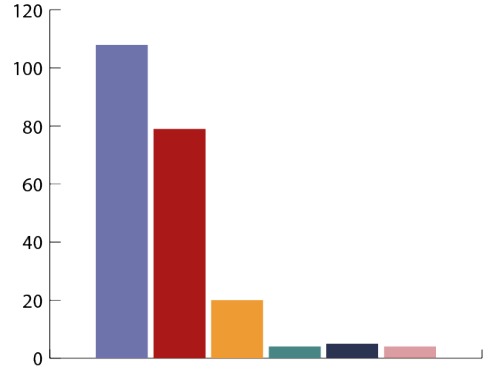
23.6 More opportunities for flexible/ less than full time working



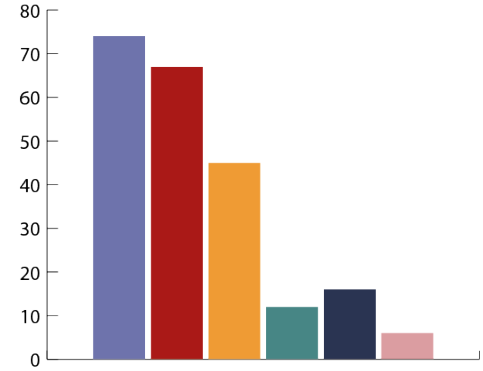
23.7 A pre-defined maximum number of on-call shifts



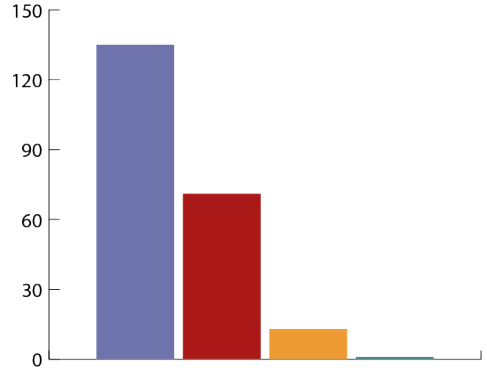
23.8 Separation of emergency and elective work



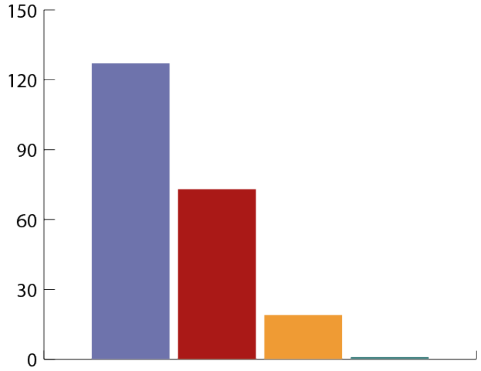
23.9 Additional clinical support e.g. ANP



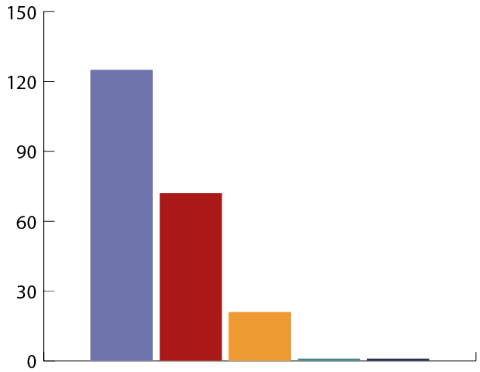
23.10 Additional clinical support e.g. Physicians associate



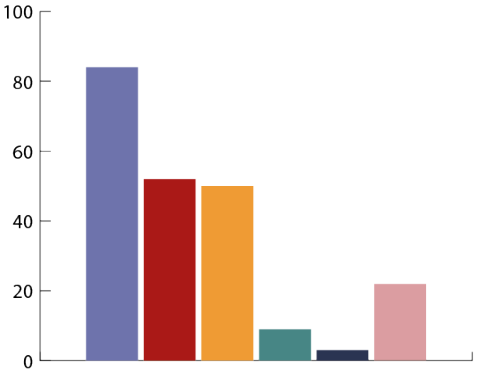
23.11 Additional clinical support e.g. SpR attached to your service



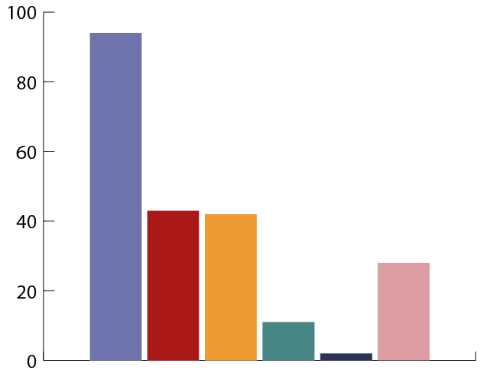
23.12 Better resources such as secretarial support



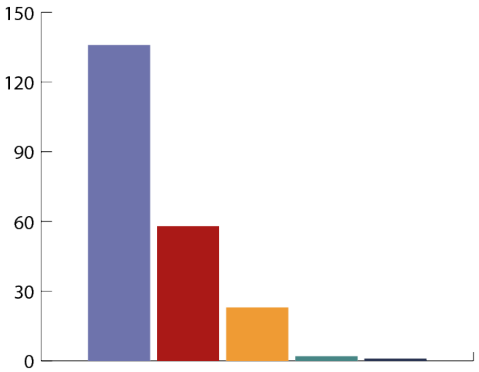
23.13 Better resources such as office space



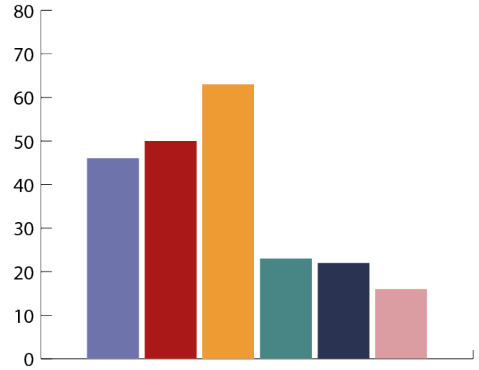
23.14 Protected beds for elective work



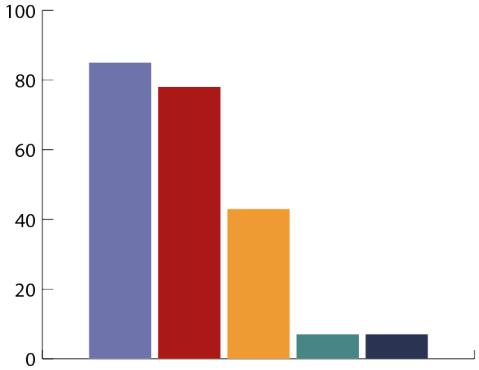
23.15 Guaranteed access to theatres, procedure rooms, endoscopy etc.



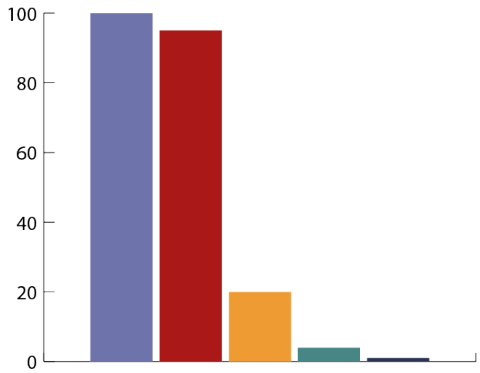
23.16 Connection to a model 4 hospital/ greater exposure to hospital group colleagues



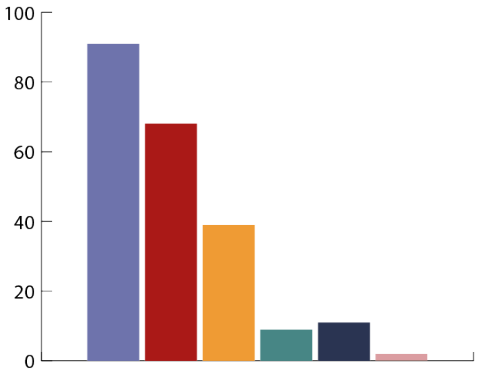
23.17 Ability to undertake private work



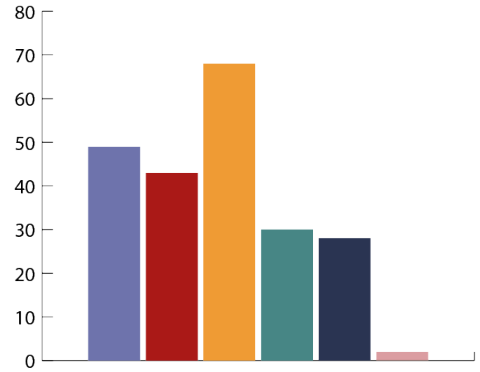
23.18 Protected time for academic / research activity



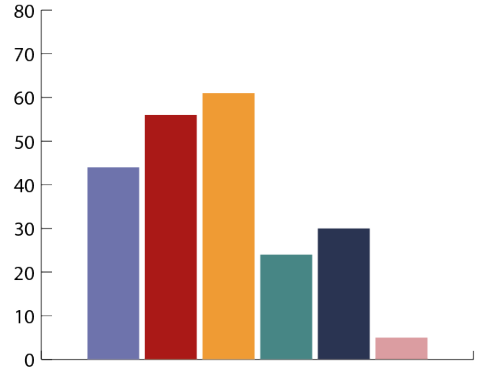
23.19 Protected time for educational activity/ teaching



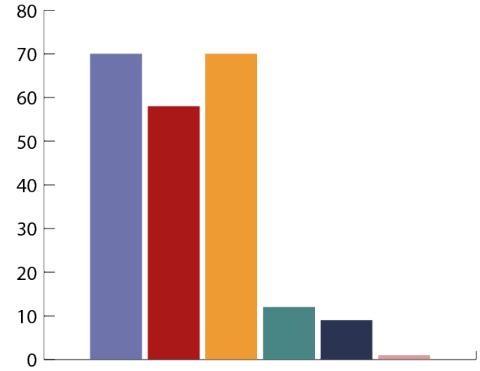
23.20 Regionalised training during HST years



23.21 A shorter HST scheme



23.22 A modified HST scheme to incorporate more general and less sub-specialised training



23.23 A funded scholarship

NATIONAL
DOCTORS
TRAINING
& PLANNING

ROYAL
COLLEGE
OF SURGEONS
IN IRELAND