An Coimisiún um Pá na Seirbhíse Poiblí
PUBLIC SERVICE PAY COMMISSION

REPORT OF THE PUBLIC SERVICE PAY COMMISSION

RECRUITMENT AND RETENTION MODULE 1

AUGUST 2018

Contents

Chairman's Foreword

In this second phase of the Commission's work we were obligated by our Terms of Reference to undertake an examination of whether, and to what extent, there are difficulties in recruiting and retaining staff in key areas of the public service identified in our first Report. The Commission decided to undertake that task modularly. It first examined recruitment and retention issues in respect of nurses, midwives, Non-Consultant Hospital Doctors and Hospital Consultants in the public health service. This report contains the Commission's conclusions and recommendations in relation to those professional categories.

The conclusions reached are based on our assessment of the very considerable body of evidence with which we were presented. The analysis and evaluation of that evidence proved to be both time consuming and challenging. In undertaking that task and in formulating appropriate recommendations, the collective skill and broad experience of the members of the Commission was invaluable.

The recruitment and retention of key staff is a central function of management in every organisation. In the public health service it is a dominant imperative. The quality of the health service is dependent on the availability of highly skilled, well trained and appropriately qualified health care professionals, who can deliver health services to those who need them. As is apparent from the findings contained in this report, there is growing international demand for nurses, midwives and doctors. The acknowledged excellence of those trained and working in the Irish public health service means that they are highly mobile and their retention will continue to present challenges. Moreover, the health service is and will continue to be dependent on a degree of external recruitment. The imperative of recruiting the right people with the appropriate qualifications and skills, against competition from other jurisdictions, requires that the overall employment, professional development package, working conditions and culture available in Ireland be sufficient to attract the right people when and where they are needed.

In this report, the Commission has identified difficulties that exist in meeting the workforce requirements in respect of the categories examined. Our conclusions and recommendations are intended to assist policy makers in identifying those areas of current practice in relation to recruitment and retention that can be improved upon so as to ameliorate those difficulties. However, as the report makes clear, the source of such difficulties as they exist are multifactorial and no one initiative, taken in isolation, can provide a solution. It also identifies some significant limitations in the data available on recruitment and retention in the health service.

The Commission was assisted greatly in fulfilling its task by the quality of submissions received from a number of interested Parties. We are grateful to those Parties for the time and effort that they gave in preparing those submissions and in attending before the Commission to present and elaborate upon them. I also wish to acknowledge the co-operation that the Commission received from a number of organisations that provided the Commission with data and other information which it requested. I wish to acknowledge, in particular, the assistance that the Commission received from Mr Sean McHugh, Chairman of the Oversight Group established by the WRC Agreement between the HSE, INMO and SIPTU on nurse recruitment. Mr McHugh met with the Commission on two occasions and at our request he prepared a very helpful paper on issues relating to nurse recruitment and retention. Those documents received are available on the Commission's website at https://paycommission.gov.ie/.

Responsibility for providing the Commission with research and other material, implementing decisions and drafting this report rested with our Secretariat. It comprised of an excellent and dedicated team of Civil Servants led by the current Secretary to the Commission, Joan Curry, and before her appointment by Áine Stapleton. Joan, and before her Áine, brought to this role an accumulated wealth of experience in public administration, combined with wisdom and courtesy, which was an invaluable resource upon which I and the other members of the Commission depended. I also wish to place on record our appreciation of the work performed on our behalf by the other members of the Secretariat, Angelena Hollingsworth, Dean Watt, Donal Lynch, Evan Coady, James Maher, Karen Murphy, Liam Gleeson, Linda Beasley, Stephen Owens, Susan McKiernan, Tony Cleary and Turlough O'Brien.

The Commission was required to work to a very tight timeframe. In order to produce and present this report the members of the Secretariat were required to work long hours in drafting and redrafting the text as directed by the Commission. They did so willingly and without complaint. On my own behalf and that of my colleagues I wish to place on record our particular appreciation of their work in that regard.

Finally, I wish to record my appreciation of the dedicated work of my colleagues in producing this report. They each made a very substantial and generous commitment in terms of their time and in prioritising the work of the Commission over their many other commitments. For me, it continued to be a singular pleasure to work, as chairman, with such dedicated and knowledgeable individuals.

Kevin Duffy
Chairman, Public Service Pay Commission

Dated: 31st August 2018

Executive Summary

Context

The Public Service Pay Commission (the Commission) was established to advise Government on public service remuneration policy. The public service employs over 300,000 public servants across a range of employments and professions spanning the various sectors of the Civil Service, Local Authorities, Non-Commercial State Agencies and in the health, education, justice and defence sectors. The Commission has a broad Terms of Reference and its initial task was the provision of inputs on how unwinding of the Financial Emergency Measures in the Public Interest (FEMPI) legislation 2009 to 2015 should proceed.

The Commission's current task is to seek to establish in the first instance whether, and to what extent, a difficulty exists in terms of recruitment and retention for specific groups/grades/sectors of the public service and where a difficulty is identified, examine the full range of causal factors. Chapter 6 of the Commission's May 2017 Report identified some groups/grades/sectors in respect of whom such difficulties appeared to exist.

The Commission's Terms of Reference for this phase of its work as determined by the Minister for Finance & Public Expenditure and Reform follow this Executive Summary.

The focus of this report is on public health service employment numbers before and during the period since the moratorium on recruitment in the public service. Trends in numbers, turnover and vacancy rates are also examined. In addition the Commission considered the impacts of the unwinding of FEMPI, as provided for in the Public Service Pay Agreement 2018-2020, the range of causal factors impacting on recruitment and retention patterns and have had regard to the international context both in terms of pay comparators and as an external employer for Irish health service graduates.

It is apparent to the Commission that where some recruitment and retention difficulties have been identified the causes of such difficulties are multifactorial. This report sets out the Commission's conclusions and recommendations with regard to those recruitment and retention challenges identified in respect of nurses and midwives, Non-Consultant Hospital Doctors (NCHDs) and Hospital Consultants (consultants). The Commission acknowledges that the Parties must have full regard to other demands on the public purse when dealing with the implementation of the conclusions and recommendations set out in its report.

Methodology and Data Analysis

The Commission was tasked with providing evidence based findings on its examination of recruitment and retention matters. To assist in its deliberations the Commission invited submissions and met with stakeholders relevant to the groups under examination. It also sought key data sets relating to recruitment transactions and departures that could illustrate whether a difficulty existed or not. While this information was not available to the extent that the Commission would have wished, the Commission acknowledges the co-operation of the HSE and Voluntary hospital sector in seeking to comply with its various data requests. The Commission considers that the complex public health service HR structure comprising of both centralised and distributed functions, the poor tracking of relevant data on recruitment and retention transactions and the adequacy of systems to coordinate such data are factors which must be recognised as constraining its capacity to make definitive evidence based conclusions.

In its first Report the Commission referred to difficulties experienced in obtaining accurate, relevant, timely and complete data. That is a matter which again requires comment. The inability to provide or the absence of data required to support a coherent, comprehensive evidence informed approach to recruitment and retention matters including workforce planning, for nurses in particular, is a matter of concern. It remains the view of the Commission that measures to address these deficits need to be put in place.

The interested stakeholders to Module 1 who made submissions and met with the Commission are listed on the Commission's website at https://paycommission.gov.ie/.

Recruitment and Retention

The Commission is keenly aware of the broader environment surrounding the matter of recruitment and retention in the context of delivery of health services in Ireland. The international and domestic landscape with regard to changing demographics is well-documented as is the emerging global challenge in the recruitment and retention of healthcare professionals. The impact of movement in what is a mobile international health labour market is keenly felt in Ireland because of the quality of graduates produced. The Commission also acknowledges that Ireland benefits from the inward migration of skilled healthcare professionals.

The Commission has been made aware of many initiatives underway and evidence available indicates some have been more successful than others. All of the indications are that the demand for healthcare service provision is likely to increase in the future generating demand for more nurses and doctors, therefore momentum must be maintained to support such recruitment and retention initiatives. While some initiatives may be 'one-off' in nature, collectively they are part of a broad range of actions required to deliver sustainable progress in recruitment and retention to the Irish public health service now and in the future. Consequently the Commission encourages the continued effort required from all stakeholders for their success.

An international pay comparison carried out indicated to the Commission that, notwithstanding some of the specific non-competitive findings, current pay rates do not appear to be unduly affecting the number of nurses, midwives and doctors applying to work abroad. Indeed the Commission remains of the view, expressed in its first Report, that remuneration is not the main issue impacting on recruitment and retention where difficulties exist.

Health service employment, since 2013, has gradually been returning to pre-moratorium levels, the Commission has however identified that difficulties exist in meeting workforce requirements in respect of some of the categories examined. Evidence examined by the Commission indicates continuing difficulties in retaining nurses and midwives in specific areas and that training and promotion opportunities are the key influencers of migration and turnover in NCHDs. The evidence also suggests that there is a general difficulty recruiting consultants, with certain specialities and locations experiencing more significant problems.

The Commission understands that there is an ongoing challenge to maintain services across the Irish public health service due to an annual cycle of staffing peaks and troughs.

Nurses and Midwives

The nursing and midwifery numbers have increased since 2013, with reported numbers of 36,777 at the end of 2017. The Commission believes that a positive outcome to the discussions underway on new entrant salary scales will further assist in the recruitment and retention of nurses and midwives, particularly those who are embarking upon or are in the early stages of their career in the public health service.

While the available evidence suggests that none of the turnover rates reported are significantly out of line with those experienced in private sector employment, every effort should be made to minimise the rate of turnover as far as possible. When a qualified nurse or midwife leaves the public health service the value of that public investment is lost and further additional cost in terms of money and time is incurred in seeking a replacement. In the Commissions view there is a case for providing additional incentives for qualified nursing and midwifery staff to remain in the public health service. In the Commission's view, these should be targeted at those who acquire additional qualifications and those who accrue long continuous service. Evidence from the employer shows that there continues to be difficulty in retaining nurses and midwives in specific areas. Currently, a Location Allowance is paid to nursing staff engaged in 13 service areas throughout the health service, including A&E and Theatre. The Location Allowance is not currently applicable to maternity services. There is also a Specialist Qualification Allowance currently paid to nursing staff who acquire post-graduate qualifications in their relevant disciplines. These allowances are applicable to grades up to and including Clinical Nurse Manager 2 or equivalent.

The Commission recommends that these allowances should be increased by 20% on the same terms as apply currently. The Commission further recommends that they be extended to maternity services on the same basis as they apply to the other 13 service areas.

Staff nurses and midwives are eligible to attain the grade of Senior Staff Nurse/Midwife after gaining 20 years relevant nursing experience post-qualification. The Commission recommends that this experience requirement should be reduced to 17 years.

NCHDs

Since 2013, the number of NCHDs has increased by 26% to 6,331 in 2017. Evidence from the Commission's own analysis and various other studies show that the distribution of this increase in NCHDs has been weighted towards an increase in NCHDs in non-training posts to comply with the European Working Time Directive (EWTD). In addition, Ireland is highly reliant on foreign trained doctors to fill non-training posts despite producing the highest number of medical graduates per capita in the OECD.

The Commission believes that while compliance with the EWTD is extremely important, in the context of the planned move to a consultant-delivered health service, it is questionable whether the level of increase in non-training posts is consistent with the goal of a future health service that is to be delivered by consultants.

The Commission acknowledges the prioritisation of the key areas identified in the MacCraith reports. The *Seventh Progress Report* of the MacCraith process requires arrangements to be put in place to progress the four key issues:

- Protected training time;
- Refund of fees;
- Transfer of tasks; and
- The position of 'service grade doctors' who do not occupy training posts.

The Commission also acknowledges the conclusions of the NDTP's *Seventh Annual Assessment of NCHD Posts,* many of which are analogous to recommendations of the *MacCraith Report*. The Commission would endorse prioritisation of the key areas identified in both reports which will have the potential to deliver improvements in the employment, training environment and family lives of NCHDs.

Consultants

Consultants were not subject to the *Moratorium on Recruitment and Promotions in the public service* and the number of consultants employed in the public service has steadily increased over the last decade.

However, the aggregate level of vacancies for consultant posts at the end of 2017 and evidence of recruitment campaigns with very low levels of applications, suggest a general difficulty recruiting consultants. Variations examined suggest a more significant problem recruiting to certain specialities and in certain locations. Additionally, the appointment of consultants not on the Specialist Division of the Register of Medical Practitioners to consultant posts is a strong indication of challenges in relation to recruiting for certain specialities/locations.

As highlighted in the MacCraith and Keane reports, the consultant recruitment process appears not to function effectively. However, the Commission acknowledges progress already made on recommendations from these reports including individually tailored time commitments being made available, where possible, for both new and existing consultant posts.

A number of initiatives have been introduced to improve consultant recruitment, including the 2015 Agreement which provides for an increased pay scale, availability of incremental credit depending on experience of the candidate and new career structures, yet there continues to be a recruitment challenge.

The Commission believes that the implementation of the settlement of the 2008 Consultant Contract claim, while necessary of itself, will serve to highlight further the differential in pay between the pre-existing cadre of consultants and new entrants. Policy responses that may be proposed for new entrants across the public services generally may not address the degree of pay differential which currently applies to new entrant consultants.

The Commission proposes that the Parties to the Public Service Stability Agreement jointly consider what further measures could be taken, over time, to address this difficulty.

Items not within Terms of Reference

A particularly noticeable aspect of the staff side submissions was the extent to which they urged the Commission to recommend increases in basic pay as a means of resolving recruitment and retention issues. Although the Commission is not persuaded, based on the evidence available, that current pay arrangements are in themselves a significant impediment to recruitment, it is in any event prevented by virtue of its Terms of Reference from undertaking a general pay review for any group.

The exercise that the Commission is engaged with is specifically focused on a comprehensive, evidence based examination and analysis of recruitment and retention issues. The Commission was also made aware that the current Public Service Stability Agreement, while providing for consideration of any proposals that may arise on foot of the Commission's report, precludes the pursuance of claims for increases in pay or improvements in conditions of employment beyond those provided for by the Agreement during the term of the Agreement.

The Commission was left in no doubt that nurses and midwives are seriously aggrieved at what they regard as anomalies in the current pay structures relative to other professions working in the public health service. The Commission recognises that there is no mechanism currently in place that would allow for these issues to be addressed or dealt with in isolation.

The Commission nevertheless believes that thought has to be given by the Parties to the Public Service Stability Agreement to consider putting arrangements in place, at an appropriate time, and without compromising the stability of the public service pay bill, to allow for the adequacy of current pay arrangements more generally to be fully examined.

Terms of Reference

The Public Service Pay Commission (PSPC) is established to advise Government on Public Service remuneration policy.

Purpose

The findings of the Commission will contribute to and inform Government's considerations in relation to public service remuneration and assist the Department of Public Expenditure and Reform in discharging its negotiation function on behalf of Government.

The PSPC will consider such other remuneration matters as it may be asked to consider by the Minister for Public Expenditure and Reform from time to time, including:

1. Providing objective analysis on the appropriate pay levels for identifiable groups within the public sector;
2. Comparing appropriate rates for identifiable groups with prevailing private sector/market rates. This should have regard to evidence on recruitment and retention trends in respect of each group;
3. Comparing appropriate rates for identifiable groups within the public service with their equivalents in other jurisdictions, particularly where internationally traded skillsets are required, having due regard to differences in living costs; and
4. Providing objective analysis on the appropriate pay levels for officeholders' pay and pensions.

When reaching its findings the Commission shall have regard to:

- The superannuation and other benefits applying in the public service;
- Security of tenure, where it applies to public servants;
- Pay comparisons taking account of relevant characteristics;
- The public service reform agenda;
- Evidence on recruitment and retention within the public service;
- Any other relevant matters including impact on national competitiveness and sustainable national finances and equity considerations; and
- Any other issues as they are determined by Government.

Procedures

In progressing its work, the PSPC should utilise and analyse existing datasets and reports, as prepared and published by existing state and other agencies as appropriate. The PSPC may also undertake or commission additional research or data gathering where further information is required to comprehensively progress its Terms of Reference. The PSPC may invite relevant stakeholders to make submissions to the Commission to further assist its considerations.

The PSPC must publish its findings and the evidence on which these are based.

The PSPC will not take the place of direct negotiations between Government and employee representatives.

Phase 2

In accordance with Section 3 of the Public Service Stability Agreement 2018-2020 and consistent with its overall Terms of Reference, the Commission should:

1. Seek to establish in the first instance whether, and to what extent, a difficulty exists in terms of recruitment and retention for specific groups/ grades/sectors of the public service;
2. Where a difficulty is identified, examine the full range of causal factors, having regard as the Commission considers relevant to:
    - The totality of the current remuneration package available;
    - The planned future pay adjustments and alleviations from current rates of the Pension Related Deduction (PRD) provided for in the Public Service Stability Agreement 2018-2020;
    - Remaining Financial Emergency Measures in the Public Interest (FEMPI) pay unwinding post-2020, where applicable;
    - Supply constraints, for example, of newly qualified graduates of relevant post-leaving cert /3rd level programmes;
    - Work environment/organisational issues;
    - Career structures;
    - Learning and development provision;
    - Communications/engagement;
    - Other relevant HR practice or organisational issues; and
    - Any other factor considered relevant by the Commission.
3. Develop appropriate methodological and analytical criteria to ensure a robust evidence-based approach to this exercise;
4. Have regard to arrangements and best practice in other jurisdictions and, where appropriate, the domestic private sector in Ireland in relation to such issues, particularly in respect of those areas where a global labour market exists as well as the responses being adopted in other jurisdictions where similar recruitment and retention problems pertain;
5. Commission such external expertise as the Commission deems necessary to inform its deliberations in the context of the methodologies developed;
6. Provide the Parties to the Public Service Stability Agreement 2018-2020 with the opportunity to make submissions to the Commission;
7. Generate a range of costed options for resolving the specific issues identified having full regard to the fiscal constraints and requirements on Government to manage the Exchequer pay bill in a sustainable way over the medium and long-term;
8. Produce a final report to the Minister by end-2018 and/or at such interim stages as the Commission may decide.

Chapter 1: Introduction and Methodology

Chapter 1:
Introduction and Methodology

1.1 Establishment and Operation of the Commission

On 18 October 2016 the Minister for Public Expenditure and Reform, announced the establishment of a Public Service Pay Commission (the Commission) on a non-statutory basis, the role of this Commission is advisory in nature. The Commission's work is not intended to duplicate the dispute resolution and adjudicative functions of the industrial relations institutions of the State or to offset the process of collective bargaining as the primary mode of pay determination in the public service.

The members of the Commission are:

- Kevin Duffy (Chairman)
- Marian Corcoran
- Ultan Courtney
- Ruth Curran
- Noel Dowling
- Michael Kelly
- Seán Lyons
- Peter McLoone

In May 2017, the Commission published its first Report providing input on how the unwinding of the Financial Emergency Measures in the Public Interest (FEMPI) legislation should proceed. This was used as a basis for negotiations which led to the extension of the Public Service Stability Agreement (PSSA). Section 3.1.1. of the PSSA noted a finding from the Commission's report which stated that *"consideration could be given to commissioning a more comprehensive examination of underlying difficulties in recruitment and retention in those sectors and employment streams where difficulties are clearly evident"*. Section 3.1.2. of the PSSA went on to provide for such an examination and stated that:

- The Parties to this Agreement will have the opportunity to make submissions to the Commission on this matter.
- The Commission will conduct a comprehensive examination and analysis of the particular issues in question, commissioning external expertise as required, and taking into account the full range of causal factors in each case. The Commission will be asked to generate options for resolving the issues identified. In this regard, the Commission will develop specific methodological and analytical criteria to support it in carrying out this exercise.
- The Commission will be asked to complete this exercise by end-2018.
- The Commission will advise the relevant Parties on the outcome of its assessment, which will then be the subject of discussion between the relevant Parties. It is accepted by the Parties that the output from this exercise will not give rise to any cross-sectoral relativity claims.
- The implementation of any proposals that may arise on foot of the Commission's report will fall to be considered by the Parties.

1.2 Work Programme

On the 17 October 2017, the Minister for Finance & Public Expenditure and Reform forwarded Terms of Reference for the second phase of the Commission's work to formally commence the process. The Terms of Reference are available in full at the start of this report and on the Commission's website at https://paycommission.gov.ie/.

The Commission decided to adopt a modular approach to its work programme, whereby Module 1 considers issues relating to nursing and midwifery, Non-Consultant Hospital Doctors (NCHDs) and Hospital Consultants (consultants). Module 2 will consider those other grades/specialities where evidence of recruitment and/or retention difficulties were found to exist in Chapter 6 of the Commission's

first Report. The Commission's Statement of Approach to Phase 2 of its work is available on the Commission's website at https://paycommission.gov.ie/work-of-the-commission/phase-2/pspc-statement-of-approach/.

The Commission sought written, evidence-based submissions from stakeholders to Module 1. Relevant submissions were received from six respondents in relation to the work being undertaken. In addition, meetings were held with a range of stakeholders to explore further points raised in their submissions. The Commission also analysed data provided by the public service employers, by the staff representative bodies and other relevant stakeholders for the purpose of investigating claims of recruitment and/or retention difficulties. The Commission also engaged external experts to undertake two significant pieces of research; a survey and structured interviews and an international pay comparison of each cohort, to provide further insight into the recruitment and retention issues that are likely to impact on these grades. The Commission was supported in its work by a Secretariat seconded from the Civil Service. Submissions received by the Commission are published on the Commission's website at https://paycommission.gov.ie/submissions/.

1.3 Structure of Report

Recruitment and retention practices in any organisation, including those delivering services to the citizens of the State, must take place within a framework that supports the delivery of services having due regard to fiscal, economic and other relevant factors. Accordingly, Chapter 2 summarises the economic context, including an analysis of planned future pay adjustments provided for in the PSSA. Chapter 3 looks at health sector challenges in the national and international context. Chapter 4 summarises the findings of the international pay comparisons. The Commission's Terms of Reference require it to consider causation. Causal factors impacting on recruitment and retention generally are discussed in Chapter 5. Chapters 6, 7 and 8 discuss recruitment and retention issues which arise for nurses and midwives, NCHDs and consultants, respectively. The Commission's concluding comments are provided in Chapter 9. Detailed analyses and supporting documentation are set out in the appendices to this report.

1.4 Items not within Terms of Reference

A number of specific issues were raised by stakeholders that related to employment streams outside of the Commission's Terms of Reference, including the Irish Medical Organisation's (IMO) submission on Public Health Doctors. The Commission's Terms of Reference require it to seek to establish in the first instance whether, and to what extent, a difficulty exists in terms of recruitment and retention for specific groups/grades/sectors of the public service in accordance with Section 3 of the PSSA. Accordingly, the Commission commenced this work in relation to those grade/specialities where evidence of specific difficulties in recruitment and/or retention have already been identified in Chapter 6 of its first Report.

While Public Health Doctors were not one of the specialities included in Chapter 6, the Commission made some enquiries regarding this speciality. The final report from the MacCraith process (Department of Health, 2017) made additional recommendations with regard to Public Health Medicine, recommending the establishment of a working group to examine matters and make recommendations on the following items:

- The current and future role of the public health specialist in Ireland, including the appropriate skill mix in relation to public health functions;
- The attractiveness of public health medicine as a career option;
- The curriculum and content of the specialist training scheme, and associated administrative arrangements relating to the rotation of trainees around the system;
- Any requirement for Post-Certificate of Satisfactory Completion of Specialist Training sub-specialisation;
- The replacement rates required to fill existing public health specialist posts in order to ensure the viability of the specialist training scheme and any expansion that may be required to plan for future service developments; and
- Measures to enhance the awareness of public health medicine as a career option at undergraduate level and during the Intern year.

The Commission's understanding is that, in response to these recommendations, a report on the role, training and career structures of Public Health Doctors was commissioned and is currently under consideration by the Department of Health. Given the likely impact of this report on the future development of the speciality, the Commission did not feel that it would be appropriate to take a view on current or possible future recruitment or retention issues for this group, in isolation from consideration of the findings of this exercise.

For these reasons, and the fact that Public Health Doctors were not within the Terms of Reference, the Commission considered that any further deliberations pertaining to Public Health Medicine would not be appropriate.

1.5 Methodology

The Commission considered several sources of data across a number of years to provide evidence on the factors that impact recruitment and retention. It focused primarily on recent trends, i.e. 2013-2017, as well as data from 2007 to give a longer term reference point. The Commission developed a number of detailed data requests directed at gathering evidence on recruitment and retention issues in respect of certain grades identified in Module 1 of its work.

Many different forms of data can assist in analysing the incidence and causes of recruitment and retention difficulties. Information on recruitment transactions and details of employment turnover over time are probably the most directly relevant sources for assessing if, and to what extent, difficulties arise.

In seeking to establish if there are difficulties in recruiting, the focus should be on the number of approved places by grade and location, the number of these that were advertised, how many applications were attracted, the number of interviews that resulted, and the posts that were filled or left vacant. Regrettably, this information was not available to the extent that the Commission would have wished.

In relation to retention, the rate of departures over time by grade, age band and reason for leaving are important indicators. Such information on the flows into, and out of, employment would make it possible to relate the times and places where difficulties were most acute to patterns in the possible causes of those difficulties.

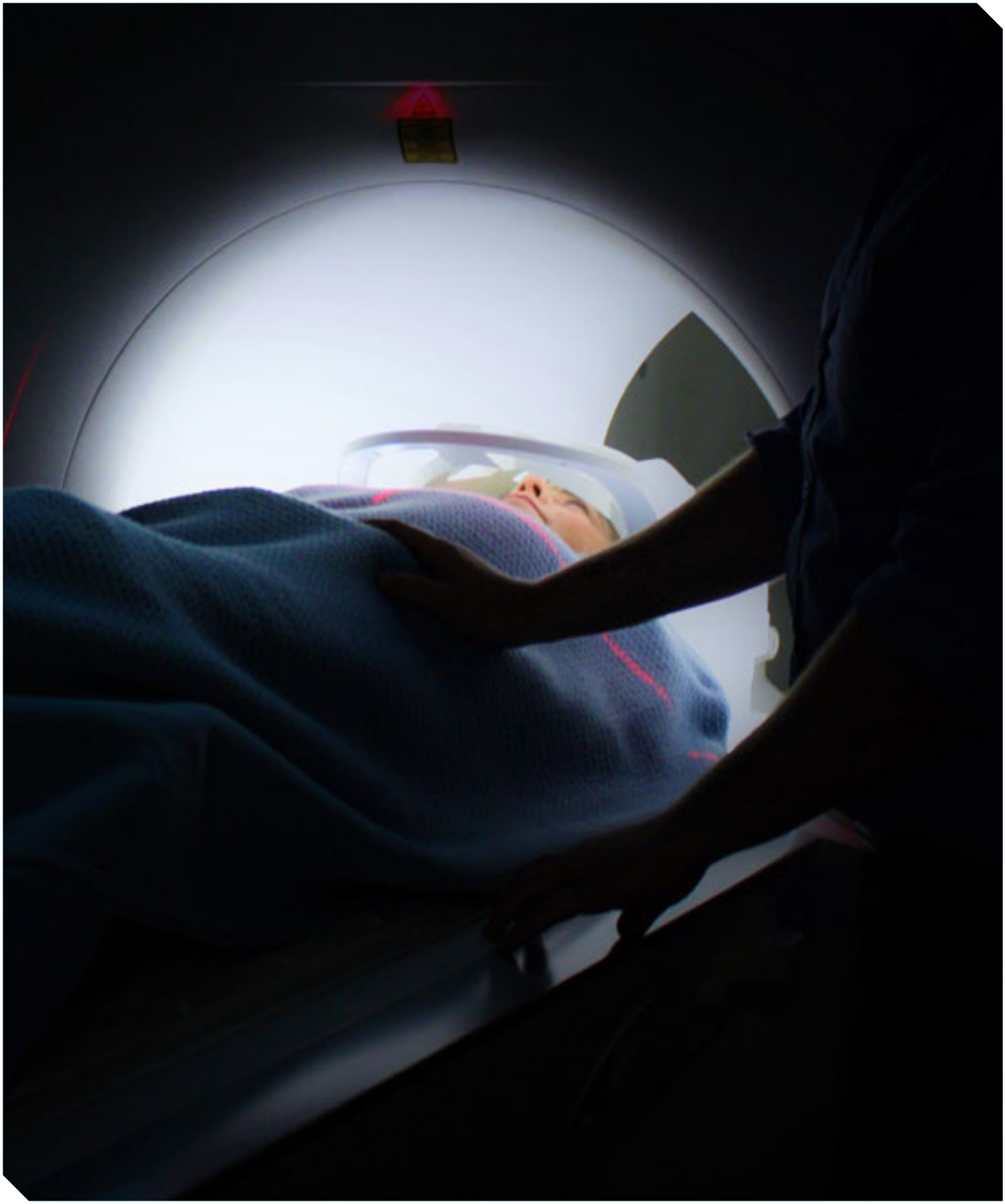
The Commission sought to obtain from public health service employers the types of data described above in relation to the experience at national and individual hospital/Community Health Organisation (CHO) level. Submissions were also sought from the relevant staff representative associations on factors which, in their opinion, impacted on recruitment and retention of their respective groups. However such detailed information is not generally available within the public health service.

Much of the information provided by both the employer and representative groups relied on broader indicators such as trends in staff numbers, turnover rates or evidence on staffing adequacy. Such indicators can be affected by recruitment and retention difficulties and are also influenced by other complicating factors.

The Commission engaged with the Department of Business, Enterprise and Innovation, the Office of the Government Chief Information Officer, SOLAS, the Central Applications Office (CAO), the Higher Education Authority (HEA), the Higher Education Statistics Agency (HESA) in the United Kingdom (UK), the Medical Council of Ireland (Medical Council) and the Nursing and Midwifery Board of Ireland (NMBI) to develop available data that could inform analysis of the supply and registration of nurses and doctors. The Commission would like to thank all those who contributed to the report.

As already noted, two independent pieces of research were commissioned; a survey and number of structured interviews and an international pay comparison of each cohort. This research provides further insight into the recruitment and retention issues that are likely to impact on these grades. More information on the methodology of each of these analyses is available in Appendix C and within each of the respective reports, which are available on the Commission's website at https://paycommission.gov.ie/.

Chapter 2: Economic Environment and Remuneration



Chapter 2:
Economic Environment and Remuneration

2.1 Introduction

The Commission's Terms of Reference provide that where a recruitment and or retention difficulty is identified the Commission should examine the full range of causal factors, having regard as the Commission considers relevant to:

- The fiscal constraints and requirements on Government to manage the Exchequer pay bill in a sustainable way over the medium and long-term;
- The totality of the current remuneration package available;
- Planned future pay adjustments and alleviations from current rates of the Pension Related Deduction (PRD) provided for in the Public Service Stability Agreement 2018-2020; and
- Remaining FEMPI pay unwinding post-2020, where applicable.

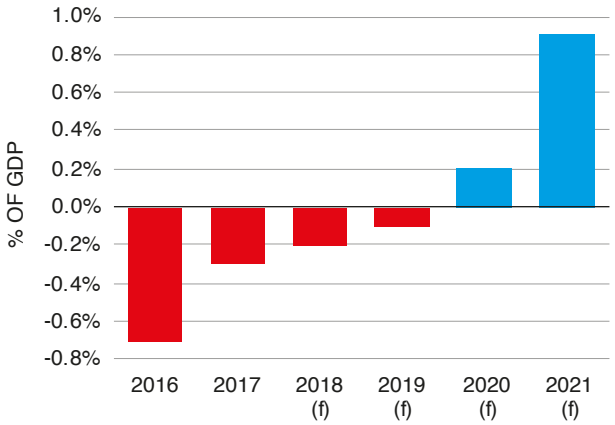
The first section of this chapter provides an update of the main fiscal and economic indicators presented in Chapter 3 of the Commission's first Report. The second section outlines the historic movements and future developments in public service pay to provide the financial context for any future negotiations on nurse, midwife, NCHD and consultant pay.

2.2 Fiscal and Economic Environment

The 2008 financial crisis impacted all areas of the Irish economy and resulted in a steep decline in tax receipts and a reduction in government expenditure. Since 2008, the gap between General Government Expenditure and General Government Revenue resulted in the State running a budget deficit. This deficit reached its highest point in 2010 and has been declining since. In 2016, the deficit as a percentage of Gross Domestic Product (GDP) was at 0.7%, and is forecast to decline up to 2019; for 2020 and 2021 a small surplus is forecast.

Total revenue, which is driven by receipts from taxes such as income tax and corporation tax, exceeded 2007 levels for the first time in 2016 and is forecast to continue increasing over the medium term. Total expenditure by the State, on items such as social payments and employee compensation, is forecast to increase by more than €10 billion, reaching €85 billion by 2021.

Figure 2.1: General Government Balance, 2016 - 2021



Source: Department of Finance

To safeguard the management of the national finances, Government expenditure operates within national and European Union (EU) fiscal frameworks. The cornerstone of these frameworks is the Stability and Growth Pact (SGP), which ensures Governments plan fiscal policy based on stable and sustainable levels of expenditure rather than leave fiscal and expenditure policy exposed to a boom-bust cycle.

Since 2016, Ireland's fiscal framework has been operating within the Preventative Arm of the SGP. This requires EU Member States to run budget deficits of 3% or less and reduce their debt as a percentage of GDP by 5% on average per year, until such time as the debt is below 60% of GDP. Ireland is not fully subject to the debt rule until after 2019.

Public debt in Ireland peaked in 2012 at 120% of GDP, and fell below 80% of GDP in 2015. The level of debt as a percentage of GDP is forecast to reduce to 58.7% in 2021. It should be noted that while factors such as a lower deficit have reduced the level of debt since 2012, substantial increases in GDP, such as the 27% increase in 2015 which does not reflect the real growth rate of the economy, suggest the real economy's ability to service the debt is lower than it might appear given the raw numbers.

It is well documented that GDP figures are less relevant for Ireland than for other countries. The primary reasons are the high proportion of Foreign Direct Investment (FDI) activity in the Irish economy, and the international statistical classifications (e.g. the classification of aircraft leasing within national accounts), which can have a disproportionate impact on measures of economic activity in Ireland. The Central Statistics Office (CSO) developed a new concept Modified Gross National Income (also known as GNI*) to more accurately reflect the income standards of Irish residents than GDP[1].

The Government's stated medium term (i.e. beyond 2021) debt target aims to reduce debt levels to 55% of GDP. However, once major capital projects, directed at boosting potential output, have been completed, the Government will then target a further reduction in the debt ratio to 45% of GDP (Department of Finance & the Department of Public Expenditure and Reform, 2018). Reducing the debt further is intended to reduce the amount of interest payable, improve fiscal robustness and insulate against Ireland's openness to external shocks such as a 'hard Brexit', or changes in United States of America (US), UK and EU policies in relation to corporation taxes which may impact FDI flows into Ireland.

The economic environment has become more positive since 2012, with employment and output growth forecasts indicating positive trajectories into the future. GDP recovered from pre-crisis levels in 2014 and has increased significantly since then. Estimates from the CSO indicate that GDP increased by 7.2% in 2017 and the Department of Finance forecasts GDP to grow at declining rates to 2021. A more reliable component of GDP in terms of national consumer spending is personal consumption, which increased by 4% and 1.6% in 2016 and 2017 respectively, and is forecast to grow by an average of 2.3% over the medium term. Currently there are no official forecasts of real GNI* growth.

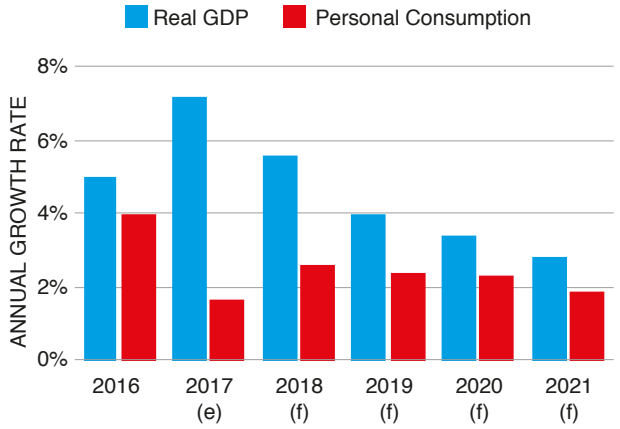
Table 2.1: General Government Debt, 2016 - 2021

	2016	2017 (e)	2018 (f)	2019 (f)	2020 (f)	2021 (f)
Billions (unless otherwise stated)						
Gross Debt	€200.6	€201.3	€206.3	€209.4	€207.7	€211.4
Gross Debt % of GDP	72.8%	68.0%	66.0%	63.5%	60.2%	58.7%
Gross Debt % of GNI*	106.0%	100.1%	96.9%	93.6%	88.9%	86.8%

Source: Department of Finance

1 GNI is the sum of value added by all resident producers plus any product taxes (minus subsidies) not included in the valuation of output plus net receipts of primary income (compensation of employees and property income) from abroad. GNI* differs from actual GNI in that it excludes, *inter alia,* the depreciation of foreign-owned, but Irish-resident, capital assets (most notably intellectual property and assets associated with aircraft leasing) and the undistributed profits of firms that have re-domiciled to Ireland. Forecasts for GNI* are compiled on the purely technical assumption that this variable grows in line with nominal GNP.

Figure 2.2: Economic Growth, 2016 - 2021



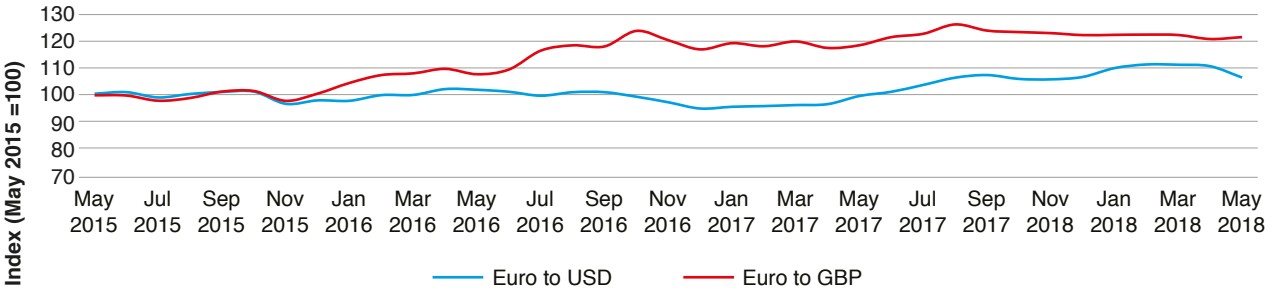
Source: CSO and Department of Finance

While the projections for economic growth and increased fiscal sustainability are all very positive over the medium term, there are a number of risks to the economic and fiscal environment.

In terms of the external economic environment, Ireland's relatively small size and open economy make it vulnerable to rapid changes in the regional and global environment. Increased barriers to trade globally, possibly as a result of a hard Brexit and changes to US trade policy, could have a very negative impact on the domestic economy.

The Irish economy is the most vulnerable of the Eurozone economies to the consequences of Brexit. Should the outcome of the continuing EU-UK negotiations result in a WTO-type arrangement between the EU and the UK, this would have a particularly detrimental impact on Irish-UK trade. This could potentially arise over the short term if the EU and UK do not agree to a transitional arrangement. Some impact is already materialising in the volatility of sterling/euro exchange rates. The value of the euro has increased by 11% against the pound sterling since the UK's Brexit referendum (June 2016), and by 22% since June 2015. Similarly the value of the euro has increased by 4% against the US dollar since June 2016. These increases in the value of the euro reduce the competitiveness of Irish exports in these markets. In terms of earnings, workers that earn in euro are better off, all else being equal, compared to those earning pounds sterling or US dollars.

Figure 2.3: Index of Euro-Pound Sterling and Euro-US Dollar Exchange Rates, 2015 - 2018



Source: Central Bank of Ireland

The risks to the economy domestically centre on the potential for the economy to overheat due to full employment and stronger than forecast growth. A reduction in competitiveness (e.g. increased labour costs) would impact on the export led sector resulting in risks to both employment and output. Housing supply pressures which restrict the mobility of labour could also impact competitiveness. Moreover, employment and output are concentrated in a small number of sectors, which exposes these elements to firm or sector specific shocks.

The risk to the national finances domestically stems from a number of sources, including the standard long-term influences such as inflation, demographic pressures and increases in interest rates. The most discernible risks that could impact the public finances include an increase in contribution to the EU budget occasioned by stronger than expected growth in GDP and sanction or financial penalty arising from non-achievement of EU climate change and renewable energy targets. Added to these risks is a lack of certainty on how Brexit will impact the EU Budget.

As the economy continues to improve there is likely to be excessive public expectation of budgetary policy on top of the existing pressures to address constraints arising from increases and changes in the structure of the population. There is also a risk to Government revenues from tax concentration, specifically corporate tax concentration. In this context, the top ten companies in Ireland are responsible for nearly 40% of the total corporation tax take. Unexpected company exits or financial under-performance of the top-ten companies has the potential to seriously impact this revenue flow. The Irish Fiscal Advisory Council (2018) estimate that the loss of one large company could reduce corporation tax revenues by 4%.

There is also risk of adverse or unexpected litigation outcomes against the State which could result in a significant level of expenditure over and above that provided for in the budget and which could pose a risk to budgetary targets. For example, the recent case of the Irish hospital consultants challenging the decision of the State in relation to their contractual terms was settled at an estimated cost to the State of around €200 million in one-off costs and €60 million in annual costs. Additionally, there are ongoing negotiations between the Department of Public Expenditure and Reform (DPER) and staff representative bodies on new entrants pay, costed by that Department at approximately €200 million.

Turning specifically to public health service demand, which is intrinsically linked to the topic of this report, most projections indicate that future demand for health services in Ireland will be a great deal higher than the levels experienced today. Analysis carried out by the ESRI indicates that demand for public hospital services could increase by up to 37% in the case of inpatient bed days and up to 26% in the case of Emergency Department attendances by 2031, as a result of an increasing and ageing population. The Department of Health's (2018) *Capacity Review* baseline forecast indicates that, if occupancy rates can be reduced by 10%, Inpatient and Adult Critical Care beds would still need to increase by up to 56% by 2030. Additionally, implementation of the *Sláintecare* Report may have further implications for the required supply of services, if proposals set out therein such as universal healthcare are rolled out and models of care are reformed.

2.3 Public Service Pay and Pensions

Public service pay and pensions are a very significant component of Government expenditure. During the economic crisis the public service pay and pension bill was reduced to assist with balancing of national finances. The reduction was achieved by a number of FEMPI measures, and a moratorium on recruitment and promotion which resulted in a decrease in headcount. As the position of the national finances improved and service demands increased, both the numbers and the pay of public servants have started to be restored to pre-crisis levels.

The public service, which is composed of the Civil Service, the education sector, health sector, Non-Commercial State Agencies, the defence sector and Local Authorities, grew above 2007 levels in 2017, with 317,495 Whole Time Equivalents (WTEs) employed. The primary driver of this increase was Exchequer funded employees. While Local Authority staff are not paid directly from the Exchequer, the 22% reduction since 2007 in the WTEs employed in Local Authorities has yielded significant savings by way of reducing the required level of general Exchequer financial support to Local Authorities.

Table 2.2: Public Service Employment in Whole-Time Equivalents, 2007 - 2008, 2013 - 2017

	2007	2008	2013	2014	2015	2016	2017	Change 2007-17
Exchequer Funded	278,050	285,380	260,673	262,857	271,568	279,715	290,046	4%
Local Authorities	34,987	35,008	27,544	26,786	26,630	26,862	27,449	-22%
Total Public Service	313,037	320,387	288,217	289,643	298,199	306,578	317,495	1%

Source: DPER

The gross public service pay bill decreased by 11% from 2007 to 2014. However, the 2018 gross public service pay bill is estimated to be 5% above the 2007 peak. Also during this period the PRD was introduced which reduced the pay bill by approximately €1 billion. In addition, since 2013 the impact of the PRD has reduced by 19% to €750 million in 2018, this decline is a result of successive Public Service Stability Agreements underpinned by FEMPI legislation which reduced the pay reductions applied under the 2009-2013 FEMPI Acts.

Table 2.3: Gross Exchequer Pay and Pensions Bill[2], 2007 - 2018

	2007	2013	2014	2015	2016	2017(p)	2018 (e)
Billions (unless otherwise stated)							
Gross Voted Current Expenditure	€48.6	€51.0	€50.5	€50.9	€51.8	€54.3	€55.9
Gross Exchequer Pay	€16.6	€15.1	€14.7	€15.1	€15.6	€16.6	€17.4
Gross Exchequer Pay net of PRD	€16.6	€14.1	€13.8	€14.6	€14.9	€15.9	€16.7
Gross Exchequer Pensions	€1.5	€2.8	€3.0	€2.9	€3.0	€3.1	€3.1
Exchequer Pay and Pensions as % of Current Expenditure	37.2%	34.9%	35.0%	35.5%	35.9%	36.3%	36.7%

Source: DPER

The value of the State's Accrued-to-Date pension liability (the ADL[3]) in respect of current and former public service employees was estimated as €114.5 billion at 31 December 2015. This is an increase of 16% in the ADL compared to the 2012 position. Additionally, the spending on public service occupational pensions is estimated by DPER to increase from 1.2% of GDP in 2016 to 1.5% of GDP by 2040, and to reduce as a proportion thereafter to 0.9% of GDP by 2060.

The reductions in projected public service occupational pension expenditure over the long-term arise largely as a result of the integration of public service pensions with the State Pension (Contributory) for employees who joined the public service from 6 April 1995 onwards, the increase in the minimum retirement age for new entrants from 2004, as well as the introduction of the Single Public Service Pension Scheme in 2013.

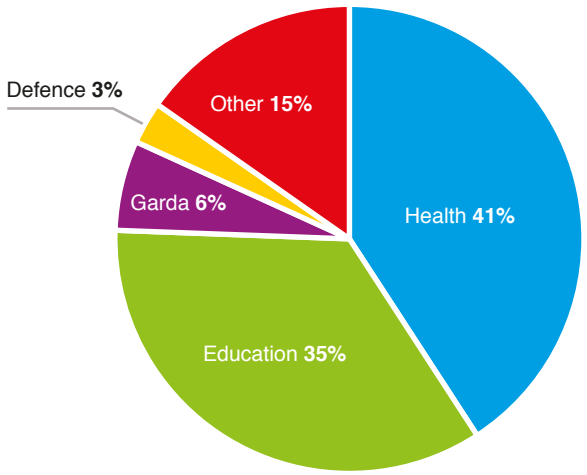
2 Pay and pension figures are exclusive of Local Authority pay and pensions which are not directly funded by the exchequer.

3 The ADL represents the present value of all future expected superannuation benefit payments arising from accrued service to 31 December 2015, including contingent benefits payable to spouses and children of current and former public service employees.

2.4 Public Service Pay - FEMPI Legislation and Public Service Pay Agreements

In 2018, the public service pay bill is estimated at some €17.4 billion, Figure 2.4 shows the main sectoral costs of the pay bill. The estimated health pay bill is €7.1 billion and accounts for 41% of the total public service pay bill. Nurses pay accounts for 34% and medical/dental pay accounts for 20% of the estimated health pay bill.

Figure 2.4: Gross Exchequer Pay Bill by Sector, 2018



Source: DPER

As previously outlined, during the economic crisis the pay, terms and conditions of public servants were adjusted by Government with the introduction of a series of Financial Emergency legislation (FEMPI Acts 2009-2013) and other various pay, pensions and non-pay measures, some of which impacted solely on new entrants to the public service. Once the necessity for this legislation diminished, having been predicated on there being a Financial Emergency, Government began the process of unwinding these measures. The Lansdowne Road Agreement (LRA) underpinned by the FEMPI Act 2015 was the first step in this process.

The Public Service Stability Agreement 2018-2020

Following the publication of the Commission's first Report in May 2017 the Government entered into talks with public service unions and staff representative bodies. A fourth public service agreement, the PSSA 2018-2020 was negotiated and ratified by the Public Services Committee of the Irish Congress of Trade Unions (ICTU) in September 2017. This extension of the LRA applies for the period 1 January 2018 to 31 December 2020 and is estimated by DPER to cost €887 million over three years. DPER has estimated that pre-committed additional expenditure on pay and pensions for 2019 is in the order of €550-€600 million. This includes public sector pay increases already agreed and increases in the pay bill associated with demographics in the education and health sector.

The PSSA and the Public Service Pay and Pensions Act 2017

Pay Measures

Under the terms of the Agreement the vast majority of public servants (i.e. those earning up to €70,000, some 90% of the total public service) will have had their pay fully restored by October 2020. The Agreement provides for increases of between 6.2% and 7.4% (or up to 10% for new entrants employed after 2012).

Table 2.4: Public Service Pay and Pensions Act 2017 - Pay Measures 2018 - 2020

Year	Start Year Measure	Mid-Year Measure
2018	1 January annualised salaries to increase by 1%	1 October annualised salaries to increase by 1%
2019	1 January annualised salaries up to €30,000 to increase by 1%	1 September annualised salaries to increase by 1.75%
2020	1 January annualised salaries up to €32,000 to increase by 0.5%	1 October annualised salaries to increase by 2%
		1 October restoration of allowances that were reduced by 5% and 8%

Note: Different payment dates apply to 'Non-covered' public servants.

Allowances

The *FEMPI (No. 2) 2009 Act* reduced certain fixed allowances by 5% or 8%. The *Public Service Pay and Pensions Act 2017* provides for the restoration of these allowances by end 2020[4]. In addition, a number of health service allowances which had been abolished for new entrants as part of the Review of Public Service Allowances in 2012 have been restored. Details of these and other allowances are set out in Appendix D.

4 The *Public Service Pay and Pensions Act 2017* provides for a single date for restoration of the reduction to allowances in October 2020. However, the officers of the Public Services Committee of ICTU have sought agreement to an earlier date for restoration and the matter has now been referred to the HRA Oversight Committee.

Pension Measures

The Agreement underpinned by the *Public Service Pay and Pensions Act 2017* also converted the PRD into a new permanent pension deduction, the Additional Superannuation Contribution (ASC). The ASC differs from the PRD in two aspects: it increases earning thresholds and reduces the contribution rates for members of the post-2012 pension schemes. Details of these measures are set out in the PSSA which is available at www.per.gov.ie/en/public-service-pay-policy/public-service-stability-agreement/.

2.5 Impacts of Various Pay Adjustments from 2008 to 2020

The following section sets out the pay reductions under the FEMPI legislation, pay adjustments provided for by the Lansdowne Road Agreement, future pay adjustments contained in the PSSA and other pay adjustments agreed since 2009. Table 2.5 sets out the impact of pay adjustments from 2008 to end 2020 by salary range.

Post-2020, the legislation provides for the restoration of the remaining FEMPI pay unwinding in two parts:

1. those with a post-PSSA salary of under €150,000; and
2. those with a post-PSSA salary of over €150,000.

Table 2.5: Impacts of Past and Planned Pay Adjustments

Pre FEMPI Salary	End LRA Pay**	End 2020 Salary	% Pre-Cut
€22,080	€22,500	€24,179	110%
€33,243	€32,500	€34,408	104%
€44,054	€42,500	€44,995	102%
€54,865	€52,500	€55,582	101%
€65,676	€62,500	€66,169	101%
€77,778	€72,500	€76,757	99%
€88,889	€82,500	€87,344	98%
€100,000	€92,500	€97,931	98%
€122,222	€112,500	€119,105	97%
€190,341	€167,500	€177,334	93%
€235,294	€200,000	€211,742	90%

*Salary ranges above show examples of the changes in salary, increases related to those salaries not presented above are approximate to the nearest salary range.

**The LRA provided for pay adjustments up to 1 April 2017 for those earning up to €65,000. The HRA provided for pay adjustments for those earning up to €110,000 up to 1 January 2018 and for those earning in excess of €110,000 up to 1 April 2019. End LRA Pay reflects pay increases accrued under that Agreement only.

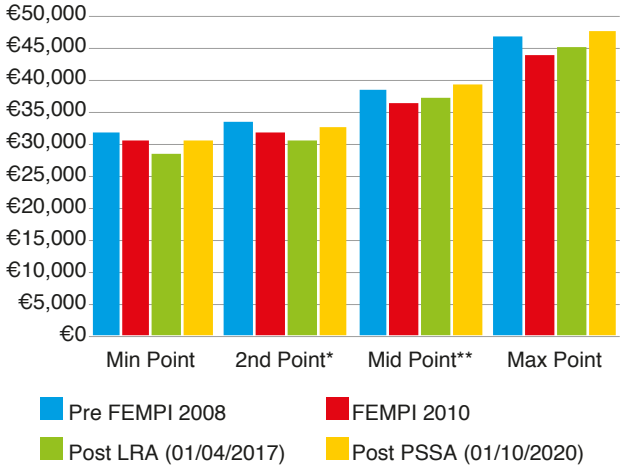
For those with a post-PSSA of under €150,000, the date of restoration must be a date after 1 October 2020 but no later than 1 July 2021. For those with a post-PSSA salary over that amount, it must be a date after 1 October 2020 but no later than 1 July 2022.

The following analysis illustrates the impact of these pay adjustments on a range of nurse/midwife, NCHD and consultant payscales. These illustrations do not take account of any consequent increases to allowances, overtime or any other additional payments.

Staff Nurse & Midwife

Figure 2.5 sets out the impact of the pay adjustments on the Staff Nurse/Midwife payscale. Following all of the planned pay adjustments the Staff Nurse payscale from the 3rd point onwards will be fully restored to 2008 levels and will benefit from some pay increases beyond the 2008 pay rates. The reductions shown for point 1 and 2 of the payscale arise from reduced rates applied to new entrants to the public service which are currently being reviewed by the Parties.

Figure 2.5: Impacts of Pay Measures - Staff Nurse & Staff Midwife, 2008 - 2020



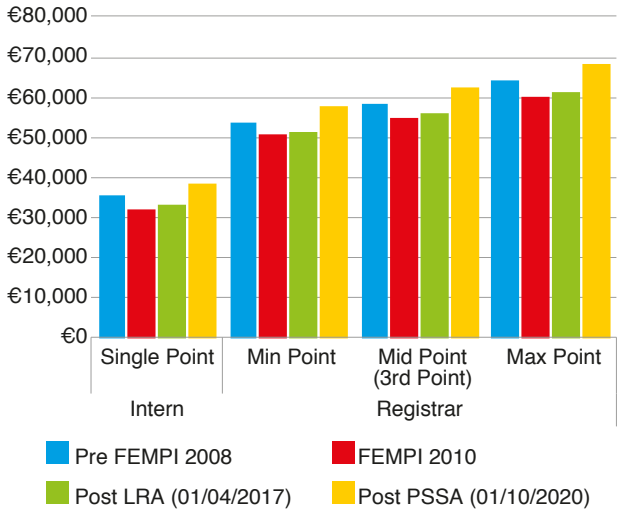
*A newly qualified Staff Nurse commences on the first point of the payscale but progresses to the second point after 16 weeks due to incremental credit awarded in respect of 36 weeks worked as a trainee nurse.

**From 1/11/2013 the 1/1/2011 new entrant scales (10% reduced) were merged with the pre-new entrant scales which resulted in two additional points being added to the start of the scale. For comparative purposes the figure above uses the mid-point of the scale which was the 5th point from 2008-2013 and the 7th point from 1 November 2013. The issue of new entrant pay is currently subject to negotiations between the Parties.

NCHDs

Figure 2.6 sets out the impact of the pay adjustments on Interns[5] and Registrars. Interns have a one point payscale which in 2008 was €35,534. This will increase to €38,252 by 1 October 2020. Registrars have a 6 point scale. In 2008 this started at €53,869 and reached a maximum point of €64,384. As a result of the PSSA the minimum point will increase to €57,987 and the maximum point will increase to €68,285. In addition to the PSSA increases, a Living Out Allowance of €3,193 per annum was incorporated into the Intern and Registrar payscale from 1 July 2017.

Figure 2.6: Impact of Pay Measures - Intern and Registrar, 2008 - 2020



Consultants

The majority of Hospital Consultants are employed under the 2008 contract, which has four different contract types that determine the proportions of private practice a consultant may undertake. Details are set out below:

- Type A – public only contract;
- Type B – consultants can see private patients on the public hospital site or in a co-located site but at least 80% of their clinical/patient output must be on public patients;
- Type B* – serving consultants whose public to private ratio in 2006 was greater than 20%. They could retain the higher ratio, subject to an overriding maximum ratio of 70:30; and
- Type C – consultants can treat private patients outside of the public hospital campus. Private patient treatment should not exceed more than 20%.

The following paragraphs present the payscales for new entrant consultants appointed from October 2012 and consultants appointed up to end of September 2012 on Type B contracts[6].

Figure 2.7 sets out the impact of the adjustments on new entrant consultants appointed from 1 October 2012 (Type B) payscale. This scale was implemented following negotiations and acceptance by the IMO of a Labour Relations Commission (LRC) agreement on 7 January 2015.

The new entrant payscale has 9 points. In 2010 a consultant who started on a Type B contract earned €128,261 at the minimum point and €168,681 at the maximum point. By 1 October 2020, a new entrant consultant will earn €135,791 at the minimum point on the scale and €178,584 at the maximum point.

Figure 2.7: Impacts of Pay Measures - New Entrant Consultant (Type B) Appointed From 1 October 2012, 2010 - 2020[7]

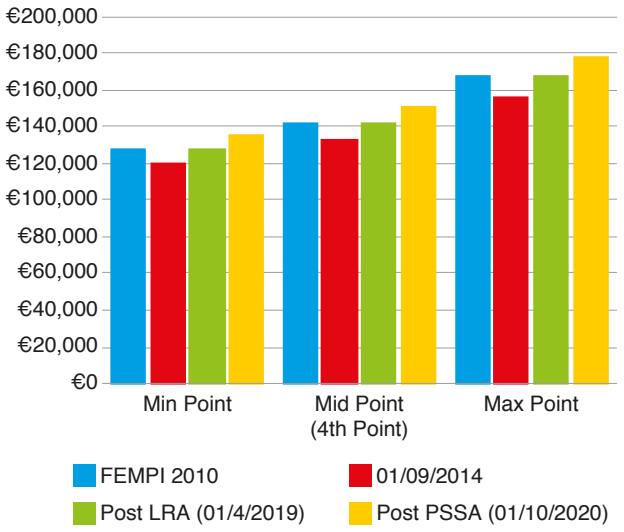


Figure 2.8 sets out the impacts of the adjustments on the consultant payscale for those appointed up to 30 September 2012 (Type B). This four point scale became a six point scale on 1 November 2013 when the first two points of the 10% reduced scale, which applied to new entrants appointed in the period from 1 January 2011 to 30 September 2012, were added to the beginning of the scale.

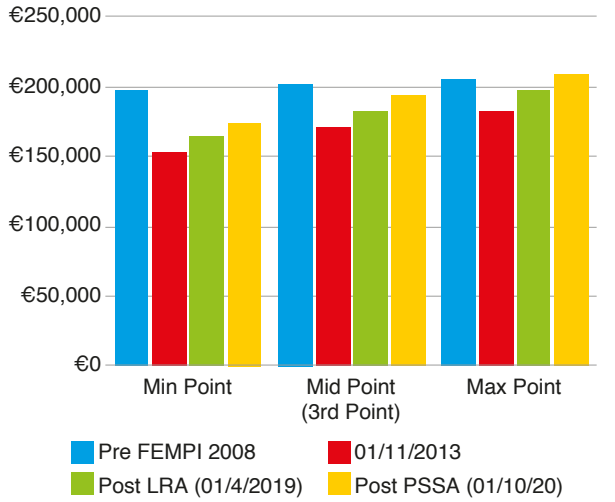
5 An intern post is a combined training and clinical service position for graduates of medical school, the successful completion of which leads to the award of a Certificate of Experience from the Medical Council. Internship is for a minimum period of 12 months.

6 56% of consultants are employed on Type B contracts.

7 DPER Guidance note on the implementation of the pay increases provided for under the Public Service Stability Agreement 2018-2020.

In 2008 a consultant on a Type B contract earned €197,296 at the minimum point, and €205,176 at the maximum point. By 1 October 2020, a consultant on this Type B contract will earn €174,436 at the minimum point on the scale and €208,001 at the maximum point. These 2020 figures are inclusive of the changes in consultants' pay as a result of the recent settlement of legal proceedings in relation to the terms of 2008 Medical Consultants contract. Full details of the settlement are available on the HSE's website at https://www.hse.ie/eng/staff/resources/consultants-contract-2008/consultant-contract-2008-settlement-agreement-guidance.pdf.

Figure 2.8: Impacts of Pay Measures - New Entrant Consultant (Type B) Appointed up to 30 September 2012[8]



Note: From 1/11/2013 the 1/1/2011 new entrant scales (10% reduced) were merged with the pre-new entrant scales which resulted in two additional points being added to the start of the scale. For comparative purposes the figure above uses the 3rd point of the scale to capture the mid-point.

Pension Related Deduction

As mentioned earlier in this chapter, the Agreement underpinned by the *Public Service Pay and Pensions Act 2017* also converted the Pension Related Deduction into a new permanent pension deduction, the ASC.

For those on pre-2013 pension schemes with standard accrual terms the threshold for paying this deduction is to increase from €28,750 to €32,000 in 2019, and €34,500 in 2020. For those on post-2012 pension schemes, the same thresholds apply but the percentage deduction rates will be reduced by one third in 2019 and by a further third in 2020. There are no changes for those who are members of pre-2013 pension schemes with fast accrual terms. Full details of the PSSA are available on the DPER website at https://www.per.gov.ie/en/public-service-pay-policy/public-service-stability-agreement/

Figure 2.9 sets out examples of the alleviations provided for in the PSSA from current rates of the PRD for those on pre-2013 standard accrual pension schemes. Similar to the PRD, those on salaries below the threshold (€34,500 in 2020) will not pay any ASC. This is a reduction in contributions of €575 for those impacted. For those on €40,000 this is a reduction in contribution from 2.8% to 1.4% and those on salaries of €200,000 will see their contribution reduce from 8.9% to 8.6%.

Figure 2.9: PRD Conversion to Additional Superannuation Contribution (Pre-2013 Standard Accrual Pension Scheme)

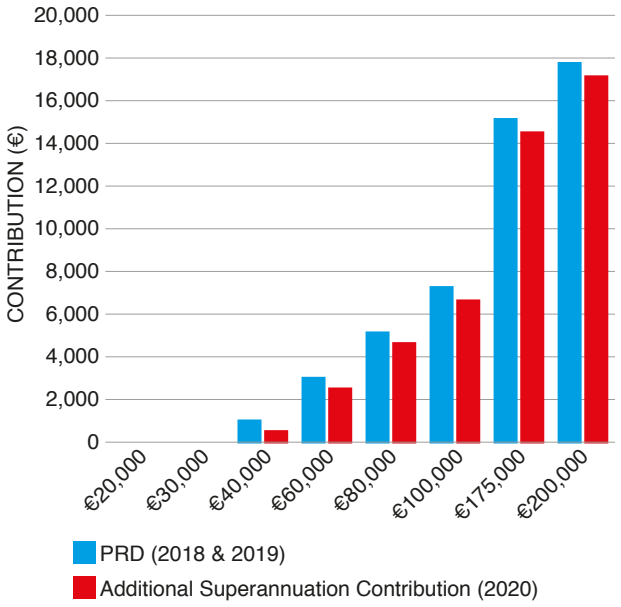
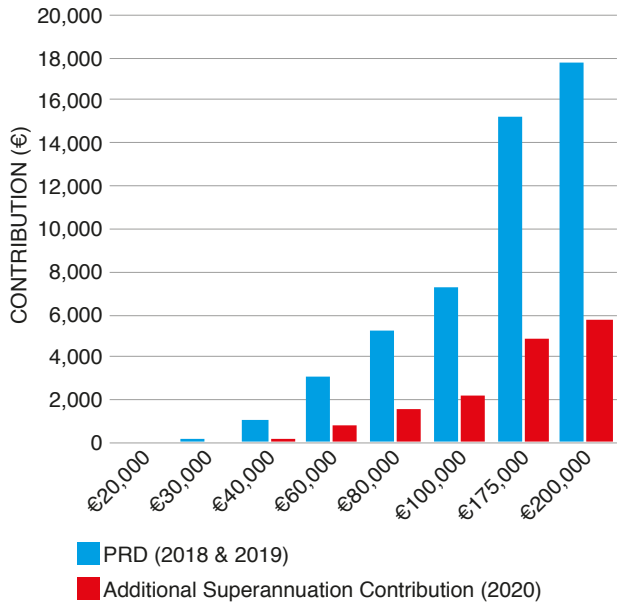


Figure 2.10 sets out examples of the alleviations provided for in the PSSA from current rates of the PRD for those on post-2012 standard accrual pension schemes. Similar to the PRD, those on salaries below the threshold (€34,500 in 2020) will not pay any ASC. Those on salaries between €30,000 and €200,000 will see a reduction in contributions between €125 and €12,076 respectively. For those on €30,000 this is a reduction in contribution from 0.4% to 0% and those on salaries of €200,000 will see their contribution reduce from 8.9% to 2.9%.

8 DPER Guidance note on the implementation of the pay increases provided for under the Public Service Stability Agreement 2018-2020 .

Figure 2.10: PRD Conversion to Additional Superannuation Contribution (Post-2012 Standard Accrual Pension Scheme)



The Totality of the Current Remuneration Package

The Commission's first Report examined the total remuneration package including pension and security of tenure. These findings can be accessed on the Commission's website at https://paycommission.gov.ie/publications/.

Appendix E presents the average pay levels including allowances, overtime and other payments in 2017. In summary:

- The average earnings for all HSE Staff Nurses and Midwives in 2017 was approximately €51,000 with allowances, overtime and other payments accounting for approximately 20% to 25% of these earnings;
- The average earnings for NCHDs in 2017 was in excess of €74,000 with allowances, overtime and other payments accounting for approximately 34% of these earnings; and
- The average earnings for consultants in 2017 was almost €180,000 with allowances, overtime and other payments accounting for approximately 9% of these earnings. These figures are exclusive of earnings from private practice.

2.6 Summary

The Commission's Terms of Reference provide that where a recruitment and/or retention difficulty is identified and where the Commission considers it relevant, it should have regard to:

- The fiscal constraints and requirements on Government to manage the Exchequer pay bill in a sustainable way over the medium and long-term;
- The totality of the current remuneration package available;
- The planned future pay adjustments and alleviations from current rates of the PRD provided for in the Public Service Stability Agreement 2018-2020; and
- Remaining FEMPI pay unwinding post-2020, where applicable.

The public finances have emerged from a challenging period and are now on a more sustainable path, however the level of Government debt is very high and repayments of this debt will impact on the public finances over the very long-term. The economy has also rebounded with relatively strong GDP and personal consumption growth projected over the medium term.

The signals from the projections of both the fiscal and economic environment are encouraging in the short to medium term. However, risks in the form of increased barriers to trade globally, Brexit and competitiveness have the potential to create very serious impacts on the economy and the national finances. Demand for public health services is forecast to increase significantly over the next 10 years as the population increases and ages.

The pay and pensions bill which is driven by public service numbers and pay rates accounts for over 36% of current expenditure. The pay bill declined between 2008 and 2014 but has continued to grow from 2014. The provisional pay bill net of PRD for 2017 is up 15% from 2014. The gross pensions bill has doubled from €1.5 billion to €3.1 billion between 2007 and 2017.

The LRA and the FEMPI Act 2015 began the process of unwinding the pay reductions imposed on public servants since 2009. The PSSA underpinned by the *Public Service Pay and Pensions Act 2017* will restore pay reductions imposed by this legislation by 2022. For the vast majority (90%) of public servants this will happen by 2020. It will have taken over 11 years to achieve this restoration.

Based on the data from HSE, significant additional payments such as overtime, allowances and other premium payments are a large part of the total remuneration package of nurses, midwives, NCHDs and consultants and in some cases can account for 20% to 30% of earnings.

The pay of new entrant consultants was reduced by a further 30% for those appointed from 1 October 2012. From 2015, a new nine point scale was introduced to address some of the issues between new entrant consultants and those appointed prior to October 2012.

Fixed allowances are due to increase by between 5% and 8% by the end of 2020. Also a number of allowances for new entrants which were discontinued as part of the Review of Public Service Allowances in 2012 have been restored. The main outstanding issue for new entrants would seem to be the introduction of two additional lower points to their respective payscales, this is currently subject to negotiation between the Parties.

The PSSA, underpinned by the *Public Service Pay and Pension Act 2017*, converted the Pension Related Deduction into a new permanent pension contribution. In doing this the Act also provides for alleviations from current rates of the PRD, the greatest of which were for those public servants who are members of the post-2012 standard accrual pension scheme.

The Commission maintains the view that decisions on the proportion of public expenditure to be allocated to public service pay are a matter for the Parties and should strike an appropriate balance between the interest of public service employees and the provision of efficient and adequate levels of public services, taking into account any constraints on the Exchequer. There is no simple formula for balancing these competing pressures, particularly as these pressures tend to shift and vary over time.

Chapter 3: Recruitment and Retention: The Context

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Recruitment and Retention: The Context

3.1 Introduction

This chapter considers international challenges in healthcare recruitment and retention, having regard to the trends and research in other jurisdictions. This chapter also provides an overview of experiences in the principal countries to which Irish healthcare staff tend to migrate, i.e. the UK, Canada, the US and Australia. The chapter also focuses on the nurse, midwife and doctor experience and summarises the responses and measures taken in these countries to improve recruitment and mitigate staff loss. A number of comparative case studies are included at Appendix F.

3.2 National and International context

Global Perspective

In order to draw upon international evidence, the Commission reviewed a range of publications. Much of this research articulates the broadly held view that many countries have insufficient numbers of health professionals to deliver essential health services with the World Health Organisation (WHO) indicating that nurse, midwife and doctor shortages will escalate into the future. In this regard global and regional health workforce demand is expected to increase in the coming decades as a consequence of population and economic growth combined with demographic, epidemiological and other factors.

The WHO (2013) report A *Universal Truth: No Health without a Workforce* reported a worldwide shortage of 7.2 million healthcare workers which is expected to increase to 12.9 million by 2035. Nurses and midwives account for nearly 50% of the world's 44 million health workforce. The report went on to identify several key causes including an ageing health workforce, staff retiring or leaving for better jobs and not being replaced, and not enough people entering the profession or being adequately trained. Increasing demands are also being put on the sector by a growing world population, with increased incidence of non-communicable diseases such as cancer, heart disease and stroke and increased complexity of healthcare in an ageing population. Internal and international migration of health workers is also exacerbating regional imbalances.

The findings from the international literature review undertaken by the Commission include the following:

- Over 45% of countries have less than one doctor per 1,000 population. Ireland had 2.9 doctors per 1,000, the USA, Canada and UK had between 2.7 and 2.8, while Australia had 3.5 doctors per 1,000 population in 2015. The OECD average was 3.3 per 1,000 population;
- The European Commission (2012) estimated a potential shortfall of around one million health workers in the EU by 2020;
- Recent studies on the migration of health professionals have shown several high-income countries to be dependent on foreign workers in order to avoid shortages of qualified health workers. In England up to 35% of registered physicians are foreign-trained, with countries such as Oman, the United Arab Emirates and Saudi Arabia having much higher levels of dependence (above 80%). In the United States shortages of 500,000 nurses and 44,000 family physicians are forecast by 2025. Japan is also experiencing shortages and projects that the domestic supply of physicians will not overcome deficits until 2036. The Australian Bureau of Statistics reports that the country relies heavily on migrant doctors and nurses. Health Workforce Australia projects a reduced supply of up to 109,000 nurses by 2025.

- Countries with a lower income level have also started recruiting abroad; in June 2013, Brazil launched a programme to recruit 6,000 physicians and other healthcare professionals.

Ireland Overview

With a population of 4.8 million (CSO, 2016) and a health workforce of over 120,000, Ireland is a relatively small player in the international healthcare labour force. The Department of Health, however, concludes in its November 2017 report *Working Together for Health* that due to this country's highly regarded educational standards, and English as a first language, Irish healthcare staff are in high demand internationally and consequently have a high level of mobility.

Nurses and midwives are mainly recruited immediately after graduation in Ireland. As detailed in Chapter 6, an estimated 12% of public health service nurses and midwives are foreign nationals. While there has been an increase in the number of nurses employed over recent years, some specialist areas with relative shortages have been brought to the attention of the Commission. These shortfalls are being addressed by focused external recruitment and an expansion of training places.

A Department of Health report, *Health in Ireland Key Trends 2017* cited Eurostat data on life expectancy, showing that in 2015 life expectancy for males was 79.6 years and 83.4 years for females. With an increase in life expectancy and an associated increase in healthcare demand Ireland, in common with other advanced economies, is also experiencing a rise in the burden of chronic disease.

A HSE (2016) report, *A Health Behaviour Change Framework and Implementation Plan for Health Professionals in the Irish Health Service,* indicated that approximately 38% of Irish people over 50 years have one chronic disease with 11% having more than one. Chronic disease accounts for 80% of all GP visits and 60% of hospital bed days. As the number of older people increases, the number of people with chronic disease will pose a particular challenge for public healthcare.

Future of Healthcare Provision

In 2016, the Dáil Committee on the Future of Healthcare was established with the goal of achieving cross-party political agreement on the future direction of the public health service, and devising a ten year plan for reform. The resulting *Sláintecare Report* outlines an agreed vision and strategic plan to transform the Irish public health service and concludes that the Irish health service is currently not providing the population with fair or equitable medical care.

The *Sláintecare Report* found that a critical change is required in developing workforce planning and strategies to recruit and retain staff whilst disentangling public and private care. One of the eight fundamental principles of the report is the provision of an enabling environment by developing a health service workforce that is appropriate, accountable, flexible, well-resourced, supported and valued. In this context, high quality workforce planning is required to meet current and future staffing needs, and measures to ensure that public hospitals and all service provision units become an attractive place to work for experienced, high quality staff. The main recommendations relating to the recruitment and retention of the health workforce are:

- The HSE and the Department of Health must develop their integrated workforce planning capacity so as to guarantee that sufficient numbers of well-trained and well-motivated staff are deployed in a targeted way to deliver care in the most appropriate care setting, and that the Irish health service becomes a place where people feel valued and want to work. This will require the re-training of existing staff in many cases to ensure capabilities for integrated care;
- The staff recruitment should take place at regional level, or at a more local level if practicable and in conjunction with local clinical managers; and
- The recruitment of hospital consultants and NCHDs should be to Hospital Groups rather than to individual hospitals, as part of meeting the medical staffing needs of smaller hospitals.

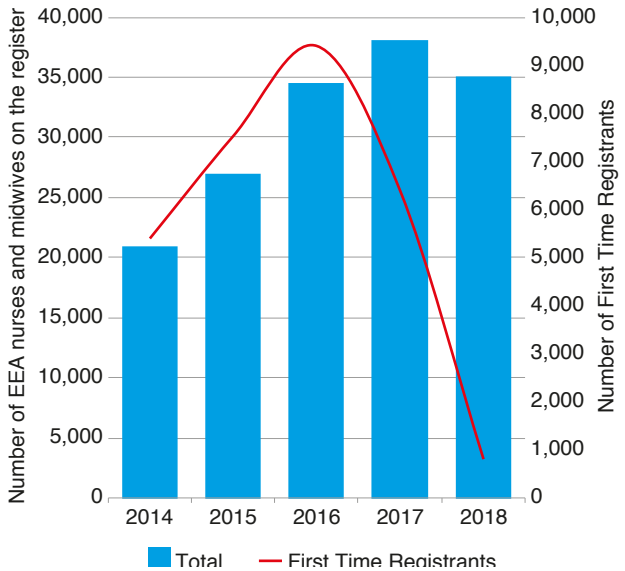
Implications of Brexit

Ireland has close cultural ties with the UK and remains an important trading partner. While there is a lack of clarity on the conditions that will apply when the UK leave the EU, there is consensus that Brexit is likely to have a negative impact on the UK and Irish economies.

A 2018 National Health Service (NHS) briefing paper to the House of Commons indicates that EU citizens account for around 10% of doctors and 7% of nurses in the UK. As the UK exits from the EU there is potential for restrictions on the free movement of people. In this context, medical workforce movement between Ireland and the UK, and between the EU member states and the UK, is likely to change.

Evidence suggests that the supply of EU nursing staff to the UK is in decline as a result of Brexit. The proportion of European Economic Area (EEA) nurses and midwives on the UK Nursing and Midwifery Council's register has declined from 5.5% in 2017 to 5.1% in 2018. Figure 3.1 shows that year on year EEA nurse and midwife registrations has fallen from 6,382 to 805 and the overall total of EEA nurses and midwives has dropped from 38,024 to 35,115. It is possible that some of these have been applying to join the register in Ireland, given that data from the Nursing and Midwifery Board of Ireland (NMBI, 2016) indicates applications have increased from 1,045 in 2013 to 4,323 in 2016.

Figure 3.1: EEA Nursing and Midwife Registrations in the UK, March 2014 - March 2018



Source: Nursing and Midwifery Council, UK

3.3 Workforce Mobility

Causal Factors

The motivations underpinning international migration are multi-faceted. Extrinsic factors such as the opportunity to travel, experiencing new cultures and other lifestyle choices have just as much bearing as the more well-known intrinsic factors of personal development, improved terms and conditions, a better work environment, increased remuneration, career development and progression.

The motives behind the migration of health professionals are varied. A 2017 Royal College of Surgeons (RCSI) study on trainee doctor emigration reported large-scale dissatisfaction with working, training and career opportunities in Ireland. This report pointed to systemic factors that need to be addressed by national health workforce planners if Ireland is to retain and benefit from a motivated medical workforce.

Demand, Mobility, Migration

Workforce mobility generally has become commonplace at both national and international level, with healthcare workers particularly in demand given their scarcity across the globe. Our healthcare staff typically choose to migrate to the UK, Australia, Canada, and the USA. These countries have significantly larger health services than Ireland, most have ongoing or emerging recruitment or retention difficulties and some have predicted significant increased future demand for these professions.

The joint employer submission stated that countries which attract Irish nurses and midwives have considerably higher turnover rates than Ireland's 6.8%, with the UK and Australian turnover rates at 15%, Canada at 20%, the US at 27%.

The attractions offered by these countries to our graduate nurses, midwives and doctors may include enhanced career development potential, better working conditions and opportunities. For some health professionals a period working abroad is often considered a requirement for career advancement. Whether such migration is permanent or temporary varies between individuals.

Brugha *et al.* (2018) showed that over 40% of NCHDs are considering migration following speciality training. There is however some evidence of declining numbers of nurses emigrating with 1,343 Certificates of Current Professional Status[1] (CCPS) verifications issued from the NMBI in 2017, down from 2,180 requests in 2007.

While many Irish trained staff choose to work abroad, there is also a significant inflow to the public health service of staff trained from other countries. Between 30%-40% of doctors are International Medical Graduates (IMGs) and as referenced earlier, over 12% of nurses and midwives are foreign nationals.

An RCSI study of factors influencing doctor migration concluded that in a globalised world, where medical graduates have a highly portable qualification, countries such as Ireland need to achieve better working and training conditions if they are to retain their medical graduates. The study also noted that Irish trained doctors have high levels of dissatisfaction and poor experiences with working conditions, training and career opportunities in comparison with the expected benefits of working abroad (Clark *et al*., 2017).

A recent RCSI study (Walsh and Brugha, 2017) articulates the need for effective measures to achieve medical workforce sustainability and suggests strategies to include better working conditions, shorter and more flexible working terms and conditions including equitable salary levels, improved access to training and research opportunities and a clearer career path. Such themes are repeated in much of the current literature (and indeed sentiment from the research/interviews carried out on behalf of the Commission). This study also considers that given the level of turnover, international recruitment is not an effective strategy for the long-term and that many of those recruited are leaving Ireland as a result of slow or stagnant career progression leading to de-skilling and onward migration. The issues with NCHD career development and progression are noted by the Commission.

In respect of nurses and midwives, the INMO/SIPTU Agreement to provide all Irish graduates with a permanent contract may encourage more graduate nurses to stay in Ireland.

3.4 Initiatives/Responses

The Commission's review of research on the international context has also identified some policy responses intended to retain healthcare workers. Common to all the approaches is the holistic, multi-channel suite of initiatives that are necessary to address these difficulties in today's globalised labour market.

The Irish public health service has been proactive in its response to the difficulties being experienced in the recruitment and retention of nurses, midwives and doctors. There are in this regard a number of common threads in successful national and international responses to recruitment and retention difficulties which include the development of inclusive leadership, strong welcome/onboarding programmes for newly qualified health professionals, career development, mentorship and coaching in order to maximise employee potential and embeddedness.

There are also a number of successful national and international recruitment and retention initiatives aimed at identifying and embedding a successful and sustained retention culture, independent of remuneration. Some of the measures employed are outlined below:

- The development of an inclusive leadership culture which, *inter alia,* actively promotes and markets the service;
- Recruitment to values to get the appropriate people into the organisation;
- Providing a mentoring system for new starters;
- Improving staff engagement by conducting staff surveys, developing action plans, sharing ideas and introducing drop in clinics to enable staff to explore development opportunities;
- Providing high quality training for recruitment managers;
- Monitoring staff morale and providing additional support where necessary;
- Retaining staff within the organisation by facilitating internal transfers to another speciality outside of normal recruitment procedures;
- Providing career coaching and guidance; and
- Reviewing exit surveys to identify common themes that require intervention.

Appendix G has more detailed examples of successful international recruitment and retention strategies.

1 CCPS are required to prove professional status by registration authorities in the destination country

3.5 Summary

Healthcare skills are in short supply globally and all indications are that such shortages will continue. The Commission acknowledges migration as an option for many healthcare professionals, particularly young graduate nurses, midwives and doctors. The exit of highly trained, professional nurses, midwives and doctors remains a significant, undesirable loss to the public health service, even if some trends would appear to indicate a proportional decline in demand for certificates required to work abroad. Given the significant financial investment by the State in the education and training of nurses and doctors it is increasingly important that strategies are developed and implemented to ensure that the medium to long-term value of that investment is retained for the benefit of the Irish public health service.

The motivations behind migration include taking a year out, securing an appropriate career path, improved working conditions, and a permanent lifestyle choice. Pay is not the only push or pull factor. Given the many reasons for migration, a multi-faceted approach to recruitment and retention is necessary. The countries that our graduates are going to are experiencing their own supply problems; the Commission's research shows that initiatives implemented in these countries are holistic and multifaceted in their response. The Commission is of the view that any and all responses put in place in the Irish health service should mirror the integrated approaches being adopted internationally.

The Commission acknowledges the continued growth in domestic supply and the need to retain these staff. It is acknowledged that the HSE has implemented a range of initiatives, detailed throughout this report to improve the ongoing experiential development and growth of its nurses, midwives and doctors. The Commission strongly believe that these responses need to continue in parallel with programmes that encourage the re-entry of Irish trained nurses, midwives and doctors into the public health service.

The principal of self-sufficiency taken in tandem with mobility trends and migration requires policy makers to engage with all of these factors. It is not in the Commission's view that it is sufficient to only fill vacancies, the Commission believes that the employer needs to embrace the full spectrum of issues in relation to retention to ensure that roles are sufficiently attractive, that individual potential is maximised and staff are valued and developed.

As a signatory to the *WHO Global Code of Practice on the International Recruitment of Health Personnel,* Ireland is obliged to be self-sufficient in its production of healthcare workers to the extent that it does not encourage the inward migration of healthcare workers. While Ireland appears to be training sufficient doctors the data available to the Commission suggests that the extent of trainee doctor migration and the increased number of IMGs conflict with this commitment. It is the Commission's view that a more optimum balance is required between the retention of Irish trained doctors and the recruitment of IMGs if the WHO commitment is to be realised.

As outlined earlier in this chapter it would appear that Brexit may have already had some effect on the number of EEA nurses choosing to work in the UK. However, the depth and persistence of this effect will depend on the conditions under which Brexit ultimately takes place.

The Commission notes the *Sláintecare* Report and its recommendations for an expanded and greater integrated workforce to include allied health professionals, nurses and doctors; the importance of addressing recruitment and retention issues of all healthcare staff and the development of integrated workforce planning which is also emphasised in the report.

Chapter 4: International Pay Comparisons

Chapter 4:
International Pay Comparisons

4.1 Introduction

The Commission's Terms of Reference provide that it may be asked to consider *"a comparison of rates for identifiable groups within the public service with their equivalents in other jurisdictions, particularly where internationally traded skillsets are required, having due regard to differences in living costs".*

As discussed in Chapter 3, the skillsets of the groups considered by this report are internationally transferable and relevant stakeholders submitted to the Commission that remuneration rates for nurses, NCHDs and consultants in the public service in Ireland are relatively unattractive in a competitive international marketplace. There are also reports of global shortages in skilled health workers. In this context, the Commission determined that it was worth providing evidence on international pay relativities in this report.

International pay comparisons are infrequently undertaken, in part because they are technically complex and it is difficult to achieve comparability. Various judgements and methodological assumptions have to be made. Previously the Review Body on Higher Remuneration in the Public Sector expressed reservations about the use of international pay comparisons, and considered that differences in matters such as remuneration structures in other jurisdictions could call into question the validity of comparisons across countries (Review Body on Higher Remuneration in the Public Sector, 2009). The pay setting mechanisms and pay rates which apply to public servants in other countries are necessarily rooted in each jurisdiction's own particular social, administrative and economic context. However, the Review Body, in its final report, concluded that whilst international pay comparisons raise many challenges, engaging suitable experts to take into account, and appropriately adjust for, relevant differences between countries mitigates against many of these challenges.

Due to the complexities of developing robust international pay comparisons, the Commission considered it appropriate to engage suitable consultancy expertise to carry out a detailed study which would take into account, insofar as possible, relevant differences between the countries covered by the study. Accordingly, the Commission engaged Treacy Consulting/Willis Towers Watson (TC/WTW), following a competitive procurement process.

4.2 Background and Methodology

In its first Report, the Commission considered Irish public sector earnings compared to the EU15 countries (excluding Greece) and European Free Trade Association (EFTA) countries. That report referenced Eurostat's Structure of Earnings Survey (SES) data to make earnings comparisons on an indicative basis across sectors. Notwithstanding its limitations, which were specified in the report, the Commission considers the SES as the most reliable published source of data for international earnings comparisons, as *"robust and comparable statistics on international earnings, particularly outside of the EU, are compromised by methodological differences"*. A similar approach was not feasible for this report, as most of the countries of interest for this phase (Australia, Canada and the United States of America) are outside of the EU and EFTA and hence are not encompassed within the Eurostat SES data. In addition, there is a requirement to examine comparative pay data for particular roles for this report, rather than at sectoral level. The Commission was also cognisant that it is not appropriate to compare gross basic salaries for common roles across countries, as it is necessary to ensure that comparisons across national boundaries are made on a more like-for-like basis. At a minimum, gross remuneration rates need to be adjusted for relevant differentials in income tax, social insurance, and purchasing power.

Comparator Countries

The countries chosen for comparison were the UK, Australia, US and Canada, based on information provided by relevant stakeholders and in submissions to the Commission. Both nurses and doctors registered in Ireland generally require a CCPS, if they intend to apply for nursing, midwifery and medical positions in other countries[1]. Accordingly, a further determinant of the host location for nurses was information derived from an analysis of CCPS from the NMBI, which gives an indication of the trends in intended destination of nurses and midwives who are planning to work abroad.

Groups Covered by the Research

Within the time period available to the Commission, it was not possible to conduct a full international benchmarking exercise encompassing detailed job evaluation and survey of all of the nursing and midwifery, NCHD and consultant grades in the public service in Ireland, and internationally. A research specification of this scale was not considered necessary to contextualise and generally compare public sector earnings for the Module 1 groups with their equivalents in the relevant comparator destinations. This analysis does not extend to a comprehensive like–for-like or job evaluation exercise of international comparators, due to the variations in health systems, qualification requirements, career paths and time taken to progress through grades and pay ranges across the host locations; rather it considers the competitiveness of pay and certain conditions of employment (e.g. annual leave) vis-à-vis other countries.

Accordingly, the Commission concluded that the international pay comparison research in respect of nurses and midwives, NCHDs and consultants should be confined to grades where identifiable comparable positions existed in other countries, and where reliable data was available in respect of those grades.

Table 4.1: Nursing and Midwifery Requests for Certificates of Current Professional Status: Popular Destinations, 2007 - 2016

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Australia	753	2588	1744	382	1162	748	619	337	324	463
Canada	152	277	397	161	160	131	117	69	51	48
New Zealand	41	53	61	49	40	51	33	10	32	23
UAE	1	3	2	7	7	16	29	92	79	94
UK	156	268	622	819	719	710	916	706	524	442
US	109	83	84	77	102	69	59	60	10	102

Source: NMBI, PSPC workings

The UK, Australia, the US, Canada, the United Arab Emirates and New Zealand were the six most frequently specified destinations in CCPS applications to the NMBI in recent years as shown in Table 4.1.

The countries which were specified in submissions to the Commission as destinations for doctors emigrating from Ireland were the US, Canada, Australia, the UK, New Zealand and the Gulf States. The UK, Australia, the US, and Canada were selected as countries which were relevant comparators for all of the groups considered by this report.

1 Equivalent information was not available for doctors, as the application process to the Medical Council for a CCPS did not record intended destination country until 2018.

Research Specification

The specification for this research required TC/WTW to undertake independent research and report on the total remuneration package (i.e. basic salary and all benefits including pension, allowances, overtime and bonus payments) and standard contracted full-time working hours for jobholders in equivalent roles to new entrant and newly appointed nurses, NCHDs, and consultants in the health service with reference to the UK, Australia, Canada, and the US. TC/WTW prepared a written report, *Pay and benefits for Nurses, Non-Consultant Hospital Doctors and Consultants – International Data.* An outline of the approach, methodology, research and findings are set out in this chapter. The full report can be found on the Commission's website at https://paycommission.gov.ie/.

Approach to Comparisons

Host Locations

All four of the countries reviewed were of a scale where different regional labour markets and taxation systems apply. Thus, the selection of the host location, at country or region level, was further refined by TC/WTW. A host location in each country was selected as a comparator where there was access to robust publicly available information on the nature of the roles in the relevant grades and pay and benefits data applicable to those grades. The rationale for the selection of the host locations is as follows:

- **US** - North Central was selected as the host location for the US due to the robustness of the not-for-profit data set available through the WTW *Health Care Compensation Survey Report, 2017.*
- **Canada** - two host locations were selected, Ontario and British Columbia, as there was evidence that both had significant populations of internationally qualified nurses and doctors.
- **Australia** - Victoria was selected as the host location for Australia, as Melbourne is a high density location with good quality accessible data and Australia has minimal regional pay differentials.
- **UK** - The UK also has minimal regional pay differentials, excluding London which is dealt with separately in the report. England was selected as host location in the UK on the basis that it had the most up-to-date accessible public pay data, and historically there is a longstanding tradition of Irish qualified nurses working in England.

For those countries where only one host location was selected (i.e. UK, Australia and US) an analysis of overall regional pay differentials for each of the groups is presented in the report, in addition to the host location findings.

Primary and Secondary Comparators

TC/WTW reviewed the qualification requirements for the relevant grades, referencing information and advice obtained from the Medical Council, the Royal College of Surgeons of Ireland (RCSI) and the NMBI. TC/WTW identified specific grades at early career points which provided suitable primary comparators as follows: Staff Nurse, Senior House Officer (SHO) and Hospital Consultant. In relation to more experienced career points for nurses and NCHDs, the levels of Registrar and Clinical Nurse Manager II/Clinical Nurse Specialist were identified as secondary comparators. However, due to the differences in career paths across locations, this data is presented for information purposes only and should not be used for comparative purposes.

Adjustments to Gross Basic Remuneration

The analysis of gross basic pay data in the report includes adjustments for local taxes, social insurance and OECD Purchasing Power Parity (PPP) indices together with an overview of allowances and other non-pay benefits. Further detail in relation to the methodology employed by TC/WTW is available in their full report on the Commission's website at https://paycommission.gov.ie/.

4.3 Research Findings

The findings of the research concerning each of the groups under consideration are outlined in this section.

Summarised Findings - Nurses

- The public service pay rate in net hourly terms for new entrant Staff Nurses in Ireland tends to be lower than the rates in other markets. New entrant Staff Nurses are highest paid in the US, followed by Canada, Australia, Ireland and the UK.
- As shown in Table 4.2 the net hourly rate, adjusted for PPP, for new entrant Staff Nurses in Ireland is €12.10; this is approximately 1% higher than the rate in the UK. The report found that the PPP adjusted net hourly rate in Ireland is considerably lower than in Australia, Canada and the US, representing just 78% of the net hourly rate for Australia, 67% of the net hourly rate for Canada and 55% of the net hourly rate for the US.
- The contracted working hours per week in Ireland (39 hours) are lower than the US (40 hours), but higher than Australia (38 hours) and the UK and Canada (both 37.5 hours).
- New entrant nurses in Australia and the UK have 35 days leave (i.e. annual leave, service leave and public holidays) two more than their counterparts in Ireland (33 days). Leave entitlements in the US and Canada are the least competitive at 31 days, and 27 days respectively.
- Overtime arrangements in Ireland compare favourably with the UK and US but are less generous than Australia and Canada.
- Ireland is competitive relative to other markets in terms of security benefits such as pension, maternity leave, sick leave and long-term disability benefits.
- There is some evidence of recruitment and retention incentives in the UK and US for nurses, but evidence from the UK suggests that the usage of certain incentives for nurses is not widespread and has declined in recent years.

Table 4.2: International Comparison of Pay, Working Hours and Leave for Staff Nurse

Remuneration Definition	Irish public service (€,000)	UK (England) 1 April, 2018		Australia (Victoria) 1 April, 2018		United States (North Central) 1 April, 2017		Canada (Ontario) 31 March, 2018	
		(€,000)	Compa-ratio	(€,000)	Compa-ratio	(€,000)	Compa-ratio	(€,000)	Compa-ratio
Annual gross basic pay data converted to euro	28.8	26.3	109%	42.3	68%	52.9	54%	42.9	67%
Gross basic pay adjusted for PPP	28.8	28.2	102%	44.4	65%	59.4	48%	46.1	62%
Net hourly rate adjusted for PPP	12.1	12.0	101%	15.5	78%	22.1	55%	17.9	67%
Standard contracted hours (working week)	39.0	37.5	104%	38.0	103%	40.0	98%	37.5	104%
Annual leave (incl. service days) plus public holidays	24+ 9 days	27+ 8 days	↓	25+ 10 days	↓	23+ 8 days	↑	15+ 12 days	↑

Source: Treacy Consulting/Willis Towers Watson

Summarised Findings - NCHDs

- The public service pay rate in net hourly terms for new entrant SHOs in Ireland tends to be lower than the rates in other markets. New entrant SHO equivalents are highest paid in Australia, followed by the US, Canada, Ireland and the UK.
- As shown in Table 4.3, the net hourly rate adjusted for PPP for new entrant SHOs in Ireland is €16.40; this is approximately 7% higher than the rate in the UK. The report found that the PPP adjusted net hourly rate in Ireland is 92% of the net hourly rate for Canada, 88% of the net hourly rate for Australia and 81% of the net hourly rate for the US.
- The contracted working hours for SHOs in Ireland (39 hours) are lower than the US (40 hours), but higher than Australia (38 hours) and the UK (37.5 hours). Information was not available in respect of contracted working hours in Canada.
- New entrant SHO equivalents in Australia and the UK have 35 days leave (i.e. annual leave, service leave and public holidays), two more than their counterparts in Ireland (33 days). Leave entitlements in the US and Canada are the least competitive (both 31 days).
- Overtime arrangements in Ireland for new entrant SHOs compare favourably with their equivalents in the UK, the US and Canada but are less generous than in Australia.
- Ireland is competitive relative to other markets in terms of security benefits such as pension, maternity leave, sick leave and long-term disability benefits.
- There is some evidence of recruitment and retention incentives in the UK and US, but evidence from the UK suggests that the usage of such incentives is not widespread and has declined in recent years.

Table 4.3: International Comparison of Pay, Working Hours and Leave for Senior House Officer

Remuneration Definition	Irish public service (€,000)	UK (England) 1 April, 2018		Australia (Victoria) 1 January, 2018		United States (North Central) 1 April, 2017		Canada (Ontario) 1 July, 2018	
		(€,000)	Compa-ratio	(€,000)	Compa-ratio	(€,000)	Compa-ratio	(€,000)	Compa-ratio
Annual gross basic pay data converted to euro	43.5	35.2	124%	52.2	83%	47.7	91%	44.4	98%
Gross basic pay adjusted for PPP	43.5	37.8	115%	47.9	91%	53.5	81%	47.7	91%
Net hourly rate adjusted for PPP	16.4	15.3	107%	18.5	88%	20.2	81%	17.8	92%
Standard contracted hours (working week)	39.0	37.5	104%	38.0	103%	40.0	98%	N/A	N/A
Annual leave (incl. service days) plus public holidays	24+ 9 days	27+ 8 days	↓	25+ 10 days	↓	23+ 8 days	↑	20+ 11 days	↑

Source: Treacy Consulting/Willis Towers Watson

Summarised Findings - New Entrant Consultants

- The public service pay rate in net hourly terms for new entrant consultants in Ireland is competitive relative to the UK and Australia, although it is important to note that in the UK there is scope for a further uplift due to the payment of Clinical Excellence Awards. new entrant consultants in Canada are paid slightly more than new entrant consultants in Ireland, while new entrant consultants in the US are paid a significantly higher rate than in all other markets.
- As shown in Table 4.4, the net hourly rate adjusted for PPP for new entrant consultants in Ireland is €40.40 and the report also found that this is approximately 22% higher than the rate in the UK. The report found that the PPP adjusted net hourly rate in Ireland is lower than Australia, Canada and the US, representing 89% of the net hourly rate for Australia, 75% of the net hourly rate for Canada and 54% of the net hourly rate for the US.
- The position in respect of contracted working hours per week for new entrant consultants in Ireland is competitive relative to all other markets. The contracted hours for new entrant consultants here (37 hours) are lower than the US (40 hours), Australia (38 hours) and the UK (37.5 hours). Information was not available for Canada.
- Ireland is also the most competitive country in respect of leave days for new entrant consultants. Leave days for new entrant consultants are highest in Ireland (40), followed by the UK (37 days) and Australia (35 days). The leave entitlement in the US was found to be the least competitive for new entrant consultants (31 days).
- Ireland is competitive relative to other markets in terms of security benefits such as pension, maternity leave, sick leave and long-term disability benefits.
- There is some evidence of bonus payments/ incentives in the UK and US.

Table 4.4: International Comparison of Pay, Working Hours and Leave for Hospital Consultants

Remuneration Definition	Irish public service (€,000)	UK (England) 1 April, 2017		Australia (Victoria) 1 January, 2018		United States (North Central) 1 April, 2017		Canada (Ontario) 31 March, 2016	
		(€,000)	Compa-ratio	(€,000)	Compa-ratio	(€,000)	Compa-ratio	(€,000)	Compa-ratio
Annual gross basic pay data converted to euro	134.3	87.5	154%	151.1	89%	203.3	66%	157.7	85%
Gross basic pay adjusted for PPP	134.3	94.0	143%	138.5	97%	228.3	59%	169.2	79%
Net hourly rate adjusted for PPP	40.4	33.0	122%	45.6	89%	74.7	54%	53.7	75%
Standard contracted hours (working week)	37.0	37.5	99%	38.0	97%	40.0	93%	N/A	N/A
Annual leave (incl. service days) plus public holidays	31+ 9 days	29+ 8 days	↓	25+ 10 days	↓	23+ 8 days	↑	N/A	N/A

Source: Treacy Consulting/Willis Towers Watson

4.4 Trends in Emigration

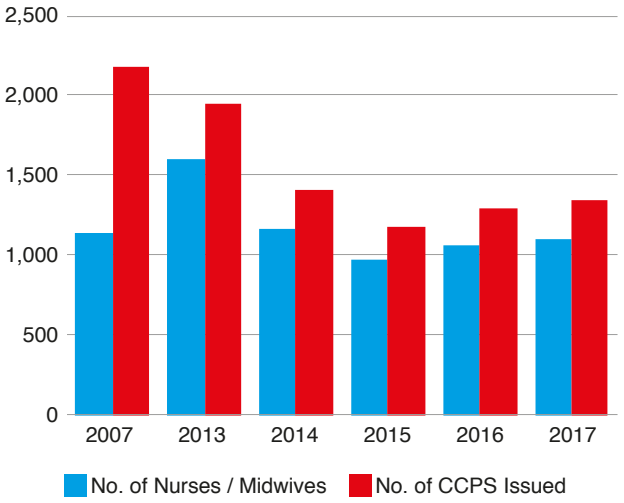
It was submitted to the Commission that remuneration rates for nurses, NCHDs and consultants in the public health service in Ireland are relatively unattractive in a competitive international marketplace and that accordingly these categories of public servants are emigrating to work overseas in English-speaking countries where salary levels are more attractive. To examine this issue further, the Commission has carried out an analysis of trends in emigration.

Nursing and Midwifery Intention to Leave

As already noted, nurses and midwives employed in Ireland generally require a CCPS from the NMBI, if they intend to apply for nursing and midwifery jobs in other jurisdictions. In the absence of centrally collated and analysed data from exit interviews, the number of CCPS issued can be used as a proxy for the number of nurses and midwives who intend to find employment abroad. As nurses and midwives can request multiple CCPS for different destinations, information is available for both the number of verifications issued and the number of nurses and midwives who received CCPS. This is illustrated in Figure 4.1.

It should be noted that not all of those who apply for CCPS will emigrate, although, as there is a cost attached to the application process, it would seem unlikely that the variation between the number of nurses who apply for CCPS and the number of nurses who emigrate would significantly differ. The number of nurses who received CCPS in 2007 was 1,140, this number peaked at 1,596 in 2013. The number of nurses making applications in 2017 was 1,096, or 3.9% less than in 2007.

Figure 4.1: CCPS Verifications Issued 2007, 2013 - 2017



Source: NMBI, PSPC workings

NCHD and Consultant Intention to Leave

CCPS trends can also can be used as a proxy for the number of doctors who intend to find employment abroad. It is not possible to disaggregate the applications to the Medical Council for CCPS into NCHD and consultant applications, or by the number of doctors making applications. Table 4.5 outlines the annual total number of CCPS issued from 2012 to 2017[2]. An overall increase of 14.7% in the number of CCPS issued between 2012 and 2017 (2,099 and 2,407 respectively) is observed. However, as the number of doctors on the Medical Register increased by 24.6% over the same period, it is the case that the number of applications proportionately decreased for this cohort.

A doctor may apply for a CCPS and may subsequently decide against emigrating. Another caveat is that some competent authorities require a CCPS for purposes other than seeking registration; e.g. the General Medical Council in the UK seeks a CCPS for a doctor who is seeking to withdraw from its Register and who holds registration in another jurisdiction. Doctors can also maintain registration in more than one country concurrently, provided they comply with the relevant competent authority's retention of registration procedures.

2 The Medical Council could not provide data in respect of CCPS issued for earlier years.

Table 4.5: Certificate of Current Professional Status Annual Numbers, 2012 - 2017

	2012	2013	2014	2015	2016	2017
Certificate of Current Professional Status	2,099	2,030	1,795	1,881	2,624	2,407

Source: Medical Council

4.5 Conclusions

The Commission has considered the findings of the TC/WTW report. While it is mindful of the shortcomings of these sorts of international comparisons, the Commission notes some indicative findings from the research. The public service pay rate in net hourly terms for new entrant Staff Nurses and new entrant SHOs in Ireland tends to be lower than rates in the comparator countries. Rates for new entrant consultants in Ireland are competitive relative to the UK and Australia but new entrant consultants in Canada are paid slightly more, and new entrant consultants in the US are paid a significantly higher rate than their equivalents in Ireland.

Ireland is competitive relative to all other markets under consideration in terms of security benefits such as pension, maternity leave, sick leave and long-term disability benefits.

The weekly contracted hours for new entrant nurses and new entrant SHOs (both 39 hours) are lower in Ireland than in the US (40 hours) but are slightly higher than in Australia (38 hours) and the UK (37.5 hours). Information was not available for Canada, except in the case of new entrant nurses, with contracted working hours of 37.5 hours per week. The position in respect of contracted working hours per week for new entrant consultants (37 hours) in Ireland is also competitive relative to all other markets. Differences in working hours were taken into account when making net pay comparisons.

Annual leave for new entrant nurses and SHOs in Ireland is not significantly out of line with other markets (33 days), although it is two days less than Australia and the UK. Ireland is the most competitive country in respect of leave days for new entrant consultants who have 40 days, with the least competitive being the US (31 days).

There is some usage of recruitment and retention incentives in the UK and US, but evidence from the UK suggests that the usage of certain incentives is not widespread and has declined in recent years.

Additionally, the Commission has not identified any satisfactory method which could be used for estimating a monetary value for non-pay benefits in one jurisdiction compared to another.

The Commission is of the view that, notwithstanding the finding that the Irish public service net hourly rate for new entrant Staff Nurses is not as competitive as other markets, current pay rates do not appear to be unduly affecting the numbers of nurses applying to work abroad, as the number of nurses making CCPS applications in 2017 was marginally less than the corresponding number in 2007, however there has been a slight increase in the number of nurses applying since 2015.

Notwithstanding the caveats around the interpretation of relevant Medical Council CCPS data, the number of doctors who intend to leave Ireland to work abroad may have increased in the period since 2012. It is not possible to break down trends in CCPS applications by grade or identify the number of actual applicants. The number of CCPS applications as a proportion of doctors registered on the Medical Register decreased marginally between 2012 and 2017 (11.5% to 10.6%). In general, pay rates for new entrant NCHDs and new entrant consultants tend to be lower than the rates available in the other countries studied.

The Commission remains of the view expressed in its first Report, that remuneration is not the only issue impacting on recruitment and retention, where difficulties exist. There are a wide range of other relevant factors when making comparison with equivalent employment roles for these groups in other countries, such as, pressurised work environment, provision of Continuous Professional Development (CPD), paid study days, clinical support and ability to offer a more attractive work environment. These other factors are considered in the next chapter in greater detail.

Chapter 5: Causal Factors Impacting Recruitment and Retention

Chapter 5:
Causal Factors Impacting Recruitment and Retention

5.1 Introduction

The Commission's first Report considered the issue of recruitment and retention in the public service, and concluded that there were certain problems in that regard in the Irish public health service.

The Commission's Terms of Reference require it to further consider these difficulties in recruitment and retention and the causal factors that contribute to such difficulties amongst the groups identified. In undertaking this module, the Commission conducted an extensive literature review to identify general causal factors impacting on recruitment and retention internationally, and specific to the health sector. This chapter also discusses some of the international evidence on the relative importance of reward and other characteristics of employment in affecting recruitment and retention in a healthcare context.

In addition the Commission conducted a survey and structured interviews of nurses and midwives, NCHDs and consultants in relation to recruitment and retention. Details on the methodology and limitations are provided in Appendix C and the full study is available on the Commission's website at https://paycommission.gov.ie/.

This chapter summarises the Commission's findings from its literature review. The first section considers labour market factors. The next two sections focus on a range of mainly non-pecuniary factors in the form of policies and practices that influence recruitment and retention, and the factors that affect retention in healthcare services. The Commission will also occasionally reference singular quotes garnered during the interviews where there inclusion is informative.

Finally the chapter includes some concluding observations.

5.2 Labour Market Factors

When individuals make decisions about whether, how much and where to work they are influenced by labour market conditions. The standard economic description of people choosing how much labour to offer (Mankiw and Taylor, 2014) involves potential workers making a set of linked decisions:

- Should I take up employment or do something else?
- If I am going to take up employment, how much of my time should I spend working?
- Given the jobs on offer and my personal circumstances and preferences, which job and employer suit me best?

The answers to these questions may well depend upon one another. For example, if a person places a high value on flexible working times for personal reasons, lack of flexible working arrangements could rule out some employers. Equally, if no jobs currently on offer are sufficiently attractive, some people will take up outside options such as additional education or home working. Others may continue to search for a period of time, remaining unemployed until a better match is available.

A similar set of choices faces those currently in employment. Labour market conditions may affect whether some employees leave a given employer to work for a different firm, leave the country or exit employment altogether.

If the attractiveness of different types of employment or employer varies, the remuneration required to attract and retain staff may also vary. These *"compensating differentials"* could be affected both by aspects of the work and the working environment. A dangerous or unpleasant job might attract less labour supply than a safe or fulfilling one, unless remuneration or other beneficial terms and conditions compensate for the differences.

Employers also need to consider labour market conditions when deciding how many people to employ and setting remuneration, terms and conditions. There are trade-offs here as well. Increasing remuneration is likely to attract more staff by encouraging more people to take up work, to offer more hours, and by making the particular employer or profession more attractive relative to others. However, employers normally want to get the best possible output/cost combination from their labour inputs. The costs are obviously affected by pay rates, but also potentially by other characteristics of working environments.

Labour markets balance the preferences of actual and potential employees for better remuneration and conditions with employers' objectives of economising on labour costs and delivery of services. Where collective bargaining is in place or where the government is the main employer in a sector, some aspects of the market mechanism are managed through institutions. However even in these cases the supply of labour is likely to be affected by market conditions in various ways; for example to the extent that those in an occupation have the option of working abroad, in the private sector or leaving the labour force.

A central question that arises in the context of the matter now under consideration is the relationship between labour market conditions and difficulties that may exist in respect to recruitment and retention. If too few potential candidates are applying for posts or not taking up offers (a recruitment problem) or staff are leaving employment at an abnormally high rate (a retention problem) this could imply either that policies and practices affecting recruitment and retention are inefficient or that labour demand has risen relative to supply. The appropriate policy responses depend upon the relative importance of these explanations.

If policies and practices do not offer the whole explanation for recruitment and retention difficulties, labour market factors may also be at play. In this regard, it is noted that most health service employers are currently trying to increase staffing levels. This implies that demand for labour in this sector is rising, and according to the evidence presented in Chapter 3, it seems likely to continue to do so for some time. To meet this demand, the supply of labour with the relevant skills will also need to grow, whether in the form of new entrants to the healthcare labour force, attracting staff from outside the public health service or from overseas.

In practice, increasing pay may or may not be the most effective option for an employer that wishes to attract more staff. Sometimes making the overall employment proposition more attractive may be more effective than a simple pay increase. It is also possible that pay increases and other improvements in conditions may reinforce one another in improving the relative appeal of an employer. What combination of these measures would be most efficient depends upon market circumstances.

5.3 Recruitment Policies and Practices

Recruitment is an important function of human resource management fulfilling the essential purpose of drawing potential human capital into an organisation. The importance for every organisation, public or private, of employing the right person for the right position in an effective manner is well documented. Careful attention must be paid to the first step of an organisations *"hire to retire"* process in order to attract and secure a quality workforce with the skills the organisation needs to deliver on its objectives and plans. Some key aspects of an effective recruitment process are listed in Boxes 5.1 and 5.2.

Box 5.1

Key Steps in Effective Recruitment (1/2)

HR Management: An employer must first implement workforce planning and forecasting to determine the optimum number of employees and the necessary skill sets required while ensuring alignment with the organisation's strategic requirements.

Policy: Recruitment policies must be fair, rigorous and transparent and assist managers to determine the best approach.

Timing: Where a recruitment process is lengthy there is a danger of a preferred candidate securing a job in another organisation; in a recent UK/CIPD survey 52% of public sector organisations surveyed believe that the length of the recruitment process has led to a loss of potential recruits.

Policy of Competitors: To gain competitive advantage organisations may need to develop policies that differentiate them from competitors.

5.4 Research Findings - Perceptions of Recruitment Process

Nurses, midwives, NCHDs and consultants were surveyed by Research Matters Ltd, on the Commissions behalf, on their perception of the efficiency and fairness of the recruitment process and their job expectations. The full report is available on the Commission's website at https://paycommission.gov.ie/.

A summary of responses in relation to their perception of the recruitment process for each grouping is presented below and further details are provided in chapters 6, 7 and 8. The Commission notes that the response rate for this survey appears to have been low (estimated at 9.7% to 13%), which indicates that the results may reflect a group with different views or preferences from the generality of the nurses, midwives, NCHDs and consultants working in the Irish public health service. The results, which are set out in this chapter and in a number of other chapters in the report should be treated as indicative only.

Recruitment Process

In general, all grades indicated a moderate to high level of satisfaction with the recruitment process. The most positive aspect of the recruitment experience was the interview process. The least positive aspect, from the perspective nurses, was the induction received on commencing the job. Consultants were least satisfied with the administrative element of the recruitment process, in particular the number of different structures or organisations involved and NCHDs were least satisfied with the administrative process in respect of pay.

Job Expectations

Nurses, midwives, NCHDs and consultants also reported a moderate to high match between job expectations and experiences. Respondents to the survey were most satisfied with their expectation regarding their job responsibilities.

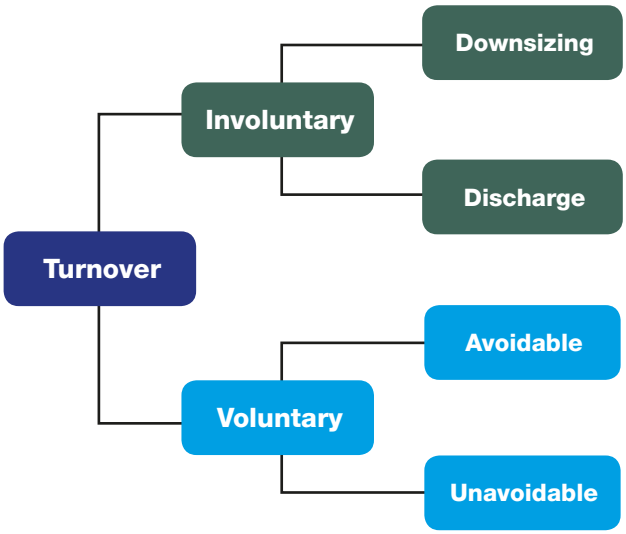
5.5 Retention Policies and Practices

This section considers retention difficulties which can develop and are influenced by a multiple range of factors and can place increased demands on an organisation and its workforce.

The principal purpose of an organisation's retention policy is to prevent the loss of effective employees from the organisation. Once a workforce is in place with the skills needed, the organisation should be working on diminishing the potential for turnover by putting effective strategies in place that both develop and retain this valuable resource. A high level of staff turnover can have very significant impacts on productivity and service levels. Therefore, once an individual is recruited into an organisation where a high level of retention is preferred, it is necessary for that organisation to implement effective retention strategies.

Types of Difficulties: Employee retention focuses on keeping or encouraging employees to remain in an organisation for the optimum, maximum period (Bidisha and Mukulesh, 2013). Retention difficulties are generally labelled turnover difficulties and are grouped under two distinct categories, involuntary and voluntary turnover (Hayes *et al.*, 2006; Heneman and Judge, 2009). Figure 5.1 represents the different categories of turnover.

Figure 5.1: Classification of Reasons for Staff Turnover



Source: Heneman and Judge, 2009

Voluntary Turnover: Voluntary turnover arises when an employee exercises their own choice to leave. Unavoidable voluntary turnover occurs outside of the organisation's control (e.g. retirements, death in service and ill health retirements). Avoidable turnover, which is the primary focus of the Commission, is turnover which could potentially have been prevented by organisational factors such as career development, training or more autonomy in a specific role.

Involuntary Turnover: Involuntary turnover refers to severance from employment by way of discharge where the employee was willing to continue performing services (Naveh and Erez, 2004) or where the employer ceases employment due to discipline and/or job performance difficulties; this is also referred to as functional turnover and can be used to address poor performance (Stovel and Bontis, 2002).

Box 5.2

Key Steps in Effective Recruitment (2/2)

Onboarding: By providing a positive experience at the beginning of an employment relationship, employees become more engaged, turnover is reduced and productivity increases. Strategies include pre-start correspondence, employees accessing a buddy/mentor to help them assimilate into their new role and work environment and ongoing one to one contact with their HR manager.

Organisational and Job Image: The job seekers perception of the employer will matter more in attracting high quality candidates than marginal differences in pay. This is especially true in early recruitment stages where potential applicants will have a rudimentary knowledge of the job and organisation.

Selection Process: It is crucial to identify the appropriate selection methods for the needs of the organisation, have professionals in the hiring team, and to follow up on the selection process in order to identify what worked well and what can be improved upon. Selection techniques can include a combination of structured interviews, references, intelligence/personality tests, and consideration of work experience and educational qualifications.

Impacts of Employee Turnover

Specific types of turnover are unpreventable and, in some cases turnover is considered necessary. However, should a significant number of performing employees choose to leave an organisation there can be substantial impacts.

Negative impacts associated with turnover can include (Gray and Phillips, 1996; Shields and Ward, 2001; Cavanagh and Coffin, 1992; Finlayson *et al*., 2002):

- Reduction in productivity and quality of service;
- Loss of organisational knowledge;
- Increased workload;
- Direct replacement costs[1];
- Increased levels of absenteeism; and
- Additional turnover.

1 Turnover costs have been estimated to range between 0.75 to 2.0 times the salaries of the employee that left (McConnell, 1999).

Potential positive impacts from a small level of turnover can include:

- New employees bring new ideas, creativity and innovation; and
- A reduction in the number of poorly performing employees.

5.6 Relative Importance of Factors for Retention in Healthcare Services

The Commission has considered a large number of reports and journal articles in developing an understanding of the drivers of recruitment and retention, with a particular focus on healthcare staff. Key among the themes from the published material is that employee commitment is determined by a cluster of factors (Fitz-enz, 1990). The Institute of Employment Studies (Robinson, Perryman and Hayday, 2004) points out that key drivers of employee engagement are a sense of feeling valued and involved with components such as decision making, the extent to which employees can voice their ideas, the opportunities employees have to develop their role and the extent to which an organisation is concerned for employees' health and well-being. A short discussion of these factors follows and quotes from the structured interviews are provided where relevant:

Culture: A contributory factor to voluntary turnover is organisational culture. Management have a significant impact in developing a desirable working culture within an organisation. A nurse in the structured interviews spoke about the *"culture of fear"* in relation to the potential to forget to administer medicines. Additionally, the level of colleague and social support impacts an organisation's culture (Lafer *et al*. 2003; Heinen *et al*, 2012).

Communication: Organisations with strong communication strategies can induce lower turnover rates (Labove, 1997). When employees understand the issues that impact their working environment they feel more involved, more comfortable in their position and less likely to leave. A doctor who participated in the structured interviews noted *"Every issue can be solved with communication…but whether its morale, or hierarchy, or errors … 90 plus percent of that is communication".*

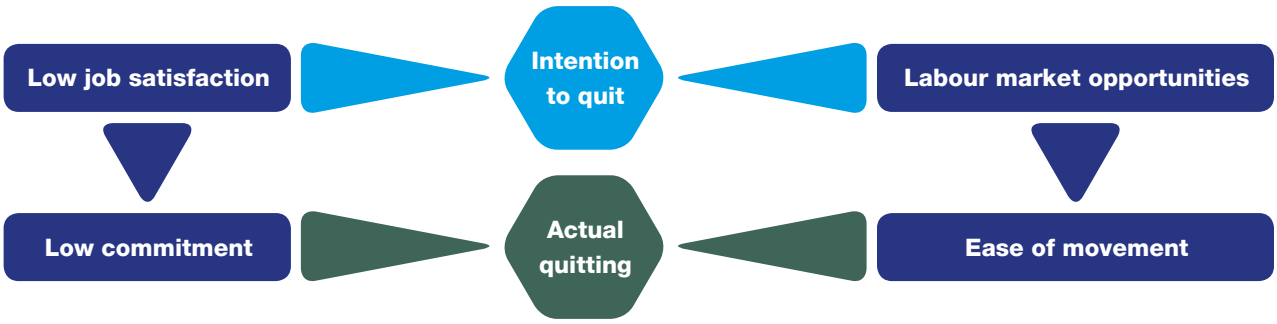
Embeddedness and Commitment: Organisational embeddedness describes the forces which influence 'stay or leave' decisions with regard to fit, structural ties and relationships both within and outside an organisation (Allen, 2006; Mitchell *et al*., 2001; Mitchell, Holtom and Lee, 2001). A good example from the interviews with module 1 grades is where one participant said *"I set up this service and I'm quite loyal to the team and so I would be reluctant to leave".* Embeddedness has been identified as an accurate predictor of turnover (Holtom and O'Neill, 2004). Off-the-job embeddedness, which keeps an individual within their current geographical area, has been found to decrease turnover, especially among women (Zatzick and Iverson, 2006).

Management and Social Support: The behaviour of management is directly correlated to employee retention (Andrews and Wan, 2009), participative leadership being key (Duffield and O'Brien-Pallas, 2003; Kroon and Freese, 2013). A significant level of negative feeling about management was raised in the structured interviews. One participant suggested *"Never have I been asked by any manager: "What can we do for you to improve the service to the patients?" I admit that I have developed over time less and less respect for management, after disappointment after disappointment by small and large managers."*

Work Environment: A flexible atmosphere and an environment where working experience is enjoyed and resourced adequately is an essential factor in employee retention (Alexander *et al.*, 1998; Spence Laschinger *et al*., 2009; Wood *et al*., 2013). The interviews with nurses and midwives found that there is *"significant stress"* and *"huge pressure"* within their wards.

Burnout: Professional burnout may be indicative of a malfunctioning system or organisation stemming from underlying working conditions (Poghosyan *et al.*, 2010). Hindrance stressors e.g. organisational politics, situational constraints, role conflict, and role overload, were found to lead to lower job satisfaction, lower organisational commitment, more withdrawal behaviours, higher turnover intentions, and higher turnover (Cavanaugh *et al.*, 2000; Podsakoff, LePine and LePine, 2007). However, challenge stressors e.g. time urgency and pressure to complete tasks can have positive effects on job attitudes resulting in less turnover (LePine, Podsakoff and LePine, 2005). One participant in the nurses and midwives structured interview stated *"Most nurses that I know can deal with a stressful day, or a stressful week … a stressful working life is not something that's sustainable".*

Figure 5.2: Relationship between Job Satisfaction, Commitment and Intention to Quit



Source: Winterton (2004).

Employee Recognition: Appreciation is a fundamental human need. Employees respond to the recognition of their good work because it confirms their value to their organisation. In recognising good performance an employer or manager is acknowledging that an individual's contribution is valued. A large number of studies over the past 20 years have shown recognition as the key to employee engagement. Research across various sectors confirms that employees that receive regular praise are more productively engaged, more likely to stay with their employer and the organisations receive higher loyalty and satisfaction scores from customers. For recognition to be most effective, it must however be relevant and specific.

Learning and Development: By providing learning and development opportunities, employers can influence the number of employees that will want to remain (Deery, 2008; Christensen Hughes and Rog, 2008). This has shown to be a relevant issue for healthcare staff in the structured interviews, with one participant suggesting that *"The quality of training is hugely important".*

Career Growth: Employees must also be able to see a clear career path in the organisation to increase the likelihood of the employee remaining (Bagga, 2013; Arnold, 2005). Influential factors are advancement plans, internal promotion and accurate career previews (Prince, 2005) which should not only focus on career progression but also on lateral movement (Torrington and Hall, 1998). In the structured interviews, a number of doctors raised the issue of clear career paths and the promotional opportunities in other countries.

Job Satisfaction: Job satisfaction is the feeling of fulfilment a person gets from their job. Organisational success is dependent on the participation of all employees with the organisation playing a role in the job satisfaction equation. One example of this from the Commission's research is where a participant said *"I enjoy what I do … just really enjoy my work, and I enjoy my job and I give it my all".*

Low job satisfaction is unlikely on its own to lead to quitting (Smith, Oczkowski and Selby Smith, 2008), but can lead to reduced organisation commitment which can subsequently develop into retention difficulties, particularly where there are similar opportunities elsewhere (see Figure 5.2).

Reward: Reward is important in both retaining and motivating employees to perform effectively and efficiently towards achieving organisational goals (Gardner, van Dyne and Pierce, 2004). The following comment was made by an Irish health service participant in the structured interviews, *"I think you should never underestimate the powerful sense that people get when they feel they're appropriately paid".* However, extrinsic reward on its own does not constitute an important retention factor, improved pay could only increase retention in the short term. Some research has found that providing additional reward in response to retention difficulties can have undesired side effects and may cultivate a mind-set of threatening to leave as a shortcut towards a pay increase.

Job Design: When employees are satisfied in their role they give their best in delivering organisational targets and personal goals (Hackman and Oldham, 1975). Job design typically refers to the way that tasks are set, or a role is structured. Jobs that contain positive behavioural elements such as skill variety, task identity, task significance, autonomy and feedback contribute to employee's satisfaction (Sageer, Rafat and Agarwal, 2012). In the structured interviews, nurses, midwives and NCHDs have highlighted negative impacts of carrying out what they consider to be extraneous and peripheral duties that they feel are more appropriate for other grades.

Job Fit: The level of compatibility with an organisation, group and job (Cable and DeRue, 2002) is positively related to organisational commitment (Verquer, Beehr and Wagner, 2003) and negatively related to intention to leave, i.e. the worse the fit the higher the turnover rate (Kristof-Brown, Zimmerman and Johnson, 2005). Group fit, which refers to the

attractiveness of the group to its members and to which the members feel they belong (Cartwright and Zander, 1953) is effective in moderating the negative effects of stress exposure and increased fatigue and burnout (Li *et al*., 2014). Job fit, which focuses on the interpersonal compatibility between individuals and their specific job (Judge and Ferris, 1992) also has strong correlations with job satisfaction and commitment and intention to leave (Kristof-Brown, Zimmerman and Johnson, 2005).

Gender: In general female employee turnover rates are higher than male turnover rates (Uludağ, Khan and Güden, 2011; Karatepe *et al*., 2006). In sectors with a growing female participation such as the medical workforce (Canadian Health Human Resources Network, 2013) different approaches to resource planning, including flexible working arrangements and incentivised structures, may be necessary to both recruit and retain this cohort. One doctor suggested that that *"If we have better flexible training, then we'd retain more".*

5.7 Conclusions

In considering the literature on recruitment and retention, it is apparent to the Commission that both internal and external drivers of recruitment and retention are multifactorial. In general it is likely to be a combination of factors that influence a person to consider, apply and take up a post in any organisation including the health service, and equally it is likely to be a combination of factors which will influence either an intention to leave or an actual exit from the organisation.

It is also apparent to the Commission that the suite of factors are neither totally extrinsic such as reward, continuing training and working conditions but that intrinsic factors such as job satisfaction, recognition and progression are also relevant.

Labour market forces play an important role when individuals make decision about whether, how much and where to work. The extent to which the Irish public health service is experiencing recruitment and retention problems, can indicate a mismatch between labour demand and supply and/or it may indicate problems with processes and policies associated with recruiting or retaining staff. The most efficient mix of policies to address such problems will depend upon the relative importance of these factors and the responsiveness of recruitment and retention to the potential set of policy measures.

Recruiting employees to provide services is an essential business requirement. It is the view of the Commission that in seeking to employ the best candidates the employer should be constantly examining the external and internal recruitment factors. External focus should include analysing and collating data on the supply and demand for candidates with the required skill sets and actively managing the promotion of the organisation as the 'employer of choice'. Internally the employer should be monitoring and forecasting resource requirements, developing appropriate recruitment policies and evolving onboarding processes. An employer who is constantly monitoring relevant internal and external recruitment factors and developing recruitment processes is likely to secure better employees, ultimately provide better services to customers and is more likely to retain their employees.

The Commission reiterates its finding from its first Report with regard to the importance of talent management and considers that a renewed emphasis and prioritisation of talent management within a workforce planning framework is needed along with specific, targeted responses including a focus on improved selection techniques, onboarding and learning and development. Improved outcomes should be rooted in multi-discipline engagement of institutional stakeholders, managerial collaboration and strong executive support.

The basic purpose of retention policies is to prevent the loss of performing employees. Job design is important because it delves into the core dignity of an employee having a variety of challenging and significant tasks which can be meaningfully progressed, with autonomy and feedback to improve their effectiveness. Linked to this is the interpersonal comparability between the individual and the organisation, group and job which has strong correlations with job satisfaction and intention to leave.

The evidence suggests that employers should provide an adequately resourced and flexible environment where the working experience is enjoyable. Staff recognition supports job satisfaction and embeddedness by acknowledging that individual and/or team efforts are appreciated and is a potent, positive management communication technique.

The evidence from the Commission's review of labour market and other causal factors confirms its belief that recruitment and retention difficulties, when they arise, are due to the combination of a number of factors and that approaches developed and implemented to mitigate such factors must also be holistic in nature.

Chapter 6: Nurses and Midwives

Chapter 6: Nurses and Midwives

6.1 Introduction

The Terms of Reference for the Commission are set out at the start of this report. In line with the Terms of Reference this chapter will consider recruitment and retention trends for nurses and midwives, one of the cohorts identified in the Commission's first Report as experiencing some recruitment and retention difficulties.

The chapter first provides a summary of issues raised in submissions made to the Commission concerning the recruitment and retention of nurses and midwives. An analysis of nursing and midwifery employment is provided for the years 2007 and 2013 to 2017. Specific shortages or gaps within nursing and midwifery are identified. This analysis proved challenging due to the limited nature of data received. Recruitment is then considered, focusing on supply, the recruitment process, application data, recruitment challenges and initiatives. This is followed by key findings from the survey and structured interviews in relation to nursing and midwifery recruitment.

Retention is examined through an analysis of available turnover data and the reasons why nurses and midwives leave. Certain retention initiatives and challenges are also considered. This is followed by the key findings in the survey regarding retention. Finally, the chapter sets out concluding observations.

6.2 Issues Raised with the Commission by the Parties

The Commission received a number of submissions with regard to matters related to nursing and midwifery recruitment and retention. The Commission also met with a range of stakeholders to hear their views and to fully understand the issues raised. The following section summarises the views and background data presented by the stakeholders to Module 1. All submissions received are available on the Commission's website at https://paycommission.gov.ie/submissions/.

Joint Employer Submission

Pay

The joint employer submission asked the Commission to note that over €1.1 billion is committed through the PSSA for the unwinding of FEMPI, which represents a significant level of investment in public service pay.

The submission stated that, when account is taken of the incremental credit earned for the nine month placement taken as part of their final year curriculum, the effective pay for first year nurses and midwives is €30,178. It was submitted that this is favourable when compared to average starting pay of Irish undergraduates in 2016/2017, reported as €28,554.

Numbers

The joint employer submission calculated that, when adjusted for increases in agency staff and Health Care Assistants (HCAs) and combined with longer working hours, the 2017 WTE nursing and midwifery total of 39,767 has marginally decreased (0.4%) compared to 2007 (39,592). Since 2013, 14 of the 18 grades have experienced growth in WTEs employed. At an individual hospital level, almost 90% of hospitals have increased nursing and midwifery WTEs since 2013 and just over 40% of hospitals have increased WTE numbers since 2007. With regard to CHOs, over half have increased nursing numbers since 2013, however nearly 90% remain below 2007 levels. In the context of staff numbers generally, the submission contended that Ireland has comparatively more nurses per capita than most OECD countries and the EU average.

Impact on Services

The joint employer submitted that there is a funded plan to increase bed capacity by 2,600 beds in acute hospitals and an additional 4,500 community beds in the coming years. This increase follows the *Health Capacity Review 2018* which projects a significant growth in demand for services across the primary, acute and social care settings. The *Health Capacity Review* also identifies that reform of current service delivery arrangements is essential if the increased demand for healthcare services is to be effectively addressed.

Nursing and Midwifery Board of Ireland Registrations

The joint employer further submitted that available data on recruitment indicated that supply of nurses and midwives is increasing. It pointed out that NMBI registrations have been increasing since 2014, the increase being driven by the recruitment of EU and non-EU nurses. The joint employer submission expressed an expectation that Irish qualified nurse registrations will increase in the coming years due to a 17% increase in total training places available since 2015. The submission also quotes CAO data which indicates that nursing and midwifery courses remain very popular with 2.9 first preference applicants for every place available.

Turnover

The submission argued that HSE turnover of 5% in 2017 (6.8% including retirements) is low. The 5% rate may overstate the true position as it is not currently possible to isolate data on nurses moving within the public health service. Even so, the joint employer argues that this rate compares favourably to the UK where turnover, it states, was at 15% in 2017. A 2014 academic paper referenced in the submission reported turnover rates of 44.3% in New Zealand, 26.8% in the US, 19.9% in Canada and 15.1% in Australia. Domestic research from Ibec shows a comparative figure of 7.2% for Irish companies in 2016. The employer submission also pointed out that requests for CCPS by registered nurses to the NMBI, which are required for nurses to practice abroad, have halved between 2011 and 2017.

Initiatives

The submission detailed a number of recruitment and retention initiatives introduced since 2015:

Pay

- Increased pay for student nurses (2016);
- Restoration of Community Allowance for Mental Health Nurses (2016);
- Derogation from normal pay policy rules for Psychiatric Nurses re-employed in the public health service (2016); and
- 36 weeks incremental credit for student placement (2016).

Agreements

- Emergency Department Agreement (2015/2016);
- PNA/Mental Health Nursing Workplace Relations Commission (WRC) agreement (2016); and
- INMO/SIPTU Recruitment and Retention Agreement (2017).

Recruitment

- International staff recruitment (2015);
- Permanent contracts to be offered to all graduating nurses and midwives within a Hospital Group or CHO;
- Additional undergraduate places; and
- Additional promotion posts (120 Advanced Nurse Practitioner (ANP) and 127 Clinical Nurse Manager (CNM) 1).

Other

- Career Break Scheme (available to all nurses with a minimum of 1 years' service);
- Sponsorship programme for Public Health Nurses (140 places);
- Retention working group established across Hospital Groups and the Office of Nursing and Midwifery Services Director (ONMSD); and
- Leadership programmes provided by the ONMSD.

Specialist Roles/Tasks

The submission pointed out that there has been an increase in the number of specialist roles (e.g. Advanced Midwife Practitioners (AMP) and Clinical Nurse Specialists). There has also been an increase in the number of HCAs employed. The joint employer also detailed the introduction of additional payments to nurses and midwives in exchange for the transfer of certain tasks which were previously the responsibility of NCHDs.

Staff Side Submission

Pay

In their submissions the staff side argued that Irish nurses and midwives work longer hours in comparison with nurses in Canada, the UK and Australia. It maintained that Staff Nurses in Ireland are paid significantly less than allied health professional colleagues working in the same hospitals and community care areas, although both are educated to the same level. The submissions noted that in the UK, nurses are recruited at the same level as therapy grades (e.g. Physiotherapist, Occupational Therapist and Speech and Language Therapist). By contrast in Ireland, in pay terms, a nurse is treated as a lesser professional than therapy grades. They stated that this results in a diminution of status for nursing and exacerbates recruitment into the profession.

The staff side noted that increases in nursing and midwifery numbers had not resulted in a reduction in HSE agency nursing expenditure which has increased by 85% since 2007 (agency nursing expenditure has increased from €54 million in 2007 to €100 million in 2017). Agency nurses are paid a similar wage to directly employed nurses. However, their net pay is higher as they are not liable to pension contributions and PRD deductions applicable in the public health service.

The INMO summarised its preferred solution to the Commission in the following terms - *"don't ignore the fact that all measures except pay have been tried and failed."*

Numbers

The staff side submitted that all nursing and midwifery grades are experiencing recruitment difficulties. Current nursing WTE numbers are below 2007 levels and have not recovered to the same extent as other grades. The submission also asserted that the ESRI report published in October 2017 supported a minimum increase of 25% in the nursing and midwifery workforce over the next five years. They indicated that shortages continue to exist for ANPs (e.g. intensive care) and registered nurses (e.g. cardiovascular care, intellectual disability care). Additionally, it was submitted that the 2017 number of Psychiatric Nurses was 7.3% below the service need identified by the HSE. In an international context, the submission noted that there is an international shortage of nursing staff, with Australia predicting a shortage of 110,000 nurses by 2025.

Impact on Services

The staff side submitted that the demographics of the nurse population, such as age of staff (65% over 40), maternity leave (3-4%) and changes in care models that require a higher number of staff, are impacting on the level and quality of services. According to the staff side, Ireland, as is the case with most developed countries, suffers from an acute shortage of nursing professionals. It was submitted that, based on research commissioned by the PNA and carried out by the RCSI in 2016 and a Barnardos' survey, staff shortages were the main obstacle in the implementation of the Government policy for mental health, as set out in the *Vision for Change* policy paper.

Nursing and Midwifery Board of Ireland Registrations

The staff side submitted that, in common with other countries, the Irish public health service is significantly dependent on overseas recruitment. They state that the number of newly registered nurses from outside of Ireland on the NMBI register for 2016 was 2,119.

Turnover

On the matter of retention, the staff side noted that the turnover rate for Staff Nurses at 7.9% was higher than other nursing grades (3.4% to 5.8%) and that in a predominantly female profession maternity leave should be factored into workforce and recruitment plans. The staff side also commented that 65% of HSE nurses are over the age of 40 and 31% are over the age of 50, many of whom have a retirement age of 60. Furthermore, the staff side drew attention to the INMO/SIPTU agreement with the employer which provided for a target of 1,224 additional WTEs by the end of 2017. At the end of 2017 an additional 847 nurses, excluding student nurses, had been employed.

Initiatives

The staff side submitted that nurses play a critical role in providing access to care not only in traditional settings such as hospitals and long-term institutions, but increasingly in primary care and in-home care settings. They highlighted recommendations made

by the WRC in August 2016 which provided for initiatives around career/training opportunities and work practices.

Other

The submissions referred to what the staff side regard as organisational deficiencies in the management of nursing and midwifery resources. Reference was made to the RN4Cast National Report for Ireland (2013), which provides a description of the nursing operational environment in Irish acute hospitals. According to the staff side, these deficiencies include the absence of a formal annual appraisal review with managers, the need for a revision of staff training, the absence of an annual professional development review, the absence of adequate financial support for professional development and training, and adequate study leave support for this purpose.

Directors of Nursing Oral Submission

A number of Directors of Nursing from different areas of the public health service provided supplementary information to the employer data request, in their capacity as managers, as agreed with the Commission. It was submitted that there are difficulties recruiting for senior management nursing and midwifery roles (CNM 3, CMM 3, Assistant Directors and Directors of Nursing). This was attributed to the current arrangements whereby grades above CNM 2 and equivalent do not receive premium and allowance payments, resulting in junior roles receiving higher pay than senior nursing managers.

It was further submitted that banding of hospitals, which determines pay levels of Assistant Directors and Directors of Nursing and Midwifery, can result in nursing managers with lower levels of responsibility receiving higher pay relative to nursing managers with greater responsibilities. An example was cited where a Director of Midwifery in a Band 2 hospital responsible for more than 8,000 births annually received lower pay than a Director of Midwifery in a Band 1 hospital with less than 4,000 births annually.

It was also submitted that retirements and emigration were the primary reasons for nurses and midwives leaving employment. It was suggested that this was not attributable to a lack of training opportunities as there is sufficient funding available for postgraduate studies. Comparisons were made with international pay levels for nurses and midwives as well as domestic allied health professionals. It was submitted that internationally recruited nurses were leaving their roles because of the high cost of living and insufficient pay, and that Brexit did not impact on Irish trained nurses relocating to the UK.

6.3 Employment Trends

Key Findings:

- Nursing and midwifery WTE numbers declined by 13.4% (5,238 WTE) between 2007 and 2013.
- Between 2013 and 2017, nursing and midwifery numbers have increased at an annual average rate of 2.2% per year, and at 2017 were 5.7% (2,229 WTE) below 2007 levels.
- The proportion of nurses and midwives working in the community sector has declined from 44.1% in 2007 to 40.3% in 2017.

Information on recruitment transactions and details of transitions out of employment over time are probably the most directly relevant sources for assessing the presence of recruitment and retention difficulties. When looking at recruitment, one would ideally like to know the number of approved posts by grade and location, the number of these that were advertised, how many applications were attracted, the number of interviews that resulted and the posts that were filled or left vacant. Regarding retention, the rate of departures by grade, age band and reason (e.g. retirement) over time would be an important indicator. With information such as this on the flows into and out of employment over time and across the public health service, it would be possible to relate the times and places where difficulties were most acute to patterns in the possible causes of difficulties.

While the Commission sought such information, it was not generally available within Ireland's public health service. Much of the information provided by both the employers and representative groups relies on broader indicators such as trends in staff numbers, turnover rates or evidence on staffing adequacy. Such indicators can be impacted by recruitment and retention difficulties but are also influenced by other factors in complicated ways. This section discusses some of the available information for the nursing and midwifery professions.

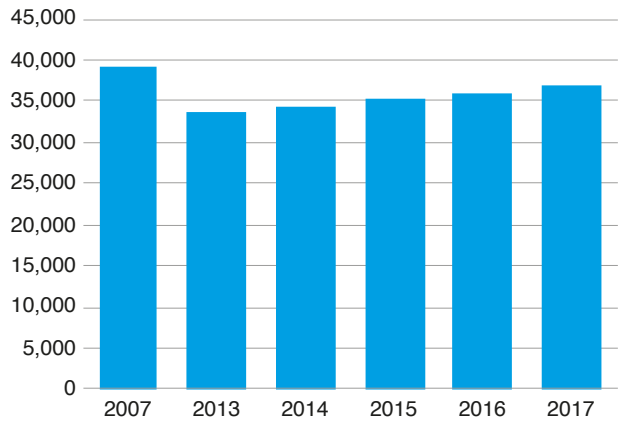
Trends in Nursing and Midwifery Numbers

This analysis is based on the HSE reported WTE numbers of nursing and midwifery at year end for 2007 (when reported numbers were highest) and from 2013 to 2017 (which includes the period since the moratorium on recruitment and promotion ended). The Commission notes that the joint employer submission made adjustments to the reported number by including the contribution of HCAs, agency nurses and longer working hours. However, the Commission believes that for its purposes, the reported WTE number is a more appropriate basis for analysis. At the end of 2017, nursing and midwifery grades made up 33.2% of the total workforce employed in the Irish public health service.

Figure 6.1 presents the evolution of reported WTE aggregate nursing numbers at year-end for the years 2007 and 2013 to 2017. Over this six year period numbers declined by 13.4% (5,238 WTE) illustrating the impact of the moratorium on recruitment. Since 2013 numbers have increased steadily by an average of 2.2% per year (752 WTE), but at 2017 year-end remained 5.7% (2,229 WTE) below the 2007 peak.

While increases in staff numbers indicate that some successful recruitment has taken place since 2013, without corresponding information on the number of approved or advertised posts during these years the Commission cannot rule out the possibility that employers sought to take on a higher number of staff but were hindered by recruitment difficulties and/or budgetary constraints. These totals may also have been affected by variations in retention, e.g. a large number of staff being recruited in a given year but this increase being substantially offset by departures.

Figure 6.1: Trends in Reported WTE Nursing and Midwifery Numbers, 2007, 2013 - 2017



Source: HSE

Analysis by Grade

For many grades, comparing 2007 WTE with 2017 figures is complicated by the changing career structure of the nursing and midwifery professions. For example, the ANP and AMP, are recently introduced grades in the public health service. Furthermore, the ANP grade has been prioritised for expansion in recent years and the number of WTE has more than doubled since 2013. As a result of this structural change, comparisons between 2007 and later years for these grades are distorted.

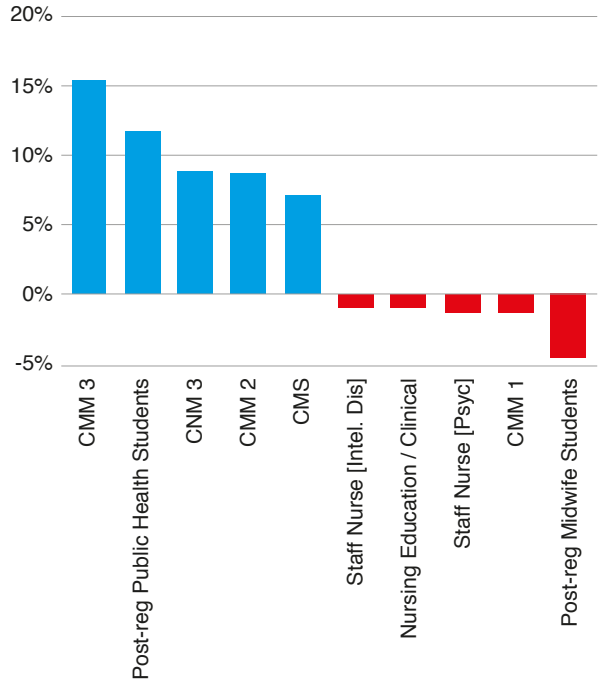
In absolute terms, General/Children Staff Nurses (+350 WTE per year) and the CNM 2 (+153 WTE per year) grades experienced the largest average annual increase over the previous four years. The Psychiatric Staff Nurse (-42 WTE per year) and Intellectual Disability Staff Nurse (-14 WTE per year) grades recorded the most significant average annual declines between 2013 and 2017.

Figure 6.2 illustrates the grades with the five largest[1] rates of increase and decline in proportionate terms. CMM 3, CMM 2 and Clinical Midwife Specialist (CMS) rank first, fourth and fifth of the grades with the largest proportionate increase, in contrast, the post-registration midwifery students that represent a proportion of the supply for the Staff Midwife grade shows the largest rate of decline over the 4-year period (-4.4%).

Appendix G to this report includes, at Table G.1, further detail on the evolution of nursing and midwifery WTE numbers by grades.

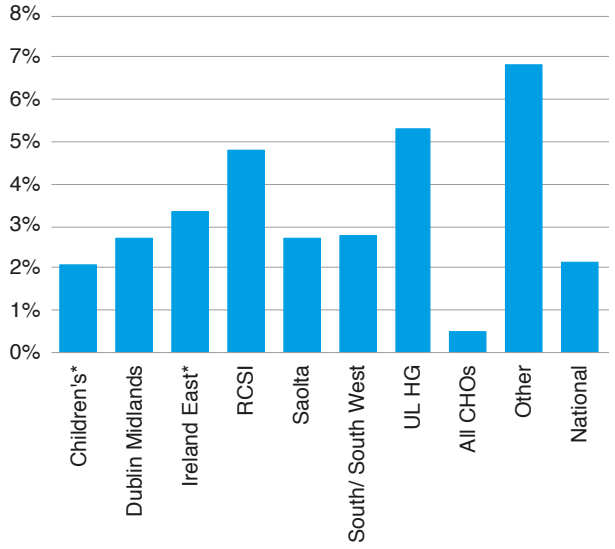
1 This analysis excludes the Advance Nurse Practitioner and Advanced Midwife Practitioner grades, as these are new grades with disproportionate rates of increase.

Figure 6.2: Nursing and Midwifery Grades with Largest Average Annual Rate of Change, 2013 - 2017



Source: HSE

Figure 6.3: Nursing and Midwifery WTE Average Annual Change by Hospital Group and CHO, 2013 - 2017



**Prior to 2014, Tallaght Hospital reported staff numbers as one unit. However from 2014 onwards, staff employed in the paediatric services are reported in the Children's Hospital Group and staff employed in other areas are reported in the Ireland East Hospital Group. To improve comparability over the years, pro rata adjustments were applied to both these Hospital Groups.*

Source: HSE

Divergence between the Acute Hospital Sector and Community Healthcare Organisations

Numbers employed within the acute hospital sector declined by 11.4% (2,459 WTE) between 2007 and 2013 but have increased annually at an average rate of 3.3% (659 WTE) since then. This strong growth has resulted in the like-for-like nursing and midwifery numbers working in acute hospitals being 0.8% (178 WTE) higher at end 2017 than the previous peak in 2007.

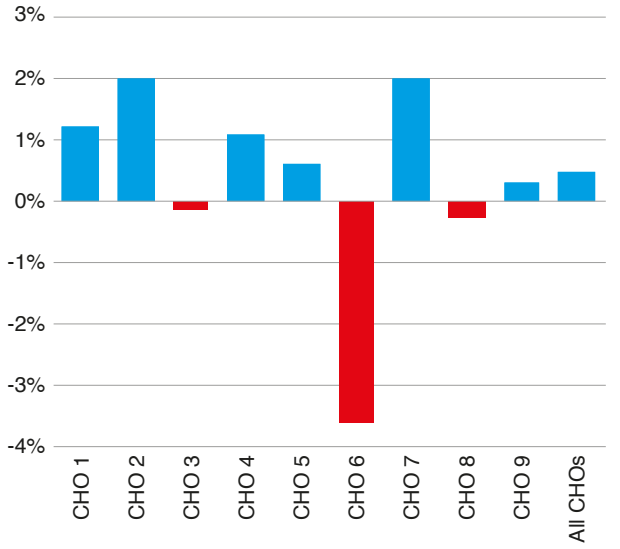
The CHO[2] sector experienced a relatively greater decline in nursing numbers during 2007 to 2013 than the acute hospital sector at 15.2% (2,587 WTE). Recovery since 2013 has also been weaker with an average growth rate of 0.5% (69 WTE) over the four years. At the end of 2017 the number employed in CHOs was 13.6% (2,311 WTE) lower than that of 2007. CHOs employed 44.1% of all nurses and midwives in the Irish public health service in 2007, by end 2017 this proportion had declined to 40.3%.

Differences within Community Healthcare Organisations

The CHO sector has shown a modest increase in nursing and midwifery numbers since 2013 (with a 4 year average of 0.5%). Further examination however, reveals large variations within the 9 CHO areas. CHO 7 (Kildare/West Wicklow, Dublin West, Dublin South City and Dublin South West) and CHO 2 (Galway, Roscommon and Mayo) have shown the highest levels of growth with a 4 year average of 2%. In contrast, CHO 6 (Wicklow, Dun Laoghaire and Dublin South East) experienced the lowest rate of change at -3.6%. The decline in CHO 6 is mostly explained by a reconfiguration of services, where some services previously in CHO 6 are now in CHO 7. There is no discernible trend in nursing and midwifery WTE numbers on either an urban/rural or Dublin/non-Dublin classification within the sector.

2 CHOs were established in 2015, they carry out a broad range of services that are provided outside of the acute hospital system and includes Primary Care, Social Care, Mental Health and Health & Wellbeing Services.

Figure 6.4: Nursing and Midwifery WTE Average Annual Rate of Change by CHO, 2013 - 2017



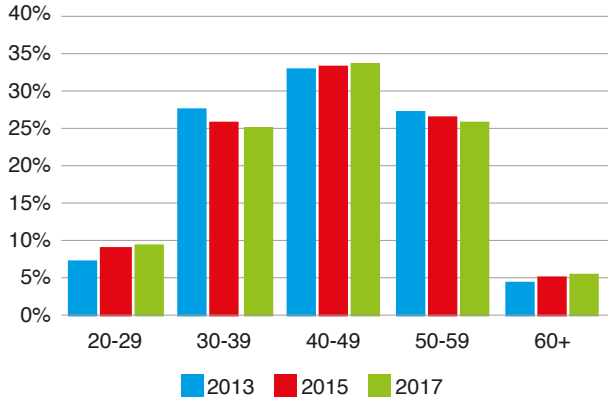
Source: HSE

Age Profile

Although important for workforce planning, relevant demographic data is not universally analysed or made available across the nursing and midwifery workforce. For example, the age profile in 2013 was available for 41.5% of the entire nursing and midwifery workforce; by 2017 this proportion had increased to 64.6%. Improvements have been made in age profile data in recent years, but there remains further room for improvement in this and other areas.

Figure 6.5 presents the age profile of the nursing and midwifery workforce using the limited data sets available. The proportion of nurses and midwives aged 20-29 has increased from 7.6% in 2013 to 9.6% in 2017. This is consistent with the expectation that much recruitment into the public health service since 2013 has taken place among recently qualified nurses and midwives.

Figure 6.5: Nursing and Midwifery Age Profile, 2013, 2015 and 2017

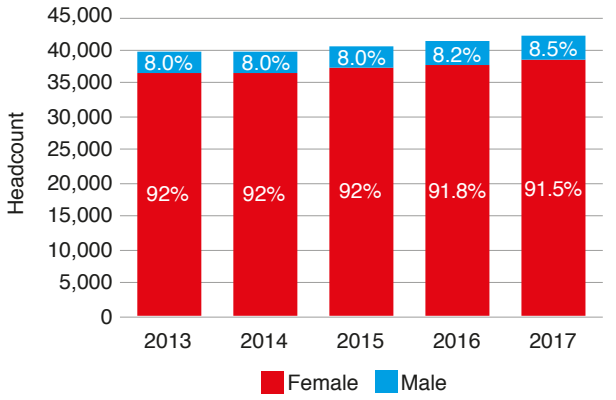


Source: HSE

Gender Profile

The gender profile of nurses and midwives remains predominately female, the proportion of male nurses has grown slightly to 8.5% in 2017 as Figure 6.6 illustrates.

Figure 6.6: Nursing and Midwifery Gender Profiles, 2013 - 2017



Source: HSE

As the nursing and midwifery workforce continues to comprise in excess of 90% females the Commission considers that long-term leave types such as maternity leave are an important consideration for workforce planning.

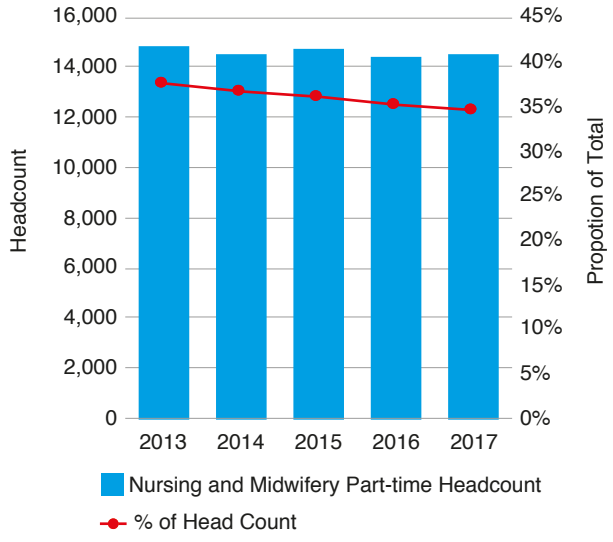
Nationality of Nursing and Midwifery Workforce

The nursing and midwifery workforce is predominately Irish, in 2017 86.4% of the sample[3] were recorded as Irish. The category of Other EU nationalities had the largest increase at 0.8% between the 2016 and 2017 samples. The growth in this cohort may be reflective of recent initiatives recruiting nurses from within the EU. This growth is in contrast to the decline in EU nurses and midwives registering in the UK, as discussed in Chapter 3. Brexit is provided as a reason for this decline, and Brexit may also impact the relative desirability of Ireland as a place to work for EU qualified nurses and midwives, at least in the short term.

Flexibility of Work Pattern

Part-time working makes up a sizeable proportion of nursing and midwifery employment as presented in Figure 6.7. The proportion of total nurses and midwives working part-time has declined from 37.4% in 2013 to 34.5% in 2017.

Figure 6.7: Number and Proportion of Nurses and Midwives Working Part-time, 2013 - 2017



Source: HSE

6.4 Specific Shortages

Staff shortages can arise due to a lack of funding or approval to employ required staff. Where attempts have been made to fill vacant posts shortages may also reflect recruitment or retention difficulties. It has been difficult for the Commission to identify or verify long-term gaps on a regional or grade specific basis as resource requirements for most nursing and midwifery service areas are not available for comparison against actual numbers employed. *The Taskforce on Staffing and Skill Mix* published its final report in February 2018, which is a welcome step in addressing this need. However, it is noted, that the report is yet to be implemented on a national basis and that the report focused on adult acute hospital care in its initial phases. Other important areas of the healthcare services continue to be without a consistent methodological process for determining nursing and midwifery workforce and skill mix needs.

Midwifery Workforce Planning

A notable exception to the general absence of workforce planning is the *HSE Midwifery Workforce Planning Project,* which published its report in April 2016. This detailed report utilises internationally recognised methodologies *(Birthrate Plus®)* and analysis of the number and complexity of births at an individual hospital level. Based on the 2014 number of births and the current model of care, the report recommended an increase in clinical midwife WTE of 149.07 WTE. The report recommended a total increase of 206.07 WTE including non-clinical roles. The 2016 report was the first iteration of this model, and future iterations with more extensive data incorporated would strengthen its implementation for midwifery workforce planning. The Commission understands that the *National Maternity Strategy* intends to revise the maternity model of care and that the implementation of this strategy will require a lower number of births to midwife ratio than utilised in the HSE (2016) midwifery workforce planning report.

In 2017, based on the INMO/SIPTU Agreement implementation report to be discussed in the following sub-section, there were vacancies of 96 midwives, but only 63 of these posts were filled (65.6%).

3 These figures are based on a sample rather than the population. For 2016, nationality details for a sample of 19,219 nursing employees (46.8% of the 2016 total nursing workforce headcount) was provided. For 2017, the sample size was 18,925 (45% of the 2017 total nursing and midwifery workforce headcount).

INMO/SIPTU Agreement

In addressing recruitment and retention difficulties in 2017, discussions were facilitated by the WRC between the Department of Health, HSE, INMO and SIPTU. The discussions yielded a number of outcomes including an agreed funded workforce plan which provided for an additional 1,224 nursing and midwifery posts in 2017.

In support of this agreement, the Minister for Health issued a ministerial direction under Section 10(1) of the Health Act, 2004; that the 2017 Nursing and Midwifery Workforce plan as provided for in the management proposals would be prioritised and encompassed in the arrangements for the implementation of the *National Service Plan 2017.*

It was stipulated that a high-level group would be established, with representation from the Department of Health, HSE, INMO and SIPTU (Nursing) under the Chairmanship of Mr Sean McHugh to oversee and report on the implementation of various proposals which formed part of the agreement.

It has been highlighted to the Commission by HR managers and Directors of Nursing and separately by the Chair of the Agreement's implementation group[4] that there were some delays in implementing parts of the agreement. In particular, delays seem to have arisen regarding delegation of sanction for recruitment to local Directors of Nursing and in providing clarity on the financial management implications. This delay may have been caused by local structural issues, where the CEO/Manager, as set out in legislation, is the Accounting Officer, but the Director of Nursing was assigned responsibility for recruiting nurses and midwives.

Additionally, it has been highlighted to the Commission by Directors of Nursing that when recruiting internationally qualified nurses and midwives, the verification of qualifications can require in excess of six months. Appointments to the HSE are subject to the provisions of the *Public Service Management (Recruitment & Appointments) Act 2004* and the Commission understand that delays will occur while candidates progress through all the required vetting and clearance procedures.

At the end of the Agreement, nursing and midwifery numbers had increased by 942 WTE (77% of the initial target). When the nursing students are excluded, the increase was 847 WTE (69% of the target). The Commission recognises that the lifting of the moratorium on recruitment, as an isolated step, was not sufficient to recruit and retain nurses and midwives at the levels required. This is evident from the extensive efforts and range of initiatives put in place in many areas of the health service in the implementation of this agreement. The Commission acknowledges that many of the initiatives introduced through this agreement are likely to continue to provide additional results in the short and medium term.

Views from Individual Employers

The Commission requested information from individual health employers about specific service areas or grades within nursing and midwifery that are experiencing recruitment difficulties. Based on the limited information received it appears that some hospitals and CHOs experience difficulties in recruiting nurses to fill specialist posts. The specialist areas that appear most problematic are theatre nurses, Intensive Care Unit nurses (including Neonatal Intensive Care Unit), Emergency Department nurses, and midwives.

The Commission notes that the *Nursing and Midwifery Workforce Analysis in the Context of Recruitment and Retention* 2017 report similarly identified issues recruiting nurses in specialist areas.

Anomalies in Pay Rates for Senior Nursing Management Roles

As initially set out by the Department of Health in 1997[5], the payscale applicable to Directors of Nursing and Assistant Directors of Nursing is based on the activities of each individual health agency, rather than the responsibility of a specific role. The Commission believes that this has led to anomalies, particularly in relation to Directors of Midwifery, where senior nursing and midwifery positions overseeing comparatively large health services receive lower pay than comparable grades with comparatively less responsibility. Consequently, some hospitals which are classified as bands with lower relative payscales may find it difficult to recruit senior nursing and midwifery managers.

4 Document provided to the Public Service Pay Commission by the Chairperson of the Oversight Group. Available at https://paycommission.gov.ie/

5 https://www.hse.ie/eng/staff/resources/hr-circulars/remuneration%20of%20director%20of%20nursing%20matron.pdf

6.5 Discussion on Nursing and Midwifery Recruitment

Supply

Nursing and midwifery posts are filled predominantly from undergraduate education programmes with internationally qualified nurses supplementing this core supply source.

Nursing and Midwifery Undergraduate Course Applications

CAO data supplied to the Commission confirms that, as a percentage, demand for nurse and midwifery courses has remained around 9% of total CAO applicants from 2007 to 2018. This is a strong indication that a career in nursing and midwifery continues to be attractive to school leavers. In 2018, there were 5,494 first preference applicants for 1,830 nursing and midwifery undergraduate places (3.06 first preference choices for every available place).

Nursing and Midwifery Undergraduate Places

Undergraduate nursing places have increased for the 2016 and 2017 academic years as illustrated in Table 6.1. A WRC facilitated agreement resulted in additional places in Psychiatric Nursing (Mental Health) in 2016 and 2017 given the expected number of retirements in the coming years. The INMO/SIPTU 2017 Agreement resulted in an additional 2,017 places for Integrated General and Children's, Intellectual Disability and General nursing. The number of midwifery places has remained constant at 140, the same level as 2006, when the direct entry route to midwifery qualification was introduced.

Table 6.1: Number of Nursing and Midwifery Undergraduate Places 2015 - 2017

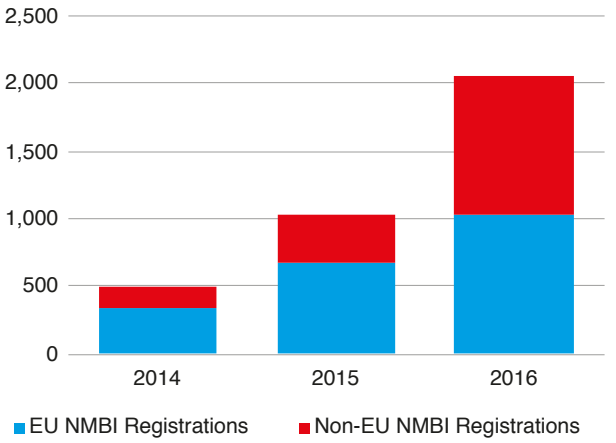
Programme	2015	2016	2017
Integrated General & Children's	100	100	140
General	860	860	920
Mental Health	290	350	420
Intellectual Disability	180	180	210
Midwifery	140	140	140
Total	1,570	1,630	1,830

Source: HSE/Joint Employer Submission

International Recruitment

Internationally qualified nurses and midwives are another key supply source for recruitment into the public health service. The NMBI record new registrations by Irish trained, EU trained and Non-EU trained categories. Figure 6.8 illustrates annual new registrations by nurses qualified outside Ireland. There are substantial year-on-year increases for EU and Non-EU qualified nurse NMBI registrations between 2014 and 2016. The combined level of internationally qualified nurses and midwives registering in 2016 was 1,552 higher than in 2013.

Figure 6.8: New Registrations of EU and Non-EU Qualified Nurses and Midwives, 2014 - 2016



Source: NMBI

Recruitment Process

The public health service can broadly be broken down into two cohorts, HSE directly funded and managed and Voluntary agencies that provide services under a Section 38 arrangement.

In HSE managed health agencies, recruitment has been primarily processed centrally through the Health Business Services (HBS) Recruit (also called National Recruitment Service). Many HSE managed health agencies only had authority to recruit for temporary positions whereas Section 38 health agencies have historically been responsible for determining and meeting their own staff requirements.

Under the INMO/SIPTU Agreement, it was intended that responsibility for recruitment would be delegated from HBS Recruit to local Directors of Nursing. This measure was proposed in order to help address the long process delays experienced in the HBS Recruit process. Evidence from a number of employers suggests a lapsed time of up to 3 months from request date to advertisement date and a significantly longer time-frame before the position was filled.

While measures for the granting of recruitment licenses to local Directors of Nursing were put in place in May 2017 this fundamental change to the recruitment process was implemented with delays in some areas (as explained in section 6.4) and the full impact should be assessed in the short and medium term.

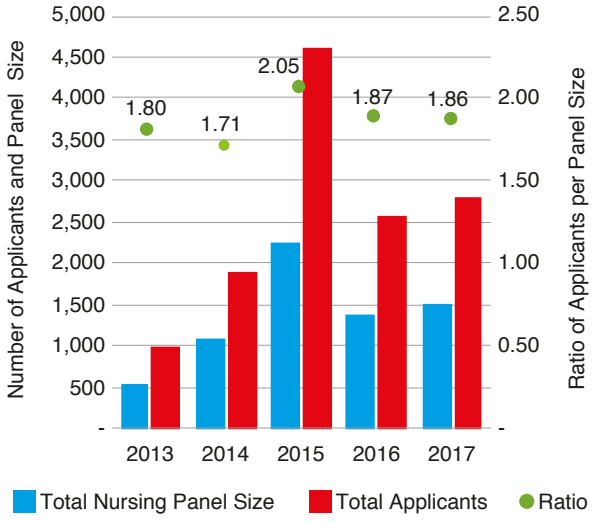
Analysis of Recruitment Campaign Data

HBS Recruit provided data for applicants per nursing panel between 2013 and 2017. This data suggests there was an average of 1.86 applicants per panel size[6] over the previous five years.

It should be noted that consistent data was only available for each panel, which in most cases will exceed the number of actual available positions, and this data only includes competitions managed by HBS Recruit. It excludes the Voluntary health agencies and a smaller number of local recruitment programmes managed by individual health organisations.

The Commission considers that this is another important area where data should be collected and analysed centrally to facilitate comprehensive, in-depth analysis of recruitment requirements, trends and other relevant indicators. For example, the absence of central data means that the three large Dublin based maternity hospitals and the three Children's hospitals are not represented in the above analysis.

Figure 6.9: Applicants for Nursing Panels, 2013 - 2017



Source: HBS Recruit

Recruitment Challenges

Public service health employers were asked to identify the most common challenges that their organisations encountered in respect of successful recruitment. Those that responded reported a number of similar challenges. The most common themes emerging were:

- Lack of HR resources to carry out local recruitment campaigns;
- Process delays for employers who continue to use HBS Recruit;
- High cost of living in cities;
- Lack of supply of nurses and midwives to certain areas;
- Inability of employer to offer work life balance; and
- Rural and regional urban centres considered unattractive.

Box 6.1
Recruitment Initiatives

National Initiatives

- Pay increases and incremental credit for student nurses (2016).
- INMO/SIPTU Recruitment and Retention Agreement (2017).
- Emergency Department Agreement (2015/2016).
- Mental health nursing graduate entry programme.
- Sponsorship for public health service employees wishing to train as nurses/ midwives (HSE Circular 009/2010).
- Sponsorship and Recruitment scheme for student Public Health Nurses.
- Higher Diploma in Midwifery sponsorship programme.
- National clinical programmes developed to promote career pathway opportunities in a number of specialist areas.

Local Initiatives

- National and international recruitment campaigns.
- Conversion of agency staff.
- Recruitment fairs and events.
- On-site accommodation.
- Offering flexible shift patterns.

6 Panel size refers to the number of potential employees on a panel.

Recruitment Initiatives

The Commission requested centrally held data and data from individual employers regarding recruitment initiatives being implemented. Requests were issued to 49 Hospitals and 9 CHO's and the Commission received 33 responses. Employers were asked, in the context of HR management, to provide information on all current strategies/initiatives being used to recruit nurses and midwives. Box 6.1 provides a sample of responses received for initiatives used at both national and local level. This reflects a significant investment of energy and resources on recruitment over recent years.

Analysis of Recruitment Aspects of Survey and Structured Interviews

This section presents the findings of the Commission's survey and structured interviews of nurses and midwives in relation to recruitment. One of the objectives of the research was to further understand the main drivers influencing recruitment difficulties. The views of practitioners may also be useful in identifying policy options to address any identified difficulties in the recruitment of nurses and midwives. Details on the methodology and limitations are provided in Appendix C and the full study is available on the Commission's website at https://paycommission.gov.ie/. The Commission notes that the response rate for this survey appears to have been very low (estimated at 9.7% to 12.3%), which means the results may well reflect a group with different views or preferences from the generality of nurses and midwives working in the public health service. The results should be treated as indicative only.

The findings from the analysis indicate that nurses and midwives are moderately satisfied with both the recruitment process and the reality of the job compared to expectation. A key finding is that the length of the recruitment process and the orientation received on commencing employment are the factors stated as impacting the most on the recruitment of nurses and midwives. One person from Human Resources in the HSE explained the process, *"there may be five processes for any one post ... What happens is you have one team on a job order, you've one team on the job spec. You've one team on the ad, you've one team on setting up the campaign and the interviewing of applicants; another team on the Garda Clearance; another team on contracting".*

Factors impacting the recruitment of graduates and managers were highlighted in the structure interviews with nurses and midwives. Nurses and midwives believe that support for graduate nurses and midwives, such as opportunities to work in areas that interest them, are important. A nurse from one hospital where a number of new initiatives, aimed at providing a more supportive environment for undergraduates and graduates, were in place commented that *"It actually has paid off… because our retention rate of our new grads, … for the last two years [we] have almost had 100% retention with one year post registration."*

Two main challenges were identified in respect of recruiting managers. First, it was noted that nurses opting for promotion may be worse off in terms of their take-home pay, due to the combination of a small increase in salary and the loss of other allowances. Second, it was noted that the role of *"person in charge"* of a designated service was not attractive, given the level of responsibility for no additional salary.

Finally, nurses and midwives stated that alternative opportunities with better pay and conditions are available in agencies and other non-HSE organisations. One manager indicated that *"Private hospitals offer quite a significant sum of money to attract people to take up a job in the private hospitals".*

6.6 Discussion on Nursing and Midwifery Retention

Turnover

Turnover captures the proportion of staff who leave an organisation. A certain level of turnover is inevitable in organisations due to retirements, end of temporary contracts, deaths and permanent infirmity. Some elements of turnover can even be considered beneficial for new ideas or more enthusiastic new entrants. High levels of turnover, however, can be indicative of low job satisfaction within an organisation or sector.

To calculate and report turnover the HSE divides the total number of leavers by the average headcount in a year. Leavers include nurses who move to other areas of the Irish public health service. The Commission considers it important to distinguish between nurses and midwives who leave the Irish public health service and those that move within the Irish public health service. This was not possible, however, due to the different HR and payroll systems that exist across the public health service. The Commission's first Report suggested that there would be merit in putting centralised systems in

place to record, monitor and analyse the detailed movement of employees, on a regular basis, and this is still the Commission's view.

Table 6.2 presents the HSE reported level of turnover for nurses and midwives for 2016 and 2017 across the health service. In 2017 the turnover rate (excluding students) was 6.8%, 0.3% lower than the 2016 rate. Excluding retirements, the 2017 turnover rate was 5%, 0.2% lower than in 2016.

Table 6.2: Total Nursing and Midwifery Turnover (excluding Students), 2016 - 2017

YEAR	Average Headcount	Leavers	Turnover Rate	Leavers (Excluding Retirements)	Turnover Rate (Excluding Retirements)
2017	40,867	2,766	6.8%	2,052	5.0%
2016	40,181	2,861	7.1%	2,085	5.2%
Y-o-Y Change	686	-95	-0.4%	-33	-0.2%

Source: HSE

Table 6.3 provides a breakdown of turnover for different grades of nursing and midwifery. The Staff Nurse/ Staff Midwife grades reported the highest level of turnover at 7.3% (5.9% excluding retirements), while the Public Health Nurse grade reported the lowest level of turnover at 3.1% (1.4% excluding retirements).

Table 6.3: Nursing and Midwifery Turnover by Grade, 2017

Grade	Average Headcount	Leavers	Turnover Rate	Leavers (Excluding Retirements)	Turnover Rate (Excluding Retirements)
Nurse Managers	8,059	509	6.3%	274	3.4%
Nurse/Midwife Specialist	1,872	80	4.3%	47	2.5%
Staff Nurse/Midwife	28,848	2,107	7.3%	1,697	5.9%
Public Health Nurse	1,748	54	3.1%	24	1.4%
Nursing (Other)	340	16	4.7%	10	2.9%

Source: HSE

Table 6.4 presents turnover by Hospital Group for 2016 and 2017 (data for previous years is not available). The Children's Hospital Group reports the highest levels of turnover at 11.9% for 2017, a large increase compared to the 2016. CHOs and the South/South West Hospital Group had slightly higher turnover in 2017 than for 2016. The remaining five Hospital Groups had lower turnover in 2017 than in 2016.

Table 6.4: Nursing and Midwifery Turnover (Excluding Students) by Hospital Group and CHO 2016 - 2017

Group	2016	2017
Children's Hospital Group	8.9%	11.9%
Dublin Midlands Hospital Group	9.6%	8.0%
Ireland East Hospital Group	7.9%	7.4%
RCSI Hospital Group	7.5%	6.4%
Saolta University Hospital Care	6.5%	5.2%
South/South West Hospital Group	6.3%	6.7%
University of Limerick Hospital Group	6.8%	5.6%
All CHOs	6.4%	6.5%
National Total	7.1%	6.8%

Source: HSE

The Commission considers that the national levels of nursing and midwifery turnover rates do not indicate a generalised retention crisis, but that the retention challenge is of an order which would justify some additional measures to reduce voluntary staff departures as far as possible. A large public investment has been made to train both nurses and midwives, and the Commission believes that reasonable measures should be taken to sustain their commitment to and participation in the public health service. Also, if certain Hospital Groups or regions consistently experience proportionately more leavers, this could indicate local factors are leading to additional difficulties. However, the available data was not sufficient for the Commission to confidently identify such patterns.

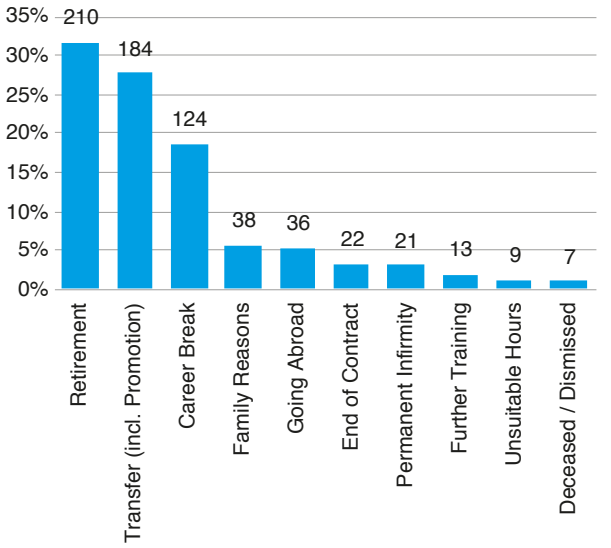
Reasons for Leaving

The benefits of understanding why employees are leaving are well established. The Commission learned that a systematic process for conducting exit interviews with employees does not exist across the public health service and considers this to be another opportunity for improvement.

In the absence of centralised and consistent information on the reasons why nurses and midwives leave their employer, the Commission requested individual health agencies to provide this data if it was available. It received data for 644 Staff Nurse/Midwife leavers in 2017 from 19 acute hospitals and 7 CHOs. This sample represents 30.6% of all Staff Nurse/Midwife leavers (2,107) in 2017. Figure 6.10 presents the results.

The most common reported reason for the sample of Staff Nurses/Midwives leaving their employer is retirement (31.7%), followed by transfer to other health agencies (including promotion) (27.7%).

Figure 6.10: Staff Nurse/Staff Midwife Reasons for Leaving, 2016



Source: HSE

Nursing and Midwifery Intention to Leave

Nurses and midwives employed in Ireland generally require a CCPS from the NMBI if they intend to apply for nursing and midwifery jobs in other jurisdictions. In the absence of centrally collated and analysed data from exit interviews, the number of CCPS issued can be used as a proxy for the number of nurses and midwives who intend to find employment abroad. As nurses and midwives can request multiple CCPS, information is available for both the number of verifications issued and the number of nurses and midwives that receive them. This was illustrated earlier in Chapter 4, see Figure 4.1.

It should be noted that not all of those who apply for CCPS will chose to emigrate. The number of nurses who received CCPS was highest in 2013 at 1,596; relative to this peak, the number in 2017 was 1,096, or 3.9% less than in 2007. The number of nurses making applications has been increasing since 2015. The number of CCPS issued was highest in 2007 at 2,180. In 2017 the comparable figure was 1,343, or 38.4% lower. This number of CCPS also increased in 2016 and 2017 relative to 2015.

The Commission considers the decline in the number of nurses and midwives who received CCPS between 2013 and 2015 as indicative of improving retention, however the subsequent increases in 2016 and 2017 suggest that this trend has reversed in recent years.

Retention Challenges

Public service health employers were asked to identify the most common challenges that their organisations encountered in respect of implementing retention initiatives. Those that responded encountered a number of similar challenges. The most common themes emerging from employers were as follows:

- The time it takes to approve flexible working arrangements and family friendly policies;
- Demand for career breaks cannot always be met due to capacity issues;
- The lack of career progression opportunities in some areas;
- Pay restrictions in the public service compared to private hospital compensation;
- Lower patient ratios, with less complexities in private hospitals compared to public hospitals;
- Cost of academic training can sometimes be a budgetary issue;
- Hospitals receiving negative media attention have limited attractiveness;
- The longer working week and unsociable hours can be off putting;
- Agency work can seem appealing due to the flexibility it offers; and
- Big city living costs along with child care costs and limited car parking in some locations.

Box 6.2
Previous Recommendations

- Setting up a dedicated HR support team
- Restoration of certain allowances
- Full delegated operational responsibility to Directors of Nursing
- Reduction in the use of agency staff
- Development of a national transfer panel
- Streamline staff mobility
- Onboarding
- Identify synergies and gaps in the system in relation to retention
- Exit interviews
- Investment in staffing in order to enhance capacity
- Development of an integrated workforce planning capacity for current and future needs
- Integrated care should be supported and developed

Based on the data received there would appear to be a lack of capacity to implement some initiatives in many hospitals and CHOs in the public health service. Although flexible working hours is an aspiration of most hospitals and CHOs, it would appear that resources do not always allow them to be offered or implemented. As this seems to be an important factor for individual practitioners, it should not be viewed as an insurmountable obstacle but rather, should receive greater priority at policy level and in operational planning at local level.

Retention Initiatives

There are currently a number of strategies and programmes intended to improve retention among nurses and midwives. Some of the initiatives being rolled out nationally include the offer of permanent contracts to graduates along with the option of a career break after one years' service, and the re-introduction of the pre-retirement pension scheme initiative. The INMO/SIPTU Agreement in 2017 also provided for a suite of retention initiatives to be made available to health service employers. Additionally the *Sláintecare Report* in May 2017 recommended some other initiatives. See Box 6.2 for a sample of the previously recommended initiatives in 2017 from the HSE, the *Sláintecare Report* and the INMO/SIPTU Agreement.

While developing and implementing initiatives is a positive step, the Commission recommends that these initiatives should be appropriately evaluated to ensure that the most effective are prioritised.

Career development is an integral part of the Irish public health service drive to retain its workforce. For nurses and midwives, this is implemented through the Centres of Nursing and Midwifery Education (CNME) provision. The primary focus is on the strategic development of person centred care and leadership through support for excellence and innovation-building capacity in nursing to enhance care and service delivery. This is achieved through Regional Centres for Nursing and Midwifery Education (RCNME) and the National Leadership and Innovation Centre (NLIC) for Nursing and Midwifery. Information on training programmes are set out in Table 6.5.

Table 6.5: Education, Training and Development Programmes, 2017

Office	Programmes Delivered in 2017
RCNME	3,843 Programmes to 28,027 Nurses and 1,914 Midwives
National Leadership & Innovation Centre	Leaders for compassionate care, Clinical Leadership Competency ePortfolio, Future Nurse and Midwife Leaders Development Programme, Facilitator Training & Mentoring Training
NLIC Masterclasses	Healthcare Commissioning, Business Case Development, Quality Improvement & Clinical Leadership in Practice
CNME	Transfer of Tasks Training

Source: HSE

National and Local Initiatives

The Commission requested information on current retention initiatives in place to retain nurses and midwives from individual health employers and centrally. Box 6.3 outlines a sample of initiatives being implemented at both national and local level.

On a local level it is evident that flexible working arrangements, improvements in academic training and rotation programmes are used as initiatives in the retention of staff. However, data on the success of these initiatives is not available at this point in time.

Analysis of Retention Aspects of Survey and Structured Interviews

This section presents the findings of the Commission's survey and structured interview of nurses and midwives in relation to retention. One of the objectives of the research was to further understand the main drivers influencing retention. Details on the methodology and limitations are provided in Appendix C and the full study is available on the Commission's website at https://paycommission.gov.ie/. As noted earlier in this chapter, the response rate for this survey appears to have been very low (estimated at 9.7% to 12.3%), which means the results may well reflect a group with different views or preferences from the generality of nurses and midwives working in the public health service. The results should be treated as indicative only.

Box 6.3
Retention Initiatives being Implemented

National Initiatives

- Restoration of the Community Allowance for Mental Health Nurses (2016)
- Emergency Department Agreement (2016)
- PNA/Mental Health Nursing WRC Agreement (2016)
- Recruitment and Retention Agreement (2017)
- Career Break Scheme (2017 - available to all nurses with 1 year service)
- Increased education being provided by ONMSD (2017)
- Sponsorship programme for Public Health Nurses (140 places)
- Retention Working Group established across Hospital Groups (2018)

Local Initiatives

- Flexible working arrangements
- Improved academic training
- Rotation programmes
- Retention workshops
- Pre-Retirement Initiatives
- Staff engagement Initiatives
- Clinical Facilitators
- Accommodation costs Assistance

The survey results indicate that over a third (36%) of nurses and midwives intend to leave their current job in the next two years. The factors that those who indicated an intention to leave most frequently highlighted were staffing levels, demand of the work environment and better job opportunities elsewhere.

The most frequently cited factors that contribute to nurses and midwives staying in their jobs are suitable working hours, personal or family reasons, convenient location and patients/service users are easy to work with.

The results indicate that the individual and job characteristics which are predictive of a higher likelihood of leaving the job, the organisation, and/or the nursing profession are:

- Age – there is a higher incidence to leave amongst younger nurses and midwives;
- Time taken to get to work – there is a higher incidence of intention to leave amongst nurses and midwives who spend more time travelling to work;
- New recruit status - there is a higher incidence of intention to leave amongst new recruits (i.e. less than two years); and
- Training and promotional opportunities - fewer training and promotion opportunities are associated with a higher intention to leave.

For new recruits specifically (i.e. those appointed in the last two years) job expectations are an important predictor of intention to leave the organisation.

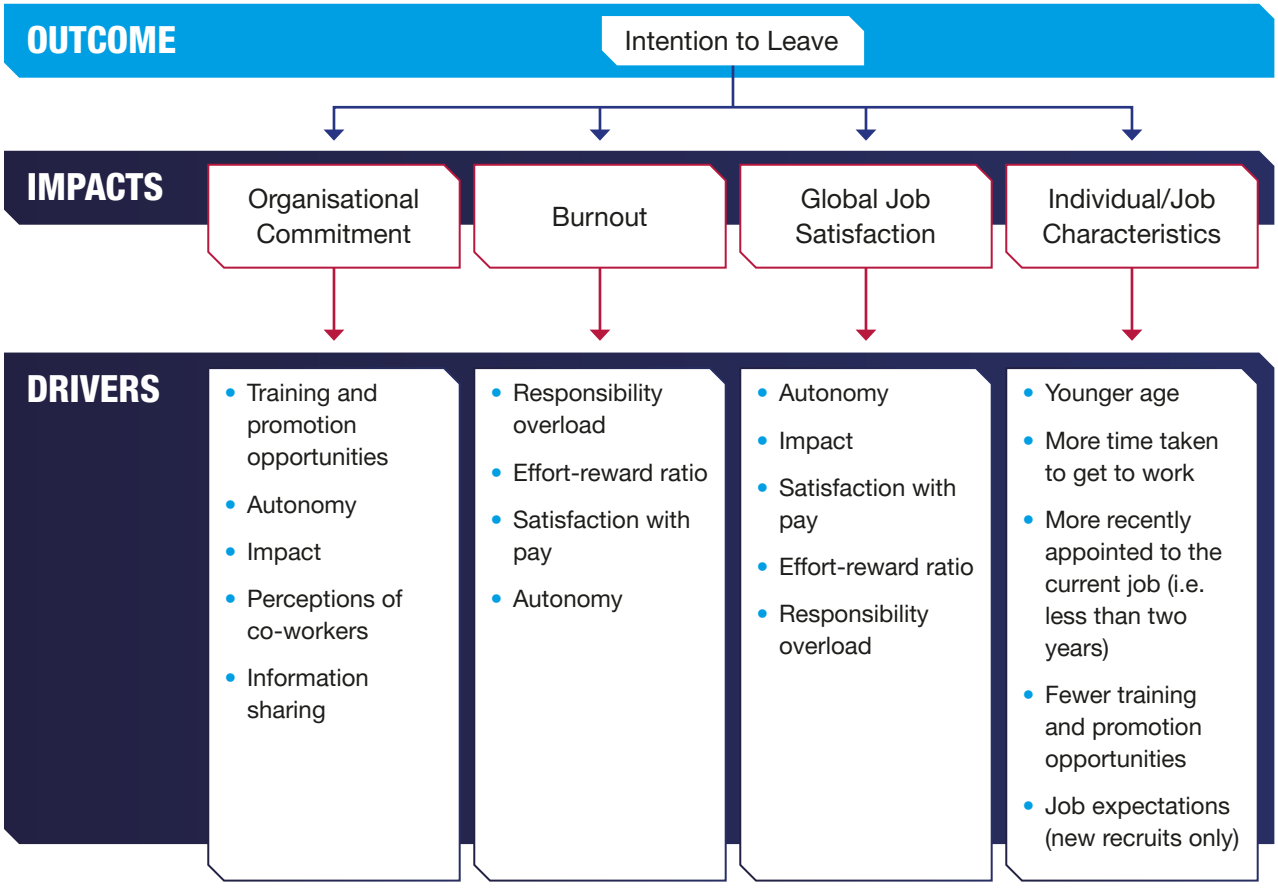
Additionally, lower global job satisfaction, lower organisational commitment and higher levels of burnout emerge as predictors of a higher likelihood of intention to leave. It is relevant to note that a range of characteristics can affect these 'impacts', as illustrated in Figure 6.11.

In relation to the qualitative research, nurses and midwives commented favourably on some advantages of nursing, including its variety and the ability to work almost anywhere. One participant said: *"It's a good job, there's nothing difficult about it. It's a passport to anywhere in the world. And working in [specific area] teaches you about life, it teaches you about everything".*

Job satisfaction was highlighted as being high in situations where individuals are able to work in an area that interests them, use their skills and expertise, make a positive impact, and be valued by patients. One nurse noted that *"the most rewarding part of my job at the moment [is] really just going to work".*

The sources of the most challenges arising in respect of nurses' work are, an increase in the level of demand (due to increases in the number of patients and in the complexity of problems arising) and, inadequate staffing levels. One nurse summed up the main problem as follows; *"the whole environment has gotten so much busier ... no matter if you're in the acute services or if you are out in the primary care, everywhere is so busy".*

Figure 6.11: Drivers and Impacts of Intention to Leave, Nurses and Midwives



Source: Research Matters, PSPC workings

It is clear from the analysis of interviews undertaken that several inter-related factors contribute to intentions among some people to leave their job, organisation or profession. The primary reason suggested by those who were interviewed was excessive workload, due to the perception of inadequate staffing and high turnover levels. One nurse remarked that *"I really do believe a lot of it [retention problem] is staffing. Having worked in a different country as a nurse, ... There was always a good amount of staff. When there's more staff, it's less pressure on you".*

Some nurses and midwives highlighted difficulties in the hours they work, particularly because of the physicality of the work they do. The importance of being able to adopt more flexible and shorter working hours was also stressed.

The organisational context was also seen as having a strong impact on nurses and midwives' intention to leave. In this context it was suggested that the overall level of pay was too low, specifically relative to agency nurses, healthcare workers (e.g. HCA), other members of the multidisciplinary team (e.g. Occupational Therapists, Physiotherapists), and those working in similar type professions (e.g. teachers). One nurse reported that nurses working for agencies were paid at a higher rate than if they were on a direct temporary contract, despite *"doing exactly the same work"* with the organisation. Another commented that *"a nurse will never get at the max of the [teachers'] scale".* Working in an environment where nurses felt valued, involved and listened to, as well as being provided with safe equipment and training and development were issues highlighted by nurses as being very important.

6.7 Conclusions

Nurses and midwives constitute 33% of the total staffing of the Irish public health service. The Commission acknowledges the very high quality of care provided by the nursing profession to patients in hospital and community care settings. The Commission is also aware of the increasing demands being placed on the profession with the rapid changes in health service provision against the backdrop of proportionately less resources, particularly over the last decade.

It is apparent to the Commission that disputes over the adequacy of staffing levels have existed in respect of nurses and midwives since 2007. This is primarily due to the application of the public service moratorium and other budgetary constraints. The overall reduction in numbers from a high of 39,006 in 2007 to a low of 33,768 in 2013 was not matched by a corresponding reduction in demand placed on the public health service generally. In fact demand increased over that period and continues to do so.

The *Sláintecare Report* recognised an 8% increase in population growth in the period 2006 to 2016 which undoubtedly added to increases in the level of health services being delivered. Population ageing is also recognised internationally as increasing disproportionately the volume and complexity of demands placed on health and social care.

The submissions presented to the Commission by the staff side strongly contended that a combination of these factors directly contributed to a high level of burnout and low level of job satisfaction, which was first reported in the RN4CAST Study 2009 to 2011, *A Nursing Workforce under Strain.*

The findings from the qualitative research undertaken by the Commission, as part of this examination, suggest that an emerging challenge in relation to the retention of nurses and midwives at present, is the increased demand for services which, in many instances, can lead to consequential increase in the ratio of patients to nurses/midwives.

Although there is clear evidence that nursing and midwifery numbers have increased since 2013, (with reported numbers of 36,777 at the end of 2017), the information contained in the submissions to the Commission by both management and staff side confirm that this increase is not simply as a result of the lifting of the moratorium but also required the development of a wide range of special recruitment initiatives to both attract and retain nurses and midwives from the domestic market and abroad. The Commission note that some initiatives proved more successful than others.

A particularly noticeable aspect of the staff side submissions was the extent to which they urged the Commission to recommend increases in basic pay as a means of resolving recruitment and retention issues. In fact the INMO submission presented its position to the Commission in the following stark terms:

> ***"don't ignore the fact that all measures except pay have been tried and failed – accept the market reality and the OECD Global Strategy on Human Resources for Health Workforce 2030 which states what member countries must do in terms of improving pay and conditions in order to recruit and retain its nursing and midwifery workforce".***

The Commission is not persuaded, based on the evidence available, that current pay arrangements are, in themselves, a significant impediment to recruitment. The Commission is in any event, prevented by virtue of its Terms of Reference from undertaking a general pay review for any group.

The Minister for Finance & Public Expenditure and Reform met the Commission on 26 October, 2017 and emphasised on behalf of Government:

"This is not a pay review nor can it be".

The exercise the Commission is engaged with is specifically focused on a comprehensive, evidence based examination and analysis of recruitment and retention issues. The Commission was also made aware that the current PSSA, while allowing for the implementation of any proposals that may arise on foot of the Commission's report, precludes the pursuance of claims for increases in pay or improvements in conditions of employment beyond those provided for by the agreement during the term of the agreement.

The Commission was left in no doubt that nurses and midwives are seriously aggrieved at what they regard as anomalies in the current pay structures relative to other professions working in the public health service. The Commission recognise that there is no mechanism currently in place that would allow for these issues to be addressed or dealt with in isolation.

The Commission nevertheless believes that thought has to be given by the Parties to the PSSA to consider putting arrangements in place, at an appropriate time, and without compromising the stability of the public service pay bill, to allow for the adequacy of current pay arrangements more generally to be fully examined.

The Commission expects that the *Sláintecare Report* will now be an important influence on current and future health policy in Ireland. To succeed, the Commission believes that the implementation plan for Sláintecare, given the scale of the changes envisaged, will require considerable changes in how we plan, organise, and resource the workforce.

In particular, the effectiveness of the Sláintecare plan will require a greater understanding of what nurses, midwives, doctors and other healthcare staff will need to do differently so that all staff operate in an integrated manner using the full scope of their professional training, skills, and competence to achieve reform and improvements in health service delivery and development over the next decade.

Not alone will this ambition require a more coherent approach to make the best use of our highly skilled nursing and midwifery workforce, it will also be necessary to develop more effective mechanisms for identifying and implementing HR and workforce policy solutions, which will achieve improved recruitment rates and enhanced retention of the current and future nursing and midwifery workforce.

While recognising that the implementation of Sláintecare will undoubtedly involve a drive to make better use of resources, the Commission acknowledges that the nursing and midwifery professions will continue to be key players in the successful implementation of reform and developing new and better models of care for patients. Inevitably this will result in an expanded role for nurses and midwives with the professions taking on new tasks and some current tasks being assigned to others.

Our analysis supports the emerging view from a number of recent reports that a funded three year nursing and midwifery workforce plan needs to be developed.

The workforce plan should take account of a range of recent policy announcements including *"The National Strategic Framework for Health and Social Care Workforce Planning", "A Framework for Safe Nurse Staffing and Skill Mix in General and Specialised Medical and Surgical Care Settings in Adult Hospitals in Ireland"* and the relevant recommendations in the *Sláintecare Report.*

The Commission believes that the best way of ensuring implementation of the plan is to give consideration to assigning that role to a similarly constituted Oversight Group as was established as a result of the 2017 Agreement reached under the auspices of the WRC with the INMO and SIPTU. Furthermore, issues related to all service areas should also be comprehended within the funded workforce plan and implementation included in the Terms of Reference of such an Oversight Group.

Although there is little evidence to suggest that there are problems attracting students into training and education for the nursing and midwifery professions, retention will continue to be a challenge as other jurisdictions and the private health sector intensify efforts to attract nurses and midwives away from the Irish public health service.

The success of a funded workforce plan will require:

- Investment in the HR function both in terms of resources, data and expertise. The strengthening of the HR function and capabilities needs also to occur at CHO and Hospital Group level, particularly if the delegated authority to recruit

nurses and midwives is assigned, as happened in 2017, to a local level. Increasing local HR support will help ensure early quality recruitment followed by early compliance with the various regulatory codes of practice and appropriate local budget/ financial controls that are required prior to offering employment.

- As highlighted earlier in this chapter the work of the Commission was hindered when examining individual service areas due to limited data received from employers. Data gaps exist on vacancy rates, recruitment competitions, applications, interviews and appointments. The absence of disaggregated data specifically in relation to retention of employees was a further challenge to the Commission. These data gaps made the work of the Commission more difficult in identifying and measuring the extent of a problem in attracting recruits to specific areas. Data gaps in respect of nursing age profile also hinders workforce planning. The main reason for the absence of data as reported to the Commission was the lack of centralised systems in place to record, monitor and analyse employee data. The lack of centralised systems was mentioned in the Commission's first Report; the Commission still recommends that the Parties recognise the importance of such data for planning purposes and ensure fit for purpose systems are put in place.
- A funded workforce recruitment plan clearly needs to anticipate vacancies that are about to occur as a result of a retirement notice, notice of resignation, notification of approved career breaks, maternity leave and ensure that avoidable delays are eliminated. In particular, given that over 90% of the nursing and midwifery workforce are female, it is important to factor in maternity leave to the workforce recruitment plan.

In a workforce of this size, some elements of staff departures are predictable and this should be factored into nursing workforce planning and recruitment processes.

The Commission is aware that appointments to the HSE are subject to the provisions of the *Public Service Management (Recruitment & Appointments) Act 2004,* and that delays will occur while candidates recommended for appointment are being processed to satisfy that they meet the required regulatory protocols on proof of identity, proof of registration and Garda vetting.

The Commission found from data received by the employer that the inability to offer flexible working patterns impacted on their ability to both recruit and retain staff, and were at a disadvantage to other public health employers and agencies, who were able to offer that flexibility. This finding was further endorsed by the results from the survey and interviews where nurses and midwives highlighted the importance of flexible working options. The Commission believe that management should explore their flexible working policy to see if it can be made more widely available. The viability of a regional or Hospital Group panel of nurses and midwives who wish to work on a part-time basis could facilitate matching of work patterns from an employer's perspective and increase the availability of staff. The Commission considers that a nurse or midwife working as a part-time employee in the public health service is a better outcome than the nurse or midwife electing for employment in the private hospitals or agencies.

The Commission has noted a difference in the figures relating to the turnover of nurses and midwives in the submissions received. The joint employer submission claims that the rate of turnover is 5% when retirements are excluded and 6.8% when retirements are included. This, it was submitted, is low in absolute terms and compares favourably to the rate of turnover in the health services of other countries. It was also submitted that the turnover rate is in line with what is experienced in private sector employments generally.

For their part, the nursing unions contend that the turnover rate amongst those at the Staff Nurse grade is 7.9% and between 3.4% and 5.8% for other grades. This, they submitted, gives rise to significant difficulties in meeting the workforce requirements of the public health service which is compounded by the high level of absence on maternity and related leave amongst a predominately female workforce.

The Commission's attention was drawn to a report prepared by the HSE entitled *"Nursing and Midwifery Workforce Analysis in the Context of Recruitment and Retention"* dated March 2018. In this document the reported turnover rates in 2017 were given as 7.3% in the Staff Nurse Grade, 6.3% in the Nurse Manager grade, 4.3% in the Nurse Specialist Grade and 3.1% in the Public Health Nurse grade. It is evident from this report that the HSE regard these rates of turnover as a source of difficulty in maintaining stable workforce numbers.

It is clear from all of the evidence on turnover available to the Commission that the figures provided are distorted by a number of factors. They appear not to distinguish between those who leave their employment voluntarily and involuntarily through retirement or ill health. Nor do they distinguish, in all cases, between those who resign to take up other

employment outside the public health service and those who move to another public health service employer.

In relation to the information provided on turnover rates in other countries, no data was provided as to the methodology used in compiling these statistics and this renders any international comparison unreliable. The available evidence suggests that none of the turnover rates reported are significantly out of line with those experienced in private sector employment generally. However, the expertise built up amongst Ireland's nurses and midwives represents a valuable public resource. Significant public investment has contributed to the development of this expertise. When a qualified nurse or midwife leaves the public health service the value of that public investment is lost and further additional cost in terms of money and time is incurred in seeking a replacement. Also, as indicated by the HSE, this exacerbates existing difficulties in maintaining an adequate and stable workforce. Consequently, every effort should be made to minimise the rate of turnover as far as possible.

In the Commission's view there is a case for providing additional incentives for qualified nursing and midwifery staff to remain in the public health service. These should be targeted at those who acquire additional qualifications and those who accrue long continuous service. Evidence from the employer shows that there continues to be difficulty in retaining nurses and midwives in specific areas. Currently, a Location Allowance is paid to nursing staff engaged in 13 service areas through the health service, including A&E, and Theatre. The Location Allowance is not currently applicable to maternity services. There is also a Specialist Qualification Allowance currently paid to nursing staff who acquire post-graduate qualifications in their relevant disciplines. These allowances are applicable to grades up to and including Clinical Nurse Manager 2 or equivalent.

The Commission recommends that these allowances should be increased by 20% on the same terms as apply currently[7]. The Commission further recommends that they be extended to maternity services on the same basis as they apply to the other service areas.

Staff Nurses and Midwives are also eligible to attain the grade of Senior Staff Nurse/Midwife after gaining 20 years relevant nursing experience post-qualification. The Commission recommends that this experience requirement should be reduced to 17 years.

The Commission was also made aware of an issue which according to the Directors of Midwifery exists in recruiting both Directors of Midwifery and Assistant Directors of Midwifery in certain maternity hospitals. The issue relates to the banding of hospitals and the salary levels not always corresponding to the levels of responsibility. The Commission suggest the HSE and Department of Health review this anomaly, and that pay for senior nursing and midwifery roles be based on the level of responsibility associated with the specific role.

The Commission has become aware that there is a process of engagement in contemplation between the Parties to the PSSA in relation to issues of concern regarding the increased length of the salary scale in respect of post-2011 entrants to the public service, including nurses and midwives. This process is based on a report by the Minister for Public Expenditure and Reform to the Oireachtas on 16 March, 2018 under Section 11 of the *Public Service Pay and Pensions Act 2017.*

The report made by the Minister estimated that the total cost of a two-increment advancement for all new entrant grades across the public service is in the order of €200 million per annum. The estimated cost in respect of this two-increment advancement for nurses and midwives was given as €35.5 million per annum. The average annual benefit per each WTE nurse and midwife was given as €3,594.

While the formal engagement envisaged by the Minister is yet to commence, the Commission believes that a positive outcome of this process will further assist in the recruitment and retention of nurses and midwives, particularly those who are embarking upon or are in the early stages of their career in the public health service.

Furthermore, given the strength of conviction expressed to the Commission by the profession about the pay and status comparison with what they regard as comparable health professions and the need for fundamental reforms which will impact significantly on nursing and midwifery in the context of implementing Sláintecare, the Commission believes there would be value in considering a more general review embracing the full spectrum of issues relating to scope and role (including task transfer), structure, operational flexibilities, management responsibilities, professional development and other measures designed to improve the quality and efficiency of service delivery in an integrated way, alongside any compensation issues to be argued by the staff side.

7 As referenced in Chapter 2, the *FEMPI (No. 2) Act 2009* reduced certain fixed allowances by 5% or 8%. The *Public Service Pay and Pensions Act 2017* provides for the restoration of these allowances by end 2020.

Chapter 7: Non-Consultant Hospital Doctors

Chapter 7: Non-Consultant Hospital Doctors

7.1 Introduction

The Terms of Reference for the Commission are set out at the start of this report. In line with the Terms of Reference this chapter will consider recruitment and retention trends for Non-Consultant Hospital Doctors (NCHDs), one of the cohorts identified in the Commission's first Report as experiencing some recruitment and retention difficulties. In looking at the position of doctors, the Commission was struck by the volume of work already undertaken and on-going, which reflects a serious level of policy concern about various aspects of the medical workforce in Ireland, and in particular the series of reports from the Strategic Review of Medical Training and Career Structures process (MacCraith Report). In the course of its considerations the Commission did not feel that it would be appropriate to usurp or pre-empt the work of other bodies.

This chapter first provides a summary of the issues raised in submissions to the Commission concerning the recruitment and retention of NCHDs. An overview of trends in numbers of serving NCHDs from 2007 to 2017 follows. The next section of the chapter focuses on recruitment in the context of the issues raised in submissions, including consideration of where Ireland sits in the global international labour market for NCHDs and the supply pool for NCHD posts. It also looks at the available recruitment data and identifiable recruitment challenges. The chapter then specifically considers retention issues for NCHDs. The retention section considers the exit rate for doctors registered with the Medical Council. It also looks at trends in applications for certificates to work abroad for doctors generally, as well as the key findings from the Commission's survey and structured interviews of NCHDs on the impact of different factors on intention to leave existing employment. Finally the chapter sets out concluding observations.

While the Commission has considered the position of NCHDs and consultants in distinct chapters of this report, it recognises that medical careers operate in a continuum and this has been taken into account by the Commission in its deliberations. At its most obvious, doctors generally work in teams, led by a practitioner at consultant level. Teaching and training also require close contact and on-going relationships. Perceptions by one of the other are also important. For example, the perception of NCHDs of the way in which consultants are treated is likely to influence their decisions about career planning. Equally, the attractiveness of particular posts or locations to prospective candidates for consultant positions may well be coloured by their perceptions of the quality of support available, among other considerations. In its analysis the Commission has been conscious of these interdependencies which have also shaped its conclusions in respect of both NCHDs and consultants.

7.2 Issues Raised with the Commission

The Commission received a number of submissions with regard to matters related to NCHD recruitment and retention. The Commission also met with a range of stakeholders to hear their views and to fully understand their concerns. The following section summarises the views and background data presented by the stakeholders to Module 1 and should be interpreted as a summary of what the different stakeholders submitted to the Commission. All submissions received are available on the Commission's website at https://paycommission.gov.ie/submissions/.

Joint Employer Submission

Pay

The joint employer submission states that while the pay of NCHDs depends on experience, on average an NCHD earns a basic salary of approximately €57,379 with estimated overtime and premium payments of €18,244, a total average remuneration of €75,623. The Department of Health 2018 data shows that 71% of NCHDs are in grades with a basic starting salary of between €43,462 and €65,143 per year, excluding overtime and premium payments. In addition the Living Out Allowance, valued at €3,193 per year, which was a standard part of NCHD pay up to 2012, was restored in July 2017.

Numbers

The joint employer submission stated that:

- The HSE and specific hospitals have made an enormous effort in increasing the NCHD workforce in the context of growing service pressures and the requirement to progress compliance with the European Working Time Directive (EWTD). Overall the number of NCHDs increased by 1,400 or 29% on 2007 levels.
- All categories of NCHDs have increased by between 20% and 40% since 2007. More specifically all Hospital Groups have recorded increases in the number of NCHDs since 2007, while at individual hospital level almost 80% of hospitals have increased the number of NCHDs relative to 2007.
- There has been a significant increase in the number of doctors trained in non-Irish medical schools, practically all of whom hold posts outside of the training framework. The submission notes in this regard that 76.8% of international NCHD appointments are not in training posts.

Supply

The joint employer submission states that while first preference CAO applications for medicine increased by 36% between 2008 and 2010, entry to medicine appears to have stabilised since 2014 at circa 3,200 applicants. In addition the number of honours graduates in medicine has increased by 71% in the last five years.

Turnover

The joint employer submission states that data on the outflow of NCHDs, which is collected because turnover is unusable, as rotations are reported as leaving incidents. Turnover is calculated by dividing the average annual headcount by the number of leavers in that year and because NCHDs rotate between hospitals every 6 to 12 months, the turnover for NCHDs at present is significantly overestimated.

Recruitment Processes/Issues

The joint employer submission states that in the context of the HSE's strategic approach to recruitment and retention, the National Doctors Training and Planning (NDTP) which incorporates medical education and training, consultant appointments and medical workforce planning, was established in September 2014. Its 2016/2017 assessment of NCHD posts identified key developments including the further roll-out of the national employment record, the introduction of additional speciality training posts, the introduction of a new streamlined training programme and the further development of structured international medical graduate training programmes.

The joint employer submission states that although numbers have increased, this conceals a range of issues relating to workforce configuration, including significant increases in the number of doctors trained outside of Ireland. It was also pointed out that the extent to which the specialities, particularly those delivering 24/7 unscheduled care, are dependent on large numbers of non-training doctors is an indication of broader recruitment and retention difficulties. The health service advises that they are anxious to develop appropriate contracts that will support the retention of doctors on a longer term basis, as opposed to the current generic approach, and instance service posts as an example of where a more appropriate type of contract would be of assistance.

Staff Representative Submission

Pay

The IMO claims that pay has been repeatedly found to be a driver of doctor emigration, 65% of medical students surveyed cited pay as a main reason for planned migration, and that pay rates for NCHDs in Ireland do not in the whole compare favourably with those in other English speaking jurisdictions including England, Australia, Canada and New Zealand. The submissions also consider that large discrepancies in pay render the retention of Irish NCHDs extremely difficult in an increasingly competitive, international market where medical practitioners are highly valued.

Turnover

The IMO submits that the turnover of the 14% of NCHDs who end their contracts may be an indicator of intention to leave the public health service. In addition they submit that approximately one in ten doctors aged between 25 and 34 are leaving the Irish Medical Register, most likely for posts abroad. Furthermore, research on Interns who entered the heath service in 2010 found that 45% of this group were no longer working in the public health service and had most likely emigrated (HSE, 2012).

Recruitment and Retention

According to the IMO submission, recruitment and retention has never been more challenging. They referred to a number of drivers with regard to the retention of graduate doctors, NCHD recruitment, their discontent with training and supervision, labour market pressures and particularly the poor comparison with international pay rates. The IMO also claimed that:

- Unless radical action is taken to resolve the recruitment and retention crises within the medical profession, Ireland will be unable to deliver the kind of specialist and specialised medical care taken as a right in other jurisdictions.
- Difficulties in recruitment are demonstrated by the increased reliance on foreign-trained doctors, which currently amounts to 41.6% of all doctors, while Ireland is paradoxically training 23.7 medical graduates per 1,000 population, the highest number of graduates in the EU. This, they considered, is a clear indication of the recruitment and retention crises engulfing the public health service.
- A further strong barrier to the recruitment of Irish trained doctors who have moved abroad is the negative experience of those NCHDs working in Ireland referencing factors impacting on decisions to return including long working hours and uncertain career progression.

Intention to Leave

The IMO provided results from a survey of NCHDs working abroad, which sought their views on measures that could attract them back to the Irish health service. 79% of respondents identified improved training and CPD opportunities along with improved staffing levels, workplace atmosphere, culture and support as important; 75% identified reduced working hours; 71% identified improved pay with 65% identifying improved medical facilities. In addition, many non-Irish trained doctors who take up non-training posts are also contemplating migration as their hopes of career progression are unrealised and they become de-skilled.

Additional Issues

In their submission the IMO have also highlighted:

- The removal of the training grant has led to increases in training cost for NCHDs; it is estimated that a NCHD spends €20,000 on average to fund training;
- Long working hours and continued non-compliance with EWTD;
- Dissatisfaction with the quality of training with a significant increase in emotional exhaustion and high levels of burnout; and
- The failure of the HSE to tackle many serious barriers to recruitment and retention.

7.3 Employment Trends

Key Findings:

- The number of NCHDs has increased by 30% to 6,331 from 2007 to 2017.
- The average annual increase of NCHDs in non-training posts increased by 12% compared to an average of 4% in training posts, over the 2013 to 2017 period.
- Additionally, the proportion of International Medical Graduates within the NCHD workforce has been increasing over recent years. Compliance with the EWTD is one of the primary drivers for this increase.

Overview of Data and Trend in Numbers

As discussed in the previous chapter on nurses and midwives, the Commission also sought detailed information on recruitment transactions and departures from Ireland's public health service for NCHDs, but the requested data was not generally available. Most of the following discussion focuses on broader staffing indicators that may cast light on recruitment and retention issues but which also tend to be affected by other influences.

NCHD Numbers

NCHDs make up 6% of the total staffing of the health service and are an important element in delivery of an effective health service. The number of NCHDs has increased by almost 30% during the period 2007 to 2017. This general increase in numbers is also reflected across each of the NCHD grades with the largest increase at Intern level. Table 7.1 sets out the trend in these numbers for 2007, and 2013 to 2017.

The increases in the number of NCHD posts should be considered in the context of the *Hanly Report* (Department of Health and Children, 2003) and the Government policy to move to a consultant-delivered, rather than consultant-led service. The implementation of this policy implies that the number of consultants should grow considerably, with a corresponding reduction in the number of NCHDs.

Training and Non-Training Posts

Table 7.2 sets out the trend in NCHD numbers from 2013/2014 to 2016/2017. During this time the number of trainee posts increased by an annual average of 4% while the annual average increase in non-training posts was 12%. The growth in NCHD numbers over the last three years is largely as a result of increased recruitment in order to achieve EWTD compliance. In its return to the Commission the NDTP stated that *"a significant proportion of this additional recruitment has been to smaller Model 2 and 3 hospitals and it is likely that most of the increase is represented by international medical graduates".*

Section 86 of the *Medical Practitioners Act 2007* obliges the HSE to annually assess the number and type of intern, specialist trainee and non-trainee posts required by the health service, and to publish the results of this assessment (NDTP, 2017). Since 2013/2014, the number of NCHDs in training posts has increased by 14% compared to a 42% increase in the number of NCHDs in non-training posts. Non-training doctors are employed most commonly at Senior House Officer (SHO) or Registrar level. These posts do not have a formal training component, and are commonly referred to as non-training posts.

Table 7.1: Trend in NCHD Numbers by Grade (WTE), 2007, 2013 - 2017

NCHD by Grade	2007	2013	2014	2015	2016	2017	% Change 2007* to 2017
Interns	512	631	674	712	713	720	41%
Registrar	1,633	1,683	1,689	1,869	1,980	2,074	27%
Senior House Officer	1,918	1,808	2,034	2,158	2,217	2,295	20%
Senior Registrar	0	93	146	141	186	175	88%
Specialist Registrar	818	792	854	933	964	1,067	31%
Total NCHDs	4,881	5,007	5,397	5,814	6,060	6,331	30%

*Data for Senior Registrars refer to the change from 2008 to 2017

Source: HSE

Table 7.2: NCHD Trainee and Non-Trainees, 2013/2014 - 2016/2017

NCHD Posts	2013-2014	2014-2015	2015-2016	2016-2017	Average Annual Change
Trainee*	3,370	3,504	3,706	3,838	4%
Non-Trainees	1,549	1,798	2,011	2,199	12%
Total	4,919	5,302	5,717	6,037	7%

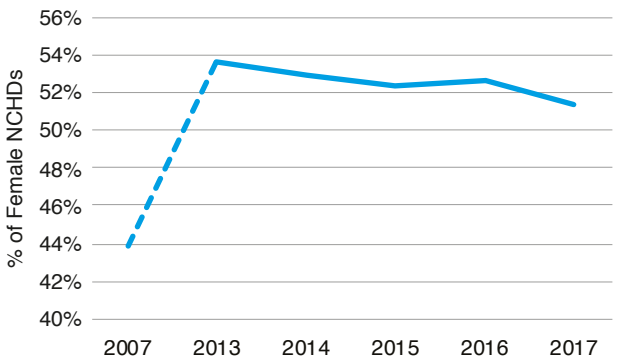
*Includes interns, Initial Specialist Training, Higher Specialist Training and International Medical Graduate Training Initiative in clinical training posts in the Irish health service. Excludes trainees in research, clinical training posts abroad, approved programme leave.

Source: NDTP

Gender

In comparison to the consultant, nursing and midwifery workforces, the gender of NCHDs is more evenly split, with a growing female workforce. From 2013 on over 50% of the NCHD workforce was female compared with only 44% in 2007. This trend can also be seen in CAO applications for medicine courses with the proportion of females, increasing from 53% to 56% between 2007/2008 and 2016/2017.

Figure 7.1: Trend in NCHD Gender, 2007, 2013 - 2017



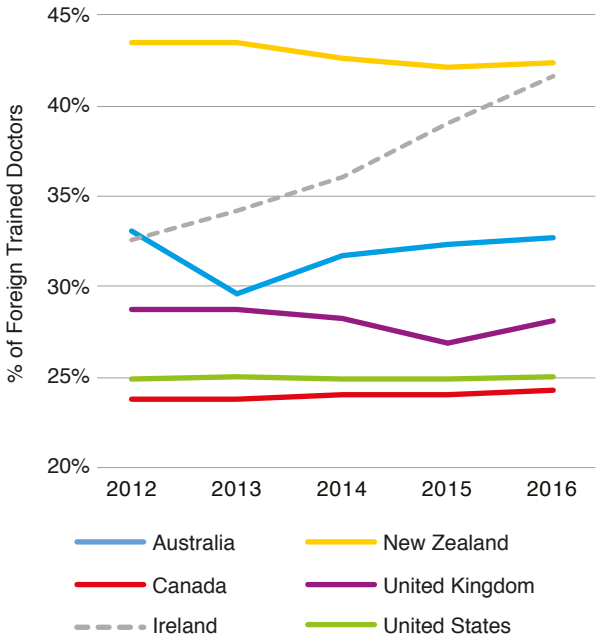
Source: HSE and DPER

Nationality

The HSE provided nationality data for a sample of NCHDs for 2016 and 2017.[1] Just over half of the NCHD workforce is of Irish nationality, with the data showing a 1.1% increase in 2017. The non-EU proportion of the workforce was 38% in 2016 and 37.6% in 2017. This is relatively high when compared with the other cohorts examined in Module 1 where the proportion of non-EU nurses was 10.1% in 2017 and proportion of non-EU consultants in 2017 was 8.2 %.

The OECD Health statistics show that Ireland's reliance on foreign trained graduates is one of the highest of all OECD countries at 42% in 2016. Figure 7.2 sets out the percentage of foreign trained doctors in the certain Anglophone countries from 2012 to 2016. The proportion of foreign trained doctors in Ireland increased from 33% to 42% over the period. Also, during this time the inflow of foreign trained doctors to Ireland has more than doubled from 783 to 1,819 (OECD, 2017). This clearly demonstrates the health service's increasing dependence on International Medical Graduates[2] (IMGs) to fill NCHD posts.

Figure 7.2: Percentage of Foreign Trained Doctors, 2012 - 2016



Source: OECD

In its 2016 Medical Workforce Intelligence report, the Medical Council stated that in 2015 over 76% of retained doctors who worked as an NCHD, not in training, had graduated outside of Ireland. The report also sets out the area of practice and proportion of retained international graduates. The specialities where the proportion of international medical graduates is greater than average are Anaesthesia,

1 In 2016 the sample size was 2,711, 43.6% of the 2016 total NCHD workforce. In 2017, the sample size was 2,870, 44% of the 2017 total NCHD workforce.

2 Doctors who have graduated from medical schools outside of the Republic of Ireland.

Emergency Medicine, Medicine, Obstetrics and Gynaecology, Psychiatry, Paediatrics and Surgery.

7.4 Discussion on NCHD Recruitment

There are two main sources of supply for NCHD: undergraduate educational programmes and international recruitment. Demand for medical courses has remained steady while the number of graduates from relevant medical courses has increased. Ireland produces the highest number of medical graduates per capita in the OECD, however the proportion of IMGs on the Medical Register is increasing year on year with a notably increasing number of doctors from Pakistan and Sudan.

Undergraduate Supply

Data received in relation to numbers applying and accepting places on medicine courses indicates that a career in the medical profession continues to be highly desirable.

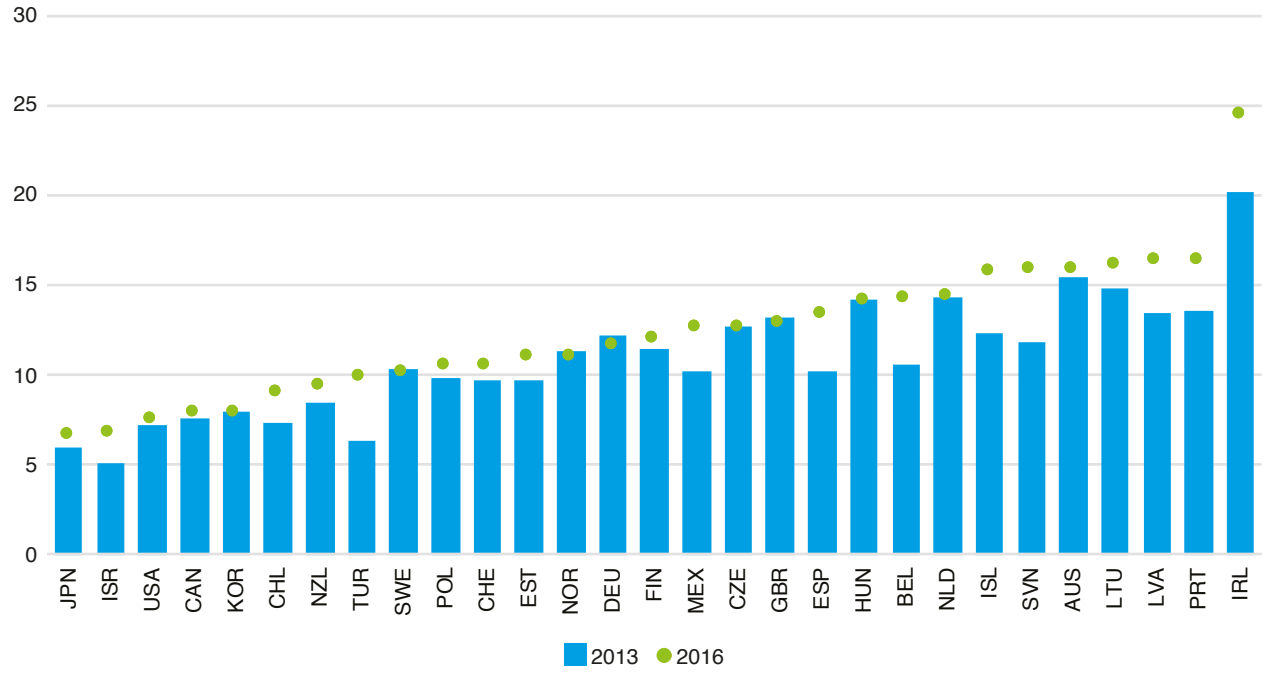
CAO application data indicates that demand for places on Level 8 medicine courses has fluctuated over the last 10 years, peaking in 2010 at 5.5% of all first preferences before decreasing to 4.6% in 2014. Demand has remained steady, ranging from 4.5% to 4.7% of all first preferences, over the last five academic years, with a slight increase to 5.2% for the 2018/2019 academic year.

Overall, the number of graduates as reported by the Higher Education Authority (HEA) from relevant medical courses has shown strong and consistent growth from 542 in 2009/2010 to 1,242 in 2015/2016, an increase of 230%. It should be noted that 56% of this growth is accounted for by the growth in the number of Irish graduates. This growth has built upon progress made as a result of the *Fottrell Report* (Department of Health and Children, 2004) which recommended that the intake of EU students to Irish medical schools should increase from 305 students per annum to approximately 725 students per annum.

Supply Pool

Ireland produces the most medical graduates per capita in the OECD. Figure 7.3 shows that in 2013 Ireland produced an average of 20.13 medical graduates for every 100,000 population, this increased to 24.4 in 2017.

Figure 7.3: Number of Medical Graduates per 100,000 Population, 2013 and 2016

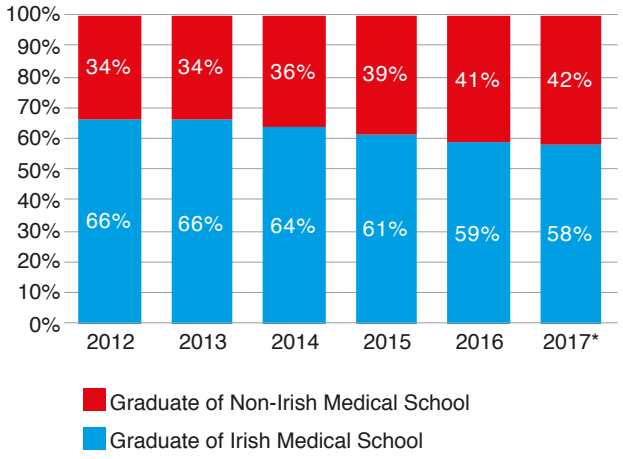


Source: OECD

International Supply

Internationally qualified doctors are a considerable source of supply for recruitment into the Irish public health service. Figure 7.4 shows that of the doctors who retained registration, the proportion of doctors who are graduates of medical schools in countries other than Ireland, has increased from 35% in 2012 to approximately 42% in 2017.

Figure 7.4: Trend in Proportion of Doctors by Country of Qualification, 2012 - 2017



* 2017 figure refers to position at 23/11/17

Source: Medical Council

Data supplied to the Commission by the Medical Council in relation to registrations according to Country of Basic Medical Qualification are set out in Figure 7.5. The number of IMGs who hold registrations in Ireland have increased for most countries over the period, while the ranking order of the top seven has changed. For example the number of IMGs from Pakistan has increased by 63% from 1,255 in 2013 to 2,042 in 2017.

Report of the National Task Force on Medical Staffing

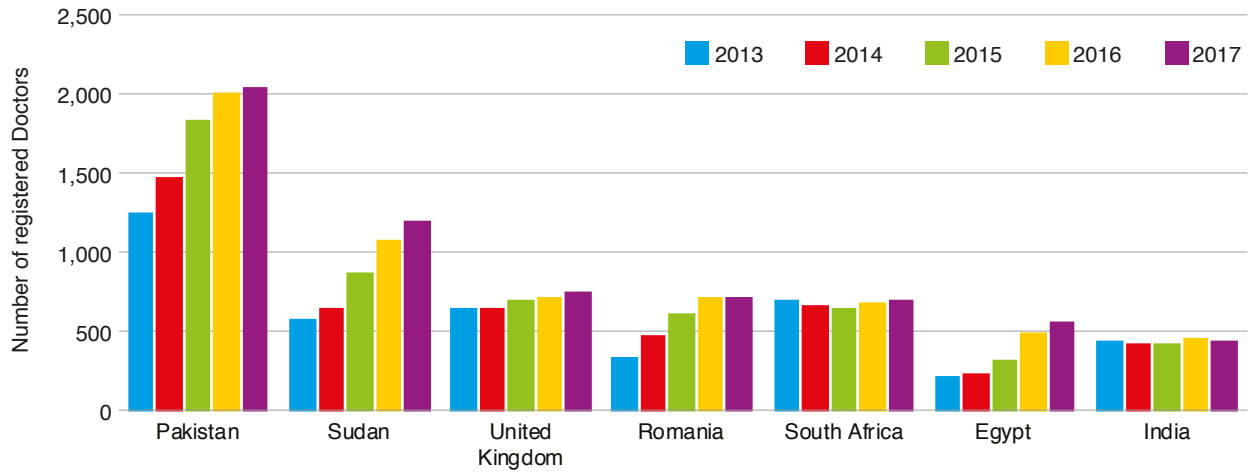
The *Hanly Report* set out the changes needed to ensure that the public health service complied with the EWTD and other issues, while providing high quality hospital care to patients and ensuring that all NCHDs are trained to the required standards. The report recommended that NCHD working hours should be reduced in line with the EWTD. In relation to staffing it recommended that:

The health service should not attempt to meet the terms of the EWTD by employing more NCHDs as this would actually *"worsen the situation for both patients and doctors".* Instead, additional consultants should be appointed as part of a move to a consultant-provided service;

- Considerations about capacity, workload and a critical mass of patients must influence where hospital services can be safely provided;
- All non-training NCHD posts should be phased out so that the health service can attract and train doctors to provide high quality care; and
- The number of hospital doctors should be regulated nationally through a single agency. Each NCHD post should also be subject to approval by a central training authority.

The trends in numbers over the last decade demonstrated that the public health service achieved compliance with the EWTD by increasing consultant and NCHD numbers. The distribution of the increase in NCHDs has been weighted towards increasing NCHDs in non-training posts. The increase in NCHD posts, particularly non-training posts is contrary to the recommendations of the *Hanly Report.*

Figure 7.5: Top Seven Non-Irish Countries of Basic Medical Qualification, 2013 - 2017



Source: Medical Council

This report is discussed further in the context of consultants in Chapter 8.

Box 7.1
Recent Recruitment Initiatives

- **Medical Career Day** - Available to penultimate and final year students.
- **Career Website** - to help plan a medical career in Ireland and provide information on medical schools, the intern year and internship, postgraduate training and how to become a specialist.
- **National Doctors Training and Planning** - The NDTP provides strategic planning for medical education and training, medical workforce planning and the approval of consultant posts.
- **The National Employee Record** was developed to minimise repetitive paperwork requirements for NCHDs and eliminate as much duplication as possible when rotating employers.

Recruitment Process

The NDTP fulfils a crucial role in the recruitment process within the HSE. The three core functions of NDTP are medical education and training, medical workforce planning and consultant post approval.

The NDTP oversees recruitment to Medical Intern posts which is conducted by Health Business Services (HBS) Recruit annually. In its return to the Commission the NDTP has stated that each competition run for intern posts is hugely over-subscribed, even where the number of posts has *doubled over the last decade. No intern posts were unfilled in 2013 to 2016. The NDTP does not hold data for 2007.*

NDTP has service level agreements in place with the Irish Postgraduate Medical Training Bodies who recruit doctors to training schemes. For the period 2013 to 2016 all training places were filled, with the exception of 17 GP training places. There was also a limited pool of applicants for some specialist schemes.

As stated earlier the Commission sought data from public service health employers in relation to the recruitment process. However for NCHDs a complete and detailed dataset on vacancy levels, recruitment competitions, applications, interviews and appointments was not provided. Those who did respond to the question in relation to recruitment stated that national recruitment campaigns were undertaken for the HSE by HBS Recruit for a period, but subsequently recruitment of NCHDs reverted back to local H.R. departments in conjunction with the training bodies.

Recruitment Trends – Entrants to Register

A useful indicator of total supply is the number of doctors maintaining their registration on the Medical Council's Register[3]. The number of doctors on the Register has been rising each year and data supplied by the Medical Council shows that in the period 2011 to 2017 the number of doctor registrations increased by over 20% to 22,649.

The 2016 *Medical Council Annual Report,* stated that 3,172 doctors registered for the first time in 2016. Since 2013, there has been a 45% increase in the number of first time registrants, the majority of this increase was driven by the General Division[4] of the Register. Table 7.3 sets out a breakdown of these first time registrants by Division.

3 The Register of Medical Practitioners in Ireland is maintained by the Medical Council and contains the name of every doctor legally allowed to practice medicine in Ireland.

4 Doctors who do not practise in training posts, who have not been proposed for a post in the Supervised Division, and who have not completed recognised specialist medical training are usually registered under General Registration. Doctors who are qualified to practice independently without supervision are registered under the Specialist Division. Those on internship training in a hospital recognised by the Medical Council are registered as Interns. Doctors who have been offered a specific supervisory post, which has been approved by the HSE, are registered on the Supervised Division. Doctors who practice medicine in an identifiable training post are registered under Trainee Specialist Division. Doctors on the register who are European Union citizens who are fully established to practise medicine in another European Union member state are registered as Visiting European Economic Area (EEA) doctors.

Table 7.3: Breakdown by Division of First Time Registrants, 2013 - 2016

	2013	2014	2015	2016	Average Annual Change
General Division	922	1,122	1,595	1,648	22%
Specialist Division	153	231	252	310	28%
Intern	698	712	726	727	1%
Supervised Division	16	24	88	71	99%
Trainee Specialist Division	394	430	459	405	1%
Visiting EEA	10	28	29	11	41%
Total	2,193	2,547	3,149	3,172	14%

Source: Medical Council

Identifiable Recruitment Challenges

While the increase in NCHD numbers would not appear to demonstrate any particular recruitment challenges in terms of total numbers, Ireland is reliant on IMGs to fill non-training posts. In its 2016 *Medical Workforce Intelligence Report,* the Medical Council stated that in 2015 over 76% of retained doctors who worked as an NCHD not in training had graduated outside of Ireland. To date there have been no difficulties with this source of supply. However, based on fluctuations in the data of country of Basic Medical Qualification provided by the Medical Council (Figure 7.5), it cannot be assumed that this will continue to be the case. Also, Ireland is a signatory to the *WHO Global Code of Practice on the International Recruitment of Health Personnel,* and this places obligations on Ireland to be self-sufficient in its production of healthcare workers and not to encourage migration into Ireland of workers who are needed in their own countries. With the substantial investment that Ireland makes in medical education, this dependence on doctors trained outside of Irish medical schools is a cause for concern.

Analysis of Recruitment Aspects of the Survey and Structured Interviews

This section presents the findings of the Commission's survey and structured interviews of NCHDs in relation to recruitment. One of the objectives of the survey and structured interviews was to further understand the main drivers influencing recruitment difficulties. Based on these perceptions and drivers it may be possible to identify policy options to address any such difficulties identified in the recruitment of NCHDs. Details on the methodology and limitations are provided in Appendix C and the full study of the survey and structured interview is available on the Commission's website at https://paycommission.gov.ie/. However, the Commission notes that the response rate for this survey was very low (12.9%), which means the results may well reflect a group with different views or preferences from the generality of NCHDs working in the public health service and should be treated as indicative only.

The findings from the analysis indicate that the NCHDs are moderately satisfied with both the recruitment process and the reality of the job compared to expectation. A key finding is that the administrative process in respect of pay and the orientation received on commencing employment are identified as having the most impact on the recruitment of NCHDs. One NCHD noted *"if you move from one [Hospital] to the other it takes eight weeks or two months, I guess, to get up and running again in terms of your emergency tax, pay and pension and all that."*

Factors impacting on recruiting NCHDs and non-EU NCHDs were highlighted in the qualitative research. NCHDs believe that the hours and stress involved as well as the costs associated with NCHDs coming through via postgraduate entry are impacting negatively on recruitment. In relation to hours and stress one doctor remarked "*…the workload. Just the stress of having an awful lot to do in a very limited amount of time".* The costs to NCHDs associated with rotations and visa fees were also highlighted.

Box 7.2

Recent Retention Initiatives

A selection of initiatives introduced by the HSE to improve NCHD retention are set out below:

- Supporting NCHD access to Protected Training Time.
- National Lead NCHD/NDTP Fellow.
- Restoration of Living Out Allowance.
- Transfer of tasks to nurses.
- HSE National Flexible Training Scheme for Higher Specialist Trainees.
- International Medical Graduate Training Initiative.
- New CPD Support Scheme.
- Reduction in working hours, changes to rosters and other measures as part of EWTD implementation.

7.5 Discussion on NCHD Retention

Turnover

When examining the retention of NCHDs turnover is not an appropriate measure as the majority of NCHDs are on specified purpose training/rotation contracts (the turnover rate for NCHDs was 73.8% in 2017). NCHDs are typically employed on six or 12-month, fixed-term contracts, at the conclusion of which they are required to seek other employment, or are re-employed on a renewed fixed-term contract. This process continues until an NCHD achieves a specialist qualification and obtains a permanent specialist post. Of the 4,793 NCHD leavers (based on headcount) in 2017, 85% left due to reaching the end of their contract and the remaining 15% were due to resignations.

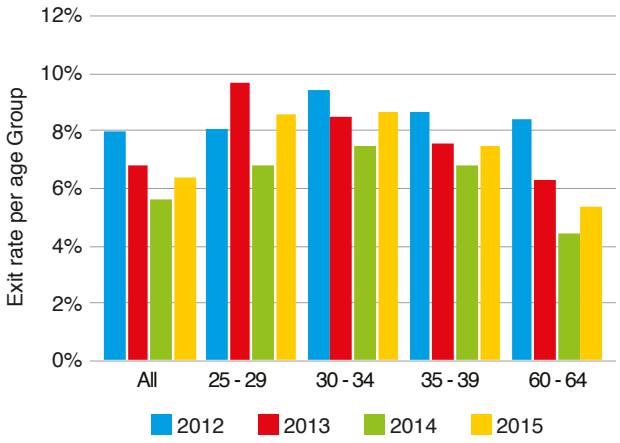
Reasons for Leaving

The Commission requested data in respect of exit interviews and reasons for leaving from all health public service employers and while the response rate was very low the majority of those who did respond stated that currently exit interviews are not conducted in respect of NCHDs. The main reason cited for leaving by those who did carry out exit interviews was the acceptance of contracts in other hospitals or countries.

Exits from the Medical Council Register

The Medical Council's Workforce Intelligence Reports indicate that based on invitations to doctors in June 2015 to retain registration for the period July 2015 to June 2016, 17,571 doctors retained registration and 1,195 doctors did not, which constituted an exit rate of 6.4% from the Medical Council's Register. This level of exits from the Register is an increase when compared to the 2014 exit rate of 5.6%. Exits for the age groups between 40 and 59 range from 2.7% to 5.9% for all of the years considered[5].

Figure 7.6: Exit Rate per Age Group of All Doctors, 2012 - 2015

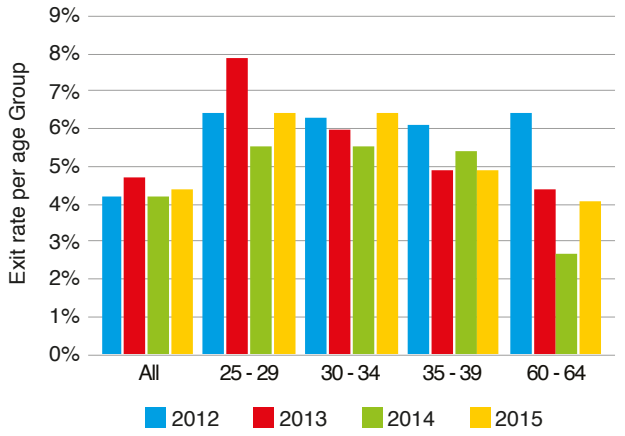


Source: Medical Council

The highest exit rates from the Register since 2012 are consistently within the 25 to 34 year old cohorts; the average exit rate for this cohort was 8.4% from 2012 to 2015. For doctors who graduated from Irish medical schools only, the 2015 exit rate was 4.4%. This is also an increase compared to the previous year, when the exit rate stood at 4.2%. Similar to the pattern observed for all doctors the exit rates are highest for those aged 25 to 34; the average exit rate for this group was 6.3% over the 2012 to 2015 period. Exits for the age groups between 40 and 59 are relatively stable ranging between 0.5% and 3.1% for all of the years considered.

5 Age groups with the highest exit rates are presented.

Figure 7.7: Exit Rate per Age Group of Graduates from Irish Medical Schools, 2012 - 2015



Source: Medical Council

Migration

NCHD retention should be considered in the context of the current high level of output from Irish medical schools and the reliance of the public health service on IMGs to fill non-training posts. A CCPS is often required by other jurisdictions when considering applications for registration on their equivalent of a register of qualified medical professionals, and can therefore be used as a relevant indicator for intention to leave. The Medical Council reports that between 2012 and 2017, the number of CCPS issued increased by 14.7%.

The migration of NCHDs is an acknowledged challenge and has been the focus of copious research. There has in this regard been a tradition of specialist trainees taking up appointments abroad in order to develop their skills and improve their opportunity for career progression; a point made in the RCSI's recent survey by some 70% of NCHDs who considered international experience as necessary to securing appointment to a prominent Irish hospital (Brugha *et al*., 2018). In this regard Medical Council trainee surveys have shown a reduction in intent to leave Ireland permanently, from 21% in 2014 to 14% in 2016. Similarly, this report found that 42% of trainee doctors planned to work abroad and ultimately make their career in Ireland with 41% planning to remain in Ireland. This improved outlook may be attributable to factors, such as the recovery of Ireland's economy and the ongoing improvements in the NCHD trainee experience and supervision.

A further RCSI study (Walsh and Brugha, 2017) points to the need for effective measures to achieve medical workforce sustainability for NCHDs and suggests strategies that include shorter and more flexible working terms and conditions, equitable salary levels, improved access to training and research opportunities and clearer career paths. Such themes are repeated in much of the current literature. This report also concludes that given the level of turnover, international recruitment is not an effective strategy and that many of those recruited are leaving Ireland as a result of slow stagnant career progression leading to de-skilling and onward migration, mainly to other wealthy countries.

Identifiable Retention Challenges

The NDTP's *Seventh Annual Assessment of NCHD Posts* 2016-2017 advises that the non-training posts comprise of two main cohorts. The main cohort of this group is made up of IMGs. According to the report many take up these posts on arrival in Ireland with a view to transferring onto specialist training programmes, but are unsuccessful due either to eligibility factors or the competitive nature of trainee selection process. As the posts they occupy are not recognised for training, and employment is normally on fixed-term contracts for either 6 or 12 months, they are unable to achieve their objectives. According to both quantitative and qualitative data, migrant doctors employed in Ireland are a potentially highly mobile cohort, many of whom are considering migrating onwards (Brugha, McAleese and Humphries, 2015). Studies have found that lack of career progression is a significant factor in migrant doctors' intentions to leave Ireland (Brugha *et al*., 2016). Other factors that impact on intentions to migrate onwards from Ireland were low salary, short-term contracts, inability to gain citizenship and overall dissatisfaction with their experiences in Ireland (Humphries *et al*., 2013).

The second (smaller) cohort is made up of doctors who are between training posts, for example a doctor who has completed Basic Specialist Training and aspires to obtain a Higher Specialist Training position. According to the NDTP most of this cohort are graduates of Irish medical schools, and the numbers are decreasing with the widespread introduction of streamlined training and the elimination of 'gap years'.

The Commission sought data from individual hospitals and CHOs in relation to recruitment and retention challenges and while the response rate was poor, a number of sites reported the following retention challenges - geographical locations, cost of living in Dublin and higher remuneration offered by private agencies.

Strategic Review of Medical Training and Career Structures

In July 2013 a Working Group chaired by Professor Brian MacCraith was established and tasked with examining and making high-level recommendations for doctors with a view to:

- Improving graduate retention in the public health service;
- Planning for future service needs; and
- Realising maximum benefit from investment in medical education and training.

The Working Group completed its work at the end of June 2014 and, in all, submitted three reports and made 25 recommendations. The reports address a range of barriers and issues relating to strategic medical workforce planning as well as career planning and mentoring support for trainee doctors.

- The first report included nine recommendations which focused primarily on the quality of the training experience;
- The second report focused on medical career structures and pathways following completion of specialist training; and
- The final report addressed issues relating to strategic medical workforce planning, and career planning and mentoring supports for trainee doctors.

The reports also addressed specific issues in relation to the specialities of Public Health Medicine, Psychiatry, and General Practice.

The MacCraith Implementation Monitoring Group, comprising of representatives of seven stakeholders, was established to oversee the implementation of the recommendations and to date has produced seven progress reports.

The *Seventh Progress Report*, published in July 2018, found that while many recommendations remain to be implemented, there has been positive developments which have addressed some of the issues raised, ranging from the introduction of a training website, a doubling of family friendly places, and the introduction of the National Employment Record and Lead NCHDs. The Report highlights the need to clarify cross-sector governance and programme management issues with a focus on programme outcomes and benefits realisation. The Report sets out a number of key recommendations to be prioritised by the HSE including:

- **Protected training time:** The report suggests that interim measures should be identified with a view to protecting training time for both trainees and trainers, and notes that while measures to protect training time have been identified and are underway they have not been fully implemented.
- **Non-core task allocation:** The report recommends that a national implementation plan should be put in place by the HSE. The report noted that examples of good practice exist at various clinical sites and the national implementation plan should take account of these. The report also notes the ongoing progress in this area under the Haddington Road Agreement.
- **Reimbursement of education fees:** The report recommends a more differentiated model that takes account of the needs and costs associated with various specialities and stages of training and that the HSE review the funding mechanism for additional training requirements with a view to addressing disparities. It is noted that management and the IMO will undertake a review of continuing education requirements of NCHDs to ensure that necessary financial and related resources meet professional development needs.
- **Issue of service posts:** The report notes that the career structures and pathways for service doctors are limited and recommend that processes are put in place by the HSE to identify how best to address this issue.

The Programme for Partnership Government includes a commitment to the full implementation of the recommendations of the MacCraith report which will greatly assist in the recruitment and retention of key medical staff.

Analysis of Retention Aspects of the Survey and Structured interviews

This section presents the findings of the survey and structured interviews of NCHDs in relation to retention. Details on the methodology and limitations are provided in Appendix C and the full study is available on the Commission's website at https://paycommission.gov.ie/. As noted earlier in this chapter, the response rate for this survey was very low (estimated at 12.9%), which means the results may well reflect a group with different views or preferences from the generality of NCHDs working in the health service. The results should be treated as indicative only.

The survey results indicate that the majority (60%) of NCHDs intend to leave their current job in the next two years. Of this 60% that intend on leaving in the next two years, 38.5% intend to leave Ireland without an intention to return. The high level of intention to

leave the job over the next two years can be partly explained by the rotational nature of the NCHD role. The factors that those who indicated an intention to leave most frequently cited were better training and job opportunities elsewhere, staffing level problems and better mentoring supervision elsewhere.

The most frequently cited factors that contribute to NCHDs staying in their jobs are personal reasons, location and disruption associated with leaving.

The study includes an econometric analysis intended to assess the relative importance of factors when they are considered together. However the set of variables that is found to be important for predicting intention to leave is sensitive to the broader set of variables that is included in the model.

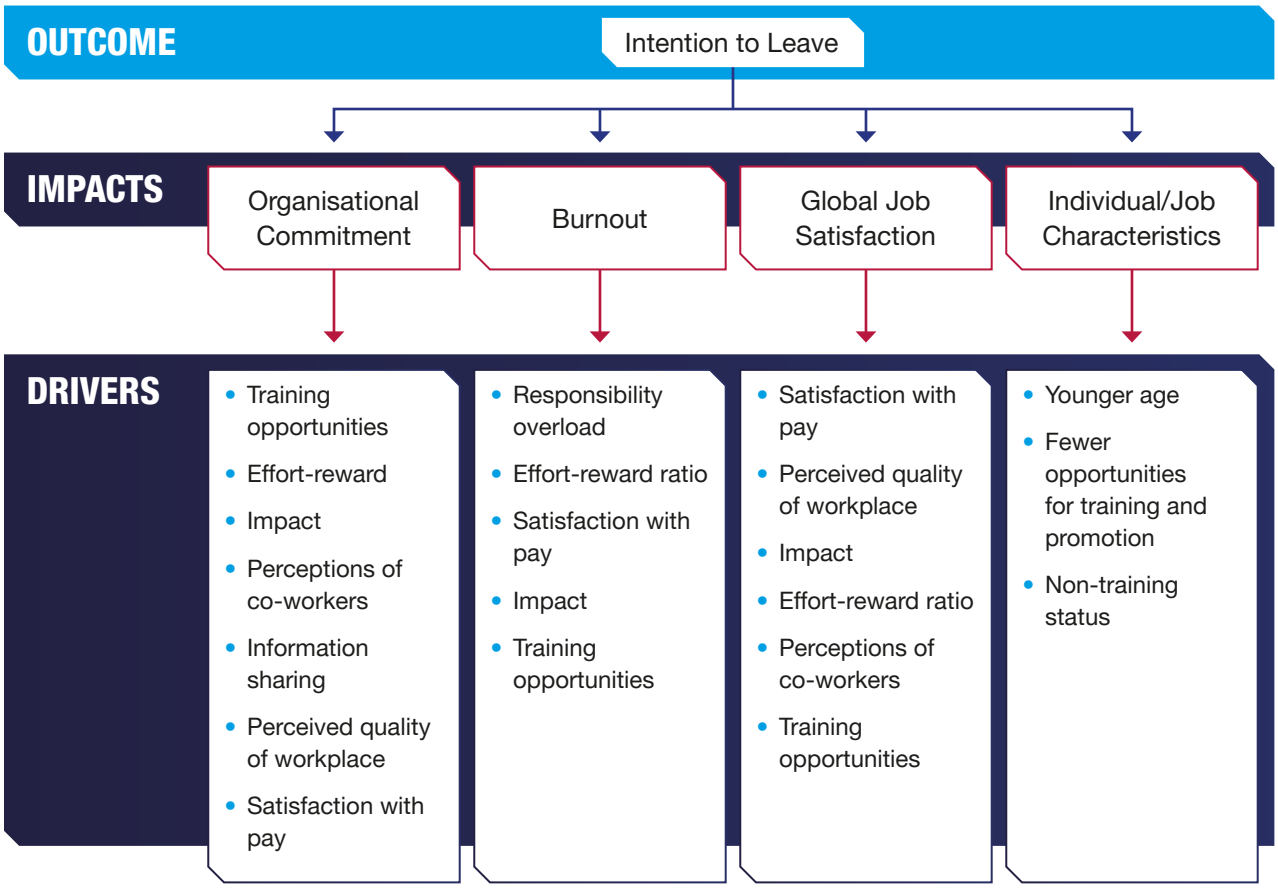
The results of these models indicate that individual and job characteristics which are predictive of a higher likelihood of leaving the job, the organisation, and/or the medical profession are:

- Age - there is a higher incidence of intention to leave amongst younger NCHDs;
- Training and promotion opportunities - fewer training and promotion opportunities are associated with intention to leave; and
- Training Status - there is a higher incidence of intention to leave amongst NCHDs in a non-training post.

Additionally, lower global job satisfaction, lower organisational commitment, and higher levels of burnout emerge as predictors of a higher likelihood of intention to leave. It is relevant to note that a range of characteristics may influence these 'impacts', as illustrated in Figure 7.8.

The findings from the qualitative research have many similarities with both the descriptive statistics

Figure 7.8: Drivers and Impacts of Intention to Leave, NCHDs



Source: Research Matters, PSPC workings

and the econometric analysis. NCHDs spoke about the satisfaction gained from making a difference to the lives of patients, taking pride in the work they do and opportunities for education and promotion as positive factors related to their job. One NCHD summed this up by stating *"I don't think we place enough value on what we do offer. And it's something I would consider quite a lot, and I think that's probably what keeps me in it".*

It was suggested that there are two peaks in the distribution of timing of NCHDs leaving: one after internship and another at fellowship. Many NCHDs acknowledged that the factors impacting on intention to leave are multifactorial. Some of the factors NCHDs' highlighted were:

- The training and promotional opportunities and the working environment compared to other jurisdictions - One NCHD said *"I considered going to the States … partly because of working conditions, and partly because of inflexibility within the training system".*
- The pay, financial incentives and level of consultant pay - One NCHD said *"the consultancy contract isn't as attractive anymore, definitely"* and another NCHD compared the level of pay compared to other jurisdictions *"When you look at countries like New Zealand, you look at Australia, when you look at Canada, [there are] a lot of incentives, such as travel expenses, such as locating expenses, such as salary being reasonably good for the amount of work that's actually being done".*

7.6 Conclusions

NCHDs make up 6% of the total staffing of the Irish public health service and are the primary pool of talent that is drawn upon to provide consultant candidates. The Commission recognises the high level of care provided by the NCHDs to patients admitted to hospitals or who are treated in community settings.

It is clear to the Commission that there has been a consistently strong level of supply of doctors over the last decade. This finding is supported by the NDTP who report that all NCHD training posts were filled in the 2013 to 2016 period. However, although the numbers of NCHDs are increasing this obscures a range of issues relating to the structure of the workforce. The distribution of the increase in NCHDs has been weighted towards increasing NCHDs in non-training posts to comply with the EWTD. The *Hanly Report* advised that increasing NCHD numbers to comply with the EWTD would *"worsen the situation for both patients and doctors".* The Commission believes that while compliance with the EWTD is extremely important, in the context of the planned move to a consultant delivered health service, it is questionable whether the level of increase in non-training posts is consistent with the goal of a future public health service that is to be delivered by consultants.

As noted above, there is a strong level of demand for NCHD training posts, however Ireland is highly reliant on foreign trained doctors to fill non-training posts despite producing the highest number of medical graduates per capita in the OECD. Reliance on foreign trained doctors may be precarious in the context of increased international demand and worldwide shortages and is at odds with Ireland's obligations under the *WHO Global Code of Practice on the International Recruitment of Health Personnel.*

The Commission's research has shown that the recruitment process itself could be improved. In particular, improvements could be made in the orientation provided when commencing a role and in the provision of information on the system of NCHDs' rotations and the costs associated with that system.

NCHD retention should be considered in the context of the current high level of output from Irish medical schools and the reliance of the public health service on foreign trained graduates to fill non-training posts. Ireland produces the highest number of medical graduates in the OECD and conversely has the highest dependency on foreign trained doctors. The public health service should encourage NCHDs, particularly those who have graduated from Irish medical schools, to remain within the Irish public health service or return after time spent abroad.

The evidence from the Commission's analysis and various other studies signal that training and promotion opportunities are the key influencer of migration and turnover of this group. Linked to this is the perception of NCHDs' future pay prospects which are impacted by the reduced consultant contracts. The research also found that NCHDs are more likely to intend to leave due to additional costs associated with training that is required to advance their careers, the negative impact of rotations on their personal lives and when they have poor working environments.

In carrying out its review of recruitment and retention issues relating to NCHDs the Commission was mindful of the commitment in the *Programme for Partnership Government* to the full implementation of the *MacCraith Report* to assist in the recruitment and retention of key medical staff.

The Commission notes that the Terms of Reference of the MacCraith Implementation Monitoring Group includes a requirement to assess the impact of the measures on the recruitment and retention of doctors (including trainees, consultants, and other specialists) in the Irish public health service and report twice yearly to the Minister for Health and at consultation meetings with trainee doctors.

The Commission is strongly supportive of the full implementation of the recommendations of the Strategic Review of Medical Training and Career Structures as they have the potential to resolve many of the issues raised with the Commission relating to recruitment and retention. In this context, the Commission is concerned that implementation of the recommendations of the *MacCraith Report* should not lose momentum and notes the reservation, in their most recent progress report, that the delivery of recommendations is not necessarily an indication that the desired improvement have been achieved. The focus following the *Seventh Progress Report* requires arrangements to be put in place to progress the four key issues which include:

- Protected training time;
- Refund of fees;
- Transfer of tasks; and
- The position of 'service grade doctors' who do not occupy training posts.

The Commission also acknowledges the conclusions of the NDTP's seventh annual assessment of NCHD posts, many of which are analogous to recommendations of the *MacCraith Report.* The Commission would endorse prioritisation of the key areas identified in both reports which will have the potential to deliver improvements in the employment, training environment and family lives of NCHDs.

Chapter 8: Hospital Consultants

Chapter 8: Hospital Consultants

8.1 Introduction

This chapter will consider recruitment and retention trends for consultants, which were one of the cohorts identified in the Commission's first Report as experiencing some recruitment and retention difficulties. Similar to the preceding chapter concerning NCHDs, the body of work flowing from the MacCraith Reports formed the backdrop to the Commission's analysis of the issues pertaining to recruitment and retention of consultants. This series of reports reflects a serious level of policy concern about the structure of the medical workforce, including on-going difficulties in the filling of pivotal clinical and academic appointments.

The chapter first provides a summary of the issues raised in submissions to the Commission concerning the recruitment and retention of consultants. An overview of trends in numbers of consultants from 2007 to 2017 is provided. The next section of the chapter focuses on recruitment in the context of the issues raised in submissions, and the supply pool for consultant posts. It also looks at the recruitment process, recruitment trends, vacancy levels and available recruitment campaign data. The chapter then specifically considers issues pertaining to the retention of consultants in the public health service, which was the area where it proved most challenging to collate detailed high quality information. The retention section analyses turnover trends and considers the exit rate for doctors registered in the Specialist Division of the Medical Register. It also looks at trends in applications for certificates to work abroad for doctors generally and the key findings from the Commission's survey of consultants concerning the impact of different factors on intentions to leave existing employment. Finally, the chapter sets out the Commission's conclusions.

8.2 Issues raised with the Commission by Parties

The Commission received several submissions related to consultant recruitment and retention and met with a number of interested stakeholders to fully explore the issues raised. The following section sets out some of the views and information presented by the stakeholders to Module 1. All submissions received are available on the Commission's website at https://paycommission.gov.ie/submissions/.

Joint Employer Submission

Pay

The joint employer submission stated that consultants who work in the public health service are engaged under three different contract and remuneration types. The submission estimates that 44% of currently serving consultants are on a Contract B under the pre-1 October 2012 terms and, on average will earn a basic salary of €176,849 in 2018, with an additional €18,129 in allowances, resulting in a gross salary of €194,978. For new entrants (i.e. post-2012 on a Type B contract) the estimated gross salary inclusive of allowances was submitted as €161,803. The employer's submission flagged the legal action taken against the State and HSE for breach of contract by over 500 consultants. This case has subsequently been settled.

Supply

The joint employer submitted that the supply of consultants is drawn from the existing pool of NCHDs, which has increased by 29% since 2008. However, it acknowledged that NCHDs in non-training posts are not eligible to become consultants.

Numbers

The submission indicated that approved consultant posts have increased by 47% from 2,169 to 3,189 since 2008, with 834 of those replacement posts, bringing the total recruitment figure to 1,854 over the last decade. It stated that the number of WTE consultants employed in the public health service increased by one third from 2,234 in December 2007 to 2,968 as of October 2017. The number of consultants employed has increased across all Hospital Groups, and at an individual hospital level; 77% of hospitals have a higher number of consultants employed compared to 2007. These increases form part of the effort to move to a consultant-delivered,

rather than consultant-led, service which the submission acknowledged as challenging.

Specialities and Sub-specialities

The joint employer stated that 127 consultants are working in specialist areas without being registered on the Specialist Division of the Register of Medical Practitioners. According to the joint employer this appears to have arisen due to local recruitment difficulties, and in specialities which experience recruitment difficulties. The submission further indicated that data from the Public Appointments Service (PAS) regarding the number of applications received for consultant posts, as of April 2018, indicated that the lowest levels of application were for posts in smaller hospitals, Psychiatry (particularly outside the main urban centres), Emergency Medicine, Radiology (including Radiation Oncology), and Pathology (specifically Histopathology). This set of specialities also showed low levels of applicants in PAS' data in respect of consultant recruitment efforts during 2016.

Tenure

The joint employer identified consultant tenure as an indicator of recruitment difficulty. Quarter 1, 2018 data from the NDTP unit of the HSE indicated that almost 10% of all consultants did not have a permanent contract (e.g. doctors working through an agency or on a fixed-term contract) but the percentages were much higher for Model 3 Hospitals (17%) and for Emergency Medicine, Psychiatry and Intensive Care (22%, 20% and 16%, respectively).

Initiatives to Improve Recruitment and Retention Outcomes

The submission outlined a number of initiatives which the HSE had introduced in response to recruitment and retention difficulties including increasing salary scales for new entrants, allowing incremental credit up to the maximum point of the relevant salary scale, and the introduction of family-friendly flexible working for consultants.

Staff Representative Associations

Pay

The staff representative associations stated that the non-implementation of the 2008 Consultant Contract terms and the pay reductions in respect of new entrant consultants (2012), in conjunction with the FEMPI pay reductions, have reduced the competitiveness of the Irish public health service as an employer within the domestic and international market.

They also asserted that the breach of contract has resulted in serious and long-lasting damage to the reputation of the public health service as a trusted employer, and that this was a significant factor, for Irish trained NCHDs in particular, in decisions about career planning.

Vacancies

The staff representative associations submitted that, notwithstanding the difficulties in quantifying the precise number of vacancies due to poor data, there are approximately 400 posts either vacant or filled on a temporary or agency basis (e.g. 31% of all approved consultant psychiatrist posts were either vacant or filled on a temporary basis).

Supply

The staff representative associations submitted that, despite graduating a sufficient number of doctors to meet domestic need and Ireland producing the highest number of medical graduates per 100,000 population in the OECD, vacancies at all levels have continued to increase.

Low Level of Applications

The staff representative associations submitted that there is a failure to fill permanent consultant posts, with one in four of the posts advertised in 2016 by PAS failing to attract any suitable candidates. It was also submitted that in 2015 over half of posts advertised received zero to two applications, increasing to 60% in 2016. It was further suggested that low levels of applications for advertised permanent posts restricts the calibre of candidate choice available to employers.

Non-specialist Appointments

The staff representative associations stated that the high number of vacancies has resulted in the appointment of non-specialist practitioners to consultant posts, which is in breach of the HSE's recruitment rules and the Medical Practitioners Act, 2007.

Emigration

It was submitted that permanent consultants are resigning and taking up positions in other English-speaking countries, and that this is a consequence of a deterioration in remuneration. It was submitted that salaries in the United States, Canada, Australia and the Gulf States are in excess of Irish rates and that when the local and national awards are taken into account, it is also the case in the UK.

The IMO canvassed opinions from a group of 77 consultants and NCHDs working in other jurisdictions. 56% reported that their pay improved by moving

abroad. Furthermore, the IMO Recruitment and Retention Survey 2017 (n=111) shows that 27% of respondents are considering taking up posts abroad. The four most frequently cited factors leading these doctors to consider a move abroad were better workplace atmosphere, higher remuneration, higher doctor staffing levels and better development opportunities.

A July 2018 Irish Hospital Consultants Association (IHCA) survey of newly appointed consultants (appointed post 1 October 2012) reported that over 70% of the 200 respondents indicated that they would consider resigning from their public hospital posts unless their salary terms were corrected. 92% confirmed that they were aware of colleagues working abroad who will not return to work in the Irish public health service. The IHCA submission also stated that there has been no reduction in Ireland's reliance on the recruitment of IMGs and that foreign doctors have accounted for 30% to 40% of all doctors registered with the Medical Council of Ireland in recent years.

Age Profile

Staff representative associations referred to the age profile of consultants employed directly by the HSE (excluding HSE funded Voluntary hospitals), which indicated that at March 2016, 25% were aged over 55 years, with 10% over 60 years of age.

8.3 Employment Trends

Key Findings:

- The number of consultants has increased by 33% from 2007 to 2017.
- The difference between serving numbers and the Establishment number has declined from a surplus of 41 in 2007 to a deficit of 169 consultants in 2017.
- Across a number of indicators, including vacancies and non-specialist appointments, the evidence shows that there are particular problems in Psychiatry.

Overview of Data and Trend in Numbers

As discussed in Chapter 6, the Commission sought detailed information on recruitment transactions and departures from Ireland's public health service for consultants but these forms of data were not generally available. Details of some specific recruitment competitions were available for consultants from PAS. However, there were significant data limitations, as well as variations, in the recruitment and retention data received over time and at the level of regions or Hospital Groups. In this section a range of indicators that might cast light on consultant recruitment and retention are considered.

Consultant Numbers

Consultants were not subject to the *Moratorium on Recruitment and Promotions in the public service (2009-2014)* and the number of consultants employed in the public service has steadily increased over the last decade. Table 8.1, shows an increase in consultant numbers of 33% from 2007 to 2017. The Establishment number, or the number of permanent consultant posts approved for filling, has also increased over the period but to a greater degree (43%), which would be expected in a circumstance where the HSE is seeking to scale up consultant numbers, as part of the effort to move to a consultant-delivered rather than consultant-led service.

Submissions to the Commission cited up to 400 posts which were either vacant, or were filled on a temporary or agency basis. However, due to the lack of precise data on the number of unfilled posts it is not possible to fully reconcile the numbers in Table 8.1 with the figures stated in the submissions, which also acknowledge the lack of certainty around numbers.

The variance between the Establishment number and the number of WTE in employment is accounted for by both part-time posts and vacant posts. The Commission chose to analyse the difference between the Establishment number and serving numbers, as they appear to be the most reliable and consistent data reported[1]. The variance fluctuates from one year to the next, but over the last decade the differential has become greater, and despite the increase in the number of consultants in post, WTE numbers serving at December 2017 remained over 5% (169) below the December 2017 establishment number (3,140).

1 In a recent response to a PQ ref 32037/18, the HSE said that there were currently 349 unmatched consultant positions in hospitals and community settings, and that an unmatched position is an indication of a vacancy. However, they also stated that the database had only recently been put in place and that the data matching exercise was not complete, advising that there *"may be variances and gaps in the data supplied to that held within hospitals".*

Table 8.1: Trends in Consultant Numbers (WTE) and Establishment Numbers, 2007, 2013 - 2017

	2007	2013	2014	2015	2016	2017
Serving number (WTE)	2,234	2,556	2,635	2,724	2,862	2,971
Establishment number	2,193	2,670	2,747	2,891	2,976	3,140
Difference	41	-114	-112	-167	-114	-169
Difference as % of Establishment number	+1.9	-4.3%	-4.1%	-5.8%	-3.8%	-5.4%

Source: HSE

Trends in Establishment Numbers

The NDTP Consultants Division is responsible for the HSE's regulatory role in consultant appointments in the public health service in Ireland; including HSE hospitals, Voluntary hospitals, Mental Health Services and other agencies. The Division processes all applications for additional or replacement consultant posts for consideration by the Consultant Applications Advisory Committee. The Division maintains the statutory register of approved consultant posts. Consultant Establishment numbers have increased by 43% since 2007 (17.6% since 2013). The 2017 Report *Towards Successful Consultant Recruitment, Appointment and Retention (HSE, 2016)* states that *"each year approximately 55% of Consultant posts approved by the HSE are additional, while 45% are replacement"* and that *"for every vacant post being recruited/advertised and filled, another new post is being approved".*

Report of the National Taskforce on Medical Staffing (Hanly 2003)

In addressing the number of consultant posts, it is necessary to consider these increases in the context of the *Hanly Report* (Department of Health and Children, 2003) and the Government policy to move to a consultant-delivered, rather than consultant-led service. The implementation of this policy requires the number of consultants to grow considerably and a concomitant reduction in the number of NCHD posts. The *Hanly Report* stated that *"in order to achieve a fully operational Consultant provided service by 2013, the Task Force estimates that some 3,600 Consultants will be needed, representing an increase of some 1,870 posts (+ 108%) over the figure for 2003".* It also states that *"the year 2013 is recommended as the target for achieving this, although this could be adjusted in the light of experience if necessary. These recommendations are accompanied by a reduction over the same time period in the number of NCHDs from about 3,900 to some 2,200".* The Establishment number of approved consultant posts in December 2017 was 3,140. This shows that the number of approved consultant posts has not yet reached the 3,600 target, which was envisaged by the report.

Table 8.2 shows that the number of consultants working in the public health service increased by 737 from 2007 to 2017. Nonetheless, this is still short of the target set by the *Hanly Report* for 2013. However, it is important to note that the envisaged reduction in the number of NCHDs (from 3,900 to 2,200) recommended in the report has not occurred. The recruitment of 1,450 additional NCHDs across the same period has meant that the overall NCHD and consultant workforce has grown over the last 10 years but the ratio of NCHDs to consultants has remained static at approximately 2:1.

Numbers across Specialities

Since 2007, the numbers serving across the specialities have increased, with the largest percentage increases in Emergency Medicine, Paediatrics, Medicine, and Pathology.

Table 8.2: Serving Number of NCHDs to Consultants (WTE), 2007, 2013 - 2017

	2007	2013	2014	2015	2016	2017
Consultants	2,234	2,555	2,635	2,724	2,862	2,971
NCHDs	4,881	5,007	5,397	5,814	6,060	6,331
Number of NCHD per Consultant	2.18	1.96	2.05	2.13	2.12	2.13

Source: HSE

Table 8.3: Trend in Consultant Numbers (WTE) by Speciality, 2007, 2013 - 2017

Speciality	2007	2013	2014	2015	2016	2017	% change 2007-2017
Anaesthesia	341	351	348	350	373	389	14.1%
Dentistry	13	16	16	15	15	16	23.1%
Emergency Medicine	53	75	75	83	92	98	84.9%
Intensive Care Medicine	0	2	3	3	3	5	N/A
Medicine	481	601	654	675	723	756	57.2%
Obstetrics & Gynaecology	120	122	124	135	140	151	25.8%
Paediatrics	103	135	148	151	157	172	67%
Pathology	163	206	207	213	230	239	46.6%
Psychiatry	341	356	351	362	362	364	6.7%
Radiology	196	240	244	249	268	270	37.8%
Surgery	410	451	465	488	498	511	24.6%
Other	13	1	1	1	1	0	N/A
Total	2,234	2,556	2,635	2,724	2,862	2,971	33%

Source: HSE

Table 8.4 illustrates the establishment numbers by speciality in 2007 and the trend from 2013 to 2017. It shows that the Establishment number for Emergency Medicine, Medicine, Paediatrics, and Pathology proportionately increased at a greater rate than the average increase of 43.2%.

Table 8.4: Trends in Consultant Establishment Numbers by Speciality, 2007, 2013 - 2017

Speciality[2]	2007	2013	2014	2015	2016	2017	% change 2007-2017
Anaesthesia	317	347	348	361	366	374	18.0%
Emergency Medicine	52	79	80	88	95	102	96.2%
Intensive Care Medicine	-	14	18	20	21	24	N/A
Medicine	451	621	641	686	708	749	66.1%
Obstetrics & Gynaecology	116	127	133	142	147	157	35.3%
Paediatrics	128	153	159	173	183	201	57.0%
Pathology	191	238	248	255	264	276	44.5%
Psychiatry	343	392	406	425	440	458	33.5%
Radiology[3]	209	258	261	274	282	289	38.3%
Surgery	386	441	453	467	487	508	31.6%
Other	-	-	-	-	-	2	N/A
Total	2,193	2,670	2,747	2,891	2,993	3,140	43.2%

Source: HSE

At the end of December 2017, serving numbers were 169 below the total Establishment number, which is 5.4% short of the overall Establishment number. However, a detailed examination of the breakdown across consultant specialities in Table 8.5 indicates that there is a more substantial shortfall in particular specialities; most notably Intensive Care Medicine (79.2% variance), Psychiatry (20.5%), Paediatrics (14.4%), Pathology (13.4%) and Radiology (6.6%).

2 Consultant Dentistry serving numbers were included in Table 8.3, but there is no corresponding Establishment number for this speciality.

3 Radiation Oncology numbers were included in Consultant Radiology reporting since 2017, so data for 2013-2016 are also included in Consultant Radiology category for ease of comparison.

Table 8.5: December 2017 Serving Numbers (WTE) compared with Establishment Numbers, 2017

Speciality	Serving Numbers	Establishment Numbers	Variance	
			Number	%
Anaesthesia	389	374	15	4.0%
Dentistry	16	-	16	N/A
Emergency Medicine	98	102	-4	-3.9%
Intensive Care Medicine	5	24	-19	-79.2%
Medicine	756	749	7	0.9%
Obstetrics & Gynaecology	151	157	-6	-3.8%
Paediatrics	172	201	-29	-14.4%
Pathology	239	276	-37	-13.4%
Psychiatry	364	458	-94	-20.5%
Radiology	270	289	-19	-6.6%
Surgery	511	508	3	0.6%
Other	-	2	-2	N/A
Total	2,971	3,140	-169	-5.4%

Source: HSE

Consultants not on the Specialist Division of the Medical Register by Speciality

In March 2008, the HSE introduced the requirement for new consultants to have membership of the Specialist Division of the Register of Medical Practitioners and the Consultant Contract 2008 reflects this provision. Submissions to the Commission indicated that a total of 127 consultants (4.2% of consultant workforce) were working in specialist areas without being registered on the Specialist Division of the Register.

A recent judgment by the President of the High Court, in respect of a case involving a practitioner being removed from the Medical Register, also highlighted the issue of non-specialists being appointed as consultants. The President directed that a copy of the judgment be forwarded to the Attorney General, the Minister for Health and Secretary General of his Department, the HSE Chief Executive, HIQA and the State Claims Agency.

The Commission notes a more recent HSE update in June 2018, which indicated that this number now stands at 133, although it was acknowledged that the number could be higher as the NDTP's database only contains registration information for approximately 90% of the consultant workforce in HSE funded posts[4]. Table 8.6 indicates that the specialities with the highest proportion of non-specialist consultants as a percentage of serving numbers are; Emergency Medicine (13.3%), Psychiatry (6.9%), Obstetrics and Gynaecology (5.3%), Medicine (4.9%) and Surgery (4.5%).

4 PQ ref 25215/18 to Minister of Health from Deputy Stephen Donnelly T.D., reply issued 26th June 2018.

Table 8.6: Consultants who do not hold Specialist Registration by Medical Speciality, June 2018

Speciality	Number of Consultants who do not hold Specialist Registration	% of Serving Numbers who do not hold Specialist Registration	% of Establishment Numbers who do not hold Specialist Registration
Anaesthesia	10	2.6%	2.7%
Emergency Medicine	13	13.3%	12.7%
Intensive Care Medicine	1	20%	4.2%
Medicine	37	4.9%	4.9%
Obstetrics & Gynaecology	8	5.3%	5.1%
Paediatrics	6	3.5%	3%
Pathology	2	0.8%	0.7%
Psychiatry	25	6.9%	5.5%
Radiology	8	3%	2.8%
Surgery	23	4.5%	4.5%
Total	133	4.5%	4.2%

Source: HSE, PSPC workings

There are two different cohorts of non-specialists as shown in Table 8.7. The first group of 61 comprises those who were either appointed permanently pre-2008 or were appointed temporarily post-2008 but subsequently acquired a contract of indefinite duration. The second group of 72, were appointed post-2008 on a temporary or locum basis either on a specified purpose/fixed-term contract, or employed through an agency.

Table 8.7: Consultants who do not hold Specialist Registration by Medical Speciality; by Cohort

Speciality	Started current post before 2008 or post-2008 in a CID	Started current post after 2008 on a non-permanent basis
Anaesthesia	9	1
Emergency Medicine	6	7
Intensive Care Medicine	1	0
Medicine	16	21
Obstetrics & Gynaecology	3	5
Paediatrics	3	3
Pathology	2	0
Psychiatry	3	22
Radiology	3	5
Surgery	15	8
Total	61	72

Source: HSE, PSPC workings

HSE Proposals to Address Non-Specialist Appointments

The Commission notes the HSE's recent statement to the Oireachtas Joint Committee on Health, in which it said that it had established a working group chaired by Professor Frank Murray, Director of the NDTP, with representation from the Medical Council, the Forum of Postgraduate Medical Training Bodies and other interested stakeholders to consider the issue of non-specialist consultants[5]. The statement also outlined the steps which are being taken by the HSE to address the issue as follows:

- **Consultants appointed pre-2008, and those with a CID**

  The expectation is that the prior career histories would entitle this group to secure registration in the Specialist Division and this group are being encouraged and supported in seeking registration now. The Working Group has been asked to engage with the Medical Council to facilitate and expedite this process.

- **Consultants appointed post-2008**

  Post-2008 consultants are to be advised that specialist registration will be required as part of securing permanent appointment. Similar financial supports will be put in place to facilitate their applications for specialist registration. Pending acquisition of specialist registration, risk assessment of the continuance of any consultants in the general division is required.

- **Direction to locum agencies**

  The HSE has a framework agreement with five agencies for the provision of locum medical staff at consultant and NCHD level. The HSE has written to the agencies advising them that it will not consider consultants registered in the General Division for any locum consultant post of any duration.

- **Minimising the timeline for filling new or replacement consultant posts**

  The HSE are clarifying the position in respect of each consultant post currently filled by a post-2008 consultant on a locum or agency basis to establish at what stage the application for approval/recruitment of the relevant permanent post is at. The aim being to eliminate impediments at any stage of the approval, advertising, shortlisting, interviewing, post-selection process to minimise situations of dependence on post-2008 consultants not in the Specialist Division.

- **Other Working Group guidance**

  The Working group will consider other guidance that it intends to issue to Hospital Groups and CHOs including a proscription on engagement of any further consultants from the General Division, and the need for hospitals to have risk stratification and mitigation processes.

Hospital Consultant Numbers Permanent and Full-Time

Table 8.8 sets out the percentage of consultants serving on permanent contracts and the percentage who are working full-time. Table 8.5 showed that there is a shortfall of 94 WTE between the 458 Establishment (approved) Psychiatric Consultant posts and the December 2017 WTE serving in Psychiatric Consultant posts; a variance of 20.5%. 75.1% of Psychiatric Consultants at December 2017 are permanent appointees, which is the lowest proportion of permanent contracts relative to serving numbers for any speciality. Submissions to the Commission identified high proportions of temporary contacts for a speciality as an indicator of recruitment and retention difficulties. If this is the case, there would appear to be a more pronounced problem recruiting to certain specialities, particularly Psychiatry and Emergency Medicine where the percentage of Emergency Medicine Consultants who are permanent appointees is also relatively low (75.2%).

The majority (83.4%) of consultants work full-time, although a range of 69.9% to 100% is evident across the specialities in Table 8.8. As indicated earlier in this chapter, where consultants are working part-time, this may account for some of the variation between the numbers serving (WTE) and Establishment numbers (headcount) in the specialities.

5 HSE Statement to the Oireachtas Joint Committee on Health, 13 June 2018.

Table 8.8: Percentage of Permanent Hospital Consultants by Speciality, 2017

Speciality	% Total Perm	% Total Full-Time
Anaesthesia	86.1%	90.4%
Dentistry	89.5%	78.9%
Emergency Medicine	75.2%	82.6%
Intensive Care Medicine	100.0%	100.0%
Medicine	81.3%	82.6%
Obstetrics & Gynaecology	87.4%	82.6%
Paediatrics	82.5%	69.9%
Pathology	87.8%	84.0%
Psychiatry	75.1%	82.3%
Radiology	86.7%	90.6%
Surgery	83.1%	81.9%
Overall	82.7%	83.4%

Source: HSE

Age Profile

In 2017, based on a sample size of 56.8% of the consultant workforce, 27% of consultants were aged 55 years or over, and 11% were aged 60 years or over. This age profile would be expected given the significant experience required for doctors to become consultants, however the percentage of HSE consultants in these age cohorts has increased since 2013, when 23% were aged 55 years or over and 8% were aged 60 years or over.

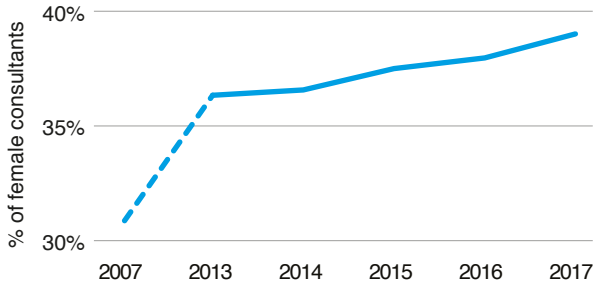
Nationality

The HSE provided nationality data for a sample of consultants for 2016 and 2017. In 2016 the sample size was 1,327; 42.3% of the 2016 total consultant workforce. In 2017, the sample size was 1,304, 40.2% of the 2017 total consultant workforce. The breakdown has not changed over the last two years and, unlike the NCHD population, the consultant workforce is predominately Irish at 83.8% in 2017.

Gender

The consultant workforce differs from the composition of the NCHD cohort in respect of gender. The gender of NCHDs is more evenly split, while the consultant workforce is largely Irish and male. The female proportion has increased from 31% in 2007 to 39% in 2017.

Figure 8.1: Trend in Consultant Gender 2007, 2013 - 2017



Source: HSE and DPER

Pay

There are several different consultant payscales, depending on the type of contract and date of appointment. It is also worth noting that the majority of consultants, with the exception of those on Type A contracts, have the capacity to enhance their earnings by engaging in varying degrees of private practice depending on their contract type. Further detail in respect of consultant pay is provided in Chapter 2. The most relevant aspect of consultant pay for this chapter is the potential impact of the two tier pay system on the recruitment and retention of new entrant consultants.

The recent settlement of legal proceedings by consultants, in relation to non-payment of an increase specified in the 2008 Consultant Contract, has led to an even greater disparity between consultants appointed before 2012 and new entrant consultants appointed after that date. Full details of the settlement are available on the HSE's website at https://www.hse.ie/eng/staff/resources/consultants-contract-2008/consultant-contract-2008-settlement-agreement-guidance.pdf.

Type B is the most common contract type (see Table 8.14 for further details) and the payscales for this contract type will be used for comparative purposes here. Following the settlement the salary for consultants on a Type B contract appointed up to 30 September 2012 will range from €162,635 to €193,665 (6 point scale), with effect from 1 April 2018.

The rates for new entrants appointed from 1 October 2012 are not impacted by the settlement. This cohort and any future appointees have a 9 point payscale, with the minimum and maximum points being €126,789 and €166,473, with effect from 1 April 2018. As seen in Table G.3, in Appendix G, the disparity between the minimum points of these scales is €35,846 (28.3%), with the disparity between the maximum points being €27,192 (16.3%). The levels of disparity between the remuneration for the new entrant consultants appointed from October 2012 are disproportionate, relative to the pay reductions which generally apply to new entrants to the public service.

Whilst a 10% reduction in pay for new entrant grades applied generally across the public service with effect from the 1 January 2011, an additional reduction of 30% was applied for new entrant consultants appointed from 1 October 2012. The differential in pay between the pre-existing cadre of consultants and new entrants is significantly greater than for other categories of public servant. There was some amelioration of these reductions following negotiations and the acceptance by the IMO of LRC Agreement (7 January 2015), which introduced a new nine point scale, with flexibility around the starting points.

8.4 Discussion on Hospital Consultant Recruitment

Supply

Consultant positions are generally filled from the existing pool of NCHDs or by doctors who have undertaken specialist training in other countries. The consideration of supply of NCHDs in the preceding chapter concluded that overall the number of graduates from relevant medical courses has shown strong and consistent growth and an increase of 230% from 2009/2010 to 2015/2016, and the number of NCHDs has also increased by almost 30% from 2007 to 2017. However, NCHDs who are in non-training posts are not eligible to apply for consultant positions, and in 2016/2017, as shown in Table 7.2 in the preceding chapter, 36.4% of all NCHDs are in a non-training post.

There are five divisions of the Register of Medical Practitioners with different qualification and registration requirements; one of which is the Specialist Division. The Specialist Division of the Medical Register includes doctors who have completed specialist training programmes who are normally qualified to practice as a consultant. Table 8.9 indicates that a total of 9,306 doctors were registered on the Specialist Division in 2017, which is an increase of approximately 31.2% over the 2011 figure of 7,095. This would seem to indicate that the number of registrations on the Specialist Division of the Register has been growing even faster than registrations generally since 2011 (20.4%).

Table 8.9: Trends in Medical Register by Division, 2011 - 2017

	2011	2012	2013	2014	2015	2016	2017
General Division	8,308	7,223	7,423	8,633	8,547	9,102	9,274
Specialist Division	7,095	7,357	7,567	7,929	8,370	8,807	9,306
Trainee Specialist Division	2,389	2,506	2,355	1,555	2,371	2,669	2,811
Intern Registration	670	676	788	800	932	995	1,081
Supervised Division	232	287	18	106	224	195	157
VEEA	118	135	9	26	29	27	20
Total	**18,812**	**18,184**	**18,160**	**19,049**	**20,473**	**21,795**	**22,649**

Source: Medical Council

Table 8.10 shows the number of first-time registrations across Divisions of the Register for years 2012 to 2016. It indicates that the number of first-time registrations to the Specialist Division dropped back in 2013, recovered in 2014, with further year-on-year increases thereafter, and an overall increase of approximately 38.4% over the period.

Table 8.10: First-Time Registrations across Divisions of Medical Register, 2012 - 2016

Division	2012	2013	2014	2015	2016
General	626	922	1,122	1,595	1648
Specialist	224	153	231	252	310
Intern	*	698	712	726	727
Supervised	11	16	24	88	71
Trainee Specialist	321	394	430	459	405
VEEA	15	10	28	29	11
Total	1,197	2,193	2,547	3,149	3,172

*Intern figure not available for 2012

Source: Medical Council

The Recruitment Process

As a public service agency, the HSE recruits staff under licence for the Commission for Public Service Appointments. Permanent Hospital Consultant Staff within the HSE are recruited via the Health Business Service Recruit (HBS Recruit), which in turn uses the services of PAS as the centralised provider of recruitment for permanent consultant posts. Non-permanent consultants are recruited by hospitals and mental health services directly. PAS only recruits consultants for the HSE. Section 38 Agencies, which include Voluntary hospitals, recruit permanent and non-permanent consultants directly.

As set out in Chapter 1 the Commission sought a range of data from individual Hospitals and CHOs in relation to recruitment and retention and while the response rate in respect of consultant information was poor, a number of respondents indicated that delays in the recruitment process itself, were a significant challenge in improving recruitment.

The *MacCraith Report* (Department of Health, 2013) states that *"with regard to the current multi-step Consultant appointment process, the Working Group recommends that it should be re-designed and modernised as a matter of priority. A systems and service-wide approach to posts – both new and replacement – should be incorporated, that better balances local autonomy and national coordination – in line with the Hospital Group structure".*

More recently in December 2016, a Committee appointed by the HSE concerning reform of the processes for creation, approval, recruitment and appointment to consultant posts, which was chaired by Professor Frank Keane, endorsed the findings of the MacCraith reports (2013-2014) and found that the process was multi stepped and over-complicated (HSE, 2016). It set out 33 recommendations in relation to improving the operational and administrative barriers to recruitment. Some of the issues that the report identified were administrative delays, inconsistent advertisement practices, delays in clearance process and delays in candidates progressing applications for specialist registration and/or agreeing start dates. The report set out the current process for recruiting a consultant to HSE Hospitals/Mental Health/Agencies and disclosed that from the time a letter of approval issues to the HBS, it could take over three years for a consultant to take up a post with the longest delays taking place at the following stages:

- Clearance Process (qualifications, references, registrations, Garda vetting etc.) this can take up to eight months;
- Engaging with the Candidate to complete contract documentation and agree a start date, this can take up to five months;
- It can take up two years after acceptance of offer for a Candidate to take up a post due to personal circumstances relating to training, completion of existing appointment etc.

The Committee also found, *inter alia,* that there was evidence of poor job planning and delays in processing replacement applications. In addition, it found that there were further delays at recruitment process stage and that remuneration issues resulted in delays in accepting an offer pending 'negotiation on the terms of the offer'.

An *Audit of Appointments to Consultant Positions in the Health Service Executive (HSE) conducted by the Public Appointment Service* (Commission on Public Service Appointments, 2017) recommended that PAS should impress upon the HSE the importance of proper succession planning and that although "contracting/onboarding" of the successful candidate is outside PAS' remit, the report recommended that the HSE should explore, with PAS' support, where appropriate, how it might introduce greater controls to ensure those assigned take up duty more promptly.

Recruitment Trends

PAS has supplied the Commission with trends in recruitment data from 2009 to 2017. As mentioned earlier, PAS generally only recruit on behalf of the HSE hospitals, CHOs and Agencies. Other Voluntary hospitals recruit directly and recruitment trends in respect of consultants in those hospitals are not reflected in the following tables. Table 8.11 sets out the number of consultant campaigns advertised by PAS from 2009 to 2017. 2013 saw the lowest number of campaigns with only 56 advertised, and 2015 saw the highest number of campaigns with 180 advertised.

Table 8.11: Number of Hospital Consultant Campaigns Advertised by PAS, 2009 - 2017

Year	Acute	Psychiatrist	Other	Total
2009	111	3	0	114
2010	109	8	0	117
2011	78	16	1	95
2012	100	14	0	114
2013	49	6	1	56
2014	77	33	0	110
2015	141	38	1	180
2016	83	18	0	101
2017	75	21	1	97
Total	823	157	4	984

Source: PAS

Table 8.12 looks at the number of candidates recommended by PAS to the HSE. The highest number of recommendations was in the period 2009 to 2011, this period also had the highest number of applicants per post advertised. The number of recommendations per post appear to have fallen at the same time as the introduction of reduced pay rates for new entrant consultants from October 2012.

Table 8.12: Number of Hospital Consultant Candidates Recommended to HSE by PAS, 2009 - 2017

Year	Acute	Psychiatrist	Orthodontist	Total
2009	95	25	1	121
2010	116	7	1	124
2011	97	18	0	115
2012	69	18	1	88
2013	63	16	1	80
2014	57	20	0	77
2015	91	17	0	108
2016	80	19	0	99
2017	66	22	1	89
Total	734	162	5	901

Source: PAS

Analysis of PAS Hospital Consultant Recruitment Data

Table 8.13 includes data on the number of applications for consultant competitions run by PAS between 2015 and 2017.

Table 8.13: Hospital Consultant Recruitment Data, 2015 - 2017

	2015	2016	2017
No. of Posts	**213**	**143**	**111**
No. of Applicants	**524**	**389**	**324**
Average no. of Applicants per Post	**2.5**	**2.7**	**2.9**
No. of Posts with no Applicants	**26**	**22**	**11**
- Acute	15	9	5
- Psychiatry	10	13	6
- Orthodontics	1	0	0
% of Posts with no Applicants	12%	15%	10%
No. of Posts with 1 to 4 Applicants	**125**	**84**	**65**
% of Posts with 1 to 4 Applicants	59%	59%	59%
No. of Posts with more than 4 Applicants	**62**	**37**	**35**
% of Posts with more than 4 Applicants	29%	26%	32%
Number Panelled	**193**	**136**	**110**

Source: PAS

It can be seen that the average number of applicants per post would appear to be at a very low level. There has, however, been a slight increase in the average number of applications in recent years from 2.5 in 2015 to 2.9 in 2017. There was also a slight reduction in the number of posts which attracted no applicants from 26 in 2015 (12% of total number of posts) to 11 in 2017 (10% of total number of posts). Table G.2, in Appendix G, sets out the locations of posts which received no applicants over the period and it would appear to indicate that, in general, consultant recruitment competitions for Dublin-based posts are receiving at least one applicant.

Overall, the Commission would interpret these data, given the level and nature of the posts in question and the leadership role expected of consultants, as indicative of a significant on-going problem in regard to recruitment of consultants.

Recruitment Initiatives

Information received by the Commission indicated that a number of initiatives have been introduced to address problems with recruiting consultants both at a national and local level (see Box 8.1).

Box 8.1
Recruitment Initiatives

- Implementation of Labour Relations Commission (now Workplace Relations Commission) proposals from January 2015 which entailed the introduction of increased salary rates for new entrant consultants who entered service after 1st October 2012 and an associated revised consultant career structure.
- Availability of incremental credit depending on experience of the candidate.
- Progression of 'trusted partner' status for Garda Vetting which facilitates online processing and prioritisation of applications.
- Flexible interview arrangements including the use of Skype.

Contract Type

Chapter 2 briefly outlined the different types of 2008 Contract applicable to consultants. Currently, a range of contractual arrangements apply to consultants working in the public health service, including Consultant Contract 2008, Consultant Contract 1997, the Academic Consultant Contract 1998 and Consultant Contract 1991. These differences in contractual terms arise from legacy agreements. Since 2008, the only contract available to either new entrants or consultants moving to a different post, is the Consultant Contract 2008, on which over 80% of all permanent consultants are employed. The Consultant Contract 2008 varies in two important areas. Firstly, it varies in relation to access to private practice. The four different Contract Types – A, B, B* and C – differ in respect of access to private practice, with corresponding variations in the level of basic pay. Secondly, the Contract varies depending on whether the post is classified as a standard clinical post or an academic post (Professor, Associate Professor or Senior Lecturer).

Table 8.14 sets out the approved consultant posts by contract type as of December 2017. The majority of approved consultant posts are Contract Type B which provides for private practice on the public hospital site or in a co-located site but at least 80% of their clinical/patient output must be provided to public patients. Contract Type A which provides for public only practice accounts for 17.8% of all contract types approved.

Table 8.14: Approved Consultant Posts by Contract Type, December 2017

Contract Type	% of Consultants Employed
Type A - Public Only Contract	17.8%
Type B - Consultants can see private patients on the public hospital site or in a co-located site but at least 80% of their clinical/patient output must be provided to public patients.	56.2%
Type B* - serving consultants whose public to private ratio in 2006 was greater than 20%. They could retain the higher ratio, subject to an overriding maximum ratio of 70:30.	9.6%
Type C - Consultants can treat private patients outside of the public hospital campus. Private patient treatment should not exceed more than 20%.	4.4%
Other (Category 1, Category 2, Type A Academic 50%+, Type B Academic 50%+ and Geographical Whole time without fees)	12.1%

Source: HSE

The Consultants Division of NDTP also process applications for Type C Contracts, to enable off-site practice in addition to their public commitment. A total of 32 (NDTP, 2016) applications for changing to Type C contracts were received in 2016. A number of the returns to the Commission from individual hospitals also cited contract type restrictions as being an impediment to recruitment.

Themes Emerging from Analysis of Recruitment Aspects of Survey and Structured Interviews

This section presents the findings of the Commission's survey and structured interviews of consultants in relation to recruitment. Details on the methodology and limitations are provided in Appendix C and the full study of the survey and structured interview is available on the Commission's website at https://paycommission.gov.ie/. The Commission notes that the response rate for this survey was very low (13%), which means the results may well reflect a group with different views or preferences from the generality of consultants working in the public health service and should be treated as indicative only.

The findings from the analysis indicate that consultants are moderately satisfied with both the recruitment process and the reality of the job compared to expectation. A key finding is that the orientation received on commencing a job and the information provided about the job are the most frequently cited factors impacting on the recruitment of consultants.

Recruitment planning, approval for recruitment and the duration of the process were also highlighted as factors impacting on consultant recruitment in the qualitative research. Consultants believe that the process commences at a late stage relative to the notice provided; one consultant mentioned that *"they never recruit until someone's left"*. Additionally, the number of structures and organisations involved in the process make it very lengthy and frustrating. One of the consultants that was interviewed said, *"There's a recruitment process that beggars belief … it has to go to [seven named organisations / structures] … far too many people with different agendas can block that along the way ... many of whom are completely invisible".*

Recruitment Challenges

The most common recruitment themes emerging from the Commission's analysis of submissions and data received were:

- Certain specialities and locations;
- Two-tier pay system;
- Appointment of non-specialists to consultant posts;
- Recruitment process;
- Shrinkage in number of applicants and suitable candidate pool;
- Type of contract; and
- Tenure of contract.

8.5 Discussion on Cohort Retention

Turnover

In 2017 consultant turnover[6] rates based on HSE data were 7.8% (or 6.6% excluding retirements), this is a reduction of 1.1% compared with the 2016 turnover rate. It is important to note that the data as reported by HSE does not capture movements within the health service. This means a consultant who moves between public health organisations is recorded as a leaver, even though he or she has remained within the Irish public health service. This also means that from a system perspective the turnover of consultants is likely to be overstated.

By comparison with other sectors, this rate of turnover is low. The 2017 Solas National Skill Bulletin reports turnover figures based on QHNS survey data. It reports that in 2016, the Health Associate Professionals rate was 10.3%, the rate for Teaching and other educational professionals was 8.3% and, the national average was 14.2%[7]. The substantial public investment made in the education and training of this group, any loss is costly both in monetary terms and in terms of service delivery.

The Commission's 2017 Report did not find the 2016 turnover rate to be of concern and stated that *"whilst the turnover rates set out in Table 6.3 do not appear to give cause for concern, detailed submissions in this area indicate significant movement of employees, which presents challenges and can impact on service delivery. While figures suggest that recruitment does outpace the rate of attrition nationally, there may be shortfalls at local level and for particular skill sets".*

In this report, the Commission has undertaken an examination of these shortfalls at local level and for particular skill sets and while the turnover rate has reduced in 2017, the shortfall in particular specialities and the practice of appointing candidates not on the specialist register to consultant posts would appear to point to a difficulty in recruiting and potentially also in retaining existing consultants in certain specialities and locations.

Aside from these turnover rates, there is a paucity of data readily available to facilitate a detailed analysis on a geographic basis or by specialist area. However, some of the individual hospitals/CHOs who responded to the Commission's request for data stated that they have had no issues with the retention of consultants.

6 Turnover is number of leavers in year x divided by average headcount employed in year x.

7 Intra-occupational and neutral inter-occupational movement.

Table 8.15: Hospital Consultant Turnover, 2016 - 2017

Year	Average Headcount	Starter	Leaver	Turnover rate	Leaver (excluding retirements)	Turnover rate (Excluding Retirements)
2017	3,245	328	253	7.8%	213	6.6%
2016	3,135	369	279	8.9%	243	7.7%
Y-o-Y Change	110	-41	-26	-1.1%	-30	-1.1%

Source: HSE

Exit Rates for Doctors Registered in the Specialist Divisions of the Medical Register

As discussed in Chapter 7, 6.4% of doctors exited the Register at the time of the annual retention process in 2015. When the breakdown of exits across registration divisions is considered, a low rate of exit is observed among doctors registered in the Specialist Division (3.7%).

Table 8.16 indicates that for the Specialist Division, a higher than average exit rate was observed among some specialities including Otolaryngology (9.4%), Obstetrics and Gynaecology (7.5%) and Neurology (7.4%) relative to the exit rate for doctors registered in the Specialist Division generally (3.7%).

Table 8.16: Exits from Medical Register by Speciality (Specialists only), 2012 - 2015

Speciality	2012		2013		2014		2015	
	Exits	%	Exits	%	Exits	%	Exits	%
Anaesthesia	22	3.9%	28	4.9%	28	4.8%	29	4.6%
Cardiology	8	5.9%	-	-	9	8.0%	6	5.3%
Child & Adolescent Psychiatry	8	5.8%	9	7.2%	9	7.2%	8	6.2%
Endocrinology & Diabetes Mellitus	5	6.3%	-	-	-	-	-	-
Emergency Medicine	-	-	6	6.2%	-	-	-	-
Gastroenterology	7	5.7%	-	-	-	-	-	-
General (Internal) Medicine	34	5.2%	15	3.8%	14	3.7%	15	3.7%
General Practice	-	-	57	2.0%	65	2.2%	75	2.3%
General Surgery	21	7.2%	13	4.4%	13	4.3%	10	3.1%
Geriatric Medicine	-	-	7	12.1%	-	-	-	-
Haematology (Clinical & Laboratory)	5	6.1%	5	6.0%	-	-	-	-
Histopathology	14	7.7%	7	3.8%	13	6.9%	8	4.1%
Neurology	-	-	-	-	-	-	5	7.4%
Obstetrics & Gynaecology	11	4.7%	9	3.6%	13	4.9%	21	7.5%
Occupational Medicine	-	-	5	6.3%	-	-	-	-
Ophthalmology	7	4.8%	-	-	8	6.0%	6	4.3%
Otolaryngology	5	5.5%	5	4.2%	-	-	9	9.4%
Paediatrics	16	5.1%	20	6.5%	15	4.7%	21	6.1%
Plastic, Reconstructive & Aesthetic Surgery	5	8.3%	-	-	-	-	-	-
Psychiatry	28	5.6%	20	4.3%	22	5.1%	18	4.1%
Respiratory Medicine	5	4.9%	-	-	-	-	-	-
Radiology	22	5.9%	24	6.5%	15	4.1%	17	4.4%
Trauma & Orthopaedic Surgery	11	6.0%	-	-	6	3.2%	-	-
Urology	-	-	6	9.2%	-	-	5	6.8%

*The table only includes specialities where 5 or more exits occurred. If less than that – entered for relevant year. % columns refer to the percentage of that speciality who exited the register in a given year.

Source: Medical Council - Medical Workforce Intelligence Reports 2013-2016

The latest publication of the Medical Workforce Intelligence Report was in August 2016, based on 2015 data. The Medical Council will publish a composite report based on 2016 and 2017 data in the coming months. Medical Council data provided directly to the Commission in respect of Register exits indicated that, while there was a 5.6% increase in total exits from the Medical Register between 2016 and 2017, there was a 14.5% reduction in exits from the Specialist Division over the same period.

Trends in Applications to Medical Council for Certification of Current Professional Status

A doctor currently registered in Ireland who wishes to work abroad must generally apply for a CCPS from the Medical Council. There was an increase of 14.7% in the number of CCPS issued between 2012 (2,099) and 2017 (2,407). As noted earlier, the total number of consultants also increased substantially during this period (see Table 8.1). As the number of consultants increases, a corresponding rise in certificate requests might indicate a broadly stable share of certificate requests as a proportion of the consultant population. This increase in the number of certificates issued suggests that the number of doctors who actually leave to work abroad has also increased over the period, although a doctor may apply for a CCPS and decide against emigrating. Some registration/regulatory authorities require a CCPS for reasons other than seeking registration, e.g. the General Medical Council seek a CCPS for a doctor who is seeking to withdraw from their Register and who holds registration in another jurisdiction.

Retention Initiatives

The MacCraith report recommended that more individually-tailored time commitments should be made available, and facilitated where possible, for both new and existing consultant posts. With regard to all new consultant posts, the Working Group also recommended that recruitment notices should indicate that a flexible working facility is possible. Revised approval letters began issuing in October 2015, providing for advertisement and filling of all posts on a flexible working basis. This recommendation has been implemented as of July 2016.

Themes Emerging from Analysis of Retention Aspects of the Survey and Structured Interviews

This section presents the findings of the Commission's survey and structured interviews of consultants in relation to retention. It is noteworthy that this survey took place before the announcement of the recent settlement of legal proceedings by consultants. Details on the methodology and limitations are provided in Appendix C and the full study of the survey and structured interview is available on the Commission's website at https://paycommission.gov.ie/ . As noted in the recruitment analysis, the response rate for this survey was very low (13%), which means the results may well reflect a group with different views or preferences from the generality of consultants working in the public health service and should be treated as indicative only.

The survey results indicate that about one-third of consultants who responded stated an intention to leave their current job in the next two years. Within this group, about one-third intend to leave Ireland without a plan to return. The factors that those who indicated an intention to leave most frequently highlighted were; staffing levels and better training and job opportunities elsewhere. The research also indicated that those most likely to intend to leave tend to be working part-time and are more recently appointed to the role. The most frequently cited factors that contribute to consultants staying in their jobs were working hours, personal reasons and relationships with patients.

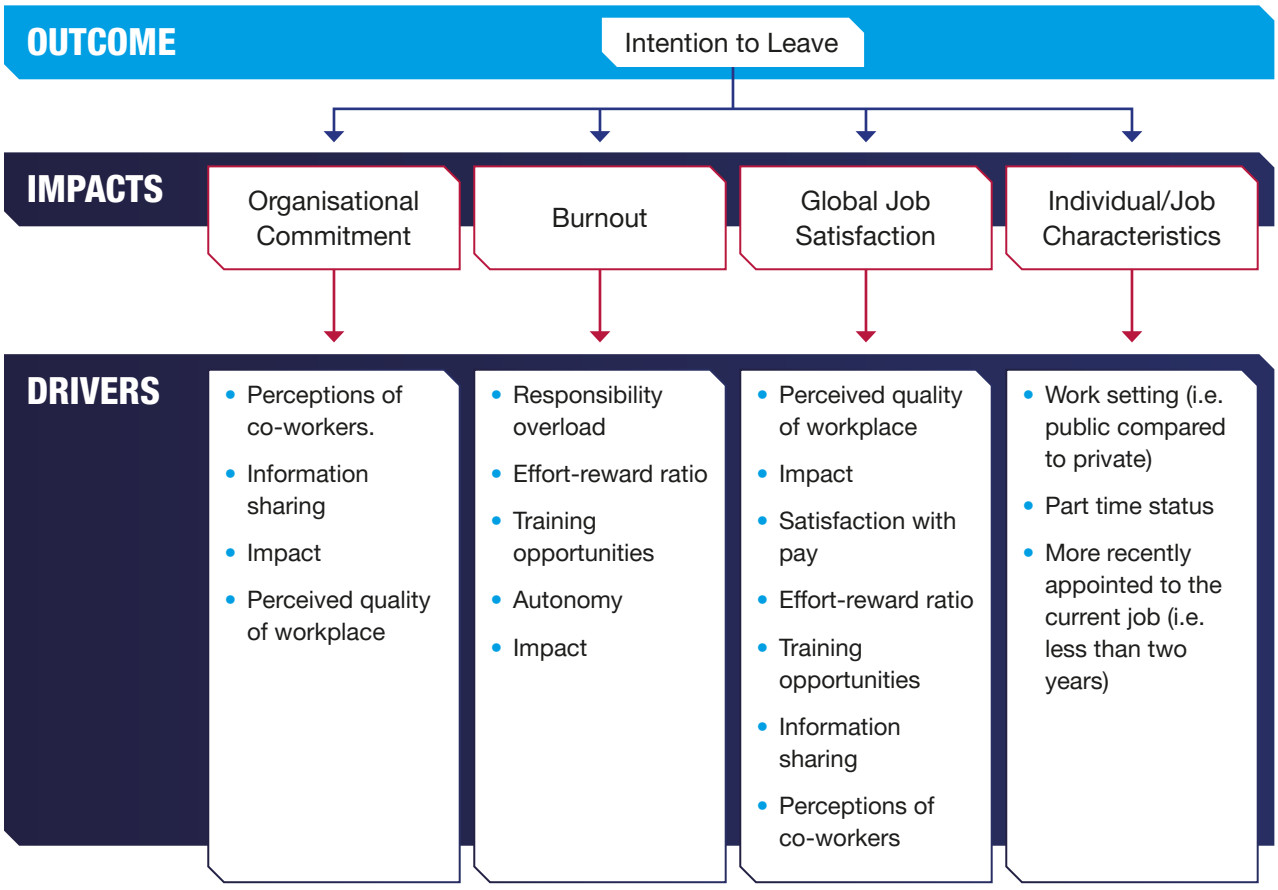
The study includes an econometric analysis to assess the relative importance of factors when they are considered together. However, the set of variables that is found to be important for predicting intention to leave is sensitive to the broader set of variables that is included in the model.

The results of these models indicate that the individual and job characteristics which are predictive of a higher likelihood of leaving the job, the organisation, and / or the medical profession are:

- Work Setting – there is a higher incidence of intention to leave amongst consultants working in public settings;
- Full/part-time status – there is a higher incidence of intention to leave amongst part-time workers; and
- New recruit status – there is a higher incidence of intention to leave amongst new recruits.

Additionally, lower global job satisfaction, lower organisational commitment and higher levels of burnout emerge as predictors of a higher likelihood of intention to leave. A range of characteristics 'drive' these 'impacts' which are presented in Figure 8.2. An implication of this is that efforts to improve drivers of global job satisfaction, organisational commitment and burnout may positively impact on consultants' job and career intentions.

Figure 8.2: Drivers and Impacts of Intention to Leave for Consultants



Source: Research Matters, PSPC workings

The findings from the qualitative research have many similarities with both the descriptive statistics and the econometric analysis. Consultants spoke about the satisfaction from working with patients and within areas that interest them. One consultant said *"I absolutely adore patients … I love it. I'd give up otherwise".* Consultants also valued a high level of autonomy, one consultant compared his level with some of his colleagues, noting: *"I have an unusually high level of autonomy in my particular job, which means that I have [fewer] frustrations perhaps than many of my colleagues".*

Consultants in the study found the following challenging: level of pay, relationships between senior management and clinicians, a lack of trust and goodwill (particularly in the context of the breach of the 2008 contract), inequitable distribution of resources and a lack of leadership and involvement in decision making. In relation to the breach of the 2008 contract, one consultant said *"I feel that there has been a huge breach of trust between the HSE and consultants".*

Consultants themselves recognised that the factors which impact on intention to leave are multifactorial. Some of the factors consultants highlighted were, the overall level of pay, pay compared to other countries and better opportunities elsewhere. One individual said *"You're well paid in general but in relative terms, you can earn more money elsewhere".*

The lack of attractiveness of specific posts, particularly, small hospitals in rural areas was summed up by one individual who said, *"They're [consultant posts in small hospitals] not attractive. The people want to go and work in the cities where they have a large number of colleagues … So, it's going to be very hard. I'll be honest with you, I don't see [that] these are the hospitals that will be sustainable".*

Retention Challenges

The most common retention themes emerging from the Commission's analysis of submissions and data received were:

- Lack of data;
- Total may mask particular difficulties in certain specialities and locations;
- Breach of trust due to non-implementation of 2008 Contract terms;
- Access to flexible working arrangements; and
- Access to better supports.

8.6 Conclusions

The Commission concludes that there is a general difficulty recruiting consultants, with more significant problems in certain specialities and geographic locations. Psychiatry, in particular, appears to be a speciality which is experiencing recruitment challenges across a number of key indicators. The Commission also notes the high proportion of non-specialists appointed to Emergency Medicine posts.

The Commission recognises that the reductions in pay which were applied to consultants appointed since 2012 were particularly severe and that the differential in pay between the pre-existing cadre of consultants and these new entrants is greater than for other categories of public servant. The Commission believes that the implementation of the settlement of the 2008 Consultant Contract claim, while necessary of itself, will exacerbate this difficulty. Policy responses that may be proposed for new entrants across the public services generally may not address the degree of pay differential which currently applies to the post-October 2012 new entrant consultants. The Commission proposes that the Parties to the Public Service Stability Agreement jointly consider what further measures could be taken, over time, to address this difficulty.

The appointment of non-specialists to consultant posts is a strong indication of challenges in relation to recruiting for certain specialities and locations. The process for correcting this appears to have already commenced with a number of corrective measures now taken and the establishment of a working group on this issue. The Commission encourages the Parties to resolve this issue as soon as possible.

The current recruitment process for consultants does not seem to function effectively with problematic delays at a number of stages in the process. This issue has already been highlighted in the MacCraith and the Keane reports, and the Commission endorses the recommendations made. The apparent decline in the number of applications for advertised consultant posts is also concerning and gives rise to quality of candidature concerns. A higher number of candidate recommendations by PAS to the HSE was also evident prior to 2012. The MacCraith report also recommended that more individually-tailored time commitments should be made available, and facilitated where possible, for both new and existing consultant posts and this recommendation would appear to have been implemented. The Commission acknowledges the progress already made in this regard and believes that further progress on the implementation of the other recommendations should now be accelerated.

The Commission was constrained in its capacity to make definitive conclusions in respect of retention of consultants due to an absence of detailed, consistent and reliable retention data, particularly by speciality and location.

Chapter 9: Concluding Comments

Chapter 9: Concluding Comments

The Terms of Reference asked the Commission, where it identified difficulties, to provide a range of options for resolving issues specific to recruitment and retention. The concluding comments of the Commission are set out in this chapter. Additional conclusions in relation to each of the groups considered in this report are provided in the relevant chapters.

Public health service employment has, since 2013, gradually been returning to pre-moratorium levels. The Commission recognises however that demand for health services has notably increased over the last decade and this in turn has intensified the pressure to employ more doctors, nurses and midwives.

Additionally the operation of the public health service is currently experiencing multiple challenges in the provision of healthcare to a growing and ageing population whilst planning for significant reform. These challenges are not unique to the Irish health service, and are also being experienced by other developed economies in the wider global context.

The evidence presented to the Commission also confirmed that there is an emerging challenge in the provision of health workers on an international scale and that this has enhanced the opportunities for Irish trained nurses, midwives and doctors to seek and secure employment abroad. These opportunities are also available to those who opt to practice in the private health sector in Ireland.

Recruitment and retention challenges, individually and collectively, have also formed the subject matter of other reports and initiatives undertaken in recent years. This report has referenced and supported many of the key recommendations arising from these reports and initiatives which are being implemented with some levels of success.

The exercise the Commission is engaged with is specifically focused on a comprehensive, evidence-based examination and analysis of recruitment and retention issues. The Commission is also aware that the current PSSA, while providing for consideration of any proposals that may arise on foot of the Commission's report, precludes the pursuance of claims for increases in pay or improvements in conditions of employment beyond those provided for by the Agreement during the term of the Agreement.

Having regard to all of the data available, the submissions made and the research carried out by the Commission, or on its behalf, the Commission has reached the following general conclusions:

1. The submissions and presentations from the nursing and midwifery staff sides asserted that nurses and midwives are seriously aggrieved at what they regard as anomalies in the current pay structures relative to other professions working in the health service. The Commission recognise that there is no mechanism currently in place that would allow for this issue to be addressed or dealt with in isolation. The Commission believes that the Parties to the PSSA should consider putting arrangements in place, at an appropriate time, and without compromising the stability of the public service pay bill, to allow for the adequacy of current pay arrangements more generally to be fully examined.

2. As highlighted earlier in this report, the work of the Commission was hindered when examining individual service areas due to poor data received from employers. Data gaps existed on vacancy rates, recruitment competitions, applications, interviews and appointments. The absence of disaggregated data specifically in relation to retention of employees was a further challenge to the Commission. The main reason for the absence of data, as reported to the Commission, was the lack of centralised systems in place to record, monitor and analyse all employee data. The lack of centralised systems' data was mentioned in the Commission's first Report and it remains the Commission's view that measures to address these deficits need to be put in place.

3. The Commission is also of the view that the absence of a medium and long-term national workforce plan based on service need and available funding is an important issue. There have been recent examples of initiatives that go some way to addressing this, however many areas of the public health service continue to be without an evidence-based workforce plan. The Commission notes that the 2017 workforce targets for nurses and midwives were determined on the basis of resolving an industrial relations dispute, and that the 2018 workforce targets for nurses and midwives were also referred to the WRC. The Commission recommends that the development of an evidence-based, quantified medium-term recruitment and retention workforce plan applicable

to the entire public health service be prioritised. The success of a medium and long-term funded workforce plan will require:

- Investment in the HR function in terms of resources, data and expertise. The strengthening of the HR function and capabilities also needs to occur at CHO and Hospital Group level, particularly if there is delegated authority to recruit at local level. Increasing local HR support will help ensure early quality recruitment followed by early compliance with the various regulatory codes of practice and appropriate local budget/financial controls that are required prior to offering employment.
- A funded workforce recruitment plan clearly needs to anticipate vacancies that are about to occur as a result of a retirement notice, notice of resignation, notification of approved career breaks, or maternity leave and ensure that avoidable delays are eliminated. In particular, given that over 90% of the nursing and midwifery workforce are female, it is important to factor in maternity leave to the workforce recruitment plan.

4. The Commission expects that the *Sláintecare Report* will now be an important influence on current and future health policy in Ireland. To succeed, the Commission believes that the implementation plan for Sláintecare, given the scale of the changes envisaged, will require considerable changes in how the public health service plan, organise, and resource the workforce. In particular, the effectiveness of the Sláintecare project will require a greater understanding of what nurses, midwives and doctors will need to do differently so that all staff operate in an integrated manner using the full scope of their professional training, skills, and competence to achieve reform and improvements in public health service delivery and development over the next decade. The Commission believe that a more coherent approach, to make the best use of our highly skilled health resources, will be required to fulfil this ambition. It will also be necessary to develop more effective mechanisms for identifying and implementing HR and workforce policy solutions, which will achieve improved recruitment rates and enhanced retention of the current and future health service workforce. While recognising that the implementation of Sláintecare will undoubtedly involve a drive to make better use of resources, the Commission acknowledges that the nursing, midwifery and medical professions will continue to be key players in the successful implementation of reform and developing new and better models of care for patients.

5. In relation to nurses and midwives the Commission found that:

There was an overall reduction in numbers from a high of 39,006 WTE in 2007 to a low of 33,768 WTE in 2013. Although there is clear evidence that nursing and midwifery numbers have increased since 2013, with reported numbers of 36,777 WTE for 2017, the increase is not simply as a result of the lifting of the moratorium but also required the development of a wide range of special recruitment initiatives to both attract and retain nurses and midwives from the domestic market and abroad. The Commission note that some initiatives proved more successful than others.

The Commission believes that a positive outcome to the discussions underway on new entrant salary scales will further assist in the recruitment and retention of nurses and midwives, particularly those who are embarking upon or are in the early stages of their career in the public health service.

The findings from the qualitative research undertaken by the Commission, as part of this examination, suggest that an emerging challenge in relation to the retention of nurses and midwives at present is the increased demand for services which, in many instances, can lead to a consequential increase in the ratio of patients to nurses/midwives.

There is a case for providing additional incentives for highly qualified nursing and midwifery staff to remain in the health service. In the Commission's view, these should be targeted at those who acquire additional qualifications and those who accrue long continuous service. A substantial body of evidence indicates that there are continuing difficulties in retaining nurses and midwives in specific areas. Currently, a Location Allowance is paid to nursing staff engaged in 13 service areas throughout the health service, including A&E and Theatre. The Location Allowance is not currently applicable to maternity services. There is also a Specialist Qualification Allowance currently paid to nursing staff who acquire post-graduate qualifications in their relevant disciplines. These allowances are applicable to grades up to and including Clinical Nurse Manager 2 or equivalent.

Recommendation: The Commission recommends that as part of the retention strategy, that these allowances should be increased by 20% on the same terms as apply currently. The Commission further recommends that they be extended to maternity services on the same basis. Provisional costings for this measure indicate an estimated cost to the Exchequer of €12-14 million per annum. The additional benefit to nurses and midwives already receiving the Specialist Qualification or Location Allowances varies from €279 to €558 per year.

Nurses and midwives working in maternity services who would receive the Location Allowance under the proposal would receive an increase in remuneration of approximately €2,300 per year.

Recommendation: Staff Nurses and Midwives are eligible to attain the grade of Senior Staff Nurse/ Midwife after attaining 20 years post-qualification relevant experience. The Commission recommends that, as a policy to retain experience in the hospitals, this service qualification should be reduced to 17 years. Provisional costings for this measure indicate the estimated full year cost to the Exchequer of €4-6 million in the year of implementation. The benefit to nurses and midwives would be circa €2,200 per year (€6,600 over the three years).

6. In relation to NCHDs the Commission concludes as follows:

There has been strong and consistent growth in NCHD numbers. The distribution of the increase in NCHDs has been weighted towards increasing NCHDs in non-training posts to comply with the EWTD, which conflicts with the recommendations of the *Hanly Report*. The Commission believes that while compliance with the EWTD is extremely important, in the context of the planned move to a consultant delivered health service, it is questionable whether the level of increase in non-training posts is consistent with the goal of a future health service that is to be delivered by consultants.

Ireland is highly reliant on foreign trained doctors to fill non-training posts despite producing the highest number of medical graduates per capita in the OECD. Reliance on foreign trained doctors may be precarious in the context of increased international demand and worldwide shortages and is at odds with Ireland's obligations under the *WHO Global Code of Practice on the International Recruitment of Health Personnel.*

The evidence from the Commission's analysis and various other studies signal that training and promotion opportunities are the key influencer of migration and turnover of this group. Linked to this is the perception of NCHDs' future pay prospects, which are impacted by the reduced consultant contracts.

The Commission is strongly supportive of the full implementation of the recommendations of the *Strategic Review of Medical Training and Career Structures* as they have the potential to resolve many of the issues relating to recruitment and retention of NCHDs. The Commission also acknowledges the conclusions of the NDTP's seventh annual assessment of NCHD posts, many of which are analogous to the recommendations of the *MacCraith Report*. The Commission endorses the prioritisation of the key areas identified in both the NDTP and MacCraith reports which will have the potential to deliver improvements in the employment, training environment and family lives of NCHDs.

7. In relation to consultants the Commission found that:

Consultants were not subject to the *Moratorium on Recruitment and Promotions in the public service* and the number of consultants employed in the public service has steadily increased over the last decade.

However, the aggregate level of vacancies for consultant posts at the end of 2017, and evidence of recruitment campaigns with very low levels of applications, suggest that there is a general difficulty recruiting consultants. The current process for recruiting consultants appears not to function effectively. This issue has already been highlighted in the MacCraith and the Keane reports.

The differential in pay between the pre-existing cadre of consultants and new entrants is greater than for other categories of public servant. The Commission believes that the implementation of the settlement of the 2008 Consultant Contract claim, while necessary of itself, will highlight further this differential in pay. Policy responses that may be proposed for new entrants across the public services generally may not address the degree of pay differential which currently applies to the post-October 2012 new entrant consultants. The Commission proposes that the Parties to the Public Service Stability Agreement jointly consider what further measures could be taken, over time, to address this difficulty.

Variation across certain specialities and locations suggests that there is a more significant problem recruiting to certain specialities and in certain locations. Additionally, the appointment of non-specialists to consultant posts is a strong indication of challenges in relation to recruiting for certain specialities/locations.

The settlement of the 2008 Contract claim may repair the breach of trust between the employer and consultants somewhat, but evidence would suggest that where trust between the employer and employee is significantly damaged, in this instance between the HSE and consultants, this issue will remain a challenge for the organisation in the medium term.

The Commission was constrained in its capacity to make definitive conclusions in respect of the retention of consultants due to an absence of detailed, consistent and reliable retention data, particularly by speciality and location.

Appendices

Appendix A:

Membership and List of Meetings

Members

Kevin Duffy (Chairman)

Marian Corcoran

Ultan Courtney

Ruth Curran

Noel Dowling

Michael Kelly

Seán Lyons

Peter McLoone

Brief biographies of the Commission members are available on the Commission's website at https://paycommission.gov.ie/about/.

Meetings

1. 12 September 2017
2. 3 October 2017
3. 26 October 2017
4. 28 November 2017
5. 19 December 2017
6. 16 January 2018
7. 6 February 2018
8. 6 March 2018
9. 10 April 2018
10. 24 April 2018
11. 1 May 2018
12. 15 May 2018
13. 29 May 2018
14. 5 June 2018
15. 19 June 2018
16. 3 July 2018
17. 10 July 2018
18. 24 July 2018
19. 14 August 2018

Minutes of these meetings will be available on the Commission's website at https://paycommission.gov.ie/work-of-the-commission/.

Appendix B:

List of Submissions Received

The interested stakeholders to Module 1 who made submissions, and met with the Commission are listed below. All submissions are available on the Commission's website at https://paycommission.gov.ie/submissions/

Main Submissions

1. DPER
2. IHCA
3. IMO
4. INMO
5. PNA
6. SIPTU – Health Division

Appendix C:

Methodology

Introduction

This appendix sets out the methodological approaches adopted by the Commission for its analysis of recruitment and retention difficulties relating to Module 1 grades.

The Commission considered several sources of data across a number of years to provide evidence on the factors that impact recruitment and retention. The Commission primarily focused on the recent trends (i.e. 2013-2017) as well as data from 2007 to give a longer term reference point.

Background to Phase 2 of the Public Service Pay Commission

Building on the approach set out in the Commission's first Report and consistent with Section 3 of the Public Service Stability Agreement 2018-2020 and the Commission's Terms of Reference, the Commission commenced by seeking relevant information on those grades and specialities where evidence of specific difficulties in recruitment and/or retention had already been identified in Chapter 6 of its first Report.

Due to the range of grades under consideration the Commission adopted a modular approach to its work. Module 1, which considers issues relating to nurses and midwives, NCHDs and Consultants, is the focus of the first recruitment and retention report and those other grades and specialities where evidence of recruitment and/or retention difficulties were found to exist in Chapter 6 of the Commission's first Report will be the focus of the second recruitment and retention report.

The Terms of Reference tasked the Commission with establishing whether, and to what extent, a difficulty exists in terms of recruitment and retention for specific grades of the public service. Where a difficulty is identified the Commission was asked to examine the full range of causal factors. The Commission requested and analysed data from a number of different sources to address these Terms of Reference.

Requests for Information

The Commission developed a number of detailed data requests, which aimed to gather evidence on recruitment and retention issues for Module 1 grades.

Many different forms of data can assist in the analysis of the incidence and causes of recruitment and retention difficulties. Information on recruitment transactions and details of employment churn over time are probably the most directly relevant sources for assessing the presence of difficulties.

When looking at recruitment, one would ideally like to know the number of approved places by grade and location, the number of these that were advertised, how many applications were attracted, the number of interviews that resulted and the posts that were filled or left vacant.

Turning to retention, the rate of departures by grade, age band and reason (e.g. retirement) over time would be an important indicator. With information such as this on the flows into and out of employment over time and across the health service, it would be possible to relate the times and places where difficulties were most acute to patterns in the possible causes of such difficulties. For example, if there were particular problems in one geographical area due to local factors, this would only be apparent if geographically-specific data could be examined.

In order to capture the types of data described above, the Commission requested data and information from the Employer, at national and individual hospital/Community Health Organisation (CHO) level, which was coordinated by DPER, Department of Health and the HSE. The Commission requested submissions from the relevant staff representative associations in relation to factors which impact on recruitment and retention of their respective groups. The Commission also requested data from the Department of Business, Enterprise and Innovation, the Office of the Government Chief Information Officer, SOLAS, the Central Applications Office (CAO), Higher Education Authority (HEA), the Higher Education Statistics Agency (HESA) in the UK, the Medical Council of Ireland and the Nursing and Midwifery Board of Ireland (NMBI) to develop

available data that could inform analysis of the supply and registration of nurses and doctors.

Additionally, the Commission commissioned two pieces of research: a survey and number of structured interviews and an international pay comparison of each cohort. This research provides further insight into the recruitment and retention issues that are likely to impact on these grades.

While the Commission sought the detailed information as described above on recruitment and retention, it was not generally available within Ireland's health service. Much of the information provided by both the employer and representative groups relies on broader indicators such as trends in staff numbers, turnover rates or evidence on staffing adequacy. Such indicators can be affected by recruitment and retention difficulties but are also influenced by other factors in complicated ways.

Public Service Data

The Department of Public Expenditure and Reform maintains a database of the number of staff employed across the public service. The data was queried for trends for each group by:

- Grade;
- Hospital Group; and
- Hospital Model.

Central HSE Data

The Commission requested national level data from the employer for the years in question. This request focused on the staff profile, turnover and vacancy data, details of recruitment competitions, details of retention difficulties, agency/locum data and pay data. A considerable amount of data was received from central HSE sources. This information was used to:

- Identify staff turnover;
- Develop trend analyses across different staff and grade types;
- Estimate the age and nationality profiles of each staff group; and
- Establish the number of applicants per post or panel place.

Individual Hospital/Community Health Organisation Data Requests

The Commission also requested hospital and CHO level data from individual employers for the relevant years. The request focused on information such as recruitment competitions, vacancies and turnover rates, evidence of recruitment/retention difficulties, outcomes of initiatives to address recruitment/retention difficulties, challenges encountered, absence rates, workforce plans, sources of supply, evidence of labour market pressures, expenditure on agency staff, vacancies filled by agency staff and the extent to which agency staff are used to cover sick leave, maternity leave, etc.

Overall 58 individual employers were asked to provide detailed information and data for each of the grades. The quality of the response received was limited and the response rate to the request was poor as indicated by the range of response rates across questions that received an answer as outlined below:

- Response rates for individual questions for:
  - » Nurses and midwives ranged from 3% to 67%;
  - » NCHDs ranged from 2% to 57%; and
  - » Consultants ranged from 3% to 55%.

The level and quality of responses from the hospitals and CHOs significantly limited the Commission's analysis. Information received was used where possible to help identify some qualitative explanations of the drivers and possible solutions to the issues identified through the assessment of the central data. However, based on the limited response, the information cannot be considered as it is not fully representative of the Irish public health service and should be treated as such.

Supply Data

The Commission requested data from the HEA, on new entrants and graduates, and from the CAO, on first preference applications and acceptances, for nursing and medicine courses. The HESA in the UK also provided data on Irish domiciled first year students and qualifiers from selected healthcare courses in UK higher education institutions.

To facilitate an accurate analysis of relevant new entrants and graduates, non-relevant courses were removed from the HEA dataset manually. Where necessary this was done with reference to the course prospectus. Where it was deemed that courses could produce future doctors and nurses they were included in the dataset. For convenience these subsets of relevant courses are simply referred to as nursing and medicine throughout this paper.

The focus of the analysis of the HEA data is on Level 8 Honours Degrees only and covers the academic years from 2009/2010 to 2015/2016.

In relation to the CAO data, net acceptances are the final acceptance recorded for an applicant on the CAO system. For example, if an applicant accepts a round 1 offer but is subsequently offered a round two place and accepts, the CAO record the last offer. The figures provided for 2017 are provisional and subject to change.

With regard to analysis of nationality/domicile it should be noted that the CAO record both nationality and country of birth for acceptances, while the HEA classifies the domicile of new entrants and graduates based on their country of permanent address prior to their entry to the course of study. Information on student nationality from the CAO was preferred for comparative purposes.

It should be noted that, in some instances, the results of the HEA and CAO analyses show slight differences between the actual figures which would be expected to be similar (e.g. CAO acceptances vs HEA new entrants). This can be explained by the differences in dates on which the CAO and the HEA capture their data.

Registration Body Data

The Commission also requested data from the registration boards for nurses and midwives, the NMBI, and for doctors, the Medical Council.

The NMBI provided data on registrations, applications to register and the number of applications for Certificates of Current Professional Status from 2007 to 2016. The data was complemented by data available in the NMBI's Annual Reports.

The Medical Council provided data on registrations, the number of applications for Certificate of Current Professional Status, Certificate of Experience and other forms of certificates and letters required to work abroad. These data were complemented by data from the Medical Council's Workforce Intelligence Reports and Your Training Counts Reports. Consistent with the Commission's approach data from 2007 and 2013 onwards was analysed where available.

Survey and Structured Interviews

Background to Survey and Structured Interviews

The objective of surveying and interviewing Module 1 grades was to further understand the main drivers influencing recruitment and/or retention, what employees perceive as their motivation in applying for and remaining in their current employment and the drivers, if any, for intending to leave their current role.

The Commission engaged Research Matters Ltd., following a competitive procurement process, to design, pilot, administer, analyse and report on a set of surveys and structured interviews of grades relevant to of the Commission's work. The Commission also engaged Prof. Edel Conway and Dr. Yseult Freeney from Dublin City University Business School to provide expert academic advice with regard to the design and administration of the research.

Research Matters Ltd. in consultation with the Commission and its academic advisors developed and carried out the survey ("Engage to Change") and structured interviews with nurses, midwives, NCHDs and consultants over the course of March, April and May 2018.

Main Survey

While separate questionnaires were developed for nurses and midwives, NCHDs, and consultants, there was considerable overlap between them. Questionnaires were developed through:

- A scoping review of peer-reviewed, grey literature and survey instrumentation;
- Contact with developers of previously validated scales;
- Advice from researchers with expertise in the area (including the Commission's advisors on this study);
- Interviews already conducted with human resource personnel and Nurse managers;
- Pre-testing with nurses (n = 4) and doctors (n = 5) currently in practice; and
- Pilot testing with nurses (n=98) and doctors (n=25).

In total, the questionnaire for nurses comprised 46 questions. The questionnaire for NCHDs and consultants consisted of 44 questions. Key components of both questionnaires are presented in Table C.1.

Questionnaire scales were constructed using the same methodology as in the 2017 Civil Service Employee Engagement Survey report (2017; p. 73-4)[1]. That is, the responses to the individual items comprising each scale were combined to form a scale score expressed as a percentage. In some cases, items on the scale had to be reverse coded. For a majority of the scales used in this study, higher scores indicate a more positive outcome.

1 Department of Public Expenditure and Reform. Civil Service Employee Engagement Survey. Dublin: Department of Public Expenditure and Reform; 2017

Table C.1: Description and Sources of Questions and Scales

Question/Scale	Description	Source
Demographic Information	Key characteristics, including employment grade; area of work; management responsibility; contact with clients / patients; type of contract; full- or part-time status; place of work; employer, sector; area of work; geographical region; age group; gender; country in which basic qualification obtained; and place of birth	n/a
Time taken to get to work	Duration of the usual journey to work (in 15-minute increments)	CSO Census Question
Highest level of qualification	Highest level of education attained (Nurses only)	CSO Census Question
Engagement	Feeling enthusiastic and inspired about job	Utrecht work engagement scale (Seppälä *et al*., 2009)
Autonomy	Perception of freedom and independence in day-to-day work	Multi-dimensional measure of psychological empowerment in the workplace (Spreitzer , 1995)
Responsibility overload	Feeling of too much responsibility in job	New scale
Impact	Belief that job has a significant impact in others' lives	Multi-dimensional measure of psychological empowerment in the workplace
Satisfaction with pay	Level of satisfaction with pay	Employee engagement study of the Irish Civil Service (CSEES study)[1]
Job satisfaction specific	Level of satisfaction with specific aspects of job (physical working conditions, flexibility of hours, physical demands, quality of care)	Copenhagen psycho-social scale (Kristensen, 2005) (3 new items added for doctors)
Job satisfaction global	General / global level of job satisfaction	Copenhagen psycho-social scale

1 Based on Australian Civil Service Engagement Survey with one additional item.

Question/Scale	Description	Source
Burnout	Feelings of work-related burnout	Oldenburg Burnout Inventory (Cammann *et al*., 1979)
Information sharing	Perception of extent to which information is shared and decisions are communicated	CSEES study
Effort	Perceived level of effort put into work	The effort-reward (ERI) ratio[2]
Reward	Perceived level of reward from work	The effort-reward (ERI) ratio
Recruitment process (new recruits only)	Perceptions of the efficiency and fairness of the recruitment process	New scale based on recruitment lifecycle and work of Larson *et al*. (1998)
Job expectations (new recruits only)	Extent to which job expectations matched job experiences	New scale[3]
Organisational commitment	Level of commitment to current organisation	Meyer and Allen Organisational commitment scale[4]
Training and promotional opportunities	Perceived opportunities for training and promotion	CSEES Survey
Training opportunities	Perceived opportunities for training	CSEES Survey plus 7 new items
Promotional opportunities	Perceived opportunities for promotion	CSEES Survey plus 3 new items
Perceptions of co-workers	Perceptions of co-workers	Workplace Affective Commitment Multidimensional questionnaire – short form subscale on affective commitment to co-workers (Perreira *et al*., 2018)
Perceptions of manager	Perceptions of effectiveness of immediate manager (Nurses) / manager career support (doctors)	Copenhagen psycho-social scale for Nurses; manager career support scale for doctors (Greenhaus, Parasuraman and Wormley, 1990)
Intent to stay in / leave job in next two years	Level of intent to leave the current job in the next 2 years	New scale
Intention to leave organisation	Level of intent to leave current organisation	Meyer *et al*. turnover intention scale (Meyer, Allen and Smith, 1993)
Intention to leave profession	Level of intent to leave profession	Meyer *et al*. turnover intention scale (Meyer, Allen and Smith, 1993)

Source: Research Matters

2 See: http://www.uniklinik-duesseldorf.de/unternehmen/institute/institut-fuer-medizinische-soziologie/forschung/the-eri-model-stress-and-health/eri-questionnaires/

3 Based on the recruitment life-cycle and the work of Larson, Lakin and Bruininks (1998)

4 http://employeecommitment.com/academic-license.html

The analysis of the survey data includes a number of regressions. All of the regression analysis used weighted data to better reflect the total population of each group.

Logistic regression analysis was used to examine intent to stay or leave the current job in the next two years. While other analysis methods, such as an ordered logit model, were possible, logistic regression was selected for two main reasons: first, the output provides the odds of staying in as well as leaving current job, which was felt to be of policy relevance, and second, since the number of consultants indicating "definitely leave" was rather small (50), collapsing categories was preferred. Ordinary Least Squares regression analysis was used to assess the parameters associated with likelihood of leaving the current organisation and profession.

Survey Distribution

In the case of nurses and midwives, the Office of the Director of Nursing and Midwifery circulated the survey details to each of the directors of Nursing and Midwifery, who were asked to circulate the survey to their staff members. The circulation of the survey to NCHDs and consultants was facilitated by the Medical Council. The Medical Council circulated the surveys to members of their register who opted in to receive research questions from the Medical Council.

Sampling frame for Nurses, Midwives, NCHDs and Consultants

For nurses and midwives, the sampling frame was based on HSE Census from November 2017 (n=42,041). The weight was computed as the population proportion divided by the proportion in the sample on the basis of sector (acute, community, other), grade (director, manager, specialist, etc.) and full-time/part-time status. This corrects for differences in response rates on the basis of sector, grade and full/part-time status and results in analyses that may be generalised to the population on the basis of these characteristics.

For NCHDs and consultants, the sampling frame was based on the Medical Council database and covered doctors who were active on the register; planned to work >30 days in Ireland in 2018; were not GPs; and had given their consent to the Medical Council to allow their email to be used (N=10,093). Using Medical Council figures, population fractions on the grade and gender of doctors were calculated and these were used as the basis for weighting the sample to provide nationally representative estimates. A summary of the survey responses, structured interviews and response rates are provided below.

Table C.2: Number of Participants and Source of Data

	Valid Survey Responses*	Structured Interviews/Focus Group	Response Rates	Commentary
Nurses' survey	3,769	44 nurses	9.7% to 12.3%**	Survey - Data weighted by grade, full/part-time status and sector Structured Interviews - One focus group with directors of nursing and 38 individual interviews
Doctors' survey	NCHDs - 766 Consultants - 598 Other (e.g. public health and community doctors) - 74	50 doctors	NCHDs - 13% Consultants - 12.9% Other - 20%	Survey - Data weighted by gender/ grade/in training/ not in training Structured Interviews – Three Focus groups with 30 NCHDs and 20 individual interviews (12 with consultant doctors).

*A number of records were removed from the analysis due to duplication and low completion rates (i.e. if the respondent completed less than 50% of questions the record was removed from the datafile).

** The minimum response rate is 9.7% on the basis that all employed nurses were available to take part and that they were contacted and asked to participate. It is estimated that, normally, 23% of the nursing population is on leave (annual leave, sick leave, maternity leave and study leave – see HSE: Midwifery Workforce Planning Report, 2016), including this gives a response rate of 12.3%. The actual response rate may be higher since the two-stage sampling means that it is possible that not all nurses in the population of 42,041 nurses received an invitation to participate.

Structured Interviews

At the end of the survey questionnaire, respondents were asked if they would be willing to take part in a telephone interview. A sample of nurses, midwives, NCHDs and consultants who volunteered to take part were selected by Research Matters Ltd. on the basis of varying individual, job and organisational characteristics, and an invitation was issued to each, with further information about the study and interview, along with a consent form.

All interviews carried out were audiotaped, transcribed, anonymised and coded. The anonymisation of the interview data involved removing all personal information (e.g. names and locations) and the assignment of pseudonyms. Where necessary, the qualitative data has been edited to safeguard participants' anonymity; it has been ensured that this has not distorted their data or changed the key messages that emerged. The analysis of focus group interviews took account of the interaction between participants, as well as the content expressed.

Limitations

In relation to the limitations, which all research is subject to, there are a few which the reader should be aware of when interpreting these results.

An online survey can be efficient for researchers and convenient for respondents. It allows a shorter time frame for data collection than more traditional methods and it allows for a substantial amount of information to be collected and easily prepared for analysis. However, the complex contexts in which recruitment and retention issues arise cannot be fully captured by survey data. This limitation was offset by conducting in-depth qualitative interviews with nurses and doctors working in a variety of settings.

The key limitation of this study is that the number of doctors in the analysis (1,438, of whom 53.3% are NCHDs, 41.6% are consultants, and 5.1% are others, such as public or community health doctors) is rather small. While every effort was made to maximise the engagement of doctors with the survey, and the weights allow for nationally representative estimates, these lower numbers mean that the statistical analyses of NCHDs and consultants are less robust than they might have been, had a higher number of doctors responded to the survey.

Another limitation to the study is that the respondents to the survey were not proportionately distributed across the overall population of nurses and doctors in Ireland and overall response rates were lower than desired. The data has been weighted to provide nationally representative estimates. Additionally, a comparison of the sample with the population along key characteristics such as gender, employment grade and sector indicate that the sample provides a good match to the population in terms of these characteristics. However, there is no way of empirically assessing the extent to which particularly enthusiastic or particularly disenfranchised individuals may have responded, therefore the low response rates may well reflect a group of nurses and/or doctors with different views or preferences from the generality of nurses and doctors working in the health service.

The key variable used in this analysis is intention to leave the job, organisation and profession. It should be noted that respondents are reporting on their intentions, although it is not clear if these respondents will act upon these intentions.

Finally, causality cannot be inferred from the survey results (as with any cross-sectional design). The results demonstrate associations and relationships but should not be used to conclude that characteristic X causes outcome Y. For more information on the methodology of the survey and structured interviews please see Appendix C and the full survey and structured interview report at https://paycommission.gov.ie/

International Comparison of Remuneration

Some stakeholders submitted to the Commission that remuneration rates for the Module 1 groups (nurses, NCHDs and consultants) in the public service in Ireland were relatively unattractive in a competitive international marketplace. Evidence was also provided of global shortages in skilled health workers. In this context, the Commission determined it was appropriate to research relevant international pay comparisons.

In its first Report, the Commission referenced Eurostat data to make earnings comparisons at sectoral level with other countries within the EU and EFTA. This approach was not feasible for Phase 2, as the countries of primary interest for Phase 2 were not encompassed within the Eurostat dataset. In addition, for this report, there was a requirement to consider comparative pay data for particular roles, and not at sectoral level. International pay comparisons are infrequently undertaken, in part because they are technically complex and it is difficult to achieve comparability. Various judgements and methodological assumptions have to be made. For this reason, the Commission considered it necessary to engage suitable consultancy expertise to carry out a detailed study which would take into account, insofar as possible, relevant differences between the countries covered by the study.

Accordingly, the Commission engaged consultants, Treacy Consulting/Willis Towers Watson (TC/WTW), following a competitive procurement process. The consultants conducted an international review of pay and benefits for nurses, NCHDs and hospital consultants, and prepared a written report setting out the relevant findings. The TC/WTW report, *Pay and benefits for Nurses, Non-Consultant Hospital Doctors and Consultants - International Data,* can be found on the Commission's website at https://paycommission.gov.ie/. The specification for this exercise was to conduct independent research and report on the total remuneration package and standard contracted full-time working hours for jobholders in equivalent roles to new entrant and newly appointed nurses, NCHDs, and consultants in the Irish public service, with reference to four other countries.

The countries chosen for comparison were the United Kingdom, Australia, the United States of America and Canada, based on information provided by the stakeholders to Module 1 and in submissions to the Commission. All of the countries reviewed were of a scale where different regional labour markets and taxation systems apply. Thus, the selection of the host location, at country or region level, was further refined by TC/WTW.

Further detail on the host location(s) selected per country, the rationale for their selection, the primary data sources, and the grades selected as comparator guides is available in the methodology section of the TC/WTW report.

Appendix D:
Nursing and Medical Allowances

Nursing Allowances

A selection of nursing allowances impacted by the 5% FEMPI reduction are set out in Table D.1. As of 1 October 2020 these allowances will be restored to their pre-reduced rate.

Table D.1: Nursing Allowances Pre and Post-FEMPI Reductions

Staff Eligible	Nursing Allowances	Current Rate	Pre-Reduced Rate
Staff Nurses and CNM 1&2	Specialist Qualification Allowance[1]	€2,791	€2,938
	Location Allowance[2]	€1,858	€1,956
Public Health Nurses and Assistant Directors of Public Health Nursing	Midwifery Qualification*	€2,791	€2,938
Psychiatric Staff Nurse	Community Allowance**	€4,962	€5,223
Senior Staff Nurse (Psychiatric)		€5,210	€5,485
Community Psychiatric Nurse		€5,442	€5,728
CNM I (Psychiatric)		€5,272	€5,550
CNM II (Psychiatric)/Community Health Nurse		€5,626	€5,922
CNM III (Psychiatric)		€5,911	€6,222
Assistant Director of Nursing - Mental Health		€5,722	€6,023
Nurses Assigned to Occupational Therapy (Qualified)		€3,732	€3,929
Standard rate applicable to new beneficiaries pursuant to WRC Agreement August 2016		€5,449	

* Restored for new entrant nurses as per Department of Health Circular 14/2017

**Rate for beneficiaries in receipt prior to 1st February 2012

1 Payable to nurses employed directly on duties in specialist areas appropriate to the qualifications listed in paragraph 4 of the HSEA document attached to Circular 112/99, where they possess relevant clinical qualification.

2 Payable to nurses engaged in the following duties A&E Departments, Theatre, Intensive Care Units, Renal Units, Cancer/Oncology Units, Geriatric Units/Long-Stay Hospitals or Units in County Homes, Secure Units in Mental Health Services, Units for the Severe & Profoundly Handicapped in Mental Handicap Services, Acute Admissions, Units in Mental Health Services. (Refer to Para 3 of the HSEA document attached to Circular 112/99). With effect from 1 January, 2004 Care of the Elderly (excluding Care of the Elderly Day Care Centres), Alzheimer's Units in both Mental Health Services and the Intellectual Disability Sector, Psycho-geriatric Wards, Elderly Mentally Infirm Units, Psychiatry of Later Life Services. (Circular 33/2004)

Restoration of Allowances for New Entrant Nurses

Following a review of allowances conducted by the Department of Public Expenditure and Reform certain allowances were discontinued for new entrants to the public service. Further to agreement reached at the WRC on 4 March 2017, under the framework of the Lansdowne Road Agreement, it was agreed that a number of allowances for post-2012 new entrant nurses would be restored as follows:

- Midwifery Qualification (€2,791);
- Registered general nurse in the community (€5,449);
- Nurse co-ordinator allowance (€19.09 per shift);
- Specialist co-ordinator allowance (nurse tutors)(€4,319); and
- Nurses assigned to occupational therapy (€3,732).

NCHD Allowances

As part of the 2012 Review of Allowances, the Living Out Allowance was discontinued for new entrant NCHDs. Following the 2017 pay negotiations it was agreed that this allowance of €3,193 would be incorporated into the Intern, Senior House Officer and Registrar payscale. It was incorporated into the Specialist and Senior Registrar salary some years ago.

Consultant Allowances

A selection of Medical Allowances impacted by the 8% FEMPI Reduction are set out in Table D2[3].

Table D.2: Medical Allowances Pre and Post-FEMPI Reductions

Medical Allowance	Current Rate	Pre-Reduced Rate
1. Consultants per 3 hour session (and pro-rata)	€119.64	€130.04
2. Emergency Sessions		
The rate at 1 above subject to a minimum fee in the case of Anaesthetists	€78.37	€85.18
The rate at 1 above subject to a minimum fee in the case of Ophthalmic Surgeons	€46.68	€50.74
3. Community Ophthalmic Physicians per 3 hour session	€173.31	€188.38
4. Special rates payable for clinics held outside a radius of 25 miles		
(a) Where the clinics are held for less than 3 hours duration;	€59.74	€64.94
minimum rate;	€119.64	€130.04
(b) Where the duration is not less than 3 hours;		
first 3 hours	€179.19	€194.78
3 hour sessional rate for hours in excess of 3 (and pro-rata)	€119.64	€130.04
5. Pool Payments		
General Teaching Hospital (per bed day)	€5.00	€5.43
General Non-Teaching Hospital (per bed day)	€3.37	€3.66
Maternity Teaching Hospital (per bed day)	€9.68	€10.52
Maternity Non-Teaching Hospital (per bed day)	€4.56	€4.96

3 On 1 January 2010 fixed rate allowances for public servants in for those in receipt of basic pay in excess of €125,000 were reduced by 8%.

Appendix E:
Totality of the Current Remuneration Package

The Commission's first Report examined the total remuneration package including pension and security of tenure. These findings can be accessed on the Commission's website at https://paycommission.gov.ie/publications/.

In order to capture the totality of remuneration for this report, the Commission has looked at the average pay levels including allowances, overtime and other payments in 2017.

Nurse Earnings

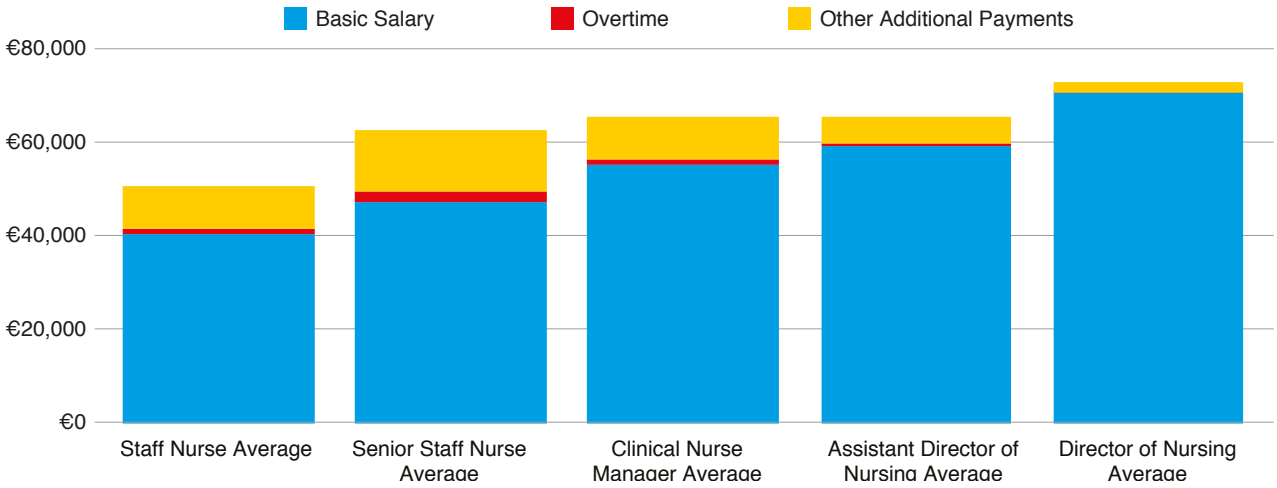
Figure E.1 sets out the average earnings of a sample of nursing grades in 2017 as provided by the HSE. The Staff Nurse/Midwife is the largest category of nurses within the health service accounting for 68.8% of nursing workforce[1]. The average earnings for all HSE Staff Nurses in 2017 was approximately €51,000 with allowances, overtime and other payments accounting for approximately 20% to 25% of these earnings.

The proportion of earnings made up of additional payments significantly reduces for the nurse manager grades; average additional payments amounting to 16% of total earnings for Clinical Nurse Managers, 10% of total earnings for Assistant Directors of Nursing and 4% of total earnings for Directors of Nursing. The 1 January 2018 payscale (excluding allowances) for Staff Nurses range from €28,768[2] to €45,537.

NCHD Earnings

Figure E.2 sets out the average earnings of NCHDs in 2017 as provided by the HSE. The average earnings for all NCHDs in 2017 was in excess of €74,000 with allowances, overtime and other payments accounting for approximately 34% of these earnings. From 1 July 2017 the Living Out Allowance of €3,193 was incorporated into the payscales of Intern, Senior House Officer and Registrar.

Figure E.1: Average Nurse Earnings, 2017



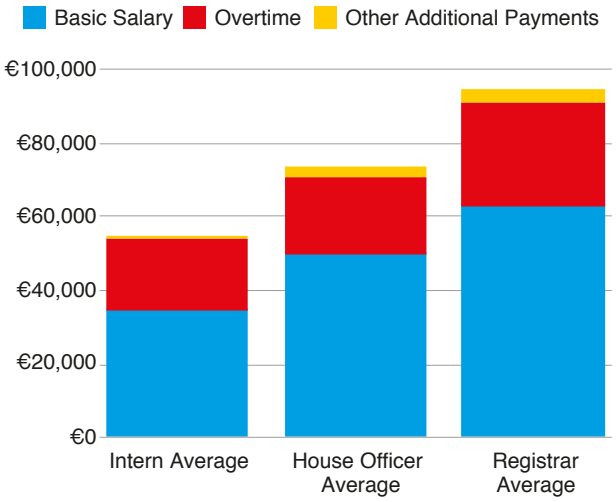
*Other Additional Payments include on call payments, allowances and weekend/public holiday hours.

Source: HBS Finance, HSE (excludes Section 38 bodies)

1 HSE Census December 2017

2 Following an industrial relations agreement on incremental credit nurses move to the second point of the Staff Nurse scale after 16 weeks. The second point is €30,178

Figure E.2: Average NCHD Earnings, 2017



*Other Additional Payments include on call payments, allowances and weekend/public holiday hours.

Source: HBS Finance, HSE (excludes Section 38 bodies)

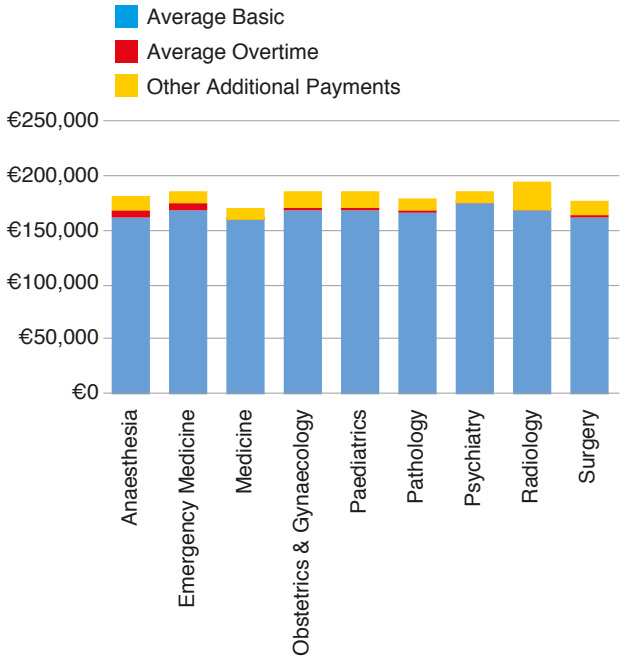
Consultant Earnings

Consultants are employed under various contract types that determine the proportions of private practice a Consultant may undertake.

The salary scale of a new entrant consultant was reduced by 30% for those appointed from 1 October 2012. Following negotiations and acceptance of the LRC agreement (January, 2015)[3] the pay of new entrant consultants has been revised, and a new nine point scale was introduced. The starting point can be adjusted up to the 6th point of the scale, depending on qualifications and experience, which is currently €149,243 (Type B), and will rise to €159,970 by October 2020. There is provision for new entrants to commence on up to the maximum point on scale in exceptional circumstances, with sanction from DPER.

Figure E.3 sets out the average earnings of Consultants in 2017 as provided by the HSE. The average earnings for all Consultants in 2017 was almost €180,000 with allowances, overtime and other payments accounting for approximately 9% of these earnings. The earnings included in figure E3 relate to earnings in respect of public practice only (private earnings applicable to Type B, Type B* and Type C contracts are not included).

Figure E.3: Average Consultant Earnings, 2017



*Other Additional Payments include on call payments, allowances and weekend/public holiday hours.

Source: HBS Finance, HSE (excludes Section 38 bodies)

3 The LRC Agreement also provides for a new career structure and performance management system.

Appendix F:
Strategic Responses to Recruitment and Retention

The Commission has undertaken a review of both recruitment and retention initiatives in other jurisdictions including the UK, Canada, and the US which have proven successful and are summarised in this Appendix.

University College Hospitals London (UCHL)

UCHL was a recipient of the Chartered Institute of Personnel and Development (CIPD) national award 2017 for recruitment and talent management which followed a highly successful campaign to recruit and retain staff in 2016. UCHL have, in this regard, maintained a low vacancy rate across all groups which at the end of 2017 was at 6.5%, reduced from 16.5% where the average vacancy rate in London is 17% and up to 30%.

UCHLs sustained recruitment drive included targeted social media campaigns featuring their staff, job fairs, open days and quicker and more efficient recruitment processes. Overall vacancy rates fell and continue to fall by the month and are at their lowest rate in two years and on the verge of zero per cent. The process has also delivered an almost one million (pound sterling) reduction in the agency pay bill for nurse and midwifery staff.

General staff losses also reduced from 14.7% to 12.8%. UCHL have introduced career clinics to encourage existing staff to transfer to other job posts within the group rather than seek employment or promotion elsewhere. The strategy provides for:

- Attendance at job fairs across the UK with a clinical team providing assessments and interviews on the day so that a job offer can be made within four hours of meeting a candidate;
- Weekly nurse assessment centres where candidates undertake a robust practical and theoretical assessment followed by a values-based interview;
- The development of a learning passport for staff, providing bespoke learning packages and senior mentoring support which targets the steps necessary to secure promotion within 12 - 24 months;
- A new Induction strategy;
- Proactive progression initiatives to rotate and promote talent; and
- A mechanism enabling public recognition of staff demonstrating UCHL's core values.

East Kent Hospitals University NHS Foundation Trust (EKHUF)

In 2016 the EKHUF which serves a population of 759,000 identified that staff turnover within the first year of employment accounted for 40.3% of the trusts overall turnover of 11%. The Trust committed to improving the overall onboarding experience from advertisement through to the completion of the local induction and probationary period.

The Trust subsequently transformed the way in which it advertises vacancies and now focuses on value based recruitment as a way to reduce turnover by ensuring that recruited staff have the values that fit with those of the organisation. They have also reinvigorated job adverts, redesigned job descriptions and introduced a new vision/ mission and set of values to recruit and work to so that staff feel cared for as individuals, safe, reassured and involved.

The key elements of the initiative, which required the support and combined efforts from teams across the Trust, included:

- Recruiting to values to get the right people to fit into your organisation;
- Providing high quality training for your recruiting managers;
- Starting induction before day one i.e. find a way to engage with new starters from appointment and sustain it;
- Delivering high quality corporate induction that focuses on the needs of new starters and not organisation compliancy; and

- Extending induction beyond day one and into the first six months through a robust, consistent local induction.

By the end of 2016 first year turnover had improved from 40% to 22%.

The UK University Hospitals (AUKUH)

The *Nurses Retention Best Practice Guide* (Association of UK University Hospitals, 2017) features nine trusts over four regions and sets out the strategies employed by the Trusts to improve nurse retention. These range from facilitating staff engagement to fostering a culture of recognition and reward along with developing a culture of staff engagement, involvement and professional excellence as follows:

- Provide strong programmes for newly qualified nurses and midwives in partnership with University preceptorship[1];
- Develop clinical rotation programmes for newly qualified nurses and external rotations to support career development;
- Introduce mentorship, coaching and motivational mapping to maximise employee potential and arrange master classes and conferences as opportunities for improved networking;
- Develop an inclusive leadership culture which, *inter alia,* actively promotes and markets the Trust;
- Improve staff engagement by promoting staff surveys, developing action plans, sharing ideas and introducing drop in clinics to enable staff to explore development opportunities;
- Monitor staff morale and provide additional support where necessary;
- Recognise and reward through an award scheme based on the nomination of staff, patients, patient families and students;
- Retain staff within the organisation by enabling internal transfers to another speciality outside of normal recruitment procedures;
- Introduce career coaches to provide career guidance and facilitate nurse transfer to augment career development and improve job satisfaction;
- Review exit surveys to identify common themes that require intervention; and
- Establish a dedicated hot-line to support staff who are considering leaving.

Nova Scotia, Canada

The response by Nova Scotia is noteworthy although it is a small player in the overall context with some 14,000 nurses. 6,000 of them are aged over 55 years of age which is a significant workforce challenge along with the recruitment of nurses in certain clinical specialities and in rural areas. The *Nova Scotia Nursing Strategy* as outlined in the body of the report has been very focused and effective.

A toolkit to accompany the *Health Recruitment and Retention Report* summarises the retention and recruitment strategies used within the healthcare system provincially, nationally and internationally; the Nova Scotia recruitment and retention toolkit is encapsulated as follows:

- Generate youth interest with a coordinated strategy to increase the awareness of healthcare and allied occupations as viable career options;
- Market and create cooperative learning opportunities for students enrolled in education programs;
- Create in-house training positions for future graduates, along with bursaries tuition reimbursement etc.;
- Incentivise foreign placement;
- Initiate mentoring and teambuilding programmes;
- Introduce career and succession planning;
- Implement management training programmes, professional development plans to assess employee aspiration and secondment opportunities;
- Establish adequate staffing levels which facilitate time off and a reduction in overtime;
- Provide workplace supports and flexible work plans to assist with work life issues;
- Ensure competitive compensation;
- Facilitate flexibility i.e. increased access to casual/part-time employees;
- Initiate programmes to alleviate workload issues and provide for professional development and leadership development; and
- Develop workplace employee appreciation programmes.

1 Preceptorship is a one-to-one educational relationship between an experienced nurse and a nursing student.

Washington Community Hospital, US

With employee turnover a key metric and performance indicator when evaluating the fiscal and operational effectiveness of any health-care facility, a study of nurse staff turnover and retention in Washington developed a ten point programme intervention designed to strengthen and standardise the new employee onboarding processes (Kurnat-Thoma *et al.*, 2017).

Post-programme implementation shows overall turnover decreasing from 18.2% to 11.9% with a new recruit decrease from 39.1% to 18.4%. The reduction in hospital and nurse turnover was rooted in multi-discipline engagement of institutional stakeholders, managerial collaboration across departments and strong executive support. The ten point programme included:

- New employee profile to present information about new recruits in departmental postings to help current staff welcome new recruits and allows staff to learn about their interests, personal goals, and preferred methods of recognition;
- A new recruit packet for all hiring managers to use when onboarding new recruits including a new recruit profile; and blank checklists, evaluation forms, for use in the first 90 days;
- A copy of their offer letter is given to confirm the offer of employment, start date, salary, and required steps in completing the onboarding process;
- A welcome call by hiring manager, with back up emails to staff, welcoming new recruits to the unit and on an ongoing basis;
- An administrative checklist to help managers ensure that the new recruit is oriented in the first two weeks of employment i.e. hospital tour, interdepartmental relationships, department safety plan, etc;
- Buddy system with high performing staff during the first 90 days to offer advice and guidance in the day-to-day aspects of work and help the new recruit acclimatise to the hospital's culture;
- Provide an onboarding checklist with an overview of what they can expect in their first 90 days of employment;
- At 30, 60 and 90 days the hiring manager asks the new recruit a series of questions on job fit, their work environment, and assesses need for support and actions to improve their experience;
- The Hiring Manager completes a 90 day evaluation of the new recruit's work performance; and
- A quarterly spotlight event - an informal meeting between the Chief Executive and new recruit is scheduled as needed to assess hospital's onboarding.

Appendix G:
Supplementary Data on Module 1 Grades

Table G.1: Trends in Nursing and Midwifery by Grade

		Dec-07	Dec-13	Dec-14	Dec-15	Dec-16	Dec-17
Director of Nursing/Midwifery	WTE	285	215	239	257	265	269
	% Change		-24.6%	11.3%	7.5%	3.2%	1.4%
Asst. Director of Nursing/Midwifery	WTE	805	702	747	785	828	864
	% Change		-12.8%	6.3%	5.1%	5.6%	4.3%
Clinical Nurse Manager 3	WTE	426	375	408	447	492	527
	% Change		-12.0%	8.8%	9.4%	10.1%	7.2%
Clinical Nurse Manager 2	WTE	4,073	3,344	3,571	3,773	3,908	3,958
	% Change		-17.9%	6.8%	5.7%	3.6%	1.3%
Clinical Nurse Manager 1	WTE	1,772	1,330	1,344	1,360	1,451	1,452
	% Change		-25.0%	1.1%	1.2%	6.7%	0.1%
Clinical Midwife Manager 3	WTE	-	22	30	31	33	38
	% Change			37.2%	4.1%	6.0%	14.2%
Clinical Midwife Manager 2	WTE	-	168	177	207	210	234
	% Change			5.3%	17.0%	1.5%	11.2%
Clinical Midwife Manager 1	WTE	-	98	86	87	91	92
	% Change			-12.5%	1.3%	4.2%	1.7%
Advanced Nurse Practitioner	WTE	32	98	104	121	162	219
	% Change		208.0%	5.6%	16.4%	34.0%	35.4%
Advanced Midwife Practitioner	WTE	-	2	3	1	2	4
	% Change			55.6%	-64.3%	100.0%	100.0%
Clinical Nurse Specialist	WTE	776	1,099	1,185	1,312	1,373	1,431
	% Change		41.6%	7.8%	10.7%	4.6%	4.3%
Clinical Midwife Specialist	WTE	25	40	40	42	43	52
	% Change		59.2%	0.8%	3.9%	2.1%	21.6%
Staff Nurses [General/ Children's]	WTE	21,205	17,725	17,823	18,231	18,434	19,126
	% Change		-16.4%	0.6%	2.3%	1.1%	3.8%
Staff Nurse [Intellectual Disability]	WTE	1,196	1,763	1,772	1,783	1,729	1,707
	% Change		47.4%	0.5%	0.7%	-3.0%	-1.3%
Staff Nurse [Psychiatric]	WTE	3,859	3,323	3,167	3,237	3,187	3,156
	% Change		-13.9%	-4.7%	2.2%	-1.5%	-1.0%
Staff Midwives	WTE	933	1,321	1,384	1,464	1,461	1,446
	% Change		41.7%	4.7%	5.8%	-0.2%	-1.0%
Public Health Nurse	WTE	1,506	1,495	1,460	1,501	1,499	1,514
	% Change		-0.8%	-2.3%	2.8%	-0.1%	1.0%
Post-registration Midwifery Students	WTE	345	97	105	103	88	80
	% Change		-71.8%	7.9%	-1.3%	-15.0%	-9.3%
Post-registration Public Health Students	WTE	147	86	116	111	112	129
	% Change		-41.5%	34.9%	-4.3%	0.9%	15.3%
Post-registration Children's Students	WTE	94	60	61	62	70	71
	% Change		-36.8%	1.5%	2.2%	13.1%	2.1%
Nursing Education/Clinical	WTE	289	266	240	245	258	256
	% Change		-7.9%	-9.9%	2.1%	5.3%	-0.8%
Other Nursing/ Midwifery	WTE	61	47	49	50	47	52
	% Change		-23.1%	5.1%	2.5%	-5.6%	9.5%

Source: HSE

Table G.2: Locations of Consultant Posts with no Applicants (2015-2017)

Location
Bantry General Hospital
Carlow/Kilkenny Mental Health Services
Cavan General Hospital
Cavan/Monaghan Mental Health Services
Cavan/Monaghan/Louth/Meath Mental Health Services
Central Mental Hospital and Galway/Roscommon Mental Health Services
Connolly Hospital
Connolly Hospital & Beaumont Hospital
Cork and Kerry Child and Adolescent Mental Health Services
Cork Mental Health Services
Cork University Hospital & Limerick University Hospital
Donegal Child and Adolescent Mental Health Services
Donegal Child and Adult Mental Health Services
Donegal Mental Health Services
Donegal West Mental Health Service (CHO Area 1)
Dublin South East/Wicklow Child and Adolescent Mental Health Services
Galway University Hospital
Laois/Offaly/Longford/ Westmeath Mental Health Services
Letterkenny University Hospital
Letterkenny University Hospital and University Hospital Galway
Louth County Hospital and the Mater University Hospital
Louth/Meath Mental Health Services
Mayo Mental Health Services & St Anne's Unit Castlebar
Mental Health Services, Specific location unknown
Midlands
Midlands Regional Hospital Portlaoise
Midlands Regional Hospital Portlaoise & Midlands Regional Hospital Tullamore
Midlands Regional Hospital Tullamore
Mid-West Mental Health Services
NSS Breastcheck Western Unit and Galway University Hospital
Our Lady of Lourdes Hospital Drogheda/Cavan General Hospital
Portiuncula Hospital
Portiuncula Hospital and University Hospital Galway
Sligo/Leitrim Mental Health Services
Sligo University Hospital
Sligo University Hospital, Letterkenny and University Hospital Galway
Sligo University Hospital and University Hospital Galway
South Tipperary Mental Health Services
University Hospital Galway and Portiuncula Hospital
University Hospital Waterford
Waterford/Wexford Mental Health Services
Wexford General Hospital

Source: PAS

Table G.3: Consultant Pay Comparison Post-Settlement of High Court case, 1 April 2018

Contract Type	Consultant Clinicians Appointed under 2008 Contract up to 30/09/2012 (pre-settlement)	Consultant Clinicians Appointed under 2008 Contract up to 30/09/2012 (post-settlement)	New Entrant Consultant Clinicians appointed since 1 Oct 2012
Type A Public only (17.8% of serving numbers at Dec 2017)	€163,856	€176,025	€134,271
	€168,580	€185,460	€140,257
	€181,932	€195,410	€148,166
	€184,549	€200,643	€152,474
	€187,166	€205,875	€158,936
	€189,783	€211,109	€164,320
			€170,782
			€176,705
			€185,885
Type B Minimum 80% public, can see private patients on-site or co-located (56.2% of serving numbers at Dec 2017)	€154,299	€162,635	€126,790
	€156,377	€170,511	€131,279
	€171,314	€180,576	€137,478
	€173,578	€184,943	€140,684
	€173,646	€189,304	€144,960
	€173,646	€193,665	€149,243
			€153,551
			€160,013
			€166,474
Type C Minimum 80% public, can see private patients off-site (4.4% of serving numbers at Dec 2017)	€135,009	€135,009	€113,076
	€139,765	€139,764	€116,369
	€149,930	€149,930	€118,238
	€150,665	€150,666	€120,911
	€155,196	€155,195	€123,583
	€156,983	€159,726	€126,790
			€131,065
			€135,875
			€141,753

Source: PSPC workings

Appendix H:
Acronyms

ADL – Accrued to Date Pension Liability

AMP – Advanced Midwife Practitioner

ANP – Advanced Nurse Practitioner

ASC – Additional Superannuation Contribution

AUKUH – Association of UK University Hospitals

CAO – Central Applications Office

CCPS – Certificate of Current Professional Status

CHO – Community Health Organisation

CMM – Clinical Midwife Manager

CMS – Clinical Midwife Specialist

CNM – Clinical Nurse Manager

CNME – Centres of Nursing and Midwifery Education

CPD – Continuous Professional Development

CSO – Central Statistics Office of Ireland

DPER – Department of Public Expenditure and Reform

EEA – European Economic Area

EFTA – European Free Trade Association

EKHUF – East Kent Hospitals University NHS Foundation Trust

ESRI – Economic and Social Research Institute

EU – European Union

EWTD – European Working Time Directive

FDI – Foreign Direct Investment

FEMPI – Financial Emergency Measures in the Public Interest

GDP – Gross Domestic Product

GNI – Gross National Income

GNP – Gross National Product

HBS – Health Business Service

HCA – Health Care Assistant

HEA – Higher Education Authority

HESA – Higher Education Statistics Agency

HRA – Haddington Road Agreement

HSE – Health Service Executive

ICTU – Irish Congress of Trade Unions

IHCA – Irish Hospital Consultants Association

IMG – International Medical Graduate

IMO – Irish Medical Organisation

INMO – Irish Nurses and Midwives Organisation

LRA – Lansdowne Road Agreement

LRC – Labour Relations Commission

NCHD – Non-Consultant Hospital Doctor

NDTP – National Doctors Training and Planning

NHS – National Health Service

NLIC – National Leadership and Innovation Centre

NMBI – Nursing and Midwifery Board of Ireland

OECD – Organisation for Economic Co-operation and Development

ONMSD – Office of Nursing and Midwifery Services Director

PAS – Public Appointments Service

PNA – Psychiatric Nurses Association

PPP – Purchasing Power Parity

PRD – Pension Related Deduction

PSPC – Public Service Pay Commission

PSSA – Public Service Stability Agreement

RCNME – Regional Centres for Nursing and Midwifery Education

RCSI – Royal College of Surgeons in Ireland

SES – Structure of Earnings Survey

SGP – Stability and Growth Pact

SHO – Senior House Officer

SIPTU – Services Industrial Professional and Technical Union

TC – Treacy Consulting

UCHL – University College Hospitals London

UK – United Kingdom

US – United States of America

WHO – World Health Organisation

WRC – Workplace Relations Commission

WTE – Whole Time Equivalent

WTW – Willis Towers Watson

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