An Roinn Sláinte
Department of Health

National Taskforce on the Non-Consultant Hospital Doctor (NCHD) Workforce

Final Recommendations Report

Contents

Foreword by Stephen Donnelly T.D., Minister for Health

I am delighted to introduce the Final Report of the National Taskforce on the Non-Consultant Hospital Doctor (NCHD) Workforce. For some time I have acknowledged that significant change is required to ensure that we improve the NCHD experience and work life balance through the development and implementation of improved NCHD structures and supports on clinical sites.

NCHDs are a critical part of our workforce and need to be supported to ensure they are retained in our health service. I have prioritised improving and supporting the NCHD experience of working and training in our health service and established the Taskforce to address the issues impacting their recruitment and retention.

There has been a rapid expansion of the NCHD workforce in the Irish health service over the past 10 years to meet health service delivery requirements. This has contributed to an already urgent need to increase and enhance the supports and services required for NCHDs to carry out their work and to complete their education and training.

We must recognise and value the enormous contribution of NCHDs in our health service. I commend the vision that the Taskforce established to ***deliver high quality education and training for all NCHDs in an accountable, respectful, and supportive working environment that facilitates sustainable work life balance.***

The Taskforce recommendations aim to assist NCHDs carrying out their duties more effectively, efficiently, and safely, and delivering the highest standards of patient care that we know NCHDs continuously strive for. The recommendations aim to support NCHDs' own health, welfare, and work life balance. This is of vital importance for NCHDs to continue to meet the demanding challenges of their daily work.

It is critical that the recommendations of the Taskforce are progressed as a matter of urgent priority by action owners. It is also critical that the implementation of the recommendations is monitored on an ongoing basis to ensure that delivery of the desired improvements impacts positively on NCHD working and training. The implementation structures in this report are underpinned by three core principles: prioritisation, collaboration, and accountability for delivery of results.

Significant progress has already been made on many of the Interim Recommendations that I published in the NCHD Taskforce Interim Report in April 2023. But there is a lot more work to do, and it is crucial that we maintain the momentum and commitment that we have seen over the past 18 months because of the work of the Taskforce.

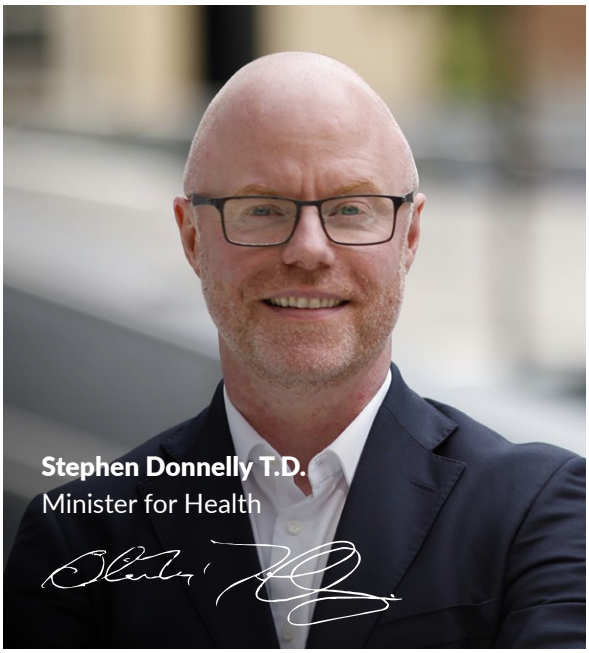
Building on the work of the Interim Report, the final report contains 44 additional recommendations. It highlights immediate recommendations to be implemented in 2024, and medium to longer term recommendations to be implemented on a phased basis with incremental improvements from 2024 to 2026. Throughout this report, the Taskforce has emphasised a critical need for immediate action in 2024, and the need to sustain ongoing tangible improvements for NCHDs in 2024 and in the years ahead.

I have written to the Chair of the HSE Board to ensure the HSE prioritises an implementation plan. I have also written to the Forum of Irish Postgraduate Medical Training Bodies asking the Forum to prioritise implementation of the recommendations.

Prioritisation of actions in the following areas in 2024 will not only deliver tangible improvements for NCHDs but will have wide-reaching positive impacts for patient care and delivery of our health services:

- **Dedicated Leadership and Support for NCHDs**
- **Improved Working Standards**
- **Education and Training Supports**
- **Information Communications and Technology (ICT)**
- **Increased Access to Training Places.**

Finally, I would like to thank all of the Taskforce members, led by the Chair, Professor Anthony O'Regan, for producing this significant body of work. I want to acknowledge the work that has already been done in 2023, but further progress is needed and at pace. I am confident that delivery of the Taskforce recommendations will support present and future retention of NCHDs in Ireland.



Stephen Donnelly T.D.
Minister for Health

Foreword by Professor Anthony O'Regan, Chair of the NCHD Taskforce

I am pleased to provide the Minister with this report on Non-Consultant Hospital Doctor working and training in Ireland and I wish to commend him on his foresight in highlighting the importance of this work.

Throughout my career I have been deeply involved in medical education and training. I am acutely aware of the key role of medical education and training, not only in the delivery of high-quality patient care, but also in the recruitment and retention of healthcare workers in Ireland.

From the outset, the National Taskforce on the NCHD Workforce has been energised and committed to understanding the unique and challenging issues facing Non-Consultant Hospital Doctors across our health service, and to providing a comprehensive solution-based set of recommendations for implementation.

This report represents broad stakeholder engagement and careful deliberation by the membership of the Taskforce. I want to thank all those who contributed to this report and emphasise the importance of the implementation of these recommendations for our population, our patients, and our colleagues, into the future.

Professor Anthony O'Regan
Chair of the NCHD Taskforce

Executive Summary

The Taskforce

The National Taskforce on the Non-Consultant Hospital Doctor (NCHD) Workforce was established by the Minister for Health in September 2022. The purpose was to put in place sustainable workforce planning strategies and policies to improve the NCHD experience and work life balance with enhanced NCHD structures and supports on clinical sites. The aim was to further develop and foster a culture of education and training at clinical site level, and plan for future configuration of the medical workforce to support delivery of healthcare in Ireland. The Taskforce defined a vision:
to deliver high quality education and training for all NCHDs in an accountable, respectful, and supportive working environment that facilitates sustainable work life balance.

Stakeholder Engagement

Stakeholder engagement was central to the work of the Taskforce. This consisted of the broad range of subject matter experts represented on the Taskforce, submissions, presentations, and in-person and virtual meetings. A bespoke national survey of NCHDs and consultants was undertaken to further guide the priority areas for consideration. A summary of the survey results, and further stakeholder engagement, is provided in Chapter 5. The outcome from these stakeholder engagements was significant in developing the recommendations outlined in this report.

Recommendations

In April 2023, the Interim Recommendations Report of the Taskforce was published. The Interim Report can be accessed here. Chapter 4 of the final report provides a progress update on implementation of the Interim Recommendations.

The medium to longer term recommendations developed by the Taskforce for the final report are outlined in Chapter 3 under five priority action areas. Each priority action area relates to particular challenges or priority issues for NCHDs and presents the key Taskforce recommendations in that area. Each priority action area follows a similar format: What is the identified challenge? What are the recommended actions?

Reflecting the complexity of the challenges experienced by NCHDs, and the interdependence between these challenges, there are some important themes such as work life balance, wellbeing, gender equality and diversity that are supported by recommendations throughout this report and in more than one of these chapters.

Priority Action Area 1 — Work Life Balance and The Working Week

These recommendations address an area identified by NCHDs as the top priority requiring urgent attention. This priority area is complex and encompasses a number of inter-related and overlapping themes that are critical for NCHDs, for example, work life boundaries; the working week; compliance with the European Working Time Directive (EWTD) and the Organisation of Working Time Act (OWTA)[1]; emergency cover; flexible training and working opportunities; and standardised introduction of more effective time and attendance management systems that provide fairness and transparency for NCHDs. This priority area also looked at enhanced ways of working and sharing of tasks between multidisciplinary teams on clinical sites leading to recommendations on interprofessional working and integrated task delivery.

The Taskforce members strived to develop clear recommendations, that are not part of the current Industrial Relations (IR) processes, but can support, complement, and enhance the IR processes so that the best possible outcomes and positive improvements for NCHDs can be achieved.

Priority Action Area 2 — The Working Environment

A positive working environment is essential for recruitment and retention of our healthcare workforce. This priority area highlights a critical need for the promotion of a culture of teamwork, respect, professionalism, and support for NCHDs. The Taskforce considered how NCHDs need to be better valued and supported by employers, and how teams and colleagues can work in a more positive manner.

Recommendations in this area relate to implementation of appropriate policies and standards; training and awareness on issues related to health and welfare/wellbeing standards; culture change; structured mentoring to support NCHDs' personal and professional development; enhanced support from Human Resources (HR), Medical Manpower (MMP) and NCHD line management to enable NCHDs to perform their duties and to develop their skills safely and effectively, including management and leadership support for consultants in their role as NCHD supervisors and trainers. The need for improved understanding of NCHD working environments and experiences, and ongoing monitoring and analysis in this area was also identified.

Priority Action Area 3 — Education and Training

These recommendations emphasise the need to prioritise and resource education and training for NCHDs on clinical sites, as being key for retention of our future medical workforce, and for supporting quality and safety of patient care. The Taskforce examined how the high level of reliance on NCHDs for service delivery on clinical sites is impacting their education and training, and how better supports need to be provided.

The Taskforce identified a critical need to ensure accountable governance on clinical sites for NCHD education and training. This priority area outlines requirements for enhanced supports for NCHDs on clinical sites from their respective postgraduate medical training bodies and addresses the need for geographical organisation of NCHD rotations.

The Taskforce highlights immediate requirements, as well as the need for longer term strategic plans for medical education and training resources, space, and capacity in infrastructural developments on all clinical sites.

1. The Organisation of Working Time Act 1997 (the OWTA) sets out minimum rest and maximum working time for employees as well as holidays and other miscellaneous issues. This Act, as amended, transposed the requirements of Directive 2003/88/EC of the European Parliament (EWTD) into national law.

Recommendations in this priority area address the need for urgent improvements on clinical sites to ensure NCHDs have access to good standards of education and training, including simulation based learning, and longer-term requirements to support doctor recruitment and retention in the Irish health service.

This priority area also highlights the importance of protected time for NCHDs and for consultants as their trainers, as well as mandatory study leave and appropriate online and virtual learning resources.

Priority Action Area 4 — Information Communications and Technology (ICT)

This priority area outlines how a current lack of supporting ICT infrastructure for NCHDs is impacting on the delivery of their duties, on their education and training, and contributes to the pressures they face daily. ICT is a complex and challenging area for the Irish health service as a whole. The Taskforce examined issues for NCHDs that are common across the healthcare workforce, as well as specific challenges for NCHDs, primarily due to the nature of their role, their education and training needs, the transient nature of NCHD rotations, and the on-call off-site nature of their work. Recommendations in this section address specific challenges for NCHDs, including efficient and flexible access to devices, systems, communications, and patient records.

Priority Action Area 5 — Workforce Configuration

This area addresses challenges posed by changing population demographics and workforce needs that have placed increased pressure on the Irish health service in recent years. To meet the needs of the population and provide high-quality effective care, it is essential that the configuration of the medical workforce evolves to meet these challenges.

In this priority area, the Taskforce examines and makes recommendations in a number of areas including increasing postgraduate training opportunities; strategic planning for undergraduate medical education and training; recognition of prior learning; NCHD career pathways; safe staffing; planning for non-doctor clinical roles and multidisciplinary teams to support the medical workforce.

Future Focus – Longer Term Recommendations

While the Taskforce focused on recommendations that would have a more immediate impact on the experience of NCHDs, the longer-term vision and future strategic direction was also considered. This highlighted initiatives that will require further scoping to determine optimum solutions and required level of investment, together with approval by the Department of Health and HSE. These initiatives relate to enhanced models of medical education, training and research, simulation based learning, structured mentorship for NCHDs and the training and delivery of advanced care by integrated multidisciplinary teams. Recommendations arising from Taskforce deliberations on enhancement of clinical education, training, and research for the development of our medical workforce, include significant change to the educational infrastructure to deliver a modern medical and clinical education system, embracing technology to meet changing demands, and training greater numbers. Achieving this goal requires a collaborative approach across healthcare professions and broader system-wide change and investment.

Implementation

The NCHD Taskforce implementation plan will be designed to support the successful implementation of Taskforce recommendations. The plan is underpinned by three core principles: prioritisation, collaboration, and accountability for delivery of results. Each recommendation has been assigned an action owner with primary responsibility for implementation. The action owners and the required reporting structures are outlined in Chapter 7.

Table 1: Executive Summary Table of Recommendations

Priority Action Area 1 — Work Life Balance and The Working Week

1	NCHD Rostering
2	NCHD Working Hours – OWTA Compliance and Verification
3	Time and Attendance Systems for NCHDs
4	Policies to support NCHD Work/ Personal Life Boundaries
5	Emergency Roster Planning
6	Flexible Training and Working for NCHDs
7	Interprofessional Working to Optimise Patient Care
8	Integrated Task Delivery: Priority Milestones Directed at Better Working and Patient Care

Priority Action Area 2 — The Working Environment

9	Health and Welfare/Wellbeing Standards for NCHDs
10	Line Management Support for NCHDs
11	NCHD Liaison and Advocacy Support
12	Bespoke Leadership and Management Training Programme for Consultants to support NCHDs
13	Reflective Practice Training and Support
14	Responsive Team Debriefing Processes
15	NCHD Return to Work Policy Following a Period out of Clinical Practice
16	Professionalism Frameworks for NCHD Positive Working Environment
17	Culture Change Programme to support Implementation of NCHD Taskforce Recommendations
18	Monitoring Improvements in the NCHD Work Environment

Priority Action Area 3 — Education and Training

Governance and Accountability

19 Chief Academic Officers

20 Group Director for Medical Education and Training

21 Strategic Planning for Medical Education and Training

22 Education and Training Space and Capacity in Infrastructural Developments

Postgraduate Training Programmes

23 Standardised Memorandum of Agreement for Delivery of NCHD Postgraduate Training

24 Quality Assurance Framework for Generic Cross Specialty Training and Standards

25 Postgraduate Medical Training Bodies to provide High Quality Learning Supports for NCHDs and Trainers

26 Geographical Organisation of NCHD Training Rotations

Clinical Site Supports and Resources

27 Educational Infrastructure and Support for NCHD Education and Training

28 Simulation Based Learning on Clinical Sites

29 Protected Time for NCHD Education and Learning

30 Protected Time for Consultant Trainers to Deliver NCHD Training

31 Mandatory Study Leave for NCHDs

32 Online and Virtual Learning and Development Resources for NCHDs

Priority Action Area 4 — Information and Communications Technology (ICT)

33 Off-Site Access: Laptops and Mobile Devices

34 Dry-round and Clinical Handover Facilities

35 Access to Workstations

36 DOH/HSE Digital Health Strategy

- → Paperless Ordering
- → Electronic Rostering, Time and Attendance
- → Electronic Health Record (EHR) systems
- → Patient Individual Health Identifier
- → National Shared Care Record

37 Reliable Connectivity

Priority Action Area 5 — Workforce Configuration

38 Increase Postgraduate Training Opportunities for NCHDs

39 Strategic Planning for Undergraduate Medical Education and Training

40 Review Recognition of Prior Learning (RPL) for Experienced Registrars

41 Career Pathways for NCHDs not in Training Programmes

42 Education and Research Career Pathways for Doctors

43 Safe Staffing for Medical Workforce

44 Planning for Non-Doctor Clinical Roles and Multidisciplinary Teams

1. The Scale of the Challenge

1. The Scale of the Challenge

The Minister for Health identified a critical need to address issues impacting Non-Consultant Hospital Doctor (NCHD) recruitment and retention in the Irish health service. Many Irish trained doctors are opting to work outside of Ireland citing poor working conditions and work life balance.[2,3,4] There is no easy solution to address these challenges given the critical shortage of doctors and other healthcare workers, the outdated infrastructure, and scale of demand for health services.

In 2018, there were 6,552 NCHDs working in publicly funded health services in Ireland. In December 2023 this number had grown to 8,729, representing an increase of more than 33% in the NCHD workforce in this period.[5] This has contributed to an environment where almost 40% of NCHDs working in our health service are not enrolled in postgraduate training programmes.[6]

The rapid expansion of the NCHD workforce to meet health service delivery requirements has contributed to an already urgent need to increase and enhance the supports and services required for NCHDs to carry out their work and to complete their education and training in our health service.

This rapid expansion has also resulted in the immigration of a large number of internationally trained doctors who make up 40% of the medical workforce in Ireland in 2021.[7] Many of these doctors are from countries which are themselves facing a shortage of doctors. Ireland, as a signatory to the WHO Global Code of Practice on the International Recruitment of Health Personnel[8], is required to apply ethical principles for international recruitment in a manner that will help to strengthen health systems of developing countries. There are global challenges associated with health personnel migration and the Irish health service must do more to strengthen healthcare workforce domestic supply and self-sufficiency.

NCHDs are a valuable part of the medical workforce, and their wellbeing and retention is of vital importance for our health service. The Irish health service needs to recognise the valuable contribution that NCHDs make and to place greater focus on prioritising and improving the working and training experience of NCHDs on clinical sites.

While the Taskforce recognises the broad challenges faced by all staff working in healthcare in Ireland and emphasises that many of their recommendations are relevant across all disciplines, the uniqueness of the NCHD employment status and structures has led to specific issues which need to be addressed to improve the wellbeing and working conditions for these critical members of the health workforce.

2. Humphries, N., Connell, J., Negin, J. et al., *Tracking the leavers: towards a better understanding of doctor migration from Ireland to Australia 2008–2018*. BMC Human Resources for Health 17, 36 (2019). https://doi.org/10.1186/s12960-019-0365-5
3. Humphries, N., McDermott, A.M., Conway, E. et al., *'Everything was just getting worse and worse': deteriorating job quality as a driver of doctor emigration from Ireland*. BMC Human Resources for Health 17, 97 (2019). https://doi.org/10.1186/s12960-019-0424-y
4. Humphries, N., McDermott, A.M., Creese, J., Matthews, A., Conway, E., Byrne, J-P., *Hospital doctors in Ireland and the struggle for work–life balance*, European Journal of Public Health, Volume 30, Issue Supplement_4, September 2020, Pages iv32–iv35. https://doi.org/10.1093/eurpub/ckaa130
5. Health Service Executive Employment Report, December 2023. Employment Reports – HSE.ie
6. HSE NDTP Medical Workforce Report 2022-2023 www.hse.ie/eng/staff/leadership-education-development/met/plan/ndtp-medical-workforce-report-2023.pdf
7. Hynes, T., O'Connor, P. (2022). An Analysis of Medical Workforce Supply, Research Services and Policy Unit, Department of Health. An Analysis of Medical Workforce Supply (www.gov.ie)
8. World Health Organisation 2010, WHO Global Code of Practice on the International Recruitment of Health Personnel. (WHO Global Code of Practice on the International Recruitment of Health Personnel)

Transient and Vulnerable Workforce

NCHDs provide an essential component of quality healthcare delivery in Ireland. Their role is critical to clinical care across our health service, and they remain the first medical point of contact for most hospital patients accessing acute and ambulatory care, resuscitation rooms and emergency departments. They also provide an essential role in the education and training of medical students, their own peers, and other healthcare professionals. Despite this vital contribution to our health service, they represent a particularly vulnerable group of healthcare workers due to their precarious employment status.

NCHDs, despite their extended career within the health service, continue to be employed as a transient workforce. A typical NCHD may move from one clinical site to another as frequently as every 3 months, and at least once every 24 months during an average of 9 years in training. While NCHDs work in HSE funded hospitals and Community Health Organisations (CHOs) throughout this time, an NCHD's move from one clinical site to another is considered a new employment contract that requires renewed credentialing and a new payroll. This continuous repetition across clinical sites is a significant personal and financial burden for NCHDs, as well as being an onerous and inefficient administrative process for the health service.

Despite the high turnover and constant churn of NCHDs within the health service, NCHD induction has traditionally focused on mandated corporate health system requirements rather than on welcoming, orientating, and equipping NCHDs with the tools needed to work at a specific clinical location and acknowledging their crucial role to the organisation. There is no basic national standard for induction of NCHDs, often no protected time for induction, and limited NCHD dedicated supports on clinical sites.

Unlike other health workers, there is no bespoke and extended induction for doctors who are internationally trained and are taking up employment in the Irish health service (outside of intern year) for the first time. These facts contribute to NCHDs feeling unsupported and undervalued in our health service. It underlines the critical need to provide equitable employment and induction supports for NCHDs for sustainable recruitment and retention in Ireland.

Medical Manpower and Human Resource Supports

Medical Manpower (MMP) departments were established in hospitals nationwide in 2002 to support NCHDs working in the Irish health service. Over the last 20 years as the NCHD workforce has doubled, MMP departments have been tasked with additional roles relating to consultant employment. Furthermore, the complexity of NCHD working has increased requiring bespoke medical manpower skills as well as training in employment issues and human resource management. During this time, MMP departments have evolved opportunistically rather than strategically, resulting in variable governance and skillsets, and lack of adequate dedicated NCHD supports from site to site.

NCHDs report high levels of difficulty accessing support and resources to address their employment concerns. MMP and Human Resource support available to NCHDs is consistently highlighted as a negative issue for employment and morale by both NCHDs and MMP managers.

Workplace Culture

Whereas strategy defines how things are intended to be done, culture is *'the way things are done around here'*.[9] Workplace culture is a complex and dynamic entity.

9. Dixon-Woods, M., Baker, R., Charles, K., et al., *Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study*, BMJ Quality & Safety. 2014;23:106-115. https://qualitysafety.bmj.com/content/23/2/106

One of the key themes that emerged from the work of the Taskforce is workplace incivility, also known as unprofessional behaviour. Undermining and unsupportive behaviours are reported as common across the health sector but NCHDs seem to be particularly exposed. This may be due to the transient nature of their employment, excessive workload, lack of adequate resourcing, and longstanding cultural 'norms' in terms of language and attitudes towards NCHDs. This is further compounded by a perceived inability to speak up when issues do arise.[10] NCHDs reported to the Taskforce that HSE policies and procedures are less likely to be actioned in their cases compared to colleagues in the health service who hold permanent employment contracts.

The issue is further compounded by a lack of dedicated and accessible line management supports to address workplace cultural issues. This refers to supports within the clinical team and within MMP departments. While many consultants are reported to be supportive, there are significant reports from both NCHDs and consultants that they lack the dedicated time and skillset to support the training, wellbeing, and work life balance of NCHDs. NCHDs highlighted the essential role of their consultant colleagues in setting the tone and delivering on these essential working and training standards. They also cited the lack of clarity on the overall responsibility for line management of employment issues for NCHDs.

Access to Basic Working Standards

On some clinical sites, NCHDs report that basic working standards are not appropriately provided. This can include access to food out-of-hours, access to drinking water, rest space, and changing facilities. The current lack of a strategic plan to develop these resources in a consistent manner across the health service is indicative of how NCHDs supports are not prioritised within the health service in Ireland.

We can no longer accept a system that simultaneously expects NCHDs to perform at a high level under extreme pressures and exaggerated working hours while neglecting their basic physiological requirements. This is particularly true in the context of NCHD retention as doctors consider opportunities outside of Ireland in competitor jurisdictions and industries.

The Effect of Contemporary Work Patterns on our NCHDs' Lives

The daily work of an NCHD is increasingly complex and stressful. The drive to achieve compliance with the Organisation of Working Time Act (OWTA) has meant changes to NCHD team structures. These result in a greater degree of movement across teams which has impacted on supervision, support, and the experiential learning of NCHDs.

The demographics of the NCHD workforce has also changed over time. The gender and age profile of doctors in training is now predominantly female and older compared to 20 years ago. This period had also witnessed a significant immigration of NCHDs. The NCHD experience is also impacted by the high number of geographical relocations resulting in constant stress of obtaining housing and childcare, while also often paying mortgages or rent elsewhere. These demographic changes require the development of support structures in areas of childcare, accommodation, and integration initiatives. Presently there is no strategic plan in the health service to develop mechanisms to address these workforce issues or to support NCHDs in meeting these challenges.

10. Creese, J., Byrne, J-P., Matthews, A, McDermott, A.M., Conway, E., Humphries, N., *"I feel I have no voice": hospital doctors'* workplace silence in Ireland. Journal of Health Organization and Management, 2021 Dec 17;35(9):178-94.)

Doctor Training in Ireland: Investing in Clinical Training on Clinical Sites

Medical training in Ireland is highly regarded internationally, and emerging data has demonstrated that up to one-third of doctors trained in Ireland choose to work long-term overseas, most notably in the UK.[11] The ease with which they secure such employment reflects the high quality of Irish trainees. The continued loss of these skilled health workers to the Irish health service has a significant impact on national healthcare delivery and workforce planning.

There have been immense changes in the training of doctors in Ireland over the last 25 years. Ireland has moved from a largely unstructured apprentice model of postgraduate medical training to structured, curriculum-based training programmes which are more focused on achieving competency rather than on duration of training time. The delivery of modern training therefore requires more support at both an infrastructural and educationalist level, but this has been severely lacking on clinical training sites. Furthermore, until now, new clinical programmes and health service infrastructural building projects lack consideration of educational needs, and this must change in the future. The Taskforce welcomes the move by HSE NDTP and the postgraduate medical training bodies to professionalise postgraduate medical education.[12]

A Workforce Less Dependent on NCHDs for Service Delivery

Ireland has lagged behind international standards in developing advanced practice and autonomous roles for the non-doctor workforce and has failed to deliver a medical system less dependent on NCHDs despite previous reports highlighting this issue.[13,14] NCHDs have become the default to cover gaps in service delivery, and thus tasked with roles that negatively impact on their ability to deliver patient care and to work within reasonable working hours. NCHDs continue to shoulder primary responsibility for many tasks that would be better delivered by other healthcare professionals including phlebotomy, cannulation, ECGs, and more. This fact is compounded by a lack of standard electronic supports, central to care in virtually all other healthcare systems, with a resultant reliance on paper-based systems for ordering tests and reporting. These issues impact on the efficacy and efficiency of NCHD working roles in Ireland.

The Taskforce fully acknowledges the enormous challenge of developing sustainable working and training conditions for the NCHD workforce in Ireland. In particular, the impact of clinical service configuration and poor infrastructure on clinical care and staff morale must be addressed. The Taskforce wishes to emphasise from the outset that many of the recommendations of this report will remain ineffective unless clinical service configuration and infrastructural deficits within the Irish health service are addressed, as these are issues critical to future NCHD workforce retention and wellbeing.

11. Pierse, T., Morris, R., O'Toole, L., Kinirons, B., Staddon, E.: *The retention of training doctors in the Irish health system*, Irish Journal of Medical Science, Feb. 16, 2023. https://pubmed.ncbi.nlm.nih.gov/36792762/
12. Forum of Irish Postgraduate Medical Training Bodies, August 2021: *A Strategic Framework for Postgraduate Medical Training in Ireland 2021-2030.* Strategy-22-10.pdf (theforum.ie)
13. Department of Health 2003, *Report of the National Taskforce on Medical Staffing (Hanly Report).* gov.ie – Report of the National Taskforce on Medical Staffing (Hanly report) (www.gov.ie)
14. Department of Health, *Strategic Review of Medical Training and Career Structure (MacCraith Reports).* gov.ie – Strategic Review of Medical Training and Career Structure (MacCraith) Reports (www.gov.ie)

2.
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2. Introduction

NCHD Taskforce Terms of Reference

The Terms of Reference requested the Taskforce to improve the NCHD experience and work life balance through the development and implementation of improved NCHD structures and supports on clinical sites. The aim was to further develop and foster a culture of education and training at clinical site level and plan for future configuration of the medical workforce to support delivery of healthcare in Ireland. Current and future Industrial Relations (IR) engagement continues to proceed in accordance with established IR practice, while the work of the NCHD Taskforce is a parallel process to improve NCHDs' training and education experience and work life balance. The Taskforce was asked to focus on both longer-term sustainable improvements to support NCHDs and highlight more immediate solutions in the short-term. Details of the Terms of Reference are attached in Appendix 1.

Membership

The Taskforce comprised 29 members including, among others, NCHDs, Hospital Consultants, Health Service Executive (HSE) Chief Clinical Officer, the Forum of Irish Postgraduate Medical Training Bodies, the Medical Council, HSE National Doctors Training and Planning (NDTP), HSE Acute Operations, HSE National HR, representatives from the Irish Medical Organisation (IMO), the Intern programme, psychiatry, general practice, and the Department of Health (DoH). The members represent key stakeholders and subject matter experts in order to provide the breadth of knowledge, clinical experience and expertise that is required to produce sustainable long-term solutions to address NCHD issues across the Irish health service. The Taskforce membership is attached in Appendix 2.

Vision and Methodology

The Taskforce members began by establishing individual workstreams in October 2022 to focus on specific priority areas, and defined a Vision for NCHDs, as follows:

> ***Deliver high quality education and training for all NCHDs in an accountable, respectful, and supportive working environment that facilitates sustainable work life balance.***

A programme of work was set out with a series of milestones and deliverables for each workstream. Members worked on identifying and defining the priority issues experienced by NCHDs, exploring potential solutions, and developing recommendations. The goal was to develop and refine short-term solutions that could be implemented immediately, along with longer-term recommendations that would require further planning and collaboration with stakeholders. The Taskforce agreed specific recommendations based on their understanding of the issues and, based on background work and discussion, provided some considerations that might be of benefit in the implementation phase. Figure 1 below illustrates how the Taskforce operated.

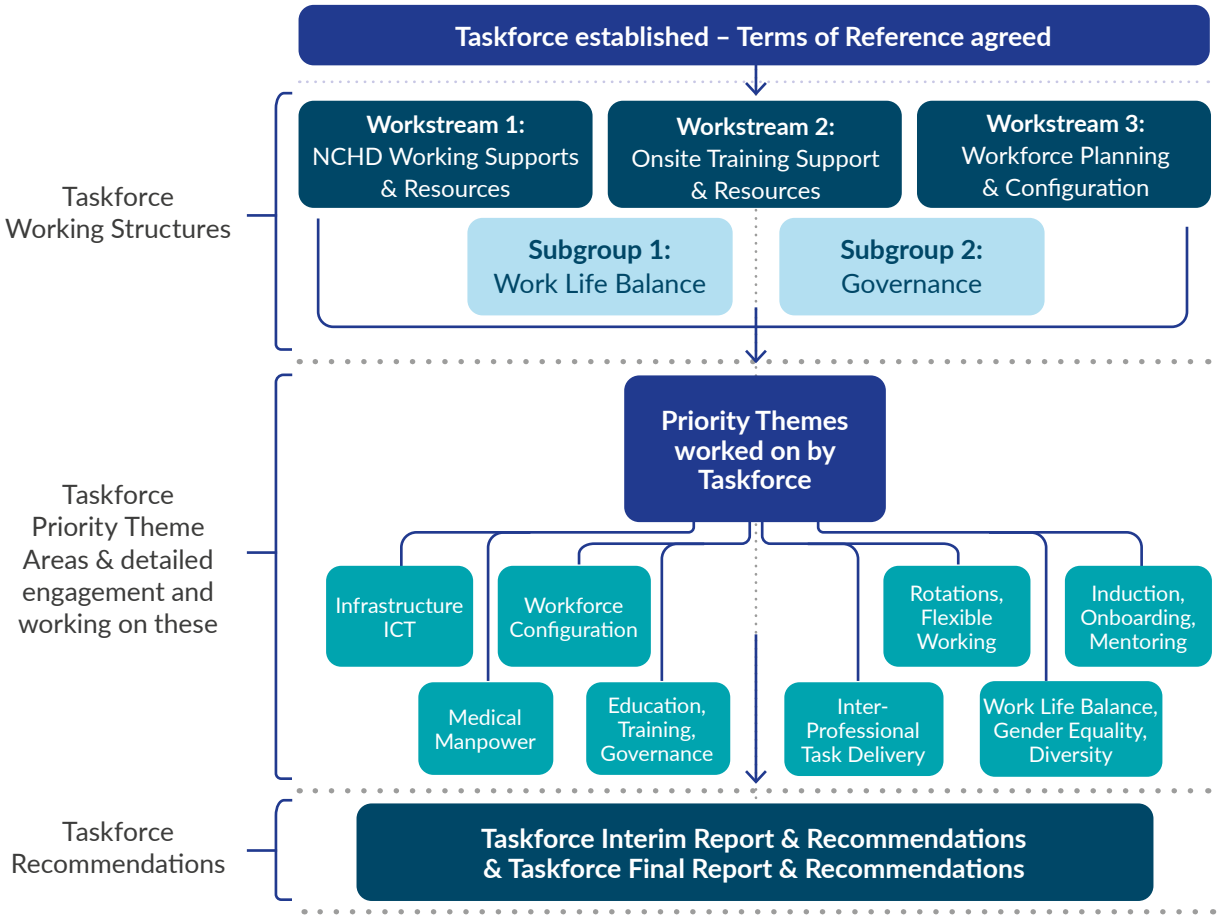


Figure 1: How the Taskforce operated.

Stakeholder Engagement

The broad scope of the Taskforce membership was a conscious decision to ensure key stakeholders relevant to the Terms of Reference could directly engage and influence the Taskforce recommendations. The aim of the stakeholder engagement undertaken by the Taskforce was to ensure other key stakeholders had an opportunity to input into the work of the Taskforce, to gather feedback from NCHDs, consultants, and other relevant groups on the priority issues and recommendations, and to identify any gaps or potential solutions for NCHDs, not identified by the Taskforce. A bespoke national survey of NCHDs and consultants was undertaken to further guide the priority areas for consideration. A summary of the survey results, and further stakeholder engagement, is provided in Chapter 5.

Recommendations

In April 2023, the Minister published the NCHD Taskforce Interim Recommendations Report, can be accessed here. The need for these interim recommendations was highlighted as critical for the work of the Taskforce from the outset, emphasising that many issues required urgent attention and should be addressed in the short-term. An update on progress with implementation of the Interim Recommendations is provided in Chapter 4.

The medium to longer term recommendations developed by the Taskforce for the final report are outlined in Chapter 3, under five priority action areas.

3. Recommendations

Priority Action
Area 1

Work Life Balance and The Working Week

IDENTIFIED CHALLENGE:

The Taskforce recognises that successful and productive clinical care and service delivery depends on the workforce striking a balance between life inside and outside of work. Despite this dependence, work life balance, and individual wellbeing for NCHDs continues to be under-recognised in the Irish health service. Work life boundaries for NCHDs can be blurred and often personal time not respected sufficiently. To improve the NCHD experience, the health service must recognise this issue and commit to structures that will improve NCHD work life balance.

Learning from clinical experience is of critical importance in a doctor's career. However, the Irish health service has become overly dependent on NCHDs for health service provision, to the detriment of the training experience.

On-site reviews of intern working clearly demonstrate that NCHDs continue to carry the primary responsibility for many tasks where the optimal delivery of these tasks should be by other members of the clinical team. This practice limits NCHDs' time delivering direct patient care to an increasingly complex clinical caseload and exacerbates unacceptable working times. Sustaining the NCHD workforce requires a new focus on embracing teamwork as part of a multidisciplinary team that is best for patient care and safety.

The Taskforce fully endorses the implementation of the key aspects of the NCHD IR (Industrial Relations) agreement and strongly encourages the timely implementation of the agreement.

The Taskforce listened to the Voice of the NCHDs. This is what we heard:

"Enhance part time/less than full time jobs, both for doctors in training and doctors who aren't in training".

"...If we create a better work life balance in medicine this will make it more attractive and encourage doctors to stay in Ireland and take up unfilled posts..."

We also heard from consultants:

"...I believe that the main reason NCHDs choose to go to Australia, and often stay longer than originally planned, is because of the much better work life balance there..."

Recommendations

1	NCHD Rostering	Lead	Timeframe
	NCHDs require prompt access to a fair and equitable roster which encompasses HSE/IMO rostering rules. This must be consistent with the European Working Time Directive (EWTD) and Organisation of Working Time Act (OWTA). To support this, the Taskforce recommends the following: a). Clinical sites (hospital sites and CHOs where appropriate) to implement a standardised electronic rostering generation system on each hospital site. This should be prioritised in the HSE Digital Strategy for implementation. b). Clinical sites must provide clear information on local rostering processes at commencement of employment. c). Rosters must be fair and equitable and must be issued to NCHDs one month in advance of start date for a minimum 13-week period. d). Postgraduate training programmes must put in place a process to deliver the mandatory training schedule (e.g. exams, study days) to NCHDs and Medical Manpower (MMP) personnel in advance of the start of the academic year.	HSE Acute Operations	From 2024

2	NCHD Working Hours – OWTA Compliance and Verification	Lead	Timeframe
	To support the reduction in NCHD working hours to achieve compliance with the Organisation of Working Time Act (OWTA), the Taskforce recommends and supports the immediate implementation of the revised NCHD OWTA Compliance and Verification process. The revised NCHD OWTA Compliance and Verification process was introduced by the HSE in November 2023. It sets out the requirements and responsibilities for NCHD OWTA compliance, monitoring and intervention (where required), for local NCHD OWTA monitoring groups at each site, and at Hospital Group level, along with strategic oversight and support from a National Working Group as required. The revised process includes guidance on the membership, purpose, role, and actions of each group.	HSE Acute Operations	From 2024

3	Time and Attendance Systems for NCHDs	Lead	Timeframe
	To support accurate recording, management, and reporting of NCHD working hours, and to ease the burden on NCHDs of manually completing timesheets, the HSE should implement Time and Attendance systems for NCHDs on all clinical sites, with appropriate governance. This system should be linked to payroll and HR systems.	HSE Acute Operations	From 2024

4	Policies to Support NCHD Work/Personal Life Boundaries	Lead	Timeframe
	The HSE should review implementation of existing policies, and, where necessary, develop and implement new policies to support the boundaries between work and personal life for NCHDs across all clinical sites. NCHDs need clarity on policies and actions relating to: a). Any contact out of hours and the enforcement of HSE's existing policy – 'Right to Disconnect' (2022)[15]	HSE National HR	From 2024

15. HSE Right to Disconnect Policy for Public Health Service Employees – 2022

b). The HSE use of NCHD personal phone numbers for clinical issues. Every MMP Department should direct NCHDs to where policies can be accessed and how they can seek advice where needed. This recommendation must be implemented in conjunction with the Dignity at Work and NCHD Liaison and Advocacy Support recommendation in this report – see Priority Action Area 2 – The Working Environment.		

5	Emergency Roster Planning	Lead	Timeframe
Recognising that local arrangements for the provision of emergency cover often unduly impact NCHDs' work life balance, the Taskforce recommends that a national group is established to examine and propose a plan around emergency rostering for implementation at clinical site level, including evaluation of models used in other jurisdictions, for example Australia.		HSE National HR	From 2024

6	Flexible Training and Working for NCHDs	Lead	Timeframe
The promotion of work life balance for NCHDs must include flexible options to achieve working and training less than full time (LTFT). This must be normalised as part of doctors' employment. The Taskforce recommends establishing agreed targets for LTFT working and training for NCHDs, with 5% of the NCHD workforce offered LTFT posts by 2026, and 10% by 2030. To support achievement of these goals, the Taskforce recommends: a). Development of a suite of national policies and procedures on LTFT working and training for NCHDs including: – A streamlined, consistent, and transparent process for NCHDs to apply for LTFT working and training on all clinical sites. This could be supported by electronic roster systems. – A process to deploy and facilitate LTFT arrangements for NCHDs enrolled in training programmes to be developed by the Postgraduate Medical Training Bodies. – Publication of a guidance document by the HSE defining NCHD entitlements while working LTFT. This should include information regarding annual leave, overtime, and study leave. – Sites with LTFT NCHDs to establish and publish a clear, user-friendly handover system that can be used by both Full Time and LTFT NCHDs. Electronic handover systems are recommended to support a safer and more accessible handover process. – Formal policy and process agreed between the Postgraduate Medical Training Bodies and the HSE on the management of LTFT trainee outcomes and competencies. b). Develop a Communication/Advocacy Awareness LTFT process to support acceptance and delivery of LTFT working for NCHDs. c). Expand the Job Sharing Programme for all training programmes to progress LTFT training. Ensure that all trainees are made aware of the availability of options, and that the options are promoted and facilitated by all training bodies.		HSE CCO	From 2024

d). Consider funding a demonstrator programme using pilot clinical sites to roll out LTFT working and training across disciplines and to inform national delivery of agreed targets.		

7	Interprofessional Working to Optimise Patient Care	Lead	Timeframe
	The HSE must develop a national framework with relevant stakeholders to optimise NCHD time for direct patient care as part of interprofessional working and multidisciplinary teams. This framework should include clear pathways for a comprehensive multidisciplinary approach to deliver specific tasks and to reduce NCHD dependency for service delivery. Each HSE Health Region will be required to ensure consistent standards for implementation of inter professional working and multidisciplinary teams across all clinical sites. A HSE multi-professional group, including NCHD representation, must consider areas of practice that can be delivered through an integrated approach by a range of appropriately trained/competent healthcare professionals. This integrated approach will require comprehensive interprofessional training, guidance and protocols maximising patient safety and efficiency. Tasks will need to be clearly defined, agreed, and allocated in a standardised, patient focused way. An implementation plan should be agreed, and the framework should be reviewed every two years.	HSE National HR	From 2024

8	Integrated Task Delivery: Priority Milestones Directed at Better Working and Patient Care	Lead	Timeframe
(i)	The responsibility for routine clerking, cannulation, phlebotomy, and discharge of patients in Endoscopy Units, Surgical and Cardiology Day wards are all tasks that can be delivered through an integrated working approach across the multidisciplinary team. The responsibility for routine phlebotomy and cannulation should not lie with NCHDs in these Units. Incremental targets are required and must be part of each site implementation plan.	HSE National HR	From 2024
(ii)	The primary responsibility for blood sampling from central venous lines on haematology and other relevant services must not lie with NCHDs. Optimum delivery should be by permanent experienced clinical staff on a consistent basis.		
(iii)	The development of cannulation teams in some model 4 hospitals to date is welcome. This resource should be established as part of the framework to support standardised integrated working across all clinical sites.		
(iv)	A resourced comprehensive daily phlebotomy service and extended phlebotomy delivered at peak hours, seven days a week, including bank holidays, must be considered and an implementation plan agreed for all acute clinical environments. The framework should also consider supporting expansion of phlebotomy skills for other staff groups in hospital settings.		
(v)	Non-clinical administrative duties must be reviewed with a plan to deliver safe and efficient processes to support rather than depend on NCHDs. These may include collating patient admission lists, ordering tests, retrieving records, and ordering consults. There are ICT solutions for many of these issues.		

What Success Will Look Like

Priority Area 1 – Work Life Balance and The Working Week

Improved NCHD work life balance and wellbeing due to greater clarity and respect for NCHD work/ personal life boundaries, along with appropriate Dignity at Work and Liaison and Advocacy support for NCHDs.

Better NCHD working week experience as a result of fair and equitable advance rostering, including study and exam leave, and time off.

NCHDs experience reduced stress and reduced administration burden as hours worked are OWTA compliant, accurately recorded by electronic time and attendance systems, and accurately reflected in the payroll.

Availability of flexible working and training options is normalised, promoted, and facilitated for NCHDs across clinical sites, with national policies and procedures introduced and implemented.

NCHD clinical education and training and skills development is enhanced by optimising NCHD time for direct patient care through interprofessional working, multidisciplinary teams, and integrated task delivery.

NCHDs working week and work life balance are improved by the development and implementation of effective emergency roster planning solutions across clinical sites.

Priority Action Area 2

The Working Environment

IDENTIFIED CHALLENGE:

The role of culture in the workplace was identified as a key contributor to the experience of NCHDs. The Taskforce highlights a critical need for the promotion of a culture of teamwork, respect, professionalism, and support for NCHDs. Unprofessional behaviour can have a detrimental impact on the NCHD experience and impact staff recruitment and retention.

The Taskforce recognises that a positive working environment is crucial to recruitment and retention of our healthcare workforce and that NCHDs need to be better valued and supported by clinical teams, managers, and employers. Implementation of the required changes in culture and wellbeing must be supported by an accountable governance structure on clinical sites.

The Taskforce listened to the Voice of the NCHDs. This is what we heard:

"...Dignity at work. Leadership to be demonstrated from HR and consultants so that NCHDs are treated with respect and dignity..."

"...NCHDs need to be comfortable and supported when saying "no" to tasks which are not medical in nature I.e. organising rotas, restocking shelves, filing, transporting patients for scans, transporting patients to the ward for admission etc..."

"...Acknowledgement that over 50% of workforce are female, many of whom have children and would like to continue working in the hospital, but for many becomes unfeasible due to rotation locations and inability to get out on time (I.e. before 7pm)..."

We also heard from consultants:

"...I believe that one of the main challenges for NCHDs in Ireland... is not feeling valued and being constantly expected to go above and beyond a reasonable workload."

Recommendations

9	Health and Welfare/Wellbeing Standards for NCHDs	Lead	Timeframe
	The Taskforce recommends that the HSE works with the Forum of Irish Postgraduate Medical Training Bodies to develop and implement wellbeing standards for NCHDs across all clinical sites.	FPGTBs	From 2024

10	Line Management Support for NCHDs	Lead	Timeframe
	NCHDs report a positive relationship with consultant supervisors but also report a lack of clarity regarding their line management, which impacts on addressing issues of concern relating to employment and professionalism. NCHDs must have appropriate line management support from consultants throughout training and employment as NCHDs. The Taskforce recommends that consultants are offered appropriate training and provided with local support in the line management of NCHDs, as required. It is recommended that consultants meet with all their NCHDs at the changeover date and outline the expected working arrangements within their department/specialty and to ensure NCHDs are rostered fairly within the teams. On an ongoing basis the consultants should continue to assess the working day/week for NCHD team members, including review of rostering such that the balance of provision of clinical care and NCHD hours are effectively managed and optimised.	HSE National HR	From 2024

11	NCHD Liaison and Advocacy Support	Lead	Timeframe
	It is imperative that NCHDs have liaison support for the duration of their employment and that HR policies relating to unprofessional behaviour, bullying and other aspects of dignity at work are immediately actioned to support NCHDs. The Taskforce recommends that clinical sites establish an accessible, responsive, and accountable NCHD liaison and support person with appropriate skills and seniority to engage with and support NCHDs in HR and employment related issues. This includes addressing emerging issues as well as responding to immediate concerns. This role must have an appropriate governance framework and support network to oversee and guide their activities. They should have frequent engagement with relevant stakeholders (including NCHDs, consultant supervisors and trainers, Medical Manpower, and executive management teams) to report the above wellbeing metrics and to coordinate necessary response actions. At a minimum this role should include (but not be limited to): • Promoting a positive working and wellbeing environment for NCHDs within the Irish health service. This will ensure close liaison with NCHDs including a key role at NCHD induction and in ongoing engagement with NCHDs to provide advice and support and identify emerging issues. • Supporting workplace professionalism and civility (e.g. incivility reports and follow-on actions taken). Assist NCHDs in accessing and actioning relevant policies and procedures. This will require a knowledge of HR and MMP policies, an ability to signpost NCHDs to the relevant services and support structures of the HSE, and to deal initially with issues via informal and formal pathways, as necessary.	HSE Acute Operations	From 2024

• Compliance with legislation and arrangements that regulate NCHD working hours and rest periods. This includes engagement with site-level OWTA monitoring groups. Where required (e.g., in a clinical role), this person should have protected time to oversee fundamental metrics that relate to NCHD wellbeing.		

12	Bespoke Leadership and Management Training Programme for Consultants to support NCHDs	Lead	Timeframe
	The Taskforce recommends the development and roll-out of a bespoke programme of leadership and management training for consultants to enhance their skills and experience to support and manage NCHDs in a complex clinical setting. This training should focus on cultural awareness and team management relevant to wellbeing and work life balance. This programme should be developed with clinical input from acute clinicians, postgraduate medical training bodies, and include learnings from established programmes. Uptake by consultants must be encouraged, facilitated, and monitored by the employer.	HSE National HR	From 2025

13	Reflective Practice Training and Support for NCHDs	Lead	Timeframe
	In the context of reflective practice becoming a core element of Professional Competence Schemes, all doctors should receive training in reflective practice. Supports should be provided in clinical settings to encourage and facilitate this practise. Training programmes in reflective practice should be identified or established with input from postgraduate medical training bodies and Medical Council and recommended for clinicians.	HSE CCO	From 2024

14	Responsive Team Debriefing Processes for NCHDs	Lead	Timeframe
	Team debriefing following difficult cases should be encouraged and facilitated in clinical settings. Senior medical staff should be trained in debriefing and facilitated to deliver debriefing with their teams when this is considered necessary (e.g. unexpected negative clinical outcome). A responsive debriefing process on clinical sites with trained facilitators is required and should include psychology support where needed.	HSE Acute Operations	From 2025

15	NCHD Return to Work Policy Following Period out of Clinical Practice	Lead	Timeframe
	All NCHDs who have a period out of clinical practice should be assisted in returning to work by a NCHD specific Return to Work Policy. The Taskforce recommends the HSE develops and implements this policy, with support from the postgraduate medical training bodies and the Medical Council, to establish mandatory supports for NCHDs returning to work after 12 months out of clinical practice, and for others where it is deemed necessary. A process to address any skills deficits will be required to be agreed and put in place. The programme should seek input and support from the HSE Occupational Health Specialist Hub for NCHDs.	HSE CCO	From 2025

16	Professionalism Frameworks for NCHD Positive Working Environment	Lead	Timeframe
	Recommendations on Positive Working Environment seek to enhance a culture of professionalism as it relates to NCHDs, incorporating a culture of trust and psychological safety. The Taskforce recommends: (i) **Mentorship** to be available for all doctors across the continuum of training from interns to consultants. (ii) **A Peer support programme** providing availability of free and confidential trained peer supporters to speak and/or meet with colleagues under stress (e.g., unexpected patient outcomes, clinical adverse events, the stress of constant change.) (iii) **A Framework for addressing unprofessional behaviour/conduct,** to include training for all staff and instilling professional accountability in each staff member throughout the organisation, led by senior management. A stepwise escalation process for addressing unprofessional conduct, including informal steps and formal interventions, and channels of communication and reporting, should be clearly recognised and communicated among staff. The Taskforce recognises work performed by South-Southwest Hospital Group, ICGP, Children's Health Ireland, and postgraduate medical training bodies, and recommends that a policy and procedure is developed with input from these stakeholders.	HSE National HR	From 2025

17	Culture Change Programme to Support Implementation of NCHD Taskforce Recommendations	Lead	Timeframe
	The HSE has existing policies on cultural change and many of the actions recommended by the Taskforce will contribute to positive cultural change. The Taskforce recommends that the HSE should leverage their Organisation Development and Change Team to deliver a change management programme that will facilitate this cultural shift and ensure that these policies and actions are implemented across all clinical sites.	HSE National HR	From 2024

18	Monitoring Improvements in the NCHD Work Environment	Lead	Timeframe
	Taskforce discussions have highlighted the need for improved understanding of the work experiences and wellbeing of NCHDs going forward, including a need to monitor improvements to the NCHD work environment resulting from Taskforce recommendations. The Taskforce recommends the development of an annual NCHD survey and consideration of independent verification to support robust monitoring of improved experience for NCHDs. Data generated could be available for use by clinical sites, HSE, Department of Health and external researchers (with appropriate ethics permission) to monitor and analyse data relating to the NCHD work environment on an ongoing basis.	HSE CCO	From 2024

What Success Will Look Like

Priority Area 2 – The Working Environment

NCHDs experience a positive working environment with a culture of teamwork, respect, and professionalism, where they feel supported and valued by peers, employers, and senior colleagues.

NCHDs are supported on employment and wellbeing issues by clear and appropriate levels of Line Management, Liaison and Advocacy support, MMP and HR support.

Incidences of bullying of NCHDs are addressed and NCHDs experience positive culture changes that emphasise trust and psychological safety for NCHDs in their working environment.

All NCHDs returning to work after a period out of clincial practice are appropriately supported by a NCHD specific Return to Work policy.

NCHDs are supported by responsive team debriefing processes, delivered by trained facilitators, including psychology support as required.

Ongoing monitoring, collection and verification of data relating to the NCHD working environment so that NCHD experience and wellbeing is improved and better understood.

Priority Action Area 3

Education and Training

IDENTIFIED CHALLENGE:

Many NCHDs and their consultant trainers in Ireland work in strained clinical environments that do not prioritise education and training for NCHDs. This has clear implications for both patient and NCHD welfare as well as recruitment and retention.

NCHD medical training and education requires delivery of complex specific training curricula guided by Medical Council accreditation standards. The expertise required to support training programme delivery is no longer possible within MMP departments alone.

To achieve the goal of delivering world-class clinical education that embraces changing demands, including technological advances, for an increasing number of NCHDs in training programmes requires ambition and innovation.

The Taskforce considered recommendations for both the clinical sites and the accredited postgraduate medical training programmes.

NCHD education and training must be prioritised through the establishment of enhanced medical education and training infrastructure and supports within HSE Health Regions using a hub and spoke model.

There is an urgent need to establish accountable governance structures on clinical sites with clearly defined roles and responsibilities. This is to ensure NCHD training is supported at all clinical sites and integrated with postgraduate medical training bodies, the Medical Council, and academic university partners in a common strategy for NCHD education and training.

The Taskforce listened to the Voice of the NCHDs. This is what we heard:

"...Protected teaching time... currently any teaching is not actually protected as can be bleeped or not allowed to attend..."

"...Train doctors. Teach them well. Support their teachers. Prioritise training and progression, not for the benefit of the NCHD, but ultimately to benefit the patient and the Irish health system...."

"...At this moment, it's hard to even imagine a system which values and trains NCHDs to even a level close to what the training bodies promise. There needs to be a focus on training rather than NCHDs filling gaps in rotas..."

We also heard from consultants:

"...NCHD training, post and quality of trainees are quite variable and very behind compared to other European and western developed countries..."

(i) Education and Training – Governance and Accountability

Recommendations

19	Chief Academic Officers	Lead	Timeframe
	A clear governance structure for education and training in the HSE Health Regions is required. The Taskforce recommends that the Chief Academic Officer role for Hospital Groups be expanded and enhanced to oversee education and training across both acute and community services in the HSE Health Regions structures. The structures for education and training should report through the Chief Academic Officer and through the Regional Executive Officer line for each HSE Health Region.	HSE Health Regions	From 2024

20	Group Director for Medical Education and Training	Lead	Timeframe
	There is an urgent need to develop accountable education and training governance structures in a hub and spoke model aligned to HSE Health Regions. These governance structures should span the whole of the medical workforce, including all NCHDs, and all doctors requiring compliance with Professional Competence Schemes. The Taskforce endorses the NDTP Group Director for Medical Education and Training pilot for NCHDs and recommends the expansion of this model to all Hospital Groups, CHOs, and HSE Health Regions as they develop. See Figure 2 following this table of Recommendations for illustration of this model.	HSE CCO	From 2024

21	Strategic Planning for Medical Education and Training	Lead	Timeframe
	The Taskforce recognises the significant investment required to deliver world class medical education and training of doctors in Ireland and endorses the need for interprofessional learning. With evolution of a requirement for increased medical training posts at all levels (undergraduate and postgraduate) the Taskforce recommends integrated, strategic planning of hub and spoke learning environments across HSE Health Regions to ensure coordinated development of academic and training opportunities. The Taskforce recommends an integrated approach between the Health and Education sectors and the establishment of a National Committee for Strategic Planning of Medical Education and Training, comprising Department of Health, Department of Further and Higher Education, Research, Innovation and Science (DFHERIS), Higher Education Institutes, postgraduate medical training bodies, HSE, and other relevant stakeholders, to develop a strategic plan for the enabling of clinical education and training and professional development of doctors in Ireland within the clinical system. This should encompass the development of advanced academic clinical learning environments with secure data sharing and storage in each HSE Health Region that integrates undergraduate and postgraduate doctor learning resources and planning. A process to ensure fair, equitable, and effective access to education and learning in clinical settings across the regions must be developed. Taskforce deliberations and research on advanced academic learning in a hub and spoke manner provide a suggested model for consideration. This is summarised in Chapter 6: Future Focus – Longer Term Recommendations.	DoH	From 2024

22	Education and Training Space and Capacity in Infrastructural Developments	Lead	Timeframe
	All new-build and retrofit/upgrade infrastructural developments across the health service should take account of educational and training capacity and the needs of NCHDs and their requirements for educational and training space. All new programmatic developments need to include educational and training capacity with direct input from clinical and educational leadership. The responsibility for ensuring this occurs lies with the Chief Executive Officer roles centrally and locally in the evolving HSE Health Regions.	HSE Capital & Estates	From 2024

Group Director for Medical Education and Training – Clinical Educator Programme Model

The Clinical Educator Programme model is designed to put in place a hub and spoke model across each Hospital Group/HSE Health Region to support training and education for all NCHDs.

The vision is that every Hospital Group will have a Group Director for Medical Education and Training. This individual is a clinician and is responsible for developing and establishing the strategic vision for postgraduate medical education and training across the group. This role reports into both the Chief Academic Officer for the Hospital Group and the NDTP Director.

The Group Director works with and is supported by local clinical leads for medical education and training. Each hospital will have a Clinical Lead responsible for on-site training and education. These clinical leads report to the Group Director. The model is supported by appropriate administrative staff.

The Group Director is responsible for establishing the Postgraduate Medical Education Training Committee for the Hospital Group. It is there that the site clinical leads and other stakeholders meet at Hospital Group level to drive forward the training and education agenda, identify synergies across the sites as well as tackle any NCHD issues that arise.

At a national level, the Group Directors across the seven hospital groups meet regularly for information sharing and collaboration to ensure the national training agenda is being driven at site level.

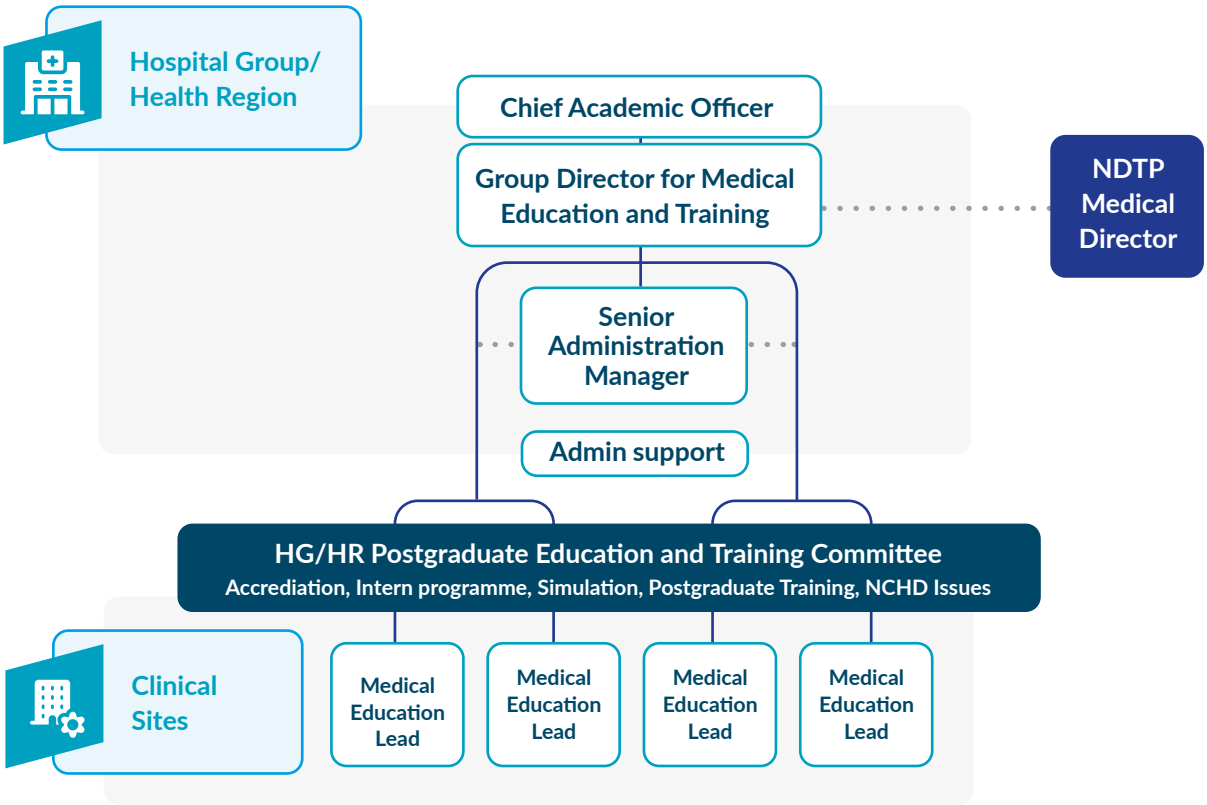


Figure 2: Clinical Educator Programme

(ii) Education and Training – Postgraduate Training Programmes

Recommendations

23	Standardised Memorandum of Agreement for Delivery of NCHD Postgraduate Training	Lead	Timeframe
	To improve consistency and accountability, a standardised memorandum of agreement on trainee support and training must be developed and agreed. The Taskforce recommends that the Forum of Irish Postgraduate Medical Training Bodies and HSE work together to develop and agree this Memorandum. The document should clearly set out the key roles and responsibilities of both parties and their remit to deliver an accountable, supportive, and effective training programme and environment.	FPGTBs	From 2024

24	Quality Assurance Framework for Generic Cross Specialty Training and Standards	Lead	Timeframe
	The Taskforce notes the development by the Medical Council of new standards for medical education and training, based on the principle of right-touch regulation, and the ongoing work of the Forum of Irish Postgraduate Medical Training Bodies on a training strategy. In this context, the Taskforce recommends the introduction of an integrated quality assurance framework to monitor generic cross-specialty training and working standards. This must be based on the principle of transparency and data sharing between postgraduate medical training bodies, the clinical sites, and the Medical Council. This new framework should reduce repetition and redundancy, enhance consistency and accountability, and enable targeted, risk-based interventions where necessary. The reporting structure should be through the evolving HSE Health Regions.	FPGTBs	From 2025

25	Postgraduate Medical Training Bodies to provide High Quality Learning Supports for NCHDs and Trainers	Lead	Timeframe
	Supportive clinical learning environments provide NCHDs with access to supervised participation in patient care, assessment and feedback, teamwork, peer collaboration and observable models of practice. The Taskforce recommends that the postgraduate medical training bodies play a leadership role in driving best practice in high quality learning environments for NCHDs. This must involve clear and accountable support from postgraduate medical training bodies (PGTBs) for trainees and trainers that is accessible on clinical training sites. The best practice approach developed by PGTBs should also be adopted by the HSE for non-training scheme doctors.	FPGTBs	From 2024

Each Training Body must: (i) Create and publish agreed policies and procedures for dealing with difficult issues arising during training, including grievance pathways. These should be clear and impartial to support resolution of training-related issues. (ii) Publish regular statistics on application numbers and admissions to training, numbers progressing each year and failing to progress, and numbers of trainees completing training each year. These data should be accessible to the Director for Postgraduate Medical Education and Training at each HSE Health Region so that they can direct enhanced support to clinical training sites that are falling below the median. (iii) Provide greater transparency on the eligibility and selection processes to postgraduate specialty training programmes. This should include a clearer description of the processes, panel size, scoring criteria, and independent oversight at interview. (iv) Ensure that consultant supervisors undertake training in their role as trainers. This should include training in supervised clinical work, coaching, assessment, feedback, and mentorship. Ensure training assessments include an assessment of and a mechanism to address issues of unprofessionalism on sites (e.g. undermining behaviour, support) as well as achievement of curricular outcomes. (v) Where trainees prematurely exit a training programme (before obtaining CSCST), the individual should be offered a structured exit interview. The feedback from these interviews must be documented and remedial actions taken where required. (vi) Regular review of these reports and actions stemming from these exit interviews should be presented to the Forum of Irish Postgraduate Medical Training Bodies and form part of the SLA discussions with HSE.		

26	Geographical Organisation of NCHD Training Rotations	Lead	Timeframe
The structure of postgraduate medical training requires that NCHD Trainees rotate across different sites and locations during postgraduate training. This is to fulfil the requirements of the curriculum and to ensure NCHDs are exposed to a variety of clinical systems and experiences. While recognising the requirement of rotation for postgraduate training, the necessity for geographic moves during training should be minimised. The Taskforce recommends that all postgraduate training programmes: (i) Provide pre-defined rotations at the outset of the training programme for a minimum of three years. (ii) All postgraduate training programmes to establish a geographic structure for training to allow trainees to remain in the same geographic area for most of the training programme. Only one geographic move requiring living relocation (i.e. new accommodation) in a 4–5-year scheme is recommended. The number of geographic relocations is the key issue. The recommendation does not infer training within one HSE Health Region or Hospital Group, although alignment with evolving governance structures is desirable as a principle.		FPGTBs	From 2024

(iii) It is recognised that a small number of training programmes do not have the appropriate number of trainees or training posts to facilitate a regionalised approach. In such cases it is recommended that the training programmes review training allocations to minimise as much as possible the geographic moves required, and that there is an oversight process to approve programmes where higher numbers of relocations are required. The Forum of Irish Postgraduate Medical Training Bodies to consider appropriate oversight and reporting. (iv) The Forum of Irish Postgraduate Medical Training Bodies to explore the feasibility of providing a national couple matching system for allocation of rotations.		

(iii) Education and Training – Clinical Site Supports and Resources

Recommendations

27	Educational Infrastructure Support for NCHD Education and Training	Lead	Timeframe
	Recognising the HSE's statutory obligation to facilitate the education and training of NCHDs and the current deficits in the educational infrastructure, there is an urgent and immediate need to invest in modern educational infrastructure that supports high quality sustainable education to meet the evolving needs of trainees. This encompasses the physical and digital tools, systems, and environments and must be delivered by skilled dedicated staff, particularly to support the essential role of clinical simulation in the education of medical professionals. All existing training locations and any future healthcare infrastructure must provide physical facilities for education and training to occur. The Taskforce recognises that this is a substantial and complex undertaking that will require a phased programme of immediate recommendations for delivery in the short-term, and continuation and delivery of further required developments over the medium to longer term. This should include: (i) provision of adequate educational space on site, appropriate to the size and complexity of the institution for individual and group learning. (ii) provision of digital learning supports (dependable Wi-Fi for access to remote and interactive learning). (iii) onsite clinical simulation facilities. (iv) responsible support personnel (administration, IT, maintenance, and clinical education and training onsite leadership) must be identified and tasked to support the function and operation of the infrastructure. All sites should, in line with recommendation 21, develop a longer-term plan for continued provision, development and operation of the educational infrastructure and learning opportunities. The scope of the suggested immediate requirement is detailed in Appendix 3. The Taskforce highlights the need to develop national purchasing frameworks for the procurement of educational resources to avoid unnecessary delays and ensure cost effectiveness in delivering on recommendations.	HSE Capital & Estates	From 2024

28	Simulation Based Learning on Clinical Sites	Lead	Timeframe
	The Taskforce recognises and welcomes the recently established National Simulation Office at the Health Service Executive (HSE) which will drive priority areas for the delivery of valuable, relevant, and sustainable clinical simulation. The Taskforce endorses the recommendations in the National Strategic Guide for Simulation on Clinical Sites (2022). The Taskforce advises that implementation teams and simulation office leadership develop the delivery requirements in a cooperative way, including application of Learning Analytics to training and assessment in simulation and clinical settings.	HSE CCO	From 2024

29	Protected Time for NCHD Education and Learning	Lead	Timeframe
	It is recommended that the HSE develop a process to allow protected time for NCHDs on clinical sites in line with the current policy, for teaching that is bleep/call free, except in emergency situations. Implementation of this requirement should be reported by clinical sites to the Group Director of Medical Education and Training.	HSE Acute Operations	From 2024

30	Protected Time for Consultant Trainers to Deliver NCHD Training	Lead	Timeframe
	Trainers must be provided with protected time to train. Clinical consultant practice plans must include clearly defined time for formal scheduled postgraduate education and training. Implementation of this requirement should take account of the different forms and distribution of teaching undertaken by consultant trainers. The teaching activity should be monitored by site Clinical Directors and be consistent with the responsibilities set out in the Memorandum of Agreement for delivery of NCHD postgraduate training.	HSE Acute Operations	From 2024

31	Mandatory Study Leave for NCHDs	Lead	Timeframe
	As provided for in the IR Agreement, study and exam leave for NCHDs must be granted and accommodated by the employer prior to Gateway Exams/ Mandatory Courses, taking account of NCHDs' medical education and training status.	HSE Acute Operations	From 2024

32	Online and Virtual Learning and Development Resources for NCHDs	Lead	Timeframe
	NCHDs should have access to virtual learning environments to access online learning and development resources.	HSE National HR	From 2025

What Success Will Look Like

Priority Area 3 – Education and Training

NCHD education and training prioritised across clinical learning environments and enhanced by establishing a regional hub and spoke model.

NCHD education and training is supported by appropriate Governance and Accountability, as well as postgraduate training programme and clinical site supports and resources.

Protected teaching time for NCHDs and trainers is factored in to each clinical site rostering system and NCHDs receive mandatory study leave.

NCHD geographic rotations planned in advance, and regionally organised to reduce impact of geographic moves on NCHD personal and family lives.

Consistent high standards for NCHD training and education, with appropriate support, accessible resources, and suitable training space.

Enhanced education and training facilities are in place for NCHDs on all clinical sites, including SIM and virtual learning.

Priority Action Area 4

Information and Communications Technology (ICT)

IDENTIFIED CHALLENGE:

NCHDs in the Irish health service currently work with a severe lack of supporting ICT infrastructure. This impacts on the delivery of their duties, on their education and training, and contributes to the pressures they face daily as NCHDs. It also directly impacts on the efficiency and quality of patient care, particularly as it results in NCHDs spending unnecessary time on administrative issues.

The Taskforce identified ICT issues that relate to NCHD working conditions including providing care from distant sites, relate to education and training, and the frequent movement between clinical sites. A digitally enabled workforce and workplace is key to the delivery of efficient and safe care.

Recognising the complexity of current ICT systems across the health service, the Taskforce sought to define clear ICT 'requirements' as essential supports for NCHDs which need to be prioritised as part of the overall HSE Digital Strategy.

The Taskforce listened to the Voice of the NCHDs. This is what we heard:

"...A lot of NCHD time is wasted trying to get information that could be readily Available if we had a unified IT system with a unified personal identity number..."

"...Improve access to basic IT tools such as secure, permanent/national email address that can be accessed on personal device or provide work device".

"...Dramatic improvements in the IT systems are needed as a matter of urgency. The impact on patient safety and staff burnout is repeatedly evident..."

We also heard from consultants:

"The poor infrastructure and IT capability in the HSE make the working environment challenging for all staff..."

Recommendations

33	Off-Site Access: Laptops and Mobile Devices	Lead	Timeframe
	NCHDs are a mobile workforce both within the environs of the hospital and through the multiple placements during their training. ICT equipment that provides secure access to all necessary hospital or community ICT systems is crucial to providing cross site or on-call off site services. NCHDs should have access to a health service laptop and mobile phone, if required.	HSE CIO	From 2024

34	Dry-round and Clinical Handover Facilities	Lead	Timeframe
	All clinical sites should identify and provide protected space that can be used by NCHDs for dry-round and clinical handover activities. This space should have computers with large screens or projectors that facilitate group discussion of cases.	HSE CIO	From 2024

35	Access to Workstations	Lead	Timeframe
	The HSE should ensure that all NCHDs on-duty have access to well-equipped and fully functioning workstations, which has been identified by the Taskforce as a critical enabler to NCHDs completing their administrative work efficiently and in a timely manner. As a guide there should be dedicated workstations for NCHDs based on a ratio of one workstation per ten patients.	HSE CIO	From 2024

36	DOH/HSE Digital Health Strategy	Lead	Timeframe
	The Taskforce fully supports the implementation of the DOH/HSE Digital Health strategy and calls for accelerated timeframe for implementation of: • Paperless Ordering – the HSE must review and equitably implement paperless order communication systems across clinical sites, to enable the electronic requesting of diagnostic tests, imaging studies, tasks, and the management of any subsequent results from such requests. • Electronic Rostering and Time and Attendance systems – the Taskforce recommends these are put in place for NCHDs as a matter of priority, to support delivery of a number of recommendations throughout this report. • Electronic Health Record (EHR) systems – to be deployed to enable improved care coordination, improved access to information at the point of care, streamlined workflows and improved collaboration. • Patient Individual Health Identifier – this will be a key enabler to supporting safer, better patient care and will support more efficient use of resources. • National Shared Care Record to create a single patient record incorporating all primary, acute, community and social care data.	HSE CIO	From 2024

37	Reliable Connectivity	Lead	Timeframe
	The HSE should ensure there is resilient and comprehensive connectivity across all clinical sites. Access to Wi-Fi, 5G and cellular coverage is imperative to the work practices of NCHDs who need to be able to access reference material during patient encounters.	HSE CIO	From 2024

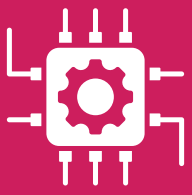
What Success Will Look Like

Priority Area 4 – Information and Communications Technology (ICT)

NCHDs education, training and working experience is supported and enhanced by ICT infrastructure.

Efficient, user friendly, paperless request system is in place across all sites for NCHDs to conduct their work.

NCHD handover processes are enhanced with greater teamworking and reduced administration.



On-call off site NCHDs have easy and timely access to patient information.

Patient safety and quality of care is improved by more efficient ICT supported service

Technical infrastructure is in place to allow NCHDs to efficiently manage their work in a timely manner.

NCHDs experience timely access to IT systems when transferring between sites.

All clinical sites have dedicated and well-equipped workstations in place for NCHDs.

Priority Action Area 5

Workforce Configuration

IDENTIFIED CHALLENGE:

Changing population demographics, increased demand for health services and shortages of healthcare workers has placed immense pressure on the Irish health service. It is essential that medical workforce configuration evolves to meet the needs of the population and provide high quality patient care. Patient care and safety are at the core of the workforce configuration recommendations and, as in other jurisdictions, should be based on agreed safe medical staffing standards.[16]

The Taskforce interim recommendations included targets for increases in the number of consultants and NCHD postgraduate training posts, together with recommended consultant to population and consultant to NCHD ratios by 2030 as follows:

- Increase the number of consultant posts in line with workforce planning projections to 6,000 with a target ratio of 110 consultants per 100,000 of the population.
- Increase the number of NCHD postgraduate training posts in line with workforce planning projections to 5,800-6,000 training NCHD posts.
- Consultant to NCHD ratio of 1:1.3 NCHDs.

Some of the key NCHD retention issues identified by the Taskforce are associated with an over-reliance on doctors to provide aspects of care where optimal patient-centric delivery could be carried out by other non-doctor members of the clinical team. The medical workforce must be configured such that the most efficient, sustainable, and cost-effective patient-centric models of care are developed to ensure that the over reliance on NCHDs for health service delivery is addressed. The expansion of the multidisciplinary team should be considered to support more efficient usage of the medical workforce resource and support improvements in the NCHD working week and improve doctor retention.

16. Royal College of Physicians, Guidance on safe medical staffing. Report of a working party, London: RCP, 2018.

The Taskforce listened to the Voice of the NCHDs. This is what we heard:

"...The notion that SpRs are enrolled on a training scheme which doesn't provide them meaning offer of employment at the end of it is very disillusioning..."

"Long term road mapping for consultant positions would allow NCHDs to prioritise gaining experience in areas where jobs will become available and allow you to take on a niche fellowship opportunity which would be appropriate for an opening position."

"...Non-BST/SpR doctors should be better supported to achieve career progression to eventual consultancy. Too often, non-scheme doctors are left to service provide and journey across Ireland with no progression..."

"...As a non-trainee doctor, I have observed a significant disparity in the opportunities provided to us compared to our fellow trainees..."

We also heard from consultants:

"...there needs to be a recalculation of the required number of NCHDs to staff a service to take into account not just covering rotas and clinics, but to make sure that the workload is not excessive..."

"Training post for all model 3 and above NCHD posts- Equity for all departments and sustainability for less vocal departments"

"...Non doctor career roles that can help with running the service i.e. advanced nurse practitioners or physician assistants..."

Recommendations

38	Increase Postgraduate Training Opportunities for NCHDs	Lead	Timeframe
	The postgraduate medical training bodies to undertake a training capacity review to identify existing NCHD posts suitable for conversion to/allocation as training posts to increase availability of specialist postgraduate training posts for NCHDs.	HSE CCO	From 2024

39	Strategic Planning for Undergraduate Medical Education and Training	Lead	Timeframe
	Department of Health, Department of Further and Higher Education, Research, Innovation and Science (DFHERIS) to develop strategies to align the supply of medical graduates to medical workforce demand projections to work towards self-sufficiency in the supply of doctors. These strategies must take into consideration appropriate resourcing required to ensure that the quality and standards of undergraduate medical education and training are maintained, with particular reference to the investment required for this expansion and to support additional capacity for clinical placements across the health sector. Strategic planning for medical education and training requires input from the clinical site educational leads to consider clinical training placements and resources required.	DoH	From 2024

40	Review Recognition of Prior Learning (RPL) for Experienced Registrars	Lead	Timeframe
	Current Recognition of Prior Learning (RPL) structures and processes should be reviewed to optimise medical workforce recruitment potential, while maintaining the required standards and experience. To address a legacy issue that exists for experienced Registrars who want to access training at an appropriate level, entry requirements for Higher Specialty Training (and equivalent) should be expanded to include recognition of equivalence of Initial Specialty Training for learning undertaken in Ireland outside of a structured accredited training programme. It is recommended that all postgraduate training programmes establish a formal mechanism to assess equivalence of Initial Specialty Training.	FPGTBs	From 2024

41	Career Pathways for NCHDs not in Training Programmes	Lead	Timeframe
	The Taskforce Interim Recommendations included annualised targets for the increase of consultants and NCHD trainees. NCHDs who are not in training programmes will continue to form part of the medical workforce and it is essential to develop permanent and sustainable career options and pathways for these doctors. It is recommended that DoH and HSE urgently examine the feasibility and potential benefits to the health service in formally establishing a new permanent grade doctor for health service delivery. The process should consider the key roles and responsibilities relevant to health service needs, the sustainability of this grade, training and regulation required, reporting relationships, and pay scale required. It should include input from other jurisdictions such as UK Specialty and Specialist (SAS) grade. It is recommended that the Medical Council consider and propose options for the general registration status of doctors in these grades; and the Forum of Irish Postgraduate Medical Training Bodies to co-ordinate with the HSE and Medical Council regarding appropriate educational programmes to support these new roles.	HSE National HR	From 2024

42	Education and Research Career Pathways for Doctors	Lead	Timeframe
	There is a need to professionalise Medical Education and Training. Recognition of the value of clinician researchers, educators, and leadership in health is crucial for the evolving workforce. The DoH should consider supporting the development of this expertise by providing dedicated consultant posts for postgraduate training, in a manner similar to undergraduate training, specifically to professionalise and support the education and training of NCHDs and to provide mentorship for research and leadership.	HSE CCO	From 2025

43	Safe Staffing for Medical Workforce	Lead	Timeframe
	It is recommended that the DoH establish a multi-stakeholder policy group for the purpose of defining benchmarks for medical safe staffing levels including clinician tier for a variety of clinical situations. It is recommended that the DoH works with the HSE to provide guidance on acceptable staffing levels for a given workload, including the optimum number and appropriate grade of doctors necessary for a given volume of admissions, case mix, number of inpatients and outpatients covered, and support provided for other specialties.	DoH	From 2024

44	Planning for Non-Doctor Clinical Roles and Multidisciplinary Teams	Lead	Timeframe
	It is recommended that there is a plan to further develop and explore advanced practice for existing non-doctor clinicians (Nursing and Midwifery, Health and Social Care Professionals (HSCPs), and new clinical grades such as Physician Associates (PA) and medical technicians to reduce the reliance on NCHDs for service delivery. The Taskforce underlines the importance of learning from international best practice and undertook a review of the Physician Associate role as it relates to the NCHD workforce in Ireland. The findings of the review demonstrated a high level of support and strong potential for the PA role to support NCHDs, but a lack of consistency and clarity on the role within the healthcare team. The Taskforce recommends that NCHD and other roles are clearly defined in the context of multidisciplinary team working and task sharing.	DoH	From 2024

What Success Will Look Like

Priority Area 5 – Workforce Configuration

NCHDs experience better support and improved work life balance as a result of increasing numbers of consultant posts and NCHD training posts.

NCHD education and training is prioritised and supported as the over reliance on NCHDs for service delivery is reduced.

The proportion of NCHDs on specialty training programmes increases, while career pathways and recognition of prior learning options are explored for NCHDs not on specialty training programmes.

NCHDs working conditions improve by achieving acceptable staffing levels that are appropriate to workload, clinical requirements, and patient safety.

NCHDs benefit from more professionalised medical education and training structures, and education and research career pathways for doctors.

NCHDs have more support from the planning and development of integrated, multidisciplinary teams including non-doctor clincial roles.

4. Interim Recommendations Progress Update

In its first six months, the Taskforce developed interim recommendations to address identified challenges for NCHDs, strengthened by specific implementation requirements, including oversight and monitoring structures. The table below provides a high-level summary of the Interim Recommendations under the seven priority themes that were included in the Interim Report, which is available here

Table 2: National Taskforce on the NCHD Workforce – Summary of Interim Recommendations

Priority Area	Recommendations
Induction and Onboarding for NCHDs on Clinical Sites	• A proposed set of specific standards for NCHDs first day of induction starting from the next rotation in July 2023 are to be introduced across all clinical sites. These reflect the key tools required to equip NCHDs to start work in a new institution. They should be delivered over a protected time-period of 4 hours in the first two days of NCHDs starting on site.
Enhanced Induction for International Medical Graduates who are new to the Irish health service	• Enhanced Induction should be provided for all International Medical Graduates (IMGs) new to the Irish health service, to support them to commence working safely in a new clinical environment, and to successfully integrate as quickly as possible, both professionally and personally.
Infrastructure – Working Environment and Supporting Infrastructure for NCHDs	• All clinical sites should meet the Taskforce's recommended 'Good Standards' on working environment to assist NCHDs in delivering their duties effectively, efficiently, and safely.
Medical Manpower (MMP) Support for NCHDs	• Dedicated MMP Liaison support role to be put in place on-site for NCHDs from July 2023. • Expand the National Employment Record (NER) to address key enhancements identified by NCHDs, including salary details, sick-leave, and post-matching details. • Provide bespoke training for MMP staff to ensure consistency with NCHD experience across all sites in employment related matters. • Conduct capacity review of existing MMP resources and set out recommended levels and standards to support NCHDs.

Priority Area	Recommendations
Medical Workforce Configuration Vision and Targets	• Agree annual targets for increases in consultants and NCHD Trainees and Framework to monitor implementation of annual targets. • Develop career pathways for non-training NCHDs including reviewing the potential for permanent service/associate grade of doctor roles. • Review other non-doctor clinical roles, including Physician Associates, to decrease reliance on NCHDs for service delivery.
Work Life Balance, Welfare/ Wellbeing and Culture	• Support the development of a HSE Occupational Health Specialist Support Hub for NCHDs. • Consider a time and motion study to gather an evidence base on NCHD work roles and tasks such that remedial actions can be considered to support the NCHD workforce.
Governance – Senior Administrative Lead for NCHD Standards and Supports	• Appoint Accountable Administrators on-site at Hospital Group/HSE Health Region level to champion and support NCHD education and training, and to implement Taskforce recommendations and training accreditation standards. It will align and integrate with the clinical educator pilot programme.

Progress Update – Introduction

Following publication of the Interim Report of the National Taskforce on the NCHD Workforce on 13th April 2023, the HSE put in place a structure to progress the implementation of the Interim Recommendations. The Interim Recommendations included a requirement for the HSE to submit a progress update to the Taskforce. The HSE submitted their update report to the Chair of the Taskforce in September 2023 outlining the implementation structure, governance, and updates on progress with the Interim Recommendations.

Implementation Governance Structures

The following Governance structures have been established by the HSE:

NCHD Taskforce Implementation Steering Group chaired by HSE Chief Clinical Officer and HSE National HR Director to oversee implementation.

- Three working groups were established to support the Steering Group, each of which has been assigned specific recommendations, as follows:
  - → Operations Working Group, chaired by Group CEO for UL Hospital Group
  - → Infrastructure Working Group, chaired by Acting Chief Architectural Advisor, HSE Capital and Estates
  - → National Working Group, chaired by Assistant National Director, HSE NDTP
- Local Implementation Groups (LIGs) Report into the Operations Working Group. Each Hospital Group and CHO has been instructed to set up a Local Implementation Group (LIG). The role of the LIGs is to ensure implementation of recommendations at site level. LIGs have been established on the majority of clinical sites.
- A project manager has been appointed to support the implementation structure.

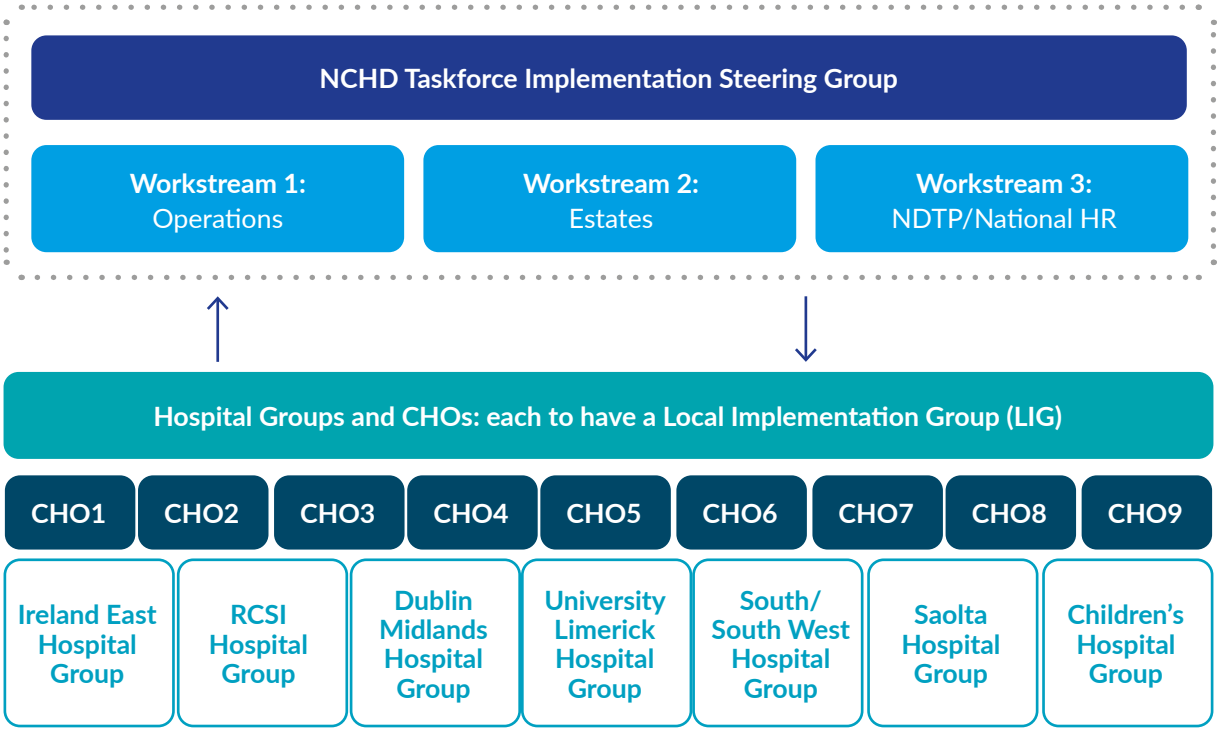


Fig 3: NCHD Taskforce Implementation Steering Group for Interim Recommendations

Interim Recommendations – Progress Update

Table 3: Summary of Progress with Implementation of Interim Recommendations

Induction for NCHDs on Clinical Sites	• All clinical sites were required to deliver induction in line with the recommended standards in the NCHD Taskforce interim report. • Compliance was monitored through a self-assessment compliance report. All 43 Hospital Sites returned the self-assessment induction compliance reports. • 95% of Hospitals reported Induction provided within 24–48 hours of NCHD commencement. • Operations group and Steering group reviewing reports to identify areas/issues that require further action.
Enhanced Induction for International Medical Graduates who are new to Irish health service	• Enhanced induction for International Medical Graduates new to Ireland delivered on 10 Pilot sites identified across all Hospital Groups. • The pilot sites received very positive feedback. A review of the pilot has commenced and will inform considerations for a national roll out in July 2024. • A national NCHD guide developed and published. The guide "Working as a Doctor in Ireland" provides important information for all NCHDs on working and living in Ireland. • A copy can be found at: Working in Ireland as a Doctor – NCHD guide.pdf (hse.ie) • The International Medical Graduates Learning Pathways Communications Course comprises of four modules throughout the academic year. To date, 160 ring-fenced places have been provided for International Medical Graduates on the pilot sites and working in the CHOs. The first module of the National Communications Course was delivered in person in September 2023 in four regions.
Working Environment and Supporting Infrastructure for NCHDs	• Clinical sites with a NCHD workforce were invited to apply for 2023 funding to address deficiencies in their facilities based on the recommended good standards published in the Interim Recommendations Report. This required undertaking a gap analysis. • 41 sites had projects approved. • Projects are supporting implementation of Taskforce recommendations in the following areas: • 37 sites to increase or enhance rest and recuperation facilities, including increased rest facilitates for off-site on-call/post call. • 12 sites to refurbish or increase showering and changing facilities. • 16 sites to provide out of hours accessibility of healthy food. • 14 sites to increase security including lockers and/or increased access control.

	• 17 sites to increase ICT and computer facilities including tablets for use on ward rounds, increased computers in the residence, better mobile and wi-fi coverage. • 8 sites to improve teaching/training facilities by refurbishment of offices/study areas and increased audio-visual access.
Medical Manpower (MMP) supports for NCHDs	• Medical Workforce (NCHD) Management course developed for Medical Manpower Manager staff offering bespoke training in effectively managing NCHD workforce. First course scheduled to be run over four days in November/December 2023. • NCHD National Employment Record (NER) Expansion – NCHD post matching has been developed and implemented. NCHD Salary and Point on Scale and sick leave features on the NER are on track for July 2024 roll-out. • Medical Manpower capacity review – initial capacity review has been undertaken and immediate deficits identified as part of this review. More in-depth review commenced to include review of MMP roles and responsibilities.
Medical Workforce Configuration Vision and Targets	• Medical workforce projections to reach 6,000 consultants by 2030 completed – a significant shortage of domestic pipeline identified. • Ongoing engagement with postgraduate medical training bodies to increase training numbers. • Aggregate supply model developed for consultant posts bringing together all the supply models for each of the Specialties. Models map from Higher Specialist Training (HST) intake to consultant employment and show new HST and consultant posts required using various scenarios. • Physician Associate (PA) – Physician Associates data gathering exercise to inform NCHD Taskforce recommendations completed.
Work Life Balance, Welfare/ Wellbeing	• HSE Occupational Health Specialist Support Hub has been established with formal launch expected in Q4 2023.
Governance – Senior Administrative Lead for NCHD Standards and Support	• Job description for Grade VIII posts aligned to the Clinical Educator pilot as per the Taskforce recommendation. Awaiting approval to proceed to recruitment.

5. Stakeholder Engagement

The unique and emerging challenges for NCHDs in Ireland are set out at the start of this report and it is noted that many of the challenges that impact NCHDs have wider systems and organisational implications which also impact other clinical and administrative staff across the health service.

This section of the report sets out the stakeholder engagement that was conducted to inform the identification of the priority areas and the development of the final recommendations.

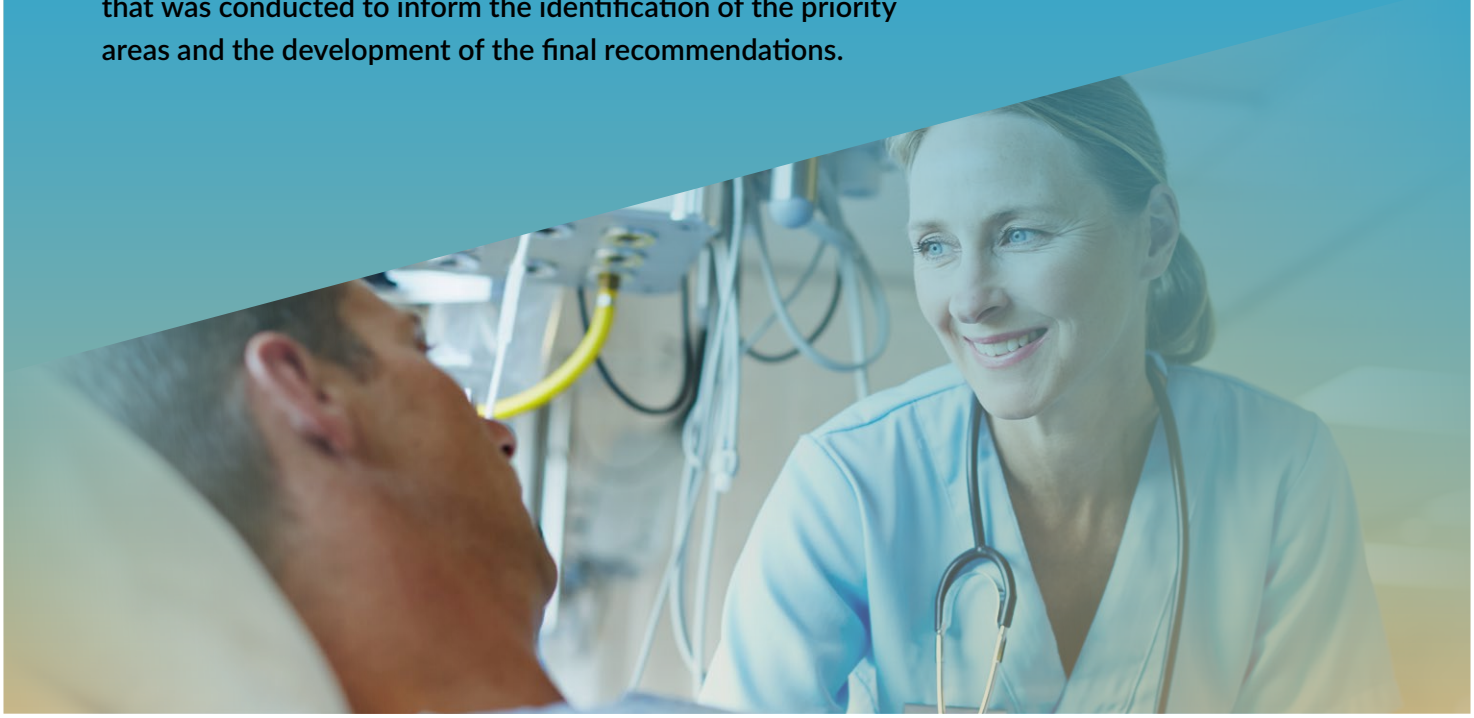


Figure 4 below shows how stakeholder engagement informed the Taskforce priority areas and recommendations.

Fig. 4: Stakeholder Engagement to inform priority areas.

Stakeholder Consultations

The Taskforce members represent key stakeholders and subject matter experts to provide the breadth of knowledge, clinical experience and expertise that is required to produce sustainable long-term solutions to address NCHD issues across the Irish health service. The Taskforce Membership is attached at Appendix 2.

To consider the broader impact of the NCHD Taskforce recommendations on HSE clinical sites, and evolving HSE Health Regions, the Chair of the Taskforce met with hospital Chief Executive Officers and Chief Academic Officers.

As part of the Taskforce engagement with stakeholders, a bespoke national survey inviting all NCHDs and consultants to submit feedback to guide and inform the priority action areas and recommendations for consideration was completed in May-June 2023. The results fed into the Taskforce work-streams. The details are provided later in this section.

Key engagements are summarised below, and a list of stakeholder bodies represented during Taskforce stakeholder engagement and consultation is provided at Appendix 4.

NDTP NCHD Leads Workshop

Members of the NCHD Taskforce, including the Chair and HSE CCO, attended the National NCHD Lead meeting hosted by the NDTP in June 2023. The national group of Lead NCHDs represents NCHDs of all disciplines who work across clinical sites nationwide. Collectively they have unique insights into the issues facing NCHDs and have assumed leadership roles in addressing NCHD challenges. The Chair of the Taskforce, in an interactive session, provided an update on priority areas being considered by the Taskforce followed by a workshop discussion to explore these areas and consider other issues of concern to NCHDs. This engagement provided important insights and additional information for the Taskforce.

Intern Programme Feedback on Task Sharing

Representatives from the Taskforce met with national intern leads and coordinators. These meetings provided information on the intern experience on clinical sites. This included intern feedback on specific tasks and had been gathered by annual assessments, audits, and surveys (across 5 hospitals).

Interns report that phlebotomy and cannulation consume a large amount of clinical time and are generally considered their primary responsibility. Availability of routine phlebotomy services is inadequate and inconsistent across sites. Additional phlebotomy and cannulation tasks increase the onerous nature of on-call leading to significant stress, impacting negatively on patient care, efficiency, and doctor well-being. Traditionally, this has resulted in extended working hours that are not in compliance with the Organisation of Working Time Act (OWTA).

Medical Manpower (MMP)

Medical Manpower (MMP) support is critical to NCHDs throughout their career. It was first established in 2002 as a dedicated NCHD service. To understand MMP issues relating to NCHDs the Taskforce Chair, Workstream Chairs, and other key members attended the national MMP managers' conference in October 2022. Engagement was conducted through a series of presentations, workshops and subsequently a detailed survey for MMP teams across clinical sites. The outcomes revealed that MMP resources are inadequate to support the increased volume of NCHDs and the additional demands on MMP departments relating to consultant employment. This engagement provided valuable supporting input to help inform the Taskforce recommendations.

Forum of Irish Postgraduate Medical Training Bodies

The Work life Balance subgroup was specifically convened to consider the issue of workplace culture. Over a series of meetings, this group engaged with representatives of the Forum of Irish Postgraduate Medical Training Bodies relating to their work on the development of NCHD wellbeing standards. In addition, evidence from the Taskforce NCHD and Consultant Survey highlighted the need for cultural change within the HSE, to create a more positive working environment and thus improved team working and wellbeing for all staff. These engagements informed relevant aspects of this report.

Technology – ICT

The importance of electronic supports and IT connectivity were identified by the Taskforce as a key area requiring investment to support NCHD working. The HSE Chief Information Officer participated in a Taskforce meeting to discuss priority requirements for NCHDs in this area and any HSE plans to address ICT connectivity issues and identified ICT gaps.

Clinical Simulation

Recognising the critical role of clinical simulation in future education, training, and clinical practice the Taskforce Chair met with the newly appointed National Clinical Simulation lead, Professor Dara Byrne. The recommendations pertaining to clinical simulation, and its place in evolving education and training needs across the spectrum of lifelong and interprofessional learning were discussed and aligned with the strategic plan of the National Simulation Office.

Learning Analytics

The Taskforce also considered the potential impact of the application of Learning Analytics to provide more effective training to doctors with associated improvements in healthcare outcomes. Representatives of the Taskforce met with the Chair of the Forum of Irish Postgraduate Medical Training Bodies National Learning Analytics Committee and the Taskforce recognises that the application of Learning Analytics may influence approaches in training into the future.

NCHD and Consultants Survey

1. Introduction

The Taskforce considered it important to seek the views of a broad base of Non-Consultant Hospital Doctors (NCHDs) and consultants, across the health service, on key issues relating to NCHDs working and training in Ireland. The aim was to invite feedback on the priority areas identified by the Taskforce, to help identify any gaps or other priorities, and to provide an opportunity for input to the development of the Taskforce recommendations.

2. Data Collection and Analysis

Feedback was invited and collected via a survey, disseminated by email to all training and non-training NCHDs and consultants. The survey consisted of both quantitative and qualitative questions, including scales, free-text questions, and commentary boxes for participants to provide free-text answers. Each question produced two datasets, one containing responses from NCHDs and one from consultants. A copy of the survey questionnaire is included at Appendix 6.

Data from quantitative questions was graphed to identify the priority areas for NCHDs and consultants, and to determine if these were reflective of the priority areas identified by the Taskforce. Thematic analysis was performed on the open-text responses. The analysis found that the priority areas identified by the Taskforce were consistent with those highlighted by NCHDs and consultants.

3. Summary of Results

In total, 743 responses were received, with a breakdown of 559 responses from NCHDs and 184 responses from consultants. Figure 5 below provides an overview of the responses.

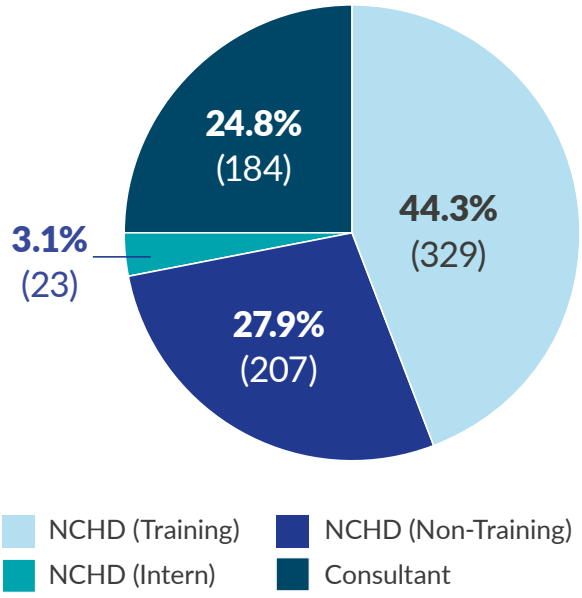


Figure 5: Number of Responses received from NCHDs and Consultants

Question 2 of the survey aimed to identify if the Taskforce priority areas were aligned with the priorities of high importance to the NCHD and consultant workforce.

Figure 6 below shows that all of the priority areas identified by the Taskforce were ranked high importance (i.e. ranked 4 or higher on a scale of 1-6) by the large majority of NCHDs and consultants in the survey.

% NCHDs and Consultants who rated each Taskforce Priority Area as 4 or higher

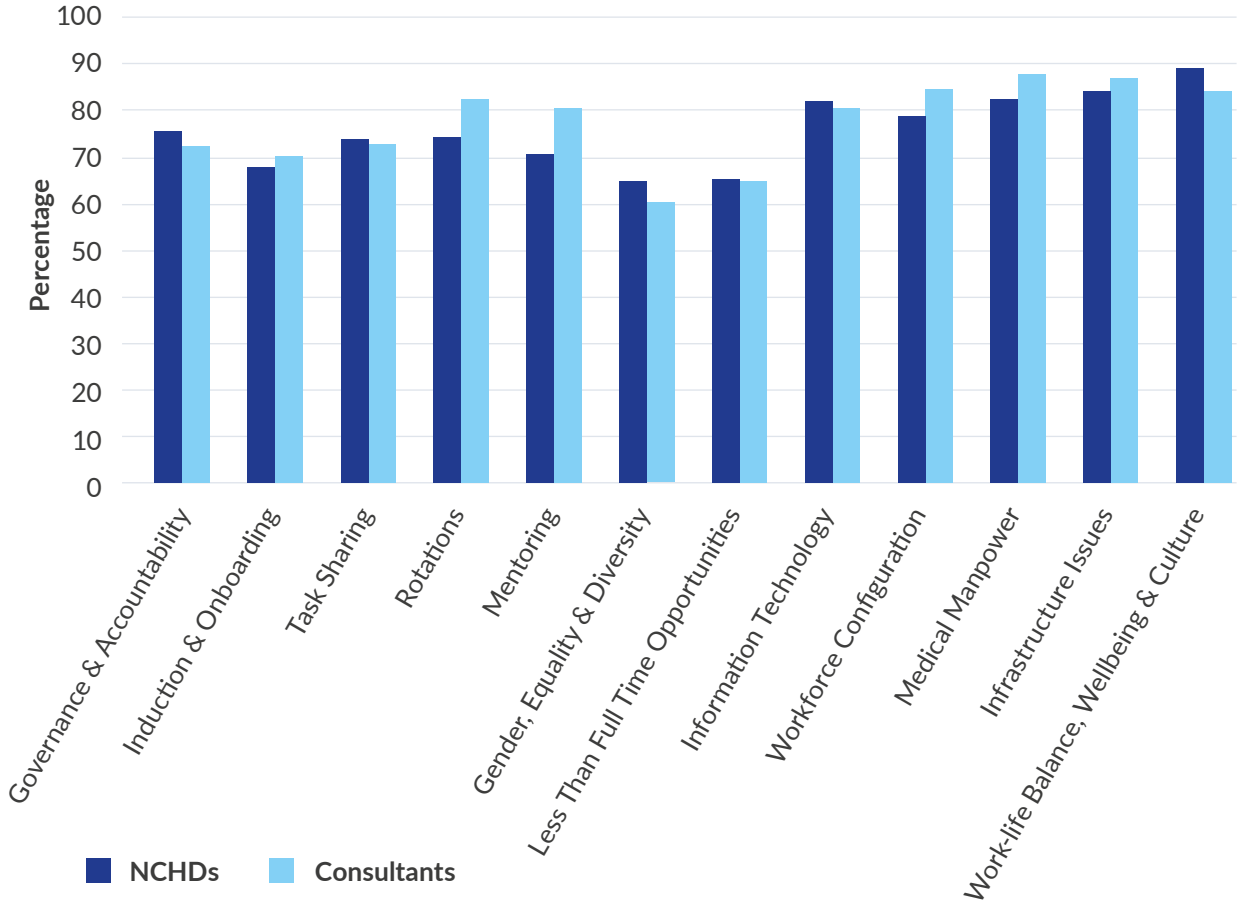


Figure 6: Taskforce Priority Areas ranked High Importance by NCHDs and by Consultants.

The second part of question 2 invited participants to submit comments on any issues relating to the priority areas that were identified and ranked. 164 comments were provided by NCHDs, and 45 comments were provided by consultants.

These comments provided rich quantitative and qualitative data and were reflective of the priority issues identified by the Taskforce. Figures 7 and 8 below show the top 10 issues highlighted by the comments that were submitted in response to Question 2.

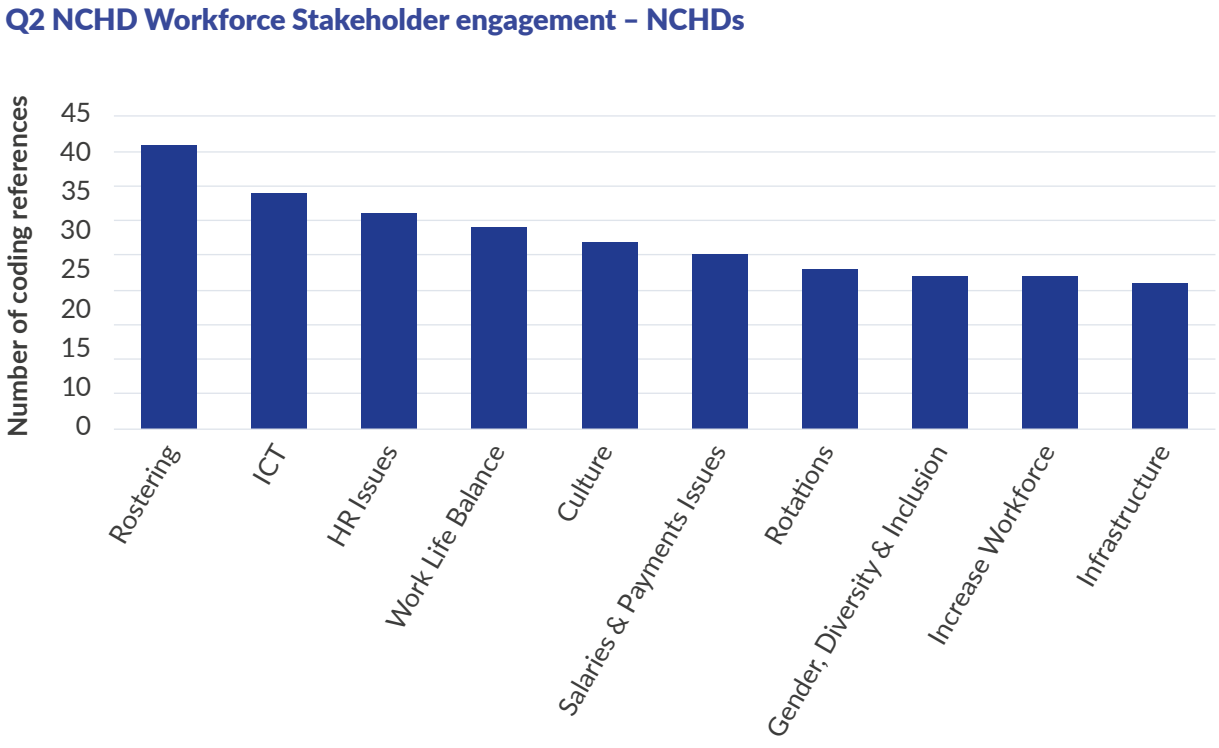


Figure 7: Top 10 issues highlighted by comments submitted by NCHDs in response to Question 2

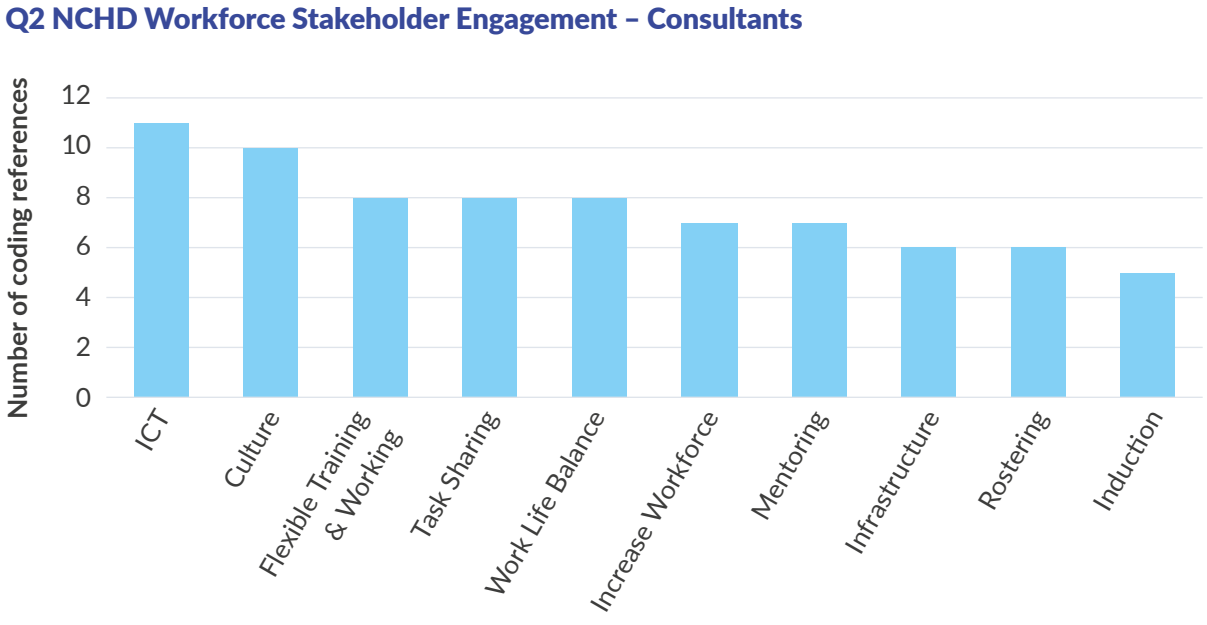


Figure 8: Top 10 issues highlighted by comments submitted by Consultants in response to Question 2

Summary of NCHD Feedback

559 responses were received from NCHDs. This included responses from Interns (4%), NCHDs not in training programmes (37%) and NCHDs in training programmes (59%).

The survey contained both quantitative and qualitative data, and this data was used to identify the top priorities for NCHDs in the Irish health service, some of which are highlighted below:

Work Life Balance & Rostering

Work Life Balance was highlighted as one of the highest priority areas in the NCHD responses. It was often mentioned in conjunction with rostering, rotations, and the impact that long hours have on the NCHDs ability to have a healthy work life balance. The comments in the NCHD responses highlighted the following Work Life Balance and Rostering priorities:

- European Working Time Directive to be implemented.
- Removal of 24-hour shifts.
- Rest periods after working 10 consecutive days in a row.
- The ability to do training rotations in regional locations.
- The availability of flexible working and training.

HR / Medical Manpower Support

HR issues were raised frequently throughout the quantitative and qualitative data from NCHDs. Among the HR issues raised were:

- Greater HR support relating to rotas, leave availability and ensuring coverage of services.
- Supports for enhanced communication between HR and NCHDs.
- A focus on resolving issues regarding dignity and respect in the workplace.
- Anti-bullying campaigns and a pathway to deal with allegations of bullying effectively.

Infrastructure & ICT

Infrastructure and ICT were identified as priorities throughout the responses from NCHDs. Their responses highlighted the following needs:

- Access to IT equipment, workspaces, and meeting rooms.
- Parking/transport availability for NCHDs.
- Access to lockers, showers, on-call sleeping areas and food.
- Childcare facilities on site or near to workplaces and accommodation during rotations.
- NCHDs also showed strong support for a Universal Health Identifier and Electronic Patient Records to be implemented, and highlighted that these would greatly reduce inefficiency and stresses that result from searching for information among paper-based records.

Workforce Configuration

NCHDs provided feedback on workforce configuration, and how changes in this area could improve their work life balance and working environment. NCHDs highlighted the following needs:

- Increased workforce numbers, both at NCHD and consultant level, to meet workload demands, to support rostering improvements, and also to help ensure safe staffing levels throughout the healthcare system.
- Full implementation of Task Sharing to help alleviate the heavy workload of NCHDs.
- NCHDs were also keen to see an increase in training places across specialties, and recognition of prior learning for doctors with extensive experience to progress.

Summary of Consultant Feedback

Work Life Balance, Wellbeing and Culture, Infrastructure, Medical Manpower, and Workforce Configuration featured as some of the areas deemed of high importance to consultants in the quantitative data, which reflected the same areas deemed highest priority by NCHDs.

Infrastructure & ICT

Consultants highlighted the need for improvements in ICT and infrastructure to help improve the working environment of NCHDs. The following were highlighted throughout consultants' responses:

- Dedicated workstations and meeting/ handover rooms for NCHDs.
- Development of a unique health identifier and electronic health record.
- Improved working conditions including modern clean facilities, access to bathrooms, rest spaces and access to food.
- On site childcare facilities, and accommodation support
- Access to parking.

Education & Training

Education and training was one of the top priority areas for consultants based on the qualitative data from Question 4. Consultants highlighted a number of areas for improvement including:

- Increase in training numbers.
- Access to training schemes for Non-EU doctors.
- Protected teaching and supervision time.
- Mentoring programmes to support doctors through their career development.
- Recognition of prior learning for those not currently on training schemes but with relevant experience.
- Effective induction for all, particularly doctors who are new to the Irish healthcare service.

Task Sharing

Task sharing was one of the areas frequently mentioned by consultants and was closely related to the Workforce Configuration theme, with some of the following suggested by consultants who responded:

- Removal of administrative tasks and non-medical duties from NCHDs.
- Increased Administration support for NCHDs and consultants.
- Increase in Advanced Nurse Practitioner and Physician Associate roles to support NCHDs.
- HR to take greater responsibility for rostering and finding locum cover as needed.

Culture

Culture was highlighted by both consultants and NCHDs. Consultants identified the following:

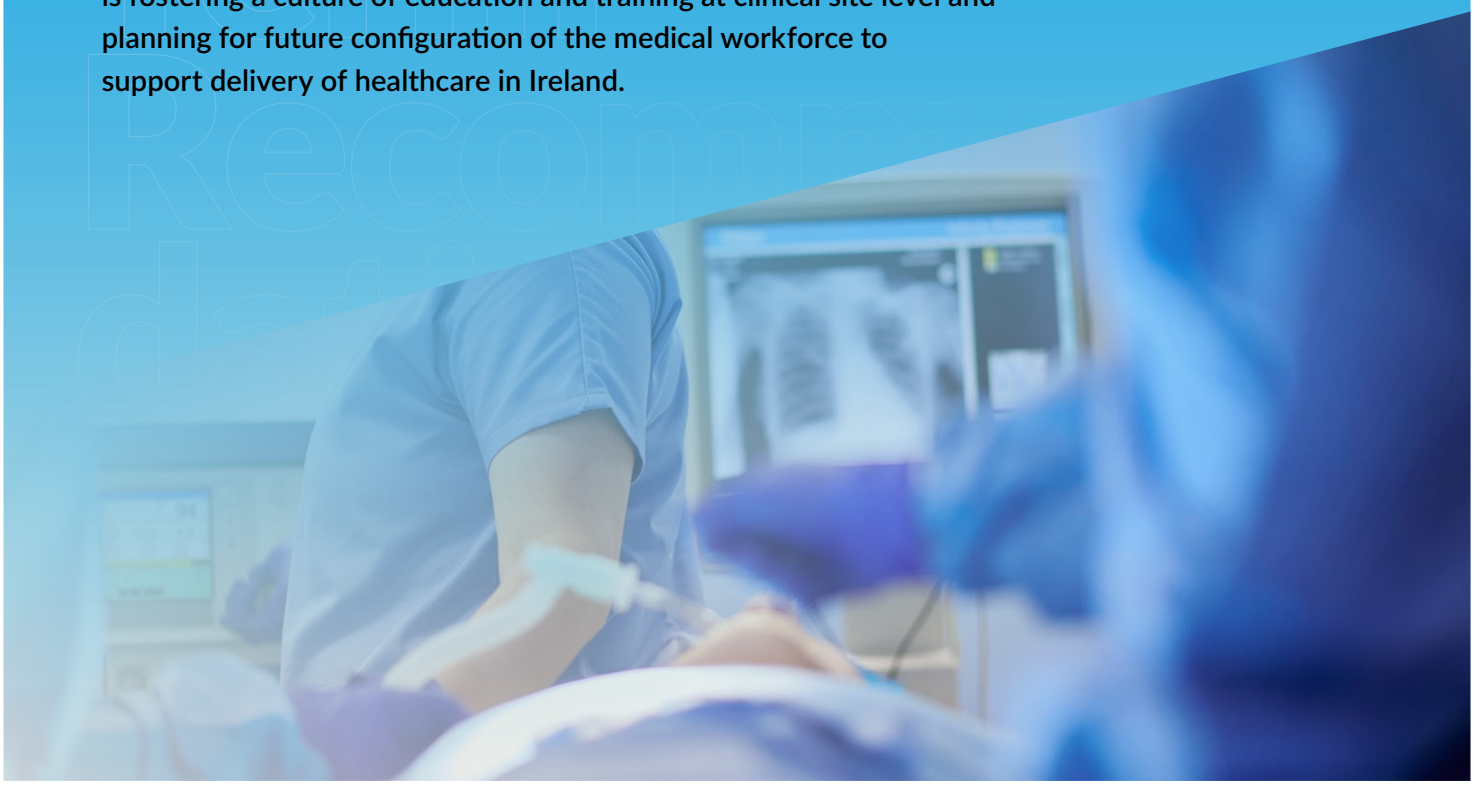
- A need to treat NCHDs with respect and as a valued member of the team.
- Ensure NCHDs are paid on time and correctly.
- Access to well-informed Medical Manpower.
- Implement and act when dignity at work and harassment issues are raised.

4. Survey Conclusions

The findings of the analysis supported the work of the Taskforce and highlighted that the priority areas which were the focus of the work of the Taskforce reflected the concerns raised by NCHDs and consultants. The comments submitted by both NCHDs, and consultants, provided valuable additional insight into the challenges experienced by NCHDs and the type of solutions or improvements required. This data helped to validate and inform the work of the Taskforce.

6. Future Focus – Longer Term Recommendations

The overall aim of the NCHD Taskforce is to put in place sustainable workforce planning strategies and policies to improve NCHD experience to support retention of NCHDs in Ireland. A key component of this work is fostering a culture of education and training at clinical site level and planning for future configuration of the medical workforce to support delivery of healthcare in Ireland.



The recommendations outlined in this report highlight priority actions to be implemented within two years with a clear aim to establish foundations to sustain and enhance state of the art medical education and training into the future. In this section we outline the work of the Taskforce in considering longer term developments. These initiatives will require further scoping to determine optimal solutions and the level of investment required to deliver the future conditions and supports required to ensure Ireland is a world class clinical academic leader in medicine. While the earlier recommendations include the establishment of groups to scope these areas, this section provides some insight into the evidence and structures considered essential by the Taskforce.

1. Education and Research

Positioning Ireland at the leading edge of clinical activity, education, and research is important for the development of our medical workforce. Evidence internationally demonstrates that doctors and consultants at all levels are more likely to work and remain within health systems if they see enhanced opportunities for training and education[17,18].

In considering the evidence and evolving needs of the health service, the Taskforce is recommending a significant change to the educational infrastructure to deliver a modern medical and clinical education system, embracing technology to meet changing demands, and training greater numbers.

Set out below is a suggested approach for consideration which would require significant investment at clinical sites to ensure that NCHDs and trainers at every location can participate in high quality relevant educational activity. Achieving this goal requires a collaborative approach across healthcare professions and broader system-wide change and investment.

An Academic Hub and Spoke Model for Medical Education and Training

A hub and spoke model in conjunction with the academic partners is suggested for enhanced medical education and training infrastructure in Ireland. This approach is illustrated in Figure 9 below.

17. Darbyshire D, Brewster L, Isba R, et al., *Retention of doctors in emergency medicine: a scoping review of the academic literature*, Emergency Medicine Journal 2021; 38:663-672.
18. Curran J, Baker P., *Factors influencing recruitment and retention of foundation doctors in geographically unpopular locations*, Future Hosp J., 2016 Feb;3(1):17-20. doi: 10.7861/futurehosp.3-1-17. PMID: 31098171; PMCID: PMC6465851.

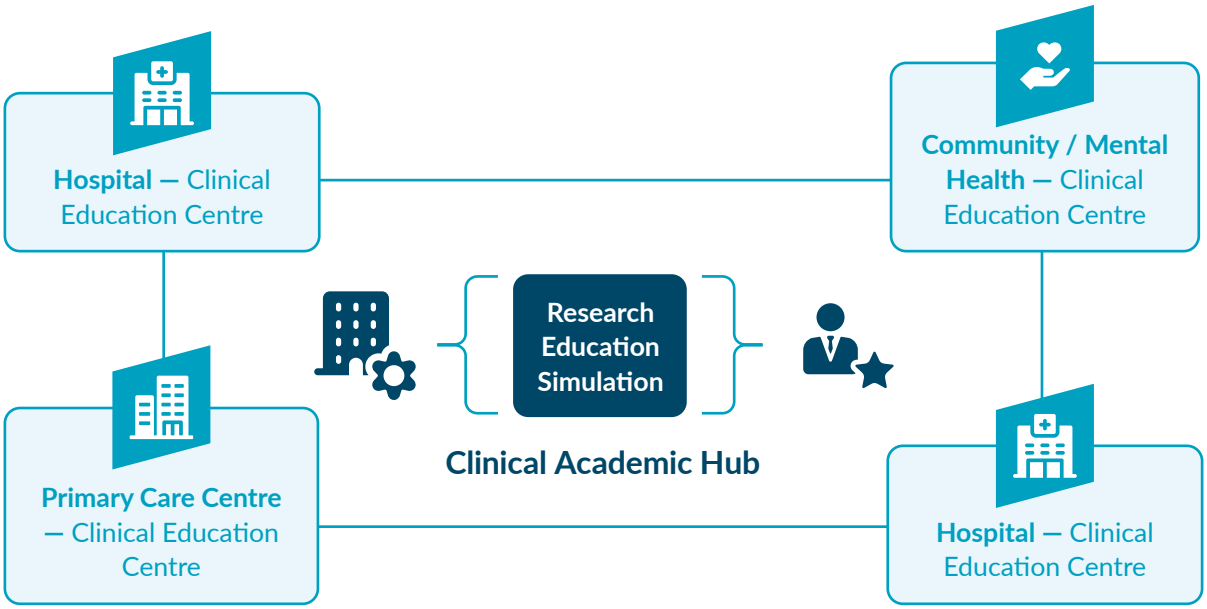


Figure 9: Schematic outline of proposed Hub and Spoke model for academic collaboration across clinical education and training sites at each Health Region. Clinical Academic Hubs will develop at each Health Region through partnership between Higher Education Institutions and larger clinical education and training sites. The Clinical Academic Hubs will provide academic support to each of their neighbouring Clinical Education Centres (spokes) including both hospital-based and community-based clinical training sites and have a centralised simulation hub that supports high-quality large-scale simulation activities within the region.

Clinical Academic Hubs

It is suggested, in line with the proposed regional approach to health service reform, that each HSE Health Region could have a Clinical Academic Hub that is suitably resourced to permit innovation and leadership in the domains of simulation, patient safety, education and research. The proposed detail of the Clinical Academic Hub infrastructural standards is set out below. This level of infrastructure could only be feasible with cooperation between Healthcare Institutions and Higher Education Institutions/ Medical Schools. The Taskforce recommends that existing partnerships between Healthcare Institutions and Higher Education Institutions are leveraged to provide this infrastructural reform. Development of a shared and sustainable funding and staffing model would be required at each hub. Detailed and agreed operational and access procedures would be required to ensure the hubs are accessible to NCHDs working across sites within their HSE Health Region.

Clinical Education Centres

The Taskforce suggests that all healthcare institutions (both community and hospital-based) develop a Clinical Education Centre (Spoke) for simulation, education, and research. The infrastructural requirements within the Clinical Education Centre would be equipped to allow NCHDs to participate in educational and research opportunities locally and virtually. Clinical Education Centres that wish to develop cutting-edge research proposals/simulation scenarios would receive timely support from their local Academic Hub. It is important to note that a Clinical Education Centre would be required at a variety of locations. Many will exist within model 3 hospitals, but others would be required at community hospitals, community psychiatric units and primary care centres to provide for the growing numbers of NCHDs working within primary care, psychiatry, and Enhanced Community Care (ECC) programmes.

Regional Approach – Research, Education, and Innovation

From 2024 onwards, HSE Health Regions will be the primary service coordination and delivery units for most of the health and social care services provided across Ireland. They will provide the governance and organisational arrangements to enable planning, management, and delivery of care for people across their region.

As set out in the HSE Health Regions Implementation Plan of July 2023, the regionalised approach will build on the closer relations established over recent years between Academic Teaching Hospitals and Hospital Groups to ensure that the benefits of Academic Health Science Systems are embedded into the design and the culture of HSE Health Regions.

The aim is to foster even closer working relations between health and social care services and the further and higher education system at regional and at national level, promoting excellence in clinical practice and clinical efficiency, to include a community care focus as well as in acute settings. The HSE Health Regions will be tasked with harnessing the resources and skills available across health service providers in their region to provide for research, ethical oversight, governance, management, and support services to promote research, transformation, and innovation within their region. This will be done to ensure that regions operate as part of a strategic national approach and as part of key international initiatives to strengthen innovation in the health sciences and in health service development.

The Taskforce welcomes the reorganisation of the health service into HSE Health Regions. The optimisation of clinical relationships between community organisations and hospitals promotes synergy for educational opportunities across these domains and into the new domain of integrated care. These partnerships currently support numerous educational and research roles for our NCHDs, and we must ensure that this is not lost as we realign our health service into HSE Health Regions. The proposed Academic Hub and Clinical Education Centre (Spoke) model would support the HSE Health Regions aim to build on these partnerships.

Potential Benefits and Advantages of the Proposed Model

- The Taskforce acknowledges that cutting edge academic supports will require collaboration between Healthcare Institutions and Higher Education Institutions. The Taskforce believes that strategic capital investment in this area would be mutually beneficial for both sectors.
- The proposed model would collectively benefit not only NCHDs but patients, healthcare professionals, the HSE and the Medical Schools.
- The Taskforce is of the view that this will help create the conditions required to attract doctors to work in the Irish health service.
- Clinical Academic Hubs could provide support to NCHDs at neighbouring healthcare institutions to design and participate in high quality research.
- These structures could support clinicians in other clinical settings within their HSE Health Region to develop bespoke educational interventions in response to patient safety concerns.
- The model aligns healthcare institutions within the HSE Health Regions, while safeguarding long-standing and effective academic partnerships that may exist with higher education institutions outside of a site's HSE Health Region.
- The Higher Education Institutions could develop reliable relationships to enhance their clinical research activity and to increase the numbers of undergraduate students across HSE Health Region settings.
- The HSE would be able to access more rapidly the research, educational and technical capabilities of the higher education sector.
- NCHDs would benefit from improved physical infrastructure and shared third level/HSE governance of academic activity.
- The infrastructure suggested will ensure that our hospitals and CHOs can accommodate training and education of the required increased numbers in undergraduate students across healthcare professions.
- It will also ensure that undergraduate students can train inter-professionally to ensure that they are prepared for the changing needs of our population and health service.

It should be noted that this is a suggested approach and there may be other potential models that could also support this type of learning and collaboration.

2. Simulation Based Learning

Simulation based learning has been shown to improve patient safety in a number of domains. Many of the events leading to patient harm are related to communication failures[19]. Team performance and interdisciplinary relationships are challenging to study in real-world events but can be a focus of improvement through simulation training. Simulation can also identify latent safety threats (LST), which could have damaging effects but may lie dormant until an adverse event takes place[20]. These LSTs can take the form of equipment issues, knowledge gaps, human factor errors and system failures and can be identified in simulation training to improve outcomes. In addition, the review of recorded simulation training in a classroom setting can be used to help participants to identify errors as they occur[21].

Patient outcomes can also be improved through simulation training and debrief, with one study finding that the detection of arrhythmia in the ED increased from 5 to 55% after simulation training[22] and another highlighting improved in-hospital cardiac arrest outcomes in those who participated in simulated codes (survival rate 42%) versus those who did not take part in this form of training (survival rate 37%)[23].

While high-fidelity simulation training and debriefing, such as could be held in an Academic Hub, have a huge impact on training and patient safety, it is also important to note that a Clinical Education Centre on each site can also provide valuable training opportunities and can improve patient safety in the hospital setting.

Doctors who took part in procedural simulation training had higher success rates for catheter insertion, fewer needle passes, arterial punctures, catheter adjustments. In addition, NCHDs trained in a simulated setting had an 85% reduction in infections when compared to those who did not undertake such training and when the procedural simulation training was rolled out to other institutions, the study found a 74% reduction in the incidence of central-line associated septicaemia.[24] This decrease in, and avoidance of, complications was credited with a significant saving in the order of 7 to 1 return on the initial investment[25].

NCHDs have consistently highlighted that the quality of training is one of the most important job-related factors, and those who enjoy their jobs were more likely to continue training[26], highlighting the potential impact that high quality education and training may have on potential recruitment and retention of NCHDs in the future.

This evidence should form the foundation of work undertaken by the National Simulation Office, in conjunction with the integrated academic education governance outlined earlier, to build and embed state of the art clinical simulation across HSE Health Regions.

19. Leonard M, Graham S, Bonacum D., *The human factor: the critical importance of effective teamwork and communication in providing safe care*. Qual Saf Health Care, 2004 Oct;13 Suppl 1(Suppl 1): i85-90.
20. Reason J., *Human error: models and management*, BMJ. 2000 Mar 18;320(7237):768-70.
21. Minor S, Green R, Jessula S., *Crash testing the dummy: a review of in situ trauma simulation at a Canadian tertiary centre*, Can J Surg. 2019 Aug 01;62(4):243-248.
22. Kobayashi L, Parchuri R, Gardiner FG, Paolucci GA, Tomaselli NM, Al-Rasheed RS, Bertsch KS, Devine J, Boss RM, Gibbs FJ, Goldlust E, Monti JE, O'Hearn B, Portelli DC, Siegel NA, Hemendinger D, Jay GD., *Use of in situ simulation and human factors engineering to assess and improve emergency department clinical systems for timely telemetry-based detection of life-threatening arrhythmias*, BMJ Qual Saf. 2013 Jan;22(1):72-83.
23. Josey K, Smith ML, Kayani AS, Young G, Kasperski MD, Farrer P, Gerkin R, Theodorou A, Raschke RA., *Hospitals with more-active participation in conducting standardized in-situ mock codes have improved survival after in-hospital cardiopulmonary arrest*, Resuscitation, 2018 Dec; 133:47-52.
24. Barsuk JH, Cohen ER, Potts S, Demo H, Gupta S, Feinglass J, McGaghie WC, Wayne DB., *Dissemination of a simulation-based mastery learning intervention reduces central line-associated bloodstream infections*, BMJ Qual Saf., 2014 Sep;23(9):749-56.
25. Barsuk JH, Cohen ER, Feinglass J, Kozmic SE, McGaghie WC, Ganger D, Wayne DB., *Cost savings of performing paracentesis procedures at the bedside after simulation-based education*, Simul Healthc., 2014 Oct;9(5):312-8.
26. C Ryan, E Ward, M Jones, *Recruitment and retention of trainee physicians: a retrospective analysis of the motivations and influences on career choice of trainee physicians*, QJM: An International Journal of Medicine, Volume 111, Issue 5, May 2018, Pages 313–318, https://doi.org/10.1093/qjmed/hcy032.

3. Mentoring for NCHDs

The Taskforce identified a need to establish a formal mentoring programme for NCHDs. Mentoring has been linked to increased retention, job satisfaction and working relationships[27]. The role of the mentor is not to be an expert, but rather a sounding board, critical friend, supporter, facilitator, strategist, catalyst, and role model[28] who helps the mentee to:

- develop their opportunities.
- develop possibilities around their problems or issues.
- identify and test commitment to appropriate goals.
- develop strategies.

Benefits of a formal mentoring scheme include improved confidence, job satisfaction, working relationships and problem-solving skills. Benefits for the health service have also been described with reduced job stress, burnout and absenteeism cited[29], leading researchers to conclude that *'Mentorship may therefore contribute to creating doctors who deliver safer and better-quality care.'*[30]

Proposed mentorship Programme

The proposed mentorship programme would be based on a developmental mentoring model, with a focus on the psychosocial development of the mentee. The role of the mentor is pastoral, providing open-door guidance, promoting, and supporting self-efficacy, goal setting, negotiation, reflection, and empowerment. This role should be separate and distinct from that of the Clinical Supervisor or Educational Supervisor. A mentor should not be involved with or have a direct influence on the career progression of the mentee and there is no line of accountability from the mentee to the mentor, thus ensuring that the power imbalance within the mentor-mentee relationship is minimised.

The role of the mentor is to help the mentee to understand the current situation and help them identify the aspects that will make a positive change to their situation, considering competing options and pressures. The mentor should help them to explore what they want, what good looks like and establish a set of goals to help them reach their goal. The mentor should guide the mentee to identify priorities to work on, develop broader perspectives, broaden their horizons, identify, and test commitment to goals, work out a pathway to achieve these and formulate a plan and timeline.

Based on this evidence the Taskforce has recommended the development of a Mentorship Framework by a key group of stakeholders with experience in delivering mentorship programmes.

Key elements of the proposed programme:

- A matching system for mentors and mentees
- Training for mentors and mentees
- Responsibilities and referral pathways
- Governance and operational oversight

4. Integrated Multidisciplinary Teams

Multidisciplinary team (MDT) roles and responsibilities are evolving and expanding in response to the changing healthcare demands, new models of care and technology developments, and teams must adapt to enrich their skill mix to deliver holistic integrated care. The medical workforce model must adapt in response to changing demographics, healthcare demands, digital health innovation and health service reform, to a workforce model that promotes integrated, person-centred care, delivered at home, or as close to home as possible.

27. Zahir, R., *'Mentoring and Wellbeing' in Focus, a publication of the Royal College of Opthalmologists*, available at: www.rcophth.ac.uk/wp-content/uploads/2023/01/Focus-Article-October-2022-Mentoring-and-Wellbeing.pdf
28. McCrossan R, Swan L, Redfern N., *Mentoring for doctors in the UK: what it can do for you, your colleagues, and your patients*, BJA Educ., 2020 Dec;20(12):404-410. doi: 10.1016/j.bjae.2020.07.005. Epub 2020 Sep 8. PMID: 33456925; PMCID: PMC7808072.
29. Harrison R, Anderson J, Laloë P, et al., *'Mentorship for newly appointed consultants: what makes it work?'*, Postgraduate Medical Journal 2014; 90:439-445.
30. Ibid.

There is a need to move from a traditional, unidisciplinary medical workforce model to an integrated multidisciplinary workforce model, based on principles of health promotion, patient empowerment and multidisciplinary cross-service care planning and delivery. New innovative model(s) of care should be explored, considering the potential for new team structures, medical roles, and skills transfer. Existing roles within multidisciplinary teams and multidisciplinary team structures may not be adequate to cover changing healthcare needs and demands. Expansion of the multidisciplinary teams, with cross-working and/or new roles may be required.

Multidisciplinary Teams Roles and Responsibilities

Professional roles and job descriptions across the multidisciplinary teams must be understood and defined, and efforts to support teaming and overcoming professional boundaries must be supported in workforce planning.[31]

Role descriptions for multidisciplinary team members should be clearly defined to ensure clarity regarding role boundaries. The expansion of the multidisciplinary teams would support a more efficient medical workforce and improvements in the NCHD working week. Careful consideration must be given to clinical governance, including ensuring that non-physicians are adequately trained, monitored, and accredited to perform associated tasks, and that appropriate regulatory structures are in place. A carefully constructed set of universal principles of operation and responsibility is required for any deviations from traditional working principles, and any tasks that have been shifted from physician to non-physician must be clearly outlined in multidisciplinary team job descriptions and scopes of work (Leong et al., 2021).

Health professionals should not be trained in isolation and interprofessional learning and training should be introduced from undergraduate level (Anderson et al., 2021). It is critical to sustain engagement between health and education bodies to ensure multidisciplinary and interprofessional working are integrated within the curricula in our education system (Leong et al., 2021)

The Taskforce recommends:

- Multidisciplinary teams involving new and emerging roles (for example Clinical Specialist and Advanced Practice posts for Nursing and Midwifery and Health and Social Care Professionals and Physician Associate roles).
- National Clinical Programmes should examine the requirements of multidisciplinary teams with their remits.
- Roles and responsibilities for multidisciplinary team members should be clearly defined to ensure clarity around role boundaries and to ensure that clinical care is optimised and less dependent on NCHDs.
- Clinicians and multidisciplinary teams should be supported by excellent administration, facilitating efficient arrangement of investigations, provision and transitions of care, communications, and the optimising of IT facilities.
- Emerging digital and telehealth technologies should be considered in the establishment of multidisciplinary teams including to improve how a multidisciplinary team works (e.g., teaming, and asynchronous working) and overall patient outcomes.
- Interprofessional learning and training is introduced from undergraduate level in the curricula for healthcare professions.
- Training programmes and continuing educational support for health workers should be linked to certification, registration and career progression mechanisms that are standardised and nationally endorsed.

31. Ibid.

- Clear, careful, and robust governance and monitoring structures and reporting must be established, for clinical (professional) aspects of governance, for multidisciplinary team governance and for system leadership (including finance and resource allocation).

Physician Associates

The Interim Recommendations of the Taskforce included consideration of the potential for non-NCHD roles, including Physician Associates (PA), to support NCHDs. The Taskforce specifically undertook a review of the PA role as it relates to NCHDs and the impact it might have to reduce dependency on NCHDs for health service delivery. The aim was to inform the final recommendations of the Taskforce relating to the impact of PAs on the NCHDs' working week, EWTD compliance, capacity to access education and training, and ability to avail of required leave for study leave and mandatory courses.

The review was completed in September 2023 and indicated a general positivity towards the role of the PA, but a lack of clarity regarding division of duties. As currently configured, it was not clear, based on the reported NCHD experience, that expansion of PA numbers would significantly impact the NCHD working hours, task sharing or release from service for education and training and the impact would likely be variable across different sites. The review concluded that to achieve maximum benefit from the PA role in supporting NCHDs, further development on the structure and scope of practice of the role is required. It is further noted that safeguards are required to ensure the role of the PA does not negatively impact NCHD experiential training in clinical and procedural settings.

Conclusion

The Taskforce highlights the importance of these initiatives for the future direction of medical education and training. Enhancing NCHD experiential learning is critical to support recruitment and retention of NCHDs and the safe delivery of quality patient care.

The Taskforce recommends these initiatives be prioritised by the Department of Health and HSE in the longer-term strategic planning of NCHD education and training and workforce planning.

The success of the Taskforce will be measured in short- and longer-term outcomes. The Taskforce accepts that the short-term deliverables related to the recommendations will form the immediate focus. The Taskforce specifically recommends that important issues discussed in depth and outlined in the Future Focus section of this report receive further consideration. A review of implementation of the Taskforce recommendations after two years and an opportunity to make updated recommendations on an interval basis is recommended.

7. Implementation of Taskforce Recommendations

To address the significant challenges facing NCHDs, it is critical that the Taskforce recommendations are implemented as a matter of urgent priority. It is also critical that the implementation of the recommendations is assessed on an ongoing basis to ensure delivery of the desired improvements impact positively on NCHD working and training.

This report highlights recommendations to be implemented in 2024. It also highlights the more medium to longer term recommendations to be implemented on a phased basis from 2024 to 2026. Some of these recommendations will require further work to scope and determine optimum solutions for implementation, following approval by the Department of Health and HSE.

As a matter of priority, implementation of recommendations in 2024 will be focused on delivering tangible improvements for NCHDs in the following areas:

- Dedicated Leadership and Support for NCHDs
- Improved Working Standards
- Education and Training Supports
- Information Communications and Technology (ICT)
- Increased Access to Training

Monitoring and Reporting

The Department of Health will oversee and monitor the timely implementation of the NCHD Taskforce recommendations. Implementation of the individual recommendations will be a matter for the individual action owners.

An overarching implementation structure will be established to monitor progress on both the immediate recommendations to be delivered in 2024 and the more medium to long term recommendations to be delivered from 2024 to 2026. All recommendation owners will be required to establish the appropriate governance structures to support and advance the recommendations. To progress several key issues collaborative working and engagement across the recommendation owners and other stakeholders will be required.

Recommendation owners will provide quarterly updates to the Minister for Health through the Department of Health on implementation progress against agreed workplans. The Department of Health will be responsible for ensuring there is ongoing monitoring and reporting of implementation of NCHD Taskforce recommendations and measurement of their impacts.

Recommendation Owners Establish Implementation Governance Structures

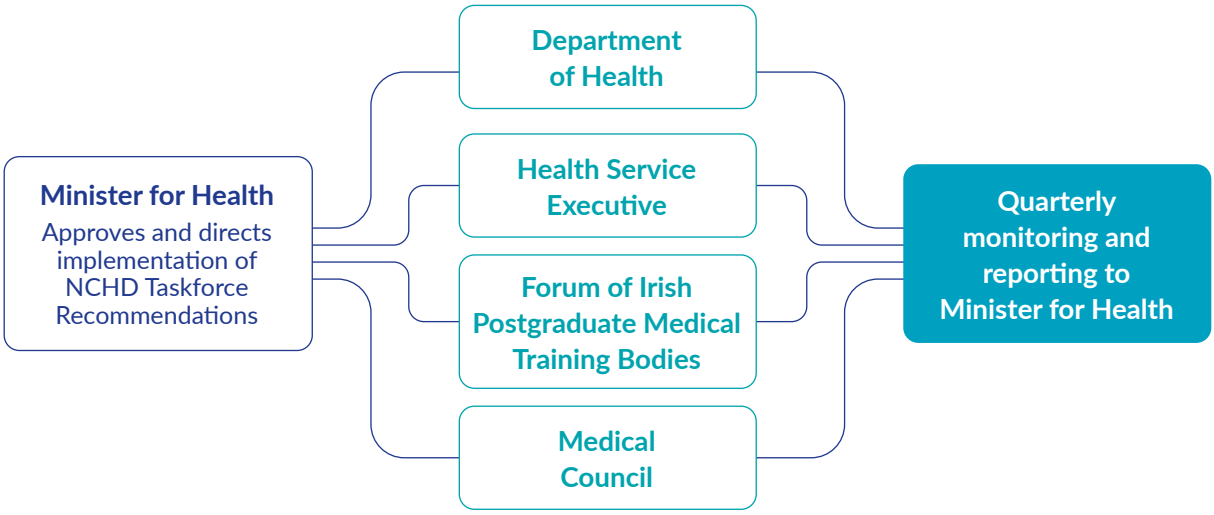


Figure 10: Implementation Governance and Reporting Structures

Governance and Transition to HSE Health Regions

The transition to the six HSE Health Regions is in progress with a full roll-out planned for 2024. The implementation of the Taskforce recommendations will occur at a point of significant transition and change for the HSE. It is critical that the current governance structures established by the HSE to implement the Taskforce Interim Recommendations, be adapted to align with the proposed HSE Health Regions and include a workstream to work on longer term initiatives identified by the Taskforce.

Aligned to this, the implementation governance structure established by the HSE to oversee the implementation of the recommendations owned by the HSE must take into consideration the new governance structures under the HSE Health Regions. Implementation structures will need to be established at national, regional, and local level. It is recommended that responsibility for implementation of the Taskforce recommendations assigned to the HSE upon the establishment of the HSE Health Regions be devolved to the Regional Executive Officers, reporting to the National Oversight Group.

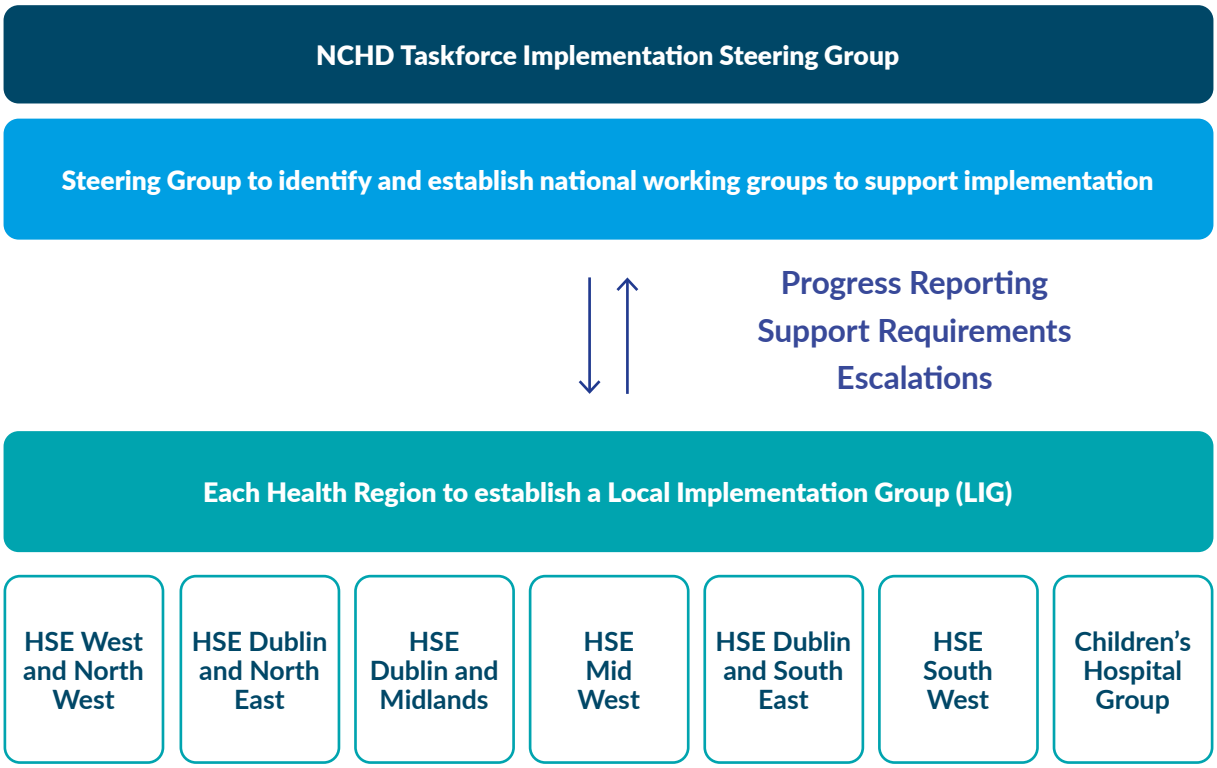


Figure 11: Proposed NCHD Taskforce Implementation Steering Group for HSE Health Regions

Funding

The Taskforce recognises that many of the recommendations have broad scope and scale and as such will require significant public investment going forward. It is recommended that the HSE incorporate and prioritise these recommendations into their wider strategic plans already underway or planned. This includes strategic plans regarding ICT, Capital and Estates Planning and National HR as well as the HSE Health Regions.

Appropriate funding to support implementation of the recommendations will be required. It is recognised that the implementation of the Taskforce recommendations will require both current and capital funding for successful and sustainable implementation.

The number, breadth and scale of the recommendations is significant, and the requirements of implementation must be considered alongside the existing priorities and commitments of the HSE.

The quantification of the cost of implementation and the resources required to deliver the recommendations were not within the scope of the work of the Taskforce and have not been fully considered by the Taskforce. It is important to note that these considerations will drive the timelines for implementation of the recommendations.

A number of the recommendations are substantial change management projects which will require significant investment. Determining dates for completion for full roll out is not possible until the preparatory business cases have been costed and completed for a full roll out. A prioritisation of the recommendations will be required to ensure there is a focus on high impact high value actions.

As more detailed implementation plans are developed by the HSE in 2024, additional funding will be required in 2025 and beyond to support continued implementation of the short- and long-term recommendations.

Monitoring and Measuring Impacts of Implemented Recommendations

The work of the Taskforce identified the need for improved understanding of the work experiences and wellbeing of NCHDs and the collection of suitable data to inform the continuous improvement of NCHD working and training conditions.

At present, different organisations including the HSE NDTP, FPGTB, Medical Council and HSE National HR (through attitude surveys) all gather data pertaining to NCHDs, but there is a lack of an overall data rich repository of NCHDs ongoing work experiences. It is essential that integrated survey and assessments are developed with data sharing and transparency. The findings of this research could be shared on an ongoing basis, be used to inform future improvement programmes, and continuously improve NCHD education and training supports and working conditions.

Implementation of Recommendations

Implementation plans will be designed to support the successful implementation of the NCHD Taskforce recommendations. The Implementation structures set out in the report are underpinned by three core principles: prioritisation, collaboration, and accountability for delivery of results. Each recommendation has been assigned an action owner with lead responsibility for implementation. These stakeholders and the required reporting structures are provided in Figure 12 below.

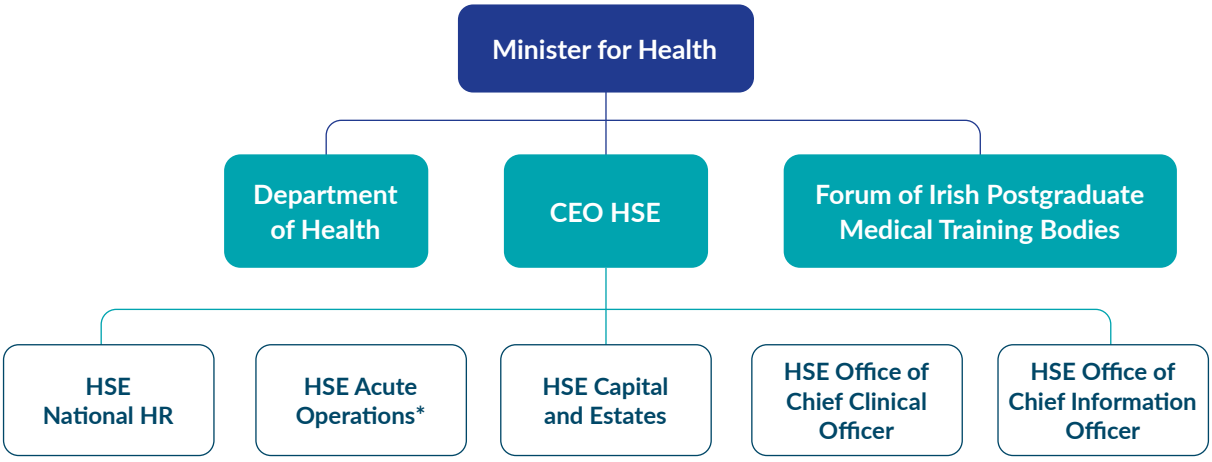


Fig. 12 NCHD Taskforce Implementation Responsibility and Reporting

Given the breadth of recommendations, a named lead must be identified for each of the areas of primary responsibility to oversee progression of the assigned recommendations, as well as provide required reports on progress. The following areas must identify a named lead:

- Forum of Irish Postgraduate Medical Training Bodies
- HSE National HR
- HSE Capital and Estates
- HSE Acute Operations*
- HSE Office of the Chief Clinical Officer (CCO)
- HSE Office of the Chief Information Officer (CIO)
- Department of Health (DoH)

* *Acute Operations until establishment of HSE Health Regions, then responsibility will be with REOs.*

The Taskforce recognises the critical need for immediate action in 2024 and the need to sustain ongoing tangible improvements for NCHDs in 2024 and in the years ahead. A number of recommendations that are to commence in 2024 will require phased implementation plans with incremental improvements over several years.

The relevant action owners and supporting stakeholders will be required to meet specific milestones in 2024, 2025 and 2026 and to provide costed implementation plans for delivery.

Implementation of Recommendations

Department of Health				
No.	**Recommendation**	**Lead**	**Support**	**Timeframe**
21	Strategic Planning for Medical Education and Training	DoH	DFHERIS, HEIs, HSE CCO	From 2024
39	Strategic Planning for Undergraduate Medical Education and Training	DoH	DFHERIS, HEIs, HSE CCO	From 2024
43	Safe Staffing for Medical Workforce	DoH	HSE CCO	From 2024
44	Planning for Non-Doctor Clinical roles and Multidisciplinary Teams	DoH	HSE ONMSD and National Office for HSCPs	From 2024

HSE CCO				
No.	**Recommendation**	**Lead**	**Support**	**Timeframe**
6	Flexible Training and Working for NCHDs	HSE CCO	FPGTBs	From 2024 Phased implementation plan
13	Reflective Practice Training and Support for NCHDs	HSE CCO	FPGTBs	From 2024
15	NCHD Return to Work Policy Following Period out of Clinical Practice	HSE CCO	HSE Health and Wellbeing	From 2025
18	Monitoring Improvements in the NCHD Work Environment	HSE CCO	HSE Acute Operations	From 2024
20	Group Director for Medical Education and Training	HSE CCO	HSE Acute Operations	From 2024 Phased implementation plan
28	Simulation Based Learning on Clinical Sites	HSE CCO	-	From 2024 Phased implementation plan
38	Increase Postgraduate Training Opportunities for NCHDs	HSE CCO	FPGTBs	From 2024
42	Education and Research Career Pathways for Doctors	HSE CCO	DoH	From 2025

HSE National HR				
No.	**Recommendation**	**Lead**	**Support**	**Timeframe**
4	Policies to support NCHD Work/Personal Life Boundaries	HSE National HR	HSE Acute Operations	From 2024
5	Emergency Rostering Planning	HSE National HR	HSE Acute Operations	From 2024
7	Interprofessional Working to Optimise Patient Care	HSE National HR	HSE Acute Operations	From 2024
8	Integrated Task Delivery: Priority Milestones Directed at Better Working and Patient Care	HSE National HR	HSE Acute Operations	From 2024 Phased implementation plan
10	Line Management Support for NCHDs	HSE National HR	HSE Acute Operations	From 2024
12	Bespoke Leadership and Management Training Programme for Consultants to support NCHDs	HSE National HR	HSE Acute Operations	From 2025
16	Professionalism Frameworks for NCHD Positive Working Environment	HSE National HR	HSE CCO	From 2025
17	Culture Change Programme to Support Implementation of NCHD Taskforce Recommendations	HSE National HR	HSE Acute Operations	From 2024
32	Online and Virtual Learning and Development Resources for NCHDs	HSE National HR	HSE CCO	From 2025
41	Career Pathways for NCHDs not in Training Programmes	HSE National HR	DoH, HSE CCO	From 2024

HSE Acute Operations*				
No.	**Recommendation**	**Lead**	**Support**	**Timeframe**
1	NCHD Rostering	HSE Acute Ops	HSE National HR	From 2024 Phased implementation plan
2	NCHD Working Hours – OWTA Compliance and Verification	HSE Acute Ops	HSE National HR	From 2024
3	Time and Attendance Systems for NCHDs	HSE Acute Ops	HSE National HR	From 2024 Phased implementation plan
11	NCHD Liaison and Advocacy Support	HSE Acute Ops	HSE National HR	From 2024
14	Responsive Team Debriefing for NCHDs	HSE Acute Ops	HSE National HR	From 2025
29	Protected Time for NCHD Education and Learning	HSE Acute Ops	HSE National HR	From 2024
30	Protected Time for Consultant Trainers to Deliver NCHD Training	HSE Acute Ops	HSE National HR	From 2024
31	Mandatory Study Leave for NCHDs	HSE Acute Ops	HSE National HR	From 2024

** Acute Operations until establishment of HSE Health Regions in place and then responsibility will be with REOs*

HSE Chief Information Officer				
No.	**Recommendation**	**Lead**	**Support**	**Timeframe**
33	Off-Site Access – Laptops and Mobile Devices	HSE CIO	HSE Acute Operations	From 2024
34	Dry-round and Clinical Handover Facilities	HSE CIO	HSE Capital & Estates	From 2024 Phased implementation plan
35	Access to Workstations	HSE CIO	HSE Capital & Estates	From 2024 Phased implementation plan
36	DOH/HSE Digital Health Strategy • Paperless Ordering • Electronic Rostering and Time and Attendance systems • Electronic Health Record (EHR) systems • Patient Individual Health identifier • National Shared Care Record	HSE CIO	HSE Acute Operations	From 2024 Phased implementation plan to be prioritised in the DOH/HSE Digital Strategy
37	Reliable Connectivity	HSE CIO	HSE Capital & Estates	From 2024 Phased implementation plan

HSE Capital and Estates				
No.	**Recommendation**	**Lead**	**Support**	**Timeframe**
22	Education and Training Space and Capacity in Infrastructural Developments	HSE Capital and Estates	HSE Acute Operations	From 2024
27	Educational Infrastructure Support for NCHD Education and Training	HSE Capital and Estates	HSE Acute Operations	From 2024 Phased implementation plan

HSE Health Regions				
No.	**Recommendation**	**Lead**	**Support**	**Timeframe**
19	Chief Academic Officers	HSE Health Regions	-	From 2024

Forum of Irish Postgraduate Medical Training Bodies				
No.	**Recommendation**	**Lead**	**Support**	**Timeframe**
9	Health and Welfare/Wellbeing Standards for NCHDs	FPGTB	HSE CCO, HSE National Health & Wellbeing	From 2024
23	Standardised Memorandum of Agreement for Delivery of NCHD Postgraduate Training	FPGTB	HSE CCO, DoH	From 2024
24	Quality Assurance Framework for Generic Cross Specialty Training and Standards	FPGTB	Medical Council	From 2025
25	Postgraduate Medical Training Bodies to provide High Quality Learning Supports for NCHDs and Trainers	FPGTB	HSE Acute Operations	From 2024
26	Geographical Organisation of NCHD Training Rotations	FPGTB	HSE CCO	From 2024 Phased implementation plan
40	Review Recognition of Prior Learning (RPL) for Experienced Registrars	FPGTB	Medical Council, HSE CCO	From 2024

Appendix 1 – Terms of Reference

Introduction

The Minister for Health, Stephen Donnelly, TD is establishing a National Taskforce focused on the NCHD Workforce.

The purpose of the Taskforce is to put in place sustainable workforce planning strategies and policies to address and improve NCHD experience to support present and future retention of NCHDs in Ireland.

The Taskforce will aim to improve the NCHD experience/work life balance through the development and implementation of improved NCHD structures and supports in hospital sites. It will aim to further develop and foster a culture of education and training at clinical site level; and plan for future configuration of the medical workforce to support delivery of healthcare in Ireland.

The current IR engagement and any future IR engagement will proceed in accordance with established IR practice.

The four priority areas to be addressed by the National Taskforce are as follows:

1. Develop strategies to address NCHD on-site structures and supports/improve work life balance.
2. Make recommendations regarding the regional organisation of postgraduate training.
3. Establish a plan to further develop and foster a culture of education and training at clinical site level.
4. Inform medical workforce planning.

As part of the work above, the Taskforce will consider and incorporate the following:

- Educational supports for the training needs of NCHDs.
- Alignment to future healthcare model, i.e., move to RHA structure.
- Gender, equality, and diversity issues.
- Attrition / retention of interns and graduates of postgraduate training programmes.
- Opportunities for career progression available in Ireland for all NCHDs.

How the Taskforce will Operate

The National Taskforce on NCHD Workforce will have four individual work steams addressing the priority areas set out above. To ensure quick progress the Minister has directed that the Taskforce be set up for 1 year.

The National Taskforce will put in place recommended actions to address the priority areas and ensure that appropriate oversight and monitoring arrangements are in place to ensure progress in implementing the recommendations.

Recommendations from the following projects/ reports will feed into the work of the National Taskforce:

- Outputs/findings and recommendations from the HSE National Doctor Training and Planning Project on Model 3 Hospitals.
- Recommendations from the *Strategic Framework for Postgraduate Medical Training in Ireland 2021-2030.*
- *The Implementation of Simulation on Clinical Sites: A National Strategic Guide* published 2021.
- *Strategic Review of Medical Training and Career Structure (MacCraith) Reports.*

Secretariat for the Taskforce will be provided by the Department of Health.

The Taskforce will provide regular progress reports to the Minister for Health and NCHDs, with an initial report provided within six months.

Membership of National Taskforce

The Taskforce will be Chaired by Professor Anthony O'Regan, Consultant Physician, Galway University Hospital, Chief Academic Officer – Saolta University Health Care Group.

* *Membership of the National Taskforce will include representatives from the following areas*

- HSE Chief Clinical Officer
- HSE National HR
- HSE Acute Operations
- HSE National Doctors Training and Planning
- DOH National HR
- DOH Strategic Workforce Planning
- 2-4 NCHDs (to include National Lead NCHD + Non-Training NCHD)
- Hospital Group CEO
- Group Academic Officer
- Group Clinical Director
- Medical Manpower Managers
- Forum of Irish Postgraduate Medical Training Bodies
- Hospital Consultant
- RCSI Graduate School of Healthcare Management.
- Medical Council
- CHO
- IMO

* *Members will be appointed for one year – The Chair has discretion to invite other members/participants if additional specific expertise is required.*

Appendix 2 – Membership of the Taskforce

Members	
Prof Anthony O'Regan (Chair)	Consultant Physician, Saolta Academic Office, University Hospital Galway, Saolta University Health Care Group,
Dr Norella Broderick	SR Psychiatry, Community Care
Dr Jennifer Carron	Cardiology SpR, Mater Misericordiae University Hospital, Dublin
Dr Sean Casey	SPR Paediatrics; National Lead NCHD Fellow 2023-2024
Prof John Cooke	Consultant Physician, Waterford University Hospital; and NDTP Group Director for Medical Education and Training
Prof Colette Cowan	Chief Executive Officer, UL Hospitals Group
Prof Mary Day	National Director, HSE Acute Operations
Dr Christina Donnellan	Consultant Geriatrician and Intern Tutor, Tipperary University Hospital
Dr Brian Doyle	SPR Anaesthesia, St Vincent's University Hospital, Dublin
Dr Jennifer Finnegan	Consultant Paediatrician, Rotunda Hospital, Dublin; and National Lead NCHD 2022-2023
Dr Laura Finnegan	SHO Urology, Mercy University Hospital, Cork
Dr Hannah Forde	Consultant Physician, Beaumont Hospital, Dublin
Dr Colm Henry	Chief Clinical Officer, HSE
Ms Anne Marie Hoey	National Director, HSE National HR
Dr Niamh Humphries	Senior Lecturer, RCSI Graduate School of Healthcare Management
Mr Leo Kearns	Chief Executive Officer, Medical Council
Ms Rachel Kenna	Assistant Secretary, Department of Health, Strategic Workforce Planning
Prof Brian Kinirons	Consultant Anaesthetist, University Hospital Galway; and Medical Director, HSE National Doctors Training and Planning
Ms Fiona Lynch	Medical Manpower Manager, Mercy University Hospital, Cork
Mr Martin McCormack	Chief Executive Officer, College of Anaesthesiologists of Ireland
Mr Kenneth Mealy	Consultant General Surgeon, Wexford General Hospital; and Chair of the Forum of Irish Postgraduate Medical Training Bodies
Dr Knut Moe	General Practice, Primary Care; and Irish College of General Practice
Dr Tamlynn Muller	Registrar, Cork University Hospital
Dr Amir Niazi	National Clinical Adviser and Group Lead for Mental Health, HSE
Prof Paula O'Leary	Dean and Head, School of Medicine, University College Cork; and Chair, Irish Medical Schools Council
Mr Kevin O'Malley	Joint Clinical Director, Ireland East Hospital Group
Ms Leah O'Toole	Assistant National Director, HSE National Doctors Training and Planning
Ms Breda Rafter	Principal Officer, Department of Health, Strategic Workforce Planning
Dr Marie Rochford	SpR Obstetrics and Gynaecology, National Maternity Hospital, Dublin
Prof Sharon Sheehan	Consultant Obstetrician; and Group Clinical Director, Dublin Midlands Hospital Group

* *Members were appointed for the term of the Taskforce. The Chair had discretion to invite other members/ participants if additional specific expertise was required.*

Appendix 3 – Education and Training Infrastructure Standards

Suggested Priorities for the Development of an Educational Infrastructure Supporting Clinical Education and Training.

The priority areas for the design and development of educational infrastructure outlined below are required to ensure that high quality, relevant and modern education, and training is available and accessible to all NCHDs. The priority areas must be implemented under the evolving governance framework for education and training outlined in this report, and in conjunction with the strategic goals for the development of clinical simulation outlined by the recently established National Simulation Office.

To ensure standardisation, quality and return on investment, it is essential that the educational infrastructure is developed as a hub and spoke model rather than standalone entities on clinical sites.

Governance

1. Each HSE Health Region will have a multi-professional education governance committee to oversee postgraduate medical education. This committee will have representation from each clinical training site in the region and educational and simulation expertise (Director of Clinical Education and Director of Simulation). The committee will have responsibility for developing the medical educational strategy across the region. The governance committee will promote the development of supportive clinical academic hubs for each region. The expertise and resources in the clinical academic hubs will support the education activities in the clinical education centres (the spokes) and be responsible for faculty development in the region. A simulation hub will be located within the academic hub. This model is summarised in Figure 13 below.
2. Each clinical site will have a multi-professional education steering committee (ESC) for postgraduate medical education. Members will function as education leads in their clinical specialty area, have protected time, and be supported by administrative staff familiar with accreditation processes. The ESC reports to the region's education governance committee. It ensures that education activities have a coordinated approach within the clinical site.

The ESC is:

a. Responsible for ensuring that training on each site achieves the Medical Council's quality assurance standards and the Forum of Irish Postgraduate Medical Training Bodies' accreditation standards.

b. Responsible for coordinating education activities on site.

c. Consulted prior to any significant investment in educational infrastructure.

d. Involved in planning the design and development of educational infrastructure within the hub and spoke model.

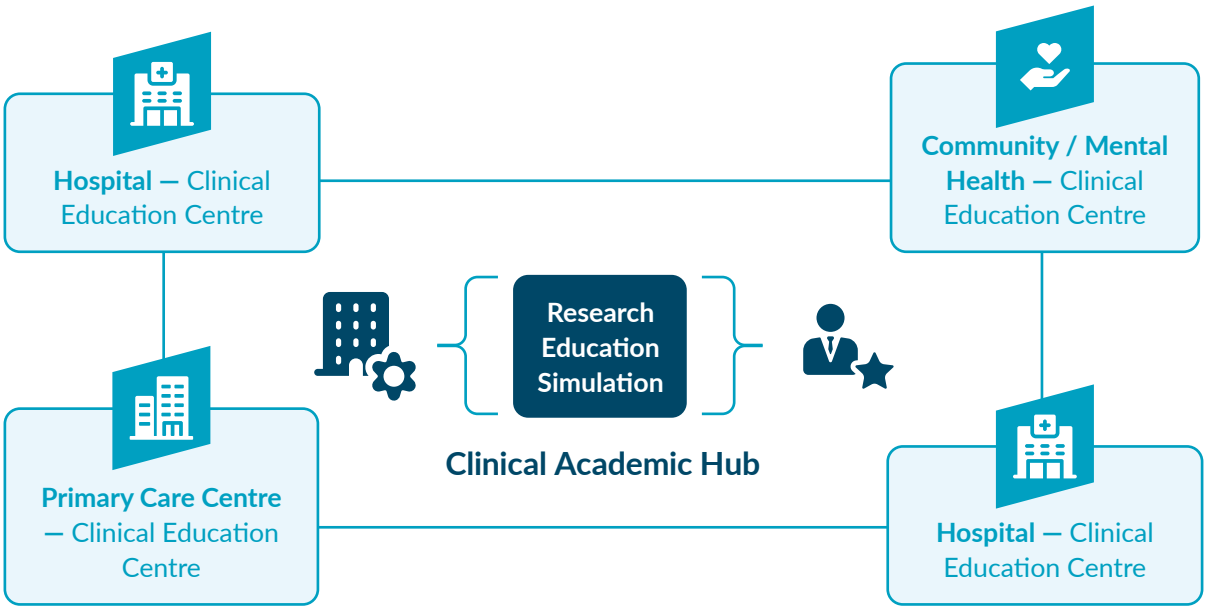


Figure 13: Schematic outline of proposed Hub and Spoke model for academic collaboration across clinical education and training sites at each Health Region. Clinical Academic Hubs will develop at each Health Region through partnership between Higher Education Institutions and larger clinical education and training sites. The Clinical Academic Hubs will provide academic support to each of their neighbouring Clinical Education Centres (spokes) including both hospital-based and community-based clinical training sites and have a centralised simulation hub that supports high-quality large-scale simulation activities within the region.

Simulation Infrastructure

An important aspect of the educational infrastructure is the collaborative development of simulation resources and facilities, aligned to the strategic direction of the National Simulation Office (NSO). The simulation infrastructure development will be HSE Health Region based and follow the hub and spoke model. Within each HSE Health Region, there will be a hub simulation facility led by a Director of Simulation that operates on a service delivery and consultancy model.

The priority areas for simulation development within HSE Health Regions are:

1. Appointing a designated Director of Simulation for each HSE Health Region, with appropriate expertise and accountability to oversee the design and delivery of simulation activities and the use of resources within a hub and spoke model. This appointment will sit on the education governance committee and has a reporting line to the Quality and Patient Safety Division within the HSE Health Region and to the National Simulation Office (NSO).
2. Establishing a Simulation Steering Committee (SSC) for each region, chaired by the Director of Simulation with representation from simulation leads on the clinical training sites and representation from other stakeholders.
3. Developing a regional strategy for designing and delivering simulation activities, adhering to international standards for best practice.
4. Identifying priority areas for simulation activities that relevant to the training needs of NCHDs and other healthcare professions but also have a focus on patient healthcare safety and quality improvement goals.
5. Accessible simulation activities and resources.
6. Resourcing and appropriate staffing of the central hub so that it can operate as a service provider for the HSE Health Region and support simulation activities on clinical training sites.

Simulation delivered within the HSE Health Regions needs to be viewed and implemented as an organisational strategy and not a discrete event or series of unconnected events. Developing a programme of simulation that is relevant and acceptable to people throughout the region and that is coherent and responsive to the needs of the region is critical to ensure a return on investment.

Hub Simulation Infrastructure

Within the academic hub, a central regional hub will possess sufficient resources (capital, human and recurrent) to meet international simulation standards and to provide complex and large-scale simulation activities for the region, faculty development opportunities and develop partnerships with stakeholders at national and clinical site levels. This includes simulation space, simulation equipment and consumables and permanent appointed expert simulation staff (technicians and simulation educators). The central hub will support the clinical sites to achieve their simulation goals by:

- Ensuring a lean approach to purchasing, maintaining, and storing simulation equipment. The hub will provide clinical training sites with equipment for specific purpose training activities.
- Supporting specific activities with expert staff as required on clinical training sites.
- Adopting a regional approach to the installation of a Simulation Management System (AV and IT) ensuring linking of activities between all sites in the region.

Clinical Education Centre 'Spoke' Simulation Infrastructure

The clinical training sites will have simulation infrastructure and equipment matched to their size, needs and scope of practice. It will provide access to staff for on-site simulation training and practice.

Requirements are:

- Sufficient simulators (task trainers and manikin) to allow for local training and practice opportunities.
- Simulation infrastructure that is multipurpose and aligned to standards of best practice (simulation room, control room and debriefing room, skills room and storage space, AV and IT simulation equipment that is capable of linking to the hub simulation facility).
- Staffing levels that support the scale of the activities. Permanent simulation staff appointments (technical and educator) will be aligned to simulation activities and will support simulation at both hub and clinical site locations and have Full Time Equivalents (FTEs) reflecting the commitment to each location.

Guidance on Implementation

Capital infrastructural purchases for simulation must receive approval from the clinical site's education steering committee. All items should be catalogued to ensure that the regional simulation lead (when appointed) is provided with an accurate list of simulation equipment across the region. Major investments (over €100,000) in single items, such as sim-man trainers, should be approved by the National Simulation Office.

Other Education Infrastructure (All Clinical Training Sites)

1. Seminar and lecture rooms will be available in sufficient numbers to ensure protected availability for NCHD training.
2. At larger sites, there will be at least one space large enough to accommodate all NCHDs for larger meetings and lectures.
3. Seminar and lecture rooms will be equipped with high quality cameras, microphones, screens, and speakers.
4. There is cloud storage available for NCHDs to store educational sessions for online viewing.
5. Seminar rooms have the ability to connect via videoconferencing software with neighbouring clinical training sites and international venues.

Research Infrastructure

1. All clinical training sites will provide hot-desk facilities for postgraduate medical researchers pursuing higher qualifications by MSc, MD, or PhD.
2. Clinical Academic Hubs should provide access to a librarian who is proficient in developing search strategies for general and systematic reviews of the literature. This librarian should also be available to remotely support NCHDs at neighbouring clinical education centres "spokes".
3. Clinical Academic Hubs should provide access to a statistician who can assist NCHDs with aspects of study design and data analysis. This statistician should also be available to remotely support NCHDs at neighbouring clinical education centres "spokes".
4. Where relevant to the clinical site research, clinical training sites should provide laboratory bench facilities to NCHDs allowing for biological sample preparation and storage.

Infrastructure Required within the Clinical Environment

1. There should be sufficient PCs within the clinical environment to ensure that NCHDs can easily access hospital systems and external learning resources (such as UpToDate and medical journals)
2. NCHDs within clinical environments should be enabled to use personal devices to access their training logs and reference materials.
3. NCHDs should have access to dedicated space within the clinical environment to engage in tutorials, handover, dry rounds, and multidisciplinary team meetings.
4. Procedural and diagnostic areas at Clinical Academic Hubs should have access to video recording allowing NCHDs and consultants to create and share training materials (with patient consent)

Appendix 4 – Stakeholder Engagement

Stakeholder Bodies
NCHDs, training and non-training
NCHD Leads
Intern Programme
Hospital Consultants
Irish College of General Practitioners (ICGP)
Irish Medical Organisation (IMO)
Hospital Group CEOs
Hospital Group CAOs
Hospital Group Clinical Directors
HSE Chief Clinical Officer
HSE National HR
HSE Acute Operations
HSE National Doctors Training and Planning
HSE Chief Information Officer
HSE National Clinical Lead for Simulation
National Group of Medical Manpower Managers
DoH Strategic Workforce Planning
Medical Council
Forum of Irish Postgraduate Medical Training Bodies
Irish Medical Schools Council
HSE Group Directors for Clinical Education and Training Model Pilot Programme
Regional Health Areas Advisory Group

Appendix 5 – Glossary / Acronyms

BST	Basic Specialist Training
CAO	Chief Academic Officer
CCO	Chief Clinical Officer
CEO	Chief Executive Officer
CHO	Community Healthcare Organisation
CIO	Chief Information Officer
CSCST	Certificate of Satisfactory Completion of Specialist Training
DoH	Department of Health
ECC	Enhanced Community Care
ECG	Electrocardiogram
ED	Emergency Department
EHR	Electronic Health Record
ESC	Education Steering Committee
EWTD	European Working Time Directive
DFHERIS	Department of Further and Higher Education, Research, Innovation and Science
FPGTB	Forum of Irish Postgraduate Medical Training Bodies
FTE	Full-Time Equivalent
HEI	Higher Education Institute
HR	Human Resources
HSCP	Health & Social Care Professional
HSE	Health Service Executive
HST	Higher Specialist Training
ICGP	Irish College of General Practitioners
ICT	Information and Communications Technology
IMG	International Medical Graduate
IMO	Irish Medical Organisation
IR	Industrial Relations
LIG	Local Implementation Group
LTFT	Less Than Full Time
LST	Latent Safety Threat
MD	Doctor of Medicine
MDT	Multidisciplinary Team
MMP	Medical Manpower
MSc	Master of Science

NCHD	Non-Consultant Hospital Doctor
NER	National Employment Record
NDTP	National Doctors Training and Planning
NSO	National Simulation Office
ONMSD	Office of the Nursing and Midwifery Service Director
OWTA	Organisation of Working Time Act
PA	Physician Associate
PGTBs	Postgraduate Medical Training Bodies
PhD	Doctor of Philosophy
RCPI	Royal College of Physicians of Ireland
RCSI	Royal College of Surgeons in Ireland
REO	Regional Executive Officer
RPL	Recognition of Prior Learning
SAS	Specialty and Specialist
SSC	Simulation Steering Committee
SHO	Senior House Officer
SLA	Service Level Agreement
SOP	Standard Operating Procedure
SpR	Specialist Registrar
ToR	Terms of Reference
UL	University of Limerick
WHO	World Health Organisation

Appendix 6 – NCHD and Consultant Survey Questionnaire

The Taskforce has been working on the following priority areas

1. Work Life Balance, Wellbeing and Culture

Work Life balance challenges facing NCHDs, including the working week, culture, and supportive environments for NCHD culture, wellbeing initiatives and supports. Organisational wide cultural change at all levels that ensures greater respect and dignity for NCHDs. Supporting trainees in difficulty and returning to work processes after a leave of absence. Supporting the HSE NCHD Occupational Health Service.

2. Infrastructure Issues

Improving the NCHD working environment to provide better supports and infrastructure to assist NCHDs in delivering their duties and to work more effectively. Improving clinical site supports, including infrastructure, for education and training. This will include clinical simulation resources.

3. Medical Manpower

Enhancing MMP supports to ensure that they are provided consistently across all sites to all NCHDs with dedicated accessible, and accountable NCHD services. Enhancing the training of MMP managers in key NCHD support issues. Expand the National Employment Record (NER) to reduce paperwork and challenges moving between sites.

4. Workforce Configuration

Recommending Medical Workforce configuration and targets to enhance NCHDs experience and patient care. This work will recommend on the non NCHD workforce as well as consultant and trainee targets.

5. Information Technology

Defining clear ICT requirements and technology enhancements for NCHDs to support their clinical working, training, and education on sites. The access to technology, streamlining and connecting information systems, providing responsive IT support, and developing paperless systems including electronic patient records is considered essential.

6. Less Than Full Time Opportunities

Considering recommendations to support the development of Less Than Full Time Opportunities as a viable option for NCHDs.

7. Gender, Equality & Diversity

Considering issues relating to Gender Equality and Diversity for NCHDs in the Irish health service.

8. Mentoring

Considering recommendations on an appropriate model of mentorship for NCHDs in the Irish health service.

9. Rotations

Considering recommendations on appropriate regional organisation of rotations.

10. Task sharing and allocation

Considering recommendations to support improvements in the area of task allocation across the medical team and to ensure a consistent approach across clinical sites.

11. Induction & Onboarding

Providing efficient, doctor focused, and time protected induction for NCHDs on key issues at the outset of their new clinical roles. This is to ensure NCHDs are aware of their roles, their supports, and are equipped to work in the new clinical setting. Specific support should be provided for NCHDs not trained in the Irish Health System.

12. Governance & Accountability

Enhancing on-site leadership for NCHD education, training, and related initiatives. Enhanced accountability and support in HSE for implementing standards and recommendations for NCHDs.

Questions

1. **Please select which category you belong to from the list below: (this information is being requested so we can be assured of receiving feedback from all NCHD groups and consultants)**

NCHD (Training)
NCHD (Non-Training)
NCHD (Intern)
Consultant

2. **On a rating scale of 1 to 6, please rate the importance of each of the areas being worked on by the taskforce below to NCHDs, where 6 is of a Higher Level of Importance and 1 is of a Lower Level of Importance. You can rate each area independently – i.e., you can rate 3 areas as a 6, 4 areas as a 2 etc.**

Work life Balance, Wellbeing and Culture
Infrastructure Issues
Medical Manpower
Workforce Configuration
Information Technology
Less Than Full Time Opportunities
Gender, Equality and Diversity
Mentoring
Rotations
Task Sharing
Induction and Onboarding
Governance and Accountability

Comment on your choices:

3. **Overall NCHD work experience/work life balance and Education and Training Please outline up to 5 priority areas and any practical actions that you consider are most important to NCHDs, not already mentioned earlier. (Please note that each area and practical action is limited to 200 words)**

Comment on your choices
(Word Limit 200 Words):

4. **Have you any other comments that you would like to make that could support the work of the Taskforce and their remit to identify sustainable workforce planning strategies and policies to address and improve NCHD work experience/work life balance and education and training (Word limit – 250 words).**

Appendix 7 – References

Australian Government – Department of Health 2021, *National Medical Workforce Strategy 2021-2031*. (20220823 Australia national-medical-workforce-strategy-2021-2031_0.pdf (gov.ie%40ssl)

Barsuk JH, Cohen ER, Feinglass J, Kozmic SE, McGaghie WC, Ganger D, Wayne DB., *Cost savings of performing paracentesis procedures at the bedside after simulation-based education.* Simulation in Healthcare : journal of the Society for Simulation in Healthcare. 2014 Oct;9(5):312-8.

Barsuk JH, Cohen ER, Potts S, Demo H, Gupta S, Feinglass J, McGaghie WC, Wayne DB., *Dissemination of a simulation-based mastery learning intervention reduces central line-associated bloodstream infections.* British Medical Journal Quality & Safety 2014 Sep;23(9):749-56.

Braun, V., & Clarke, V. (2006), *Using thematic analysis in psychology*, Qualitative Research in Psychology, 3(2), 77–101.

Byrne, D., O'Dowd, E., Lydon, S., Reid McDermot, B., & O'Connor, P. (2021), *The National Simulation Strategic Guide for the Implementation of Simulation on Clinical Sites.* Galway, NUI Galway. (Guide-to-Simulation-Implementation.pdf (universityofgalway.ie))

Creese, J., Byrne, J-P., Matthews, A, McDermott, A.M., Conway, E., Humphries, N. *"I feel I have no voice": hospital doctors' workplace silence in Ireland.* Journal of Health Organization and Management. 2021 Dec 17;35(9):178-94.). ("I feel I have no voice": hospital doctors' workplace silence in Ireland | Emerald Insight)

Curran J, Baker P. *Factors influencing recruitment and retention of foundation doctors in geographically unpopular locations.* Future Hosp J. 2016 Feb;3(1):17-20. doi: 10.7861/futurehosp.3-1-17. PMID: 31098171; PMCID: PMC6465851.

Darbyshire D, Brewster L, Isba R, et al., *Retention of doctors in emergency medicine: a scoping review of the academic literature.* Emergency Medicine Journal 2021; 38:663-672.

Department of Health, *Strategic Review of Medical Training and Career Structure (MacCraith Reports).* gov.ie – Strategic Review of Medical Training and Career Structure (MacCraith) Reports (www.gov.ie)

Department of Health 2003, *Report of the National Taskforce on Medical Staffing (Hanly Report).* gov.ie – Report of the National Taskforce on Medical Staffing (Hanly report) (www.gov.ie)

Department of Health 2022, *Women's Health Action Plan 2022-2023.* (Women's Health Action Plan 2022-2023)

Department of Health 2023, *National Taskforce on the NCHD Workforce – Interim Recommendations Report.* (gov.ie – National Taskforce on the NCHD Workforce – Interim Recommendations Report (www.gov.ie))

Dixon-Woods, M., Baker, R., Charles, K., et al.: *Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study* BMJ Quality & Safety 2014;23:106-115. (https://qualitysafety.bmj.com/content/23/2/106)

Forum of Irish Postgraduate Medical Training Bodies, August 2021: *A Strategic Framework for Postgraduate Medical Training in Ireland 2021-2030.* Strategy-22-10.pdf (theforum.ie)

Harrison R, Anderson J, Laloë P, et al., *'Mentorship for newly appointed consultants: what makes it work?'* Postgraduate Medical Journal 2014; 90:439-445.

Health Service Executive/Department of Health/Irish Medical Organisation 2022, *Agreed addendum to NCHD contract covering rostering, leave, re-location and training support for Non-Consultant Hospital Doctors.*

Health Service Executive 2022, *HSE Right to Disconnect Policy for Public Health Service Employees.* (Right to disconnect – Staff site (hse.ie))

Health Service Executive 2022, *Dignity at Work Policy for the Public Health Service.* (https://healthservice.hse.ie/staff/procedures-guidelines/dignity-at-work-policy-for-the-public-health-service/)

Health Service Executive Employment Report, December 2023. Employment Reports – HSE.ie

Health Service Executive – Human Resources Division 2018, *Strategy for Doctors Health & Wellbeing 2018-2021.* (Strategy for Doctors' Health and Wellbeing 2018-2021 – HSE.ie)

Health Service Executive – Human Resources Division 2019, *Health Services People Strategy 2019-2024 – Leaders in People Services.* (Health Services People Strategy 2019-2024 – Leaders in People Services)

Health Service Executive – Community Healthcare Organisation Dublin North City & County 2018, *Healthy Ireland Implementation Plan 2018-2022.* (cho-dncc-healthy-ireland-implementation-plan-2018-2022.pdf (hse.ie))

Health Service Executive – Children's Health Ireland Hospital Group 2022, *Healthy Ireland Implementation Plan 2022-2025.* (chi-healthy-ireland-implementation-plan.pdf (hse.ie))

Health Service Executive – National Doctors Training & Planning 2022, *Medical Workforce Report 2022-2023.* (ndtp-medical-workforce-report-2023.pdf)

Health Service Executive – National Doctors Training & Planning 2023, *Model 3 Hospitals Report.* (NDTP model-3-report1.pdf)

Humphries, N., McDermott, A.M., Conway, E. et al.: *'Everything was just getting worse and worse': deteriorating job quality as a driver of doctor emigration from Ireland.* BMC Human Resources for Health 17, 97 (2019). (https://doi.org/10.1186/s12960-019-0424-y)

Humphries, N., McDermott, A.M., Creese, J., Matthews, A., Conway, E., Byrne, J-P.: *Hospital doctors in Ireland and the struggle for work–life balance*, European Journal of Public Health, Volume 30, Issue Supplement_4, September 2020, Pages iv32–iv35. (https://doi.org/10.1093/eurpub/ckaa130)

Humphries, N., Connell, J., Negin, J. et al.: *Tracking the leavers: towards a better understanding of doctor migration from Ireland to Australia 2008–2018*. BMC Human Resources for Health 17, 36 (2019). (https://doi.org/10.1186/s12960-019-0365-5)

Hynes, T., O'Connor, P. (2022). *An Analysis of Medical Workforce Supply*, Research Services and Policy Unit, Department of Health. An Analysis of Medical Workforce Supply (www.gov.ie)

Irish Medical Organisation 2017, *IMO Position Paper on Women in Medicine.* (IMO-Position-Paper-on-Women-in-Medicine-Final.pdf)

Josey K, Smith ML, Kayani AS, Young G, Kasperski MD, Farrer P, Gerkin R, Theodorou A, Raschke RA., *Hospitals with more-active participation in conducting standardized in-situ mock codes have improved survival after in-hospital cardiopulmonary arrest.* Resuscitation. 2018 Dec; 133:47-52.

Kilty C, Wiese A, Bergin C, Flood P, Fu N, Horgan M, Higgins A, Maher B, O'Kane G, Prihodova L, Slattery D, Stoyanov S, Bennett D., *A national stakeholder consensus study of challenges and priorities for clinical learning environments in postgraduate medical education*. BMC Med Educ. 2017 Nov 22;17(1):226. doi: 10.1186/s12909-017-1065-2. PMID: 29166902; PMCID: PMC5700623.

Kobayashi L, Parchuri R, Gardiner FG, Paolucci GA, Tomaselli NM, Al-Rasheed RS, Bertsch KS, Devine J, Boss RM, Gibbs FJ, Goldlust E, Monti JE, O'Hearn B, Portelli DC, Siegel NA, Hemendinger D, Jay GD., *Use of in situ simulation and human factors engineering to assess and improve emergency department clinical systems for timely telemetry-based detection of life-threatening arrhythmias*. British Medical Journal Quality & Safety 2013 Jan;22(1):72-83.

Leonard M, Graham S, Bonacum D., *The human factor: the critical importance of effective teamwork and communication in providing safe care.*, Qual Saf Health Care. 2004 Oct;13 Suppl 1(Suppl 1): i85-90.

McCrossan R, Swan L, Redfern N., *Mentoring for doctors in the UK: what it can do for you, your colleagues, and your patients*, BJA Educ., 2020 Dec;20(12):404-410. doi: 10.1016/j.bjae.2020.07.005. Epub 2020 Sep 8. PMID: 33456925; PMCID: PMC7808072.

Minor S, Green R, Jessula S., *Crash testing the dummy: a review of in situ trauma simulation at a Canadian tertiary centre*, Canadian Surgery Forum, 2019 Aug 01;62(4):243-248.

Pierse, T., Morris, R., O'Toole, L., Kinirons, B., Staddon, E.: *The retention of training doctors in the Irish health system*, Irish Journal of Medical Science, Feb. 16, 2023. (https://pubmed.ncbi.nlm.nih.gov/36792762/)

Reason J., *Human error: models and management*, British Medical Journal, 2000 Mar 18;320(7237):768-70.

Royal College of Physicians UK 2018, *Guidance on safe medical staffing. Report of a working party.* (Safe medical staffing_Report_WEB (3).pdf)

Ryan, C., Ward, E., Jones, M., *Recruitment and retention of trainee physicians: a retrospective analysis of the motivations and influences on career choice of trainee physicians*, QJM: An International Journal of Medicine, Volume 111, Issue 5, May 2018, Pages 313–318, https://doi.org/10.1093/qjmed/hcy032.

World Health Organisation 2010, *WHO Global Code of Practice on the International Recruitment of Health Personnel*. (WHO Global Code of Practice on the International Recruitment of Health Personnel)

Zahir, R., *'Mentoring and Wellbeing' in Focus, a publication of the Royal College of Opthalmologists*, available at: https://www.rcophth.ac.uk/wp-content/uploads/2023/01/Focus-Article-October-2022-Mentoring-and-Wellbeing.pdf.

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