Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

HSE Intern Implementation Group

Interim Report

On the implementation of recommendations of the National Committee report on the Intern Year

Phase 1: May 2009 – July 2010

Report available: www.hse.ie/eng/services/publications/corporate/etr/

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M E T HSE Medical Education & Training:
Fit for Purpose, in the Irish Health Service

November 2010

Contents

List of Abbreviations used in report:

DML:	Dublin / Mid-Leinster Intern Training Network
DNE:	Dublin / Northeast Intern Training Network
DSE:	Dublin / Southeast Intern Training Network
HSE:	Health Service Executive
MWT:	Mid-West Intern Training Network
NCMET:	National Committee on Medical Education and Training *(as established in 2007 by the Department of Health & Children and the Department of Education & Science to oversee the implementation of Government policy on medical education and training as set out in the "Fottrell" and "Buttimer" Reports (2006))*
NUIG:	National University of Ireland, Galway
RCSI:	The Royal College of Surgeons in Ireland
STH:	South Intern Training Network
TCD:	The University of Dublin, Trinity College
UCC:	University College Cork
UCD:	University College Dublin
UL:	University of Limerick
WNW:	West / Northwest Intern Training Network

1.0 Introduction

The National Committee on Medical Education and Training adopted the report of its Sub-Committee on the Intern Year in July 2008 ("NCMET Report")[1]. The report was subsequently noted by the Interdepartmental Policy Steering Group on Medical Education and Training.

In May 2009, the Health Service Executive ("HSE") established an Intern Implementation Group, incorporating membership from the wide range of stakeholders involved in the intern year, including the Medical Council, Medical Schools, Postgraduate Medical Training Bodies, hospital services, primary care services and the HSE's Medical Education and Training, HR and Finance functions. The membership of the Implementation Group is provided at Appendix A.

1.1 Terms of Reference

The terms of reference of the Intern Implementation Group were as follows:

- To implement those recommendations of the Report of the Intern Sub-Committee as adopted by the National Committee on Medical Education and Training (July 2008) which fall within the executive remit of the HSE.
- To work with partner organisations to progress the implementation of recommendations which are the joint responsibility of the HSE and other agencies / bodies.

The work of the Group was divided into the period (i) May 2009 – July 2010, focusing on the implementation of relevant recommendations of the NCMET report and (ii) July 2010 – June 2011, focussing on the review of implementation to date and planning for the future roll-out of the reform process.

This Interim Report focuses on the progress of implementation during phase one – from May 2009 to July 2010.

Details of the recommendations of the NCMET report and the rationale behind them are available in the NCMET Report. A list of the recommendations of the report, along with an update on the implementation status of each is provided at Appendix B.

[1] Report of the Intern Sub-Committee, available to download at www.hse.ie/eng/services/publications/corporate/etr

1.2 Work Programme of the Implementation Group

Upon its establishment, the Intern Implementation Group immediately set about prioritising the recommendations of the NCMET Report. The programme of work of the Group was divided into distinct areas, which were based on the recommendations of the NCMET report. These areas were identified as followed:

- Intern Training Networks
- Intern Training Programme
- Current & Future Allocation of Intern Posts
- Eligibility for Intern Posts
- National Application and Matching process
- Sign-off of the Intern Year
- Communications

The work of the Group was coordinated through working papers which identified actions and achievements, discussion topics and priorities under each of the headings. Each of these areas is addressed in a separate chapter in this report.

In order to progress detailed aspects of the implementation process, two further groups were convened by the HSE which informed – and were informed by – the work of the Implementation Group:

(i) Intern Coordinators Group
(ii) Medical School Liaison Group

These groups were particularly helpful in identifying and addressing specific challenges to the reform of the intern year and, importantly, provided a forum for discussion of issues at a national level, thereby ensuring a common and coordinated approach. Those involved in these groups are listed at Appendix C.

Publication of Interim Report

This report has been agreed by the Implementation Group and will be presented, for information, to the National Committee on Medical Education and Training and the Interdepartmental Policy Steering Group on Medical Education and Training. It will be circulated to relevant parties, including students, and will be made available on the HSE's website.

Acknowledgements

The HSE's MET Unit would like to thank all those who have been involved in the implementation of the reform of the intern year. The reform process has required significant collaboration by a range of bodies and their cooperation through the process to date has ensured that considerable progress has been made during the first year of implementation. Particular gratitude is expressed to the Intern Network Coordinators and staff of the Medical Schools, all of whom worked tirelessly with the HSE's MET Unit to ensure the smooth implementation of many of the recommendations in time for the July 2010 internship intake.

2.0 Intern Training Networks

2.1 Introduction

Prior to the implementation of the recommendations of the NCMET report, intern training posts were organised on the basis of Medical School affiliations with individual hospitals. There was little national coordination of intern training places, though Schools did work together to address any vacancies or oversupply of graduates on a case by case basis.

In terms of a support structure for intern training, a number of Intern Tutors were in place, largely as a result of earlier recommendations from the Medical Council for an Intern Tutor Network. Those Intern Tutors who have been appointed have fulfilled important roles in the support of intern training but appointment of Intern Tutors has not been consistent or coordinated nationally.

2.2 NCMET Report Recommendations

The principal areas of reform of the organisation of intern training identified by the NCMET Report included the following:

- The establishment of Intern Training Networks, each of which would be based around an existing Medical School and led by an Intern Network Coordinator.
- The development of an intern training curriculum.
- Roll-out of appointment of Intern Tutors, with protected time and clear roles.

2.3 Intern Training Network Structure

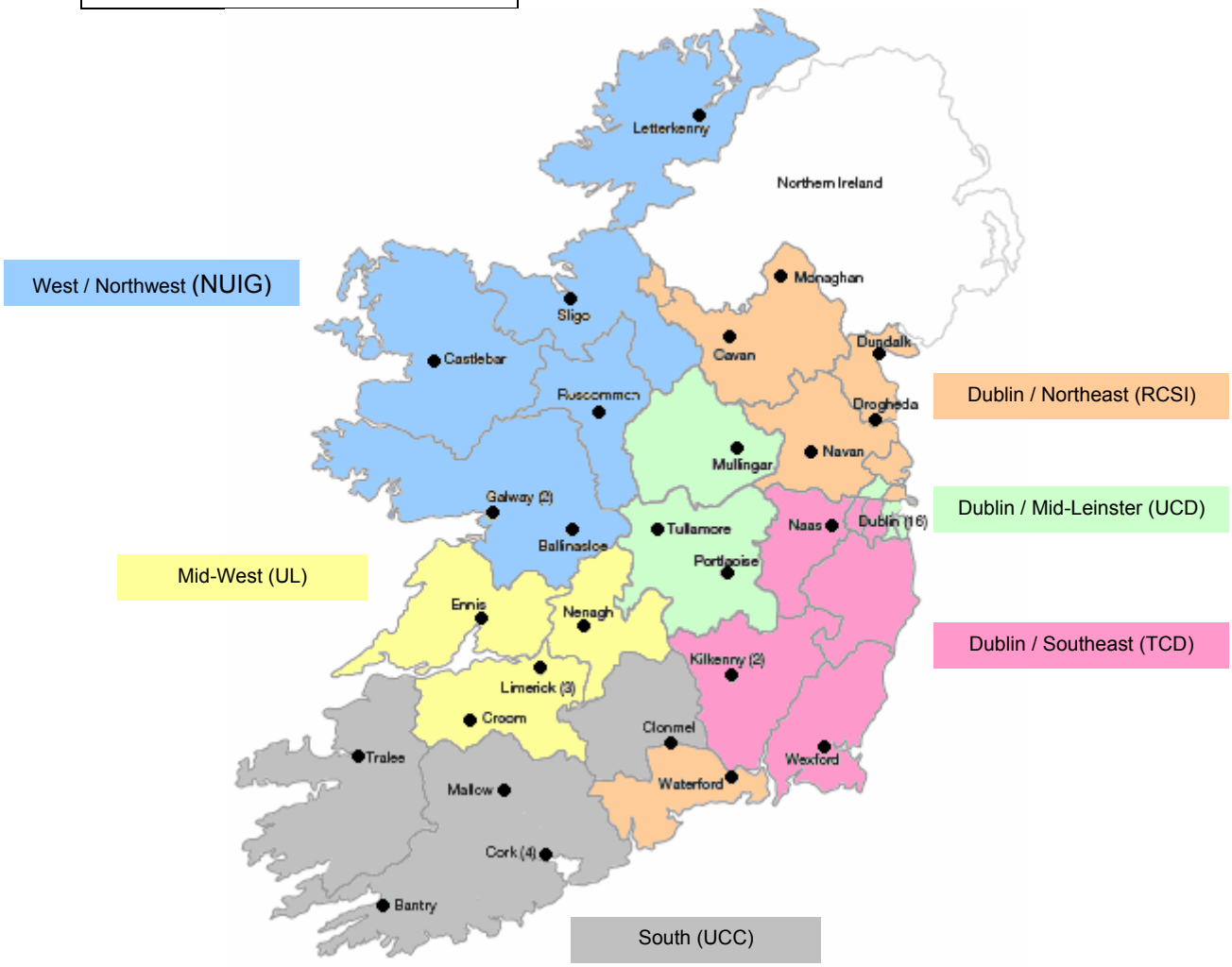
The Implementation Group immediately commenced work on the establishment of the Intern Training Network structure. Five Networks were established initially, for the intake to internship in July 2010. The sixth – the Mid-West, which is based around the University of Limerick Graduate Medical School – was established later, in anticipation of the first cohort of graduates from the School in 2011.

The six Intern Training Networks established are as follows:

Intern Training Network:	*Associated Medical School:*
West / Northwest	National University of Ireland, Galway
Dublin / Northeast	Royal College of Surgeons in Ireland
Dublin / Midlands	University College Dublin
Dublin / Southeast	University of Dublin, Trinity College
South	University College Cork
Mid-West	University of Limerick

Figure 1 illustrates the six Intern Training Networks. The names of the clinical training sites incorporated into each network are provided at Appendix D.

Fig. 1: Intern Training Networks & associated Medical School



Note: Not all locations identified above are approved for Intern training; details of the hospitals in each network involved in intern training are provided at Appendix D.

2.4 Intern Network Coordinators

The importance of clinical leadership in ensuring the successful implementation of the reforms provided in the NCMET report was recognised at an early stage in the process. In order to drive implementation in each of the Intern Training Networks, an Intern Coordinator – at consultant level - was appointed to each Network. These appointments are supported by the HSE on the basis of a commitment of one day / week.

The role of the Intern Network Coordinators is to:

- On a collective basis, provide input into the development of an intern training programme which will meet the requirements of the Medical Council and the health service;
- Be responsible for organising and overseeing the intern training programme in their Network.
- Act as the principal communication point within the Intern Training Networks for all matters relating to intern training.
- Collaborate with the HSE and other relevant bodies to ensure consistency in the implementation of reforms of the intern year.

In addition, Intern Network Coordinators will be involved in the sign-off of interns in their Network. The Medical Council is responsible for determining the mechanism for the sign-off of interns. A Medical Council Sub-Committee, including representation from relevant bodies has been established to advise the Council on appropriate arrangements.

2.5 Role of Intern Training Networks

The Intern Training Network provides a focal point for the organisation and delivery of intern training within a geographical area. The Network provides an opportunity to all of those involved in intern training in an area to develop intern training on an ongoing basis. With the Intern Network Coordinator, the network brings together relevant parties, such as Intern Tutors, Clinical Directors, postgraduate training representatives, the Medical School, local medical manpower managers and representatives of clinical sites within the region where intern training is provided.

Intern Training Networks also provide a geographic basis for the organisation of intern training posts. This has facilitated the development of a modular structure for the intern year, with intern posts largely based entirely within a Network area. Most intern posts are based on a “hub and spoke” approach, with rotations in a large teaching hospital and a smaller hospital within the same region. The distribution of intern posts is dealt with in greater detail in Chapter 3.

2.6 Intern Training Programme

A training programme has never formally been in place for interns; training has usually been provided on-site by supervising senior clinicians, in addition to some didactic teaching being provided through individual Medical Schools.

Discussions have taken place over the past year in relation to the development of a training programme for interns. These discussions to date have primarily been amongst the Intern Network Coordinators, in order to identify common elements which could be incorporated into a national intern training programme. These discussions have taken place within the context of the Medical Practitioners Act and the Medical Council's responsibility for the approval of medical education programmes. The Medical Council's guidelines on intern training have been used as the basis for discussions to date.

Work will continue during phase 2 of the implementation process on the development of an intern training curriculum, under the auspices of the Medical Council Intern Training Sub-Committee, which includes representation from all relevant stakeholders.

It is anticipated that, subject to agreement and Medical Council approval, a modular training programme will be implemented over the coming year, allowing some modules to progress while others are developed. The programme will continue to be developed over the coming years. Education programmes are likely to incorporate the following elements:

- Supervised clinical training on accredited clinical sites approved by the Medical Council, by accredited trainers of appropriate seniority
- Formal curricular elements
- Models of educational delivery to include, for example, e-learning elements and e-portfolio functions which support the ongoing training and assessment of interns in line with the curriculum and defined competencies.
- Clinical skills training.

The HSE is supporting the implementation of intern training programmes from within existing resources. In line with its legislative requirements, formal Service Level Agreements were drawn up to govern the distribution of funding and the provision of quality intern training programmes. These Agreements, which have recently been put in place, are with each of the Universities / Medical Schools in the short-term.

Achievements: Intern Training Networks

- Six Intern Training Networks established
- Intern Network Coordinators appointed to all Intern Training Networks
- Outline plan for Intern Training Programme developed
- Work on online education and assessment well progressed by Intern Training Networks
- Service Level Agreements drawn up and agreed with Universities / Medical Schools.

Actions to be addressed in Phase 2

- Intern Training Programme (Note: this falls within responsibility of Medical Council Intern Sub-Committee)
- Role of Intern Tutors

3.0 Distribution of Intern Posts

3.1 Introduction

At the time of establishment of the Implementation Group, there were 508 funded posts available for intern training in Ireland, based at 35 hospitals and two general practices[2].

The distribution of intern posts was based on affiliations between Medical Schools and individual hospitals and other clinical sites. Affiliations between Schools and hospitals varied considerably, from a concentration of intern posts associated with one School being across five hospitals, to a wide dispersal of posts across 15 hospitals in the case of another School. Additionally, some smaller hospitals with a relatively small number of interns had affiliations with a number of Medical Schools - such as one hospital with nine intern posts affiliated with three different Schools – making coordination of training and systems in place in different Schools difficult for both the hospitals and Schools involved. General practice rotations were available solely in Donegal, as part of a pilot programme successfully developed by NUIG.

Intern posts were almost entirely based on a structure of 6 months medicine / 6 months surgery. While some posts provided rotational arrangements through different sub-specialties, many did not. Additionally, only a very small number of posts provided training opportunities in specialty areas not traditionally associated with intern training.

The Group examined comparative data for consultant / intern ratios and bed number / intern ratios, which showed that there was considerable variation, even between hospitals of similar size and activity.

3.2 NCMET Report Recommendations

The NCMET Report highlighted the need for reform through:

- A modular structure for the intern year
- Availability of intern training in a wider range of specialty areas, with a particular emphasis on the development of intern training posts in primary care
- The geographic distribution of posts to the new Intern Training Networks
- The fair and transparent distribution of intern posts across Intern Training Networks

[2] Includes 6 posts funded privately, located at the Bon Secours Hospital, Cork. These posts have historically been part of the UCC intern rotations and were all included in the national application and matching system for interns implemented by the HSE for the July 2010 intake.

3.3 Geographic Approach to Intern Posts

The NCMET report recommended a geographic distribution of intern posts, within the proposed Intern Training Network structure, on a transparent and equitable basis. Based on the newly established Networks, the HSE re-allocated the existing intern posts on a geographic basis. Figures 2 & 3 compare the previous Medical School / hospital affiliations with the re-organised affiliations of Intern Training Networks and hospitals.

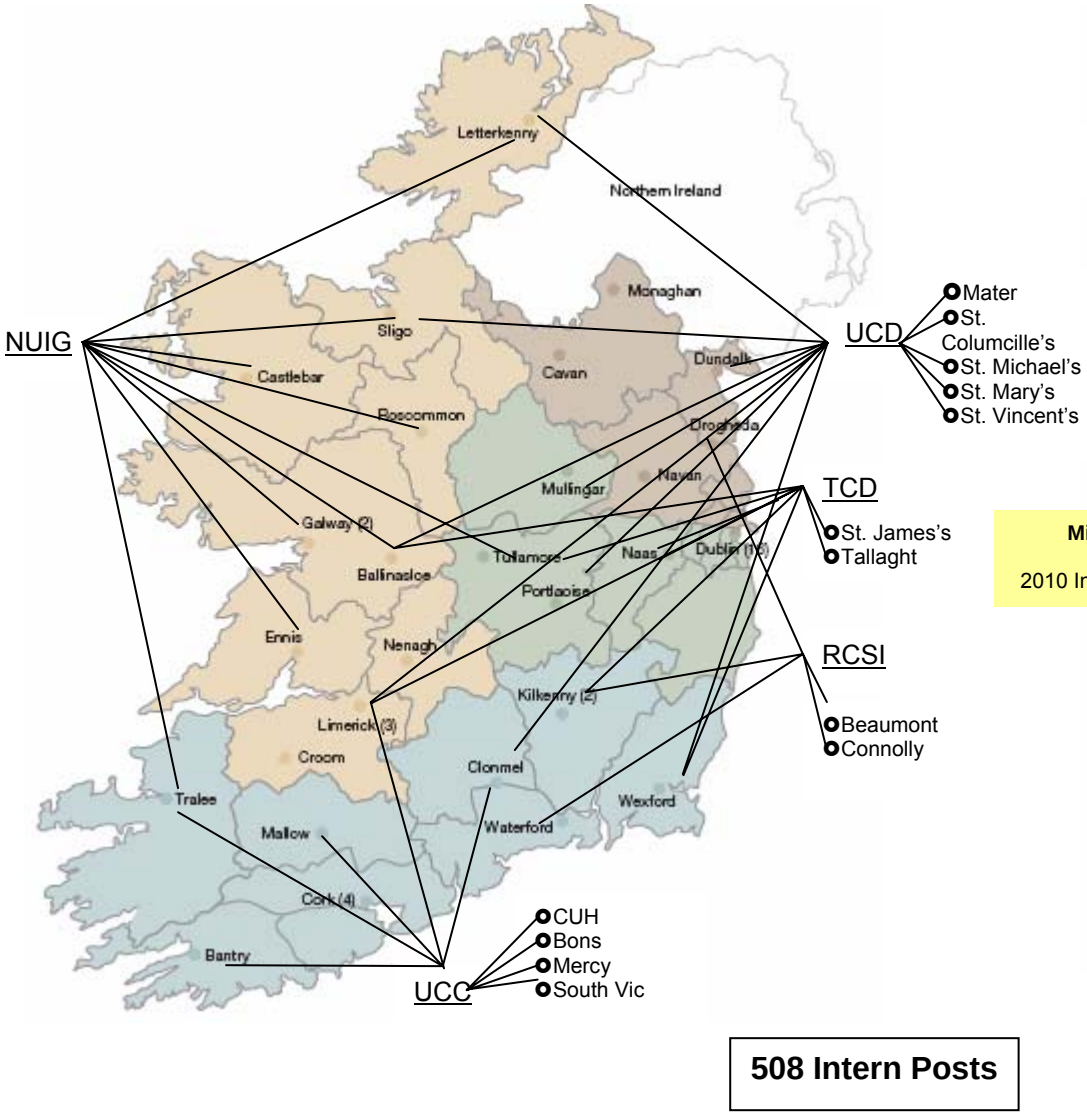
Where feasible, historical affiliations to large teaching hospitals were maintained. The main rationalisation involved was to link smaller hospitals within networks, to assign all intern posts within a hospital to a single Network and to incorporate a "hub and spoke" approach for intern posts, with rotations at a large teaching hospital and a smaller hospital/general practice. Pending the development of the Mid-West Network, posts in that region were divided for the July 2010 intake between the Dublin Mid-Leinster (UCD) Network (which historically had affiliations with the Mid-Western Regional Hospital and St. John's Hospital, Limerick) and the South (UCC) Intern Training Network (which historically had affiliations with the Mid-Western Regional Hospital). With the development of the Mid-West Intern Training Network, the distribution of intern posts will continue to be reviewed to ensure a fair and transparent distribution.

The appropriateness of training locations was taken into account in determining the allocation of intern posts. For example, a single-handed intern post at St. Mary's Hospital was withdrawn and appointed instead at the Mater Hospital. Health service configuration was another important factor in the re-allocation of intern posts; for example, intern posts previously at Louth County Hospital, Dundalk, were transferred to Our Lady of Lourdes Hospital, Drogheda, in line with service transformation in the northeast region. Service configuration will continue to be a key determinant in the ongoing distribution of intern posts.

In the majority of cases, a "hub-and-spoke" type model has been employed, with most intern posts incorporating modules at large teaching hospitals and regional hospitals, which is the preferred model both from a service provision perspective and from the perspective of affording interns the widest possible experience of provision of care. This approach is also in line with the results of a survey of recently completed interns, carried out for the NCMET Report, a majority of whom favoured intern posts incorporating both levels of exposure. Training rotations at some smaller hospitals, such as Bantry and Mallow were retained as short rotations radiating from the teaching hospital in their area.

Five general practices are also now involved in intern training, following the focus of the Group on the development of intern training opportunities in primary care settings, in line with the NCMET Report. It is hoped that intern training in primary care will be rolled out further (subject to additional posts being sanctioned), in line with the shift in focus of health services from hospital services to the greater provision of care in the community.

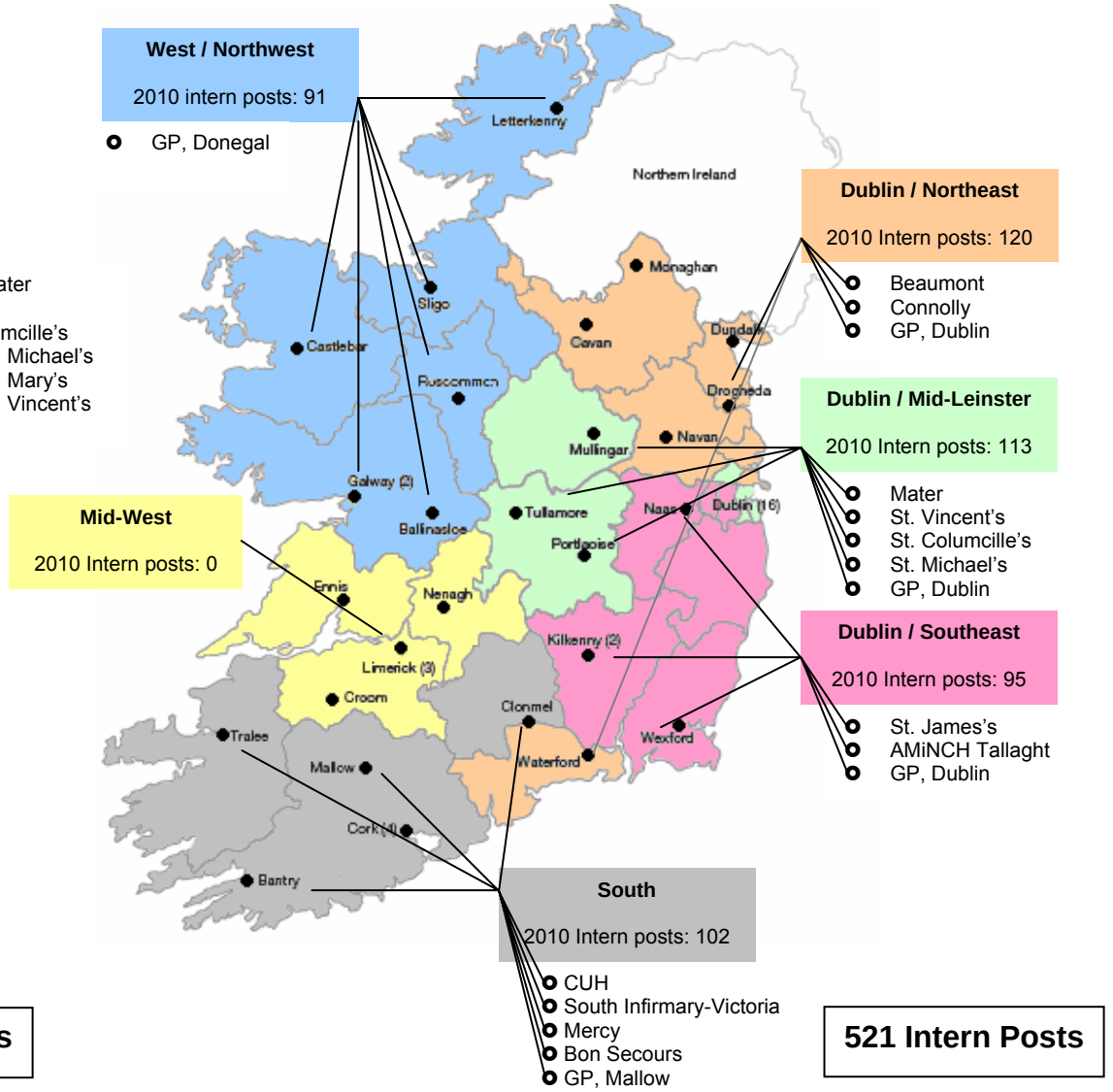
Figure 2: Historical Medical School Affiliations & Intern Post Distribution (pre July 2010)



508 Intern Posts

Note: shaded regions above refer to HSE administrative areas

Figure 3: Re-distribution of Intern post & affiliation with Networks (July 2010)



521 Intern Posts

Notes: Shaded areas above refer to Intern Training Networks. Posts in Limerick RH which were assigned to the Dublin Mid-Leinster & South Intern Training Networks for the July 2010 intake will be assigned to the MWT Intern Training Network in 2011. Waterford RH was maintained within the Dublin / Northeast due to the strong links between the RCSI and the hospital.

3.4 New Intern Posts

The NCMET Report recommended that intern training should be developed in a wider range of specialties, with General Practice being a priority area for such development. The Medical Council requires that intern posts incorporate a minimum of 3 months in each of medicine and surgery and may also include 2-4 months in the following specialties: obstetrics & gynaecology, paediatrics, general practice, emergency medicine, psychiatry and anaesthesia (incorporating perioperative medicine). (Note: Radiology was approved by the Medical Council for intern training after the completion of the 2010 intake)

Ten additional intern posts in new specialty areas were created by the HSE from within existing resources, with effect from July 1st 2010. The Intern Network Coordinators and Medical School Managers developed the rotations with their local hospitals and primary care settings. A post in General Practice was included in each of the Networks. Other specialty areas included were Anaesthesia, Paediatrics and Ophthalmology. A small number of rotations were previously available in obstetrics / gynaecology, emergency medicine and acute medical units and these were maintained.

In addition, three intern posts were created through the conversion of non-training Senior House Officer positions at two hospitals, in time for inclusion in the list of advertised posts. A number of other hospitals subsequently converted SHO posts to intern posts on a short-term basis and these were filled by existing interns (see Chapter 5 for more details on existing interns).

In total, 521 intern posts were available for advertisement and filling for the July 2010 intake.

3.5 Modular Intern posts

The NCMET report recommended a modular structure for the intern year, moving from the traditional 6 months medicine / 6 months surgery, to a 12-month appointment with a number of specialties / sub-specialties and generally including rotations to a number of distinct clinical sites.

Significant work was undertaken by the Intern Network Coordinators and the Medical Schools to provide a detailed breakdown of every intern post and to re-organise them on a modular basis. Most posts had a 4 x 3 month format, although some were sub-divided into shorter rotations (particularly at smaller hospitals). The details provided to prospective applicants set out the duration of rotations, their location and trainer(s) associated with each. This information, along with the new posts created, formed the basis of the list of 521 advertised intern posts and the proposal made by the HSE to the Medical Council, as required under the Medical Practitioners Act 2007.

Achievements: Distribution of Intern posts

- All intern posts re-distributed on a geographic basis
- Intern post distribution in line with service configuration
- Greater coherence and consistency for hospitals / clinical sites and Medical Schools in the distribution of intern posts
- 10 new intern posts in new specialty areas created from within existing resources
- General practice prioritised for intern training in line with NCMET Report and 20 interns rotating through GP slots
- Modular structure for intern posts implemented

Areas to be addressed in Phase 2

- Ongoing review of the distribution of intern posts.
- Approval for additional intern posts from Dept. Finance / Dept. Health & Children, in line with Government expansion in medical students places at undergraduate level.
- Plan for expansion of intern posts (subject to approval above), taking into account health service requirements, numbers of EEA students per area, workforce planning, bed numbers, capacity, casemix etc.
- Examine appropriateness of some training sites in light of health service reconfiguration and any advice available from the Medical Council re. accreditation of sites.
- Development of intern training opportunities at under-utilised sites, such as primary care, maternity and paediatric hospitals.

4.0 Application and Matching Process

4.1 Introduction

Prior to the implementation of the NCMET recommendations, the allocation of graduates to available intern posts was coordinated by individual Medical Schools, who advised employers of available interns. In the case of some Medical Schools, graduates had the opportunity to indicate their preferences for particular hospitals and specialties on a local basis. Hospitals filled intern posts with graduates of their affiliated Medical Schools first, before accepting applicants from other Medical Schools. The exception to this related to instances where the number of EEA graduates from a School exceeded the number of available intern places, in which case EEA nationals had to be accommodated ahead of non-EEA nationals in other areas.

The historical arrangements for the placement of interns not only restricted graduates to posts within hospitals affiliated with their Medical School but also created an unfair bias against non-EEA nationals of Schools where a larger EEA to non-EEA ratio was in place.

The NCMET Report recommended the implementation of a national application and matching system which would allow for the transparent and equitable appointment of successful graduates to intern posts on the basis of merit. Such a system would provide for a nationally coordinated recruitment of interns, ensure the adherence to EU Community Preference on a national level and also allow graduates the freedom to choose posts in other areas or, for example, to focus in on all posts in a particular specialty area of interest to them.

4.2 NCMET Report Recommendations

The NCMET Report recommended

- The introduction of a standardised central application system for intern posts
- A single national matching system, with regional elements, organised through the new Intern Training Networks

4.3 Eligibility for Intern Posts

In order to implement a national application and matching system, it was necessary to ensure that clear eligibility criteria were established. In determining eligibility for intern posts, three key factors were taken into account:

(i) **Whether the medical degree of the applicant was undertaken in Europe**: Under the Medical Practitioners Act 2007, internship registration is only open to those who have completed a basic medical degree in a European country. Graduates of

medical schools in countries outside Europe cannot be registered as interns and therefore cannot be employed as interns.

(ii) **Whether an intern year is required**: In a number of European countries, a separate internship is not required. Graduates of Medical Schools in such European countries were not eligible to apply for intern positions in Ireland[3].The intern year is available only to those who require it in order to gain a Certificate of Experience which enables the holder to apply for registration on the Trainee Specialist Division (other than as an intern) or General Division of the Register of Medical Practitioners maintained by the Medical Council. Existing interns, who had already completed partial internship or were in the process of doing so, were excluded from the national application and matching system. More information on this cohort of doctors is provided in Chapter 5.

(iii) **Time since graduation**: in view of the importance of maintenance of clinical skills in a supervised, accredited environment, applicants were required to be within two years of their date of graduation from Medical School.

Other considerations in determining eligibility related to the time of completion of final medical exams and release of results (which determined the time that centile rankings would be available) and the date of conferral, which affects the date on which they may be registered to practise by the Medical Council.

When it came to matching eligible applicants to posts, EEA/ Non-EEA nationality was a factor, particularly the requirement or otherwise for a permit to work in Ireland. The work permit system is utilised in the application of European Community Preference whereby applicants who require a work permit are ranked after all eligible applicants who do not require a permit.

4.4 Application Process

The national application process was developed and implemented by the HSE's Medical Education and Training Unit for the July 2010 intake to internship. A common application form was developed, taking into account the various application procedures which were previously in existence through Medical Schools and individual hospitals. The application documents were developed with input from Medical Manpower Managers, the Medical Council, Medical Schools and, importantly, a focus group of final year medical students, as well as the members of the Implementation Group.

The call for applications was released through the Irish Medical Schools and was published on the HSE website. Applicants were required to apply, using the common application form, directly to the HSE's Medical Education & Training Unit.

[3] For information, graduates of Medical Schools in the following countries were ineligible to apply for the July 2010 intake on this basis: Austria, Belguim, Bulgaria, Estonia, Germany, Greece, Spain, France, Cyprus, Iceland, Latvia, Hungary, Netherlands, Romania, Slovenia, Switzerland and the Slovak Republic. Graduates from these countries who wish to practise medicine in Ireland may apply directly for SHO positions and for registration on the Trainee Specialist / General Division of the Register of Medical Practitioners without completing an intern year in Ireland.

Applicants were required to include (i) their ranked preference for 20 posts, of the 521 available and (ii) their preference, in ranked order, for the five Intern Training Networks. Applicants were permitted to apply to posts in any network.

A total of 565 applications was received. Of these, 12 were immediately deemed ineligible as they did not meet the eligibility criteria provided (as summarised in section 4.3 above). The Medical Schools subsequently confirmed that a further 17 applicants had not been conferred; these applicants could therefore not proceed to the matching stage.

Of the 565 applications received, 422 (75%) were from EEA nationals and 143 (25%) were from non-EEA nationals[4]. 23 applications were received from prospective graduates of Schools outside Ireland, with the remainder coming from graduates of Irish Schools.

Statistics on the applications received are provided at Appendix E.

A centralised process for the collection of Garda vetting forms and statutory declarations was also facilitated by the MET Unit. The Garda Vetting process was coordinated by the HSE's Garda Vetting Liaison Office, which provided a national, centralised approach to the vetting process, including the review of all forms submitted and necessary follow-up, liaison with the Garda Central Vetting Unit, reviews and appropriate reporting on any disclosures received. This effective approach considerably reduced administrative requirements for hospital medical workforce administration departments.

4.5 Matching process

In developing the matching process, representatives of the Group considered matching processes in place at postgraduate level for basic specialist training programmes.

It was decided to proceed with an entirely merit-based approach, based on the centile ranking of each individual applicant. The centile calculates the position of an individual, relative to the other members of their own class. The formula employed did not rely on the comparison of actual marks attained. In the absence of a common exit exam, this was considered to be fairest and most equitable approach. The same formula was used for all applicants, regardless of Medical School of graduation.

Following receipt of centile rankings for all applicants, a ranked list of applicants was prepared, with applicants who required a work permit ranked after all eligible applicants who did not require a permit.

[4] As explained in section 4.3, non-EEA status is defined for the purposes of appointment as the requirement or otherwise for a permit to work in Ireland.

The matching process took place in two stages: (i) central matching, undertaken by officials of the MET Unit and (ii) regional matching, undertaken by the Intern Training Networks. A total of 536 applications were included in the matching process.

Stage 1, central matching, took each applicant in ranked order and allocated each to their top available intern post, as indicated in the preferences included in their application form. Where two (or more) applicants at the same centile had indicated the same preference post, a random allocation to the post was made between the applicants. In instances where an applicant's post preferences had all been exhausted owing to the allocation of those posts to higher ranked candidates, the applicant was assigned for local matching to the top available network of preference. Where this happened, a sufficient number of posts in the network were held to accommodate such applicants to ensure that lower-ranked candidates did not displace higher-ranked candidates.

At Stage 2, regional matching, the Intern Training Networks, led by the Intern Network Coordinator, took into consideration the applicant's preferences for particular locations or specialty areas. The number of applicants awaiting matching at this stage was the same as the number of posts remaining within the network. This stage also allocated candidates in ranked order.

A trial-run of the matching process was completed by the HSE's MET Unit in advance, to ensure that any potential issues were identified and addressed. The trial-run, based on certain assumptions regarding individual preferences, estimated that approximately 90% of applicants would be matched through the national matching process, with 10% remaining for local match. In practice, the matching process resulted in 88% of applicants being matched at Stage 1.

25% of all eligible applicants were matched to their first preference post. Considering that most intern posts were arranged in blocks of four rotations in different order, the actual number of applicants who were matched to their preferred rotations was even higher. 55% of all eligible applicants were matched to a post within their top 5 preferences, 71% within their top 10 preferences and 80% within their top 15 post preferences.

Following the completion of both stages of the application process, offers were issued to 521 successful applicants through the Intern Training Network to which the post was assigned. 15 eligible applicants remained on the reserve list at this point. Successful applicants received a single post offer and no swapping was posts was permitted.

Upon receipt of offers, 12 successful applicants declined the offers. These were offered to the top 12 candidates on the reserve list, one of whom declined the offer. Subsequently, a further seven candidates declined offers prior to the July 1st commencement date; two further candidates failed to commence in post at the appointed date. One further intern resigned shortly after commencement.

The matching process therefore resulted in all eligible applicants receiving an offer of a post, including all of those who were originally on the reserve list. Vacancies which arose as a result of late withdrawals, were used to accommodate existing interns (see Chapter 5 for more details on existing interns).

Following completion of the matching process, details of all matches by clinical site were provided to the Intern Training Networks and to employers, to facilitate the completion of pre-employment checks, induction training etc.

Statistics on the matching process are provided at Appendix E.

Achievements: Application and Matching

- Common application process implemented by HSE-MET for all applicants to intern training posts in Ireland.
- National matching system implemented by HSE-MET for 521 intern training posts nationally.

Actions to be addressed in Phase 2

- Transfer of central application & matching process to HSE National Recruitment Service.
- Soft copy application, moving to online application.
- Ongoing review of matching/ranking system.
- Introduction of mandatory English language testing requirements.

5.0 Existing Interns

"Existing interns" refers to the cohort of intern doctors who had graduated within the previous 1-2 years and who partially completed internship at July 2010, most having commenced in intern positions in January 2010.

In the past, a number of intern rotations were not incorporated into full 12-month posts, owing largely to legacy issues in a small number of hospitals. This has resulted in a number of interns being appointed on 6-month contracts commencing in January each year, with no guarantee of securing a second 6-month slot in order to complete their internship to the satisfaction of Medical Council requirements.

The considerable efforts by Medical Schools over the past 12 months has resulted in the vast majority of intern posts being arranged in a modular structure, most with 4 modules of three months' each. However, it will take some time to phase out the legacy issues remaining from the practice of the small number of hospitals which continued to appoint interns on short-term contracts.

Each year, there are a number of prospective medical graduates who are not in a position to take up intern posts at the usual July intake, for various reasons, such as illness at the time of exams, failure of exams or personal reasons. It was originally estimated, based on previous experience of Medical Schools, that approximately 10-15 graduates, nationally, would be in this position in July 2010. The actual number confirmed, who were "existing" interns, either in post up to June 2010 or had recently completed partial intern training, was 44 nationally. This group included 30 non-EEA nationals and 14 graduates of Medical Schools outside Ireland. The number per Medical School area ranged from 4 to 18.

Owing to a small number of advertised posts falling vacant due to offers being declined and decisions by a number of hospitals shortly before July 1st 2010 to convert vacant SHO posts to interns, it was possible to accommodate all 44 existing interns.

The NCMET report recommended a single intake to the intern year. It remains the HSE's intention to implement this recommendation to ensure that intern training is in line with specialist training programmes, which have single annual intakes, and in line with similar training programmes in other countries.

Achievements: Existing Interns

- All "existing" interns accommodated in intern training rotations, facilitating them to proceed to completion of training.

Actions to be addressed in Phase 2

- Phase-out January intake to intern training and progress single intake.

6.0 Communications

From the outset, the Implementation Group recognised the importance of ensuring clear communication with all parties involved in intern training, most importantly with final medical students. Owing to the breadth of reforms initiated simultaneously and the fluid nature of the reform process, it was difficult to provide detailed information to students until late into the academic year.

With a view to providing information on the reforms being implemented in a clear, concise fashion, the HSE's MET Unit produced "Ireland's Interns 2010: A Guide to Application and Appointment to Intern Training in Ireland 2010", in conjunction with the Medical Council and the Implementation Group. This was produced in two parts, the first released in March 2010 and the second, which included a detailed list of frequently asked questions, in April 2010. These were circulated to final medical students and were also made available on the HSE's website. The Guide was aimed at prospective applicants to intern posts both in Ireland and overseas but was also provided to relevant bodies/agencies.

In addition, the MET Unit provided communication sessions to hospital Medical Manpower and HR managers on the reforms underway regarding the intern year.

The wide membership of the Implementation Group ensured that relevant bodies were kept informed through their nominated representative(s) throughout the process.

Achievements: Communications

- Guide to Application and Appointment to Intern Training 2010 (Parts 1 & 2) published by HSE-MET Unit

Areas to be addressed in Phase 2

- Guide to Intern Application and Appointment 2011
- Direct communications sessions by HSE-MET with final medical students

7.0 Sign-Off of the Intern Year

During the course of its discussions, the Implementation Group noted decisions made by the Medical Council regarding sign-off of interns completing their training in June 2010 and its decision to endorse the establishment of Intern Training Networks. It was also noted that the Council had established a Sub-Committee to examine the appropriate execution of the Council's statutory responsibilities on the matter.

The Medical Council has recently approved criteria for granting certificates of experience for internship. It is expected that the detailed mechanism for the sign-off of intern training will be defined over the coming months. The work of the Intern Implementation Group will continue to be informed by developments of the Council in relation to all aspects of intern training.

8.0 Future Planning & Actions for Phase Two of Implementation

Many of the recommendations of the NCMET Report were addressed during the first phase of the implementation process. However, there remains a considerable work programme for phase two of the process.

Phase two of the implementation will build on the progress made to date and focus in on those areas requiring further development.

An outline of the topics for phase two of the work programme is provided below.

Phase 2 Work Programme

- Development of the Intern Training Programme under the auspices of the Medical Council Intern Sub-Committee, in line with health service requirements and Medical Council guidelines.
- Establishment of new intern posts, particularly through conversion of vacant SHO posts, where possible.
- Continued expansion of intern training in new specialty areas approved by the Medical Council for intern training, including GP, emergency medicine, paediatrics and obstetrics/gynaecology.
- Ongoing review of the distribution of intern posts in line with health service configuration, development of the Mid-West Intern Training Network and examination of the scope for expansion of intern training locations, such as in specialist acute hospitals.
- Ongoing refinement of application and matching system.
- Introduction of English language testing requirements.
- Single annual intake to internship.
- Guide to application and appointment and communications with final medical students.
- Core common induction course.

Appendix A – Membership of the HSE Intern Implementation Group May 2009 – July 2010

Martin McDonald (Chair)	Head of Leadership, Education & Development	HSE (HR)
Philip Brady*	Education & Training	Medical Council
Gerry Bury	Director of Medical Education & Training	HSE (MET)
Joe Clarke	Primary Care Adviser	HSE (Primary Care)
Mike Corbett	General Manager	HSE (Finance)
Ann Curran	Senior Executive Officer, Registration	Medical Council
John Delamere	Senior Employee Relations Executive	HSE (HR – Employee Relations)
Dara Devitt	Intern Tutor	NUIG / Galway Regional Hospitals (pilot site rep.)
Fidelma Dunne	Dean of Medical School	National University of Ireland Galway
Pauline Kane	Specialist Registrar in Palliative Medicine	Medical Council nominee
Shaun McCann	Professor of Academic Medicine and Undergraduate Teaching & Learning	Deans of Medical Schools' nominee
Eilis McGovern	Consultant Cardiothoracic Surgeon	Chair of NCMET Intern Sub-Committee
T. Joseph McKenna	(then outgoing) Chair, Forum of Irish Postgraduate Medical Training Bodies	Forum of Irish Postgraduate Medical Training Bodies nominee
Ciara Mellett	Business Manager, MET	HSE (MET Unit)
Mary O'Keeffe	Medical Manpower Manager, Cork University Hospital	Medical Manpower Managers representative
Shane O'Neill	Clinical Director & Consultant Respiratory Physician	Pilot site representative - Beaumont Hospital
Una O'Rourke	Head of Registration	Medical Council
Anne Pardy	Medical Manpower Manager	HSE (Acute Services representative)
Dermot Power	Consultant in Geriatric Medicine, Mater Hospital	Intern Tutor, Mater Hospital
David Sweeney	Medical Manpower Manager, St. James's Hospital	Medical Manpower Managers representative
Laura Viani	Consultant Otolaryngologist	Forum of Irish Postgraduate Medical Training Bodies nominee

* replaced Dr. Clodagh Cashman

Implementation programme manager: Ciara Mellett, HSE Medical Education & Training Unit

Secretariat to Group: Anna Merrigan, HSE Medical Education & Training Unit

Appendix B – Recommendations of the NCMET Report & Implementation Status

The NCMET Report made 39 recommendations in relation to the reform of the intern year. The progress to date in implementing these recommendations is set out below.

Recommendations of NCMET Report within **HSE / Implementation Group responsibility**:

Ref.	NCMET Recommendation	Status	Comment
39.	While acknowledging the statutory role of the Medical Council and without detracting from this role, the Sub-Committee recommends that the Health Service Executive should take the lead in the initial convening of a **working group** to progress the implementation of the recommendations set out in this report.	✓	HSE Intern Implementation Group established May 2009. First phase of implementation completed July 2010. Separate Medical Council Sub-Committee on Intern Training in place.
1.	Note the Medical Council's recommendation that the intern year should be the **first year of postgraduate medical training**.	✓	Noted – no implementation required.
2.	Appointments to intern posts should be for one year's duration; all interns should receive a one-year **fixed term specified purpose contract.**	Phase 2	Subject to individual employers
3.	The intern year should be a 3 x 4 month **modular structure** of 4 months medicine, 4 months surgery and 4 months selective (which may consist of another module in medicine or surgery) and this structure should apply to all existing and new posts. **Or** The intern year should have a flexible structure and should incorporate 3-4 modules with a minimum of 3 months medicine, 3 months surgery and 1-2 selectives (which may consist of another module in medicine and/or surgery) and this structure should apply to all existing and new posts.	✓	Most intern posts 4 x 3 months modular structure for July 2010 intake
4.	The **selective specialties** previously approved by the Medical Council should be introduced on a phased basis as part of a pilot approach. This expansion should be informed by service priorities, capacity, availability of resources and student preferences.	✓	New posts in general practice, anaesthesia, paediatrics, ophthalmology.
5.	**General practice should be prioritised** for inclusion as a selective specialty owing to the shifting emphasis of health services to primary care.	✓	GP intern post in place in all Networks; 20 GP rotations available
8.	All intern posts, new and existing, should be **EWTD compliant**.	✓	EWTD in place for interns. Savings from compliance funding intern development
9.	**On-call duties** (training at night and at weekends) should be retained for interns but should be significantly reformed. Night-time and weekend working must be scheduled in the context of appropriate rostering arrangements which will ensure EWTD compliance. Appropriate supervision should be provided by a designated supervisor at all times, including while on call.	✓	Ongoing implementation by individual clinical sites & supervising consultants

Ref.	NCMET Recommendation	Status	Comment
10.	Interns should have access to **flexible training**, in line with guidelines developed by the Postgraduate Medical & Dental Board for SpR/SR posts.	After Phase 2	Flexible training currently only available at HST level; not priority for intern training. May be considered in later stages of implementation.
11.	The Sub-Committee welcomes the establishment of the joint DoHC/HSE/FÁS group which will develop a tool which will allow for the assessment of supply and demand factors affecting **healthcare staffing**. The recommendations of this group should inform future developments of the intern year.	✓	Reports on Workforce planning published & taken into consideration in implementation process.
12.	The intern year is a pre-registration year* and should only be open to those that require to undertake it for the purposes of registration. Graduates who are otherwise entitled to full registration with the Medical Council should not have **access** to intern posts. **Note: since the commencement of the Medical Practitioners Act 2007, the term "pre-registration" year is no longer correct; the intern year is the first year of postgraduate medical training. This recommendation should therefore be read as "Graduates who are otherwise entitled to registration on either the trainee specialist division or the general division of the Register of Medical Practitioners maintained by the Medical Council should not have access to intern posts."*	✓	This requirement was part of the eligibility criteria for application to the July 2010 intake.
15.	A **sufficient number of intern posts** should be available to meet the number of qualifying EEA graduates from Irish medical schools. Some access to intern posts should also be available to non-EEA students of Irish medical schools, and EEA graduates of foreign medical schools. An overall total of 800 intern places is recommended on the basis of a national medical school intake of 725. This includes approximately 10% to address the requirements of non-EEA graduates of Irish medical schools and EEA graduates of foreign medical schools.	Phase 2 & 3	Subject to Dept. Finance / Dept. Health & Children agreement and HSE Employment Control Framework and Vote.
16.	The number of posts should be sufficient to meet service requirements, ensure EWTD compliance, facilitate graduate retention and ensure the protection of the State's investment in undergraduate medical education.	Phase 2 & 3	Subject to Dept. Finance / Dept. Health & Children agreement and HSE Employment Control Framework and Vote.
17.	The intern year structure must be sufficiently **flexible** to react to adjustments resulting from medical workforce requirements and service configuration.	✓	Ongoing consideration; service configuration and medical workforce requirements taken into consideration throughout implementation process.
18. & 38.	A **pilot** of the Sub-Committee's recommendations should be undertaken to further inform recommendations on numbers of posts.	✓	Pilot areas were identified and commenced work but pace of implementation resulted in widespread implementation for July 2010 intake.
19.	A **standardised central application system** for intern posts should be developed.	✓	Fully implemented by HSE for July 2010 intern intake.

Ref.	NCMET Recommendation	Status	Comment
20.	A **single national matching scheme** managed centrally, delivered regionally should be introduced and organised around the six medical schools.	✓	Fully implemented by HSE for July 2010 intern intake.
21.	**Rotations should be on a regional/network basis** e.g. a single intern post with rotations in medicine, surgery and general practice could take place on different clinical sites but these should be within a single network.	✓	Fully implemented through HSE / Medical School collaboration for July 2010 intern intake.
22.	Existing intern posts and any new posts created should be **distributed in a transparent and equitable fashion** between the intern networks, to ensure an efficient and fair system of allocation, training and supervision and reflecting the numbers of EEA students in each region.	✓	All existing intern posts re-distributed by HSE to new Intern Training Networks and review ongoing in line with establishment of MWT Network and service configuration.
23. & 30.	Each intern post should be given a **reference number**, which can be used in the compilation of a **database** of intern posts and will be compatible with databases being developed for other medical posts.	✓	Reference numbers applied to all posts & database of intern posts created; wider NCHD database under development.
24.	An **intern coordinator** should be appointed to each intern network.	✓	Intern Coordinators in place in all Networks at consultant grade.
25.	**Policies** around the appointment of interns should be developed by the HSE collaboratively on a national basis to ensure a consistent and transparent approach and in concordance with the HSE's recruitment licence.	✓	Consistent approach to application & appointment. Further scope for consistency in pre-employment checks / induction.
26.	The Medical Council recommendations that **Intern Tutors** have a dedicated session or number of sessions each week to allow them time to fulfil the role properly should be implemented, resourced at a minimum rate of: - two sessions for the first eight interns, designated in the practice plan of the tutors' contract - one extra session for each additional eight interns, designated in the practice plan of the tutors' contract The role of intern tutors, particularly in monitoring the performance of interns should be clearly defined.	Phase 2	Developments relating to Intern Tutors to be considered during Phase 2 of process.
29.			
31.	The Sub-Committee notes the feedback from interns arising from the **survey** undertaken and recommends that the intern year should incorporate structured and protected training sessions and fixed teaching sessions.	✓	Feedback from survey considered throughout implementation process, including curriculum development.
32.	Other areas identified by the survey on interns should be explored and addressed by the relevant partner organisations as appropriate e.g. supervision of interns.		
33.	The Medical Council's recommendations with regard to **induction** should be implemented on a collaborative and consistent basis.	Phase 2	Core induction to be addressed on national basis.

Ref.	NCMET Recommendation		Comment
34.	The **intern contract** should reflect the modular structure of the year, training needs, rotations and should include reference to completion of modules, remedial action etc.	✓	New NCHD contract in place and applicable to interns.
35.	The **Training Principles** to be incorporated into New Working Arrangements for Doctors in Training (appendix D Buttimer Report) include a set of General Principles for application to NCHDs and a set of specific principles for each specialty. As the intern year is now the first year of postgraduate training the subcommittee recommends that the general principles should also apply to interns and that specific principles should be developed and agreed by the stakeholders.	Ongoing Phase 2	Many of the General Principles implemented. Specialty-specific principles (where relevant) considered as part of curriculum development.
37.	Any new **consultant posts** should include defined and protected time for medical education and training, at undergraduate, intern and postgraduate levels.	✓	New consultants' contract includes reference to training of NCHDs.

Recommendations of NCMET Report within responsibility of other bodies:

Ref.	NCMET Recommendation	Responsibility	Comment
6.	We understand that a **core curriculum** for the intern year will be prepared by the Medical Council. It is recommended that this be developed in consultation with the Forum of Irish Postgraduate Medical Training Bodies, the medical schools, the HSE and the National MET Committee and that generic skills e.g. leadership, communication skills, clinical governance and team working would be included.	Medical Council, Intern Training Networks, Training Bodies & Medical Schools	Curriculum under development in line with Medical Council requirements and under auspices of Medical Council Intern Sub-Committee
7. & 27.	The Postgraduate Medical Training Bodies and medical schools should be involved with the Medical Council in drawing up the **specialty-specific curriculum** and learning outcomes for medicine, surgery and the selective modules. However, it is recognised that a decision on such an arrangement is a matter for the Medical Council itself under new legislation.	Medical Council, Intern Training Networks, Training Bodies & Medical Schools	Curriculum under development in line with Medical Council requirements and under auspices of Medical Council Intern Sub-Committee
13.	The **recommendations of the Fottrell Report** with respect to numbers of undergraduates should be kept under review.	Govt. Depts / IDPSG	Role of the Interdepartmental Policy Steering Group (IDPSG) on MET
14.	The Intern Subcommittee's concerns regarding the **implications of the increase in medical graduates** should be taken into account by the joint DoHC/HSE Workforce Planning Group and by the Postgraduate Subcommittee in their deliberations. The Sub-Committee recommends that the Interdepartmental Policy Steering Group should consider the implications of the medical workforce planning model produced by FÁS for the Workforce Planning Group when it becomes available later in 2008	Govt. Depts / IDPSG	Role of the Interdepartmental Policy Steering Group on MET
28.	The Sub-Committee acknowledges the statutory role of the Medical Council for the sign-off of the intern year and recommends that there should be a **single common pathway for the final assessment of the intern year** and its modules; which could assist the Medical Council in fulfilling its statutory role in this regard.	Medical Council	Responsibility of Medical Council. Council Sub-Committee in place to advise on appropriate mechanism.
15.	A **sufficient number of intern posts** should be available to meet the number of qualifying EEA graduates from Irish medical schools. Some access to intern posts should also be available to non-EEA students of Irish medical schools, and EEA graduates of foreign medical schools. An overall total of 800 intern places is recommended on the basis of a national medical school intake of 725. This includes approximately 10% to address the requirements of non-EEA graduates of Irish medical schools and EEA graduates of foreign medical schools.	Govt. Depts / IDPSG	Subject to Dept. Finance / Dept. Health & Children agreement and HSE Employment Control Framework and Vote.
16.	The number of posts should be sufficient to meet service requirements, ensure EWTD compliance, facilitate graduate retention and ensure the protection of the State's investment in undergraduate medical education.	Govt. Depts / IDPSG	Subject to Dept. Finance / Dept. Health & Children agreement and HSE Employment Control Framework and Vote.
36.	**Additional, ring-fenced, funding** should be provided by Government to fund the costs identified.	Govt. Depts / IDPSG	Role of the Interdepartmental Policy Steering Group on MET. Developments to date by HSE have been funded from within existing resources.

Appendix C – Intern Coordinators Group & Medical School Liaison Group

(i) Intern Coordinators Group

Intern Network Coordinators:
Prof. Michael Kerin – West / Northwest (WNW) Intern Training Network (NUIG)
Mr. Daragh Moneley – Dublin / Northeast (DNE) Intern Training Network (RCSI)
Dr. Dermot Power – Dublin / Mid-Leinster (DML) Intern Training Network (UCD)
Prof. Shaun McCann – Dublin / Southeast (DSE) Intern Training Network (TCD)
Prof. Cillian Twomey – South (STH) Intern Training Network (UCC)

Note: appointment to the role of Intern Coordinator in the Mid-West (UL) Network was made following the completion of Phase 1 of the implementation process. In the interim, Prof. Paul Finucane represented the Mid-West (UL) Intern Training Network.

Others involved in Intern Coordinators Group:

Martin Barron (RCSI)
Gerry Bury (HSE-MET)
Dara Devitt (NUIG)
Gerry Deacy (UCC)
Paul Harkin (UCD)
Arnie Hill (RCSI)
James Keane (UCHG)
Jason Last (UCD)
Ciara Mellett (HSE-MET)
Denise Sadlier (UCD)
Muirne Spooner (RCSI)
Michelle McCluskey (TCD)
Connie Mulcahy (UCC)

The Intern Network Coordinators have also met collectively on a number of occasions, primarily to progress the development of intern training and assessment.

(ii) Medical School Liaison Group

Lisa Bennett (UCD)
Barbara Cantwell (UCD)
Claire Condron (RCSI)
Therese Dixon (NUIG)
Liz Doyle (RCSI)
Sinead Dunwoody (UCD)
Ciara Mellett (HSE-MET)
Connie Mulcahy (UCC)
Michelle McCluskey (TCD)
Sharon Thompson (TCD)
Aine Wade (TCD)
Mary Gamble (UL)*

* joined the group in June 2010

Appendix D – Intern Training Networks & clinical sites

Intern Training Network 2010	Linked Medical School	Hospitals / Clinical Sites in Network 2010
West / North west	National University of Ireland, Galway	• Galway Regional Hospitals • Letterkenny General Hospital • General Practice, Donegal • Mayo General Hospital • Portiuncula Hospital • Roscommon General Hospital • Sligo General Hospital
Dublin / Northeast	Royal College of Surgeons in Ireland	• Beaumont Hospital • Connolly Hospital • Waterford RH (exception, given RCSI links with the hospital) • Our Lady of Lourdes Hospital Drogheda • General Practice, Dublin
Dublin / Midlands	University College Dublin	• Mater Misericordiae Hospital • St. Vincent's Hospital • St. Columcille's Hospital • St. Michael's Hospital • General Practice, Dublin • Midland Regional Hospital Mullingar • Midland Regional Hospital Tullamore • Midland Regional Hospital Portlaoise • Mid-West Regional Hospital Limerick • St. John's Hospital Limerick
Dublin / Southeast	Trinity College Dublin	• St. James's Hospital • AMiNCH Tallaght Hospital • General Practice, Dublin • Naas General Hospital • St. Luke's GH Kilkenny • Wexford General Hospital
South	University College Cork	• Cork University Hospital • Mercy University Hospital • South Infirmary-Victoria Hospital • General Practice, Cork • Tralee General Hospital • South Tipperary Hospital, Clonmel • Bons Secours Hospital, Cork(private) • Mallow General Hospital • Bantry General Hospital • Limerick Regional Hospital

*The Mid-West Network has since been established and will take effect from 2011 to coincide with the first graduating class from the University of Limerick Graduate Entry Medical School. For the July 2010 intern intake, posts which fell within the Mid-West Network were assigned to the Dublin/Midlands Network and the South Network.

Appendix E – Statistics – Application & Matching process

Note: The statistics provided in this appendix relate to applications received for intern training posts in the Irish Health Service, through the HSE's national application process for interns July 2010, rather than to total medical graduates.

E1. Analysis of applications received for intern posts July 2010

E1.1 Summary of applications received

Total applications received:	**565**
Eligible Applicants:	536
Ineligible at time of application:	11
Applicants subsequently not conferred 2010 (& ineligible):	18

Cases of ineligibility arose from:

(i) date of release of exam results was after the deadline, meaning that the applicant's centile ranking was not available and applicant could not, therefore, be included in the matching process.

(ii) date of conferral after July 1st, meaning that applicant could not be registered in time to commence in post;

(iii) applicant was a graduate of a Medical School in a country where a separate internship is not required;

(iv) applicant had graduated more than 2 years previously;

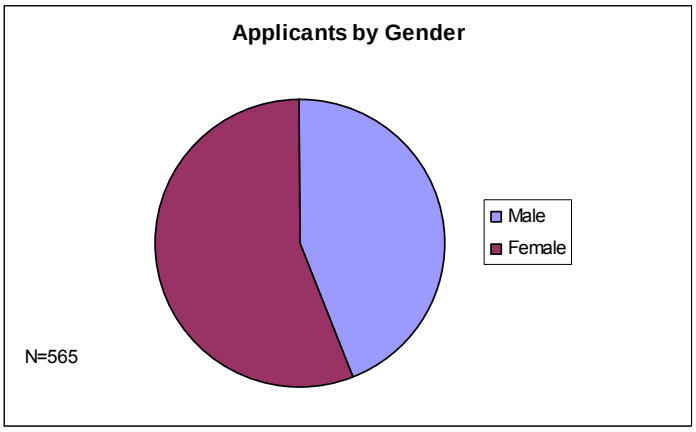
(v) applicant had already completed partial intern training.

E1.2 Gender of applicants

Table 1

Male	N=248	44%
Female	N=317	56%

Fig. 4



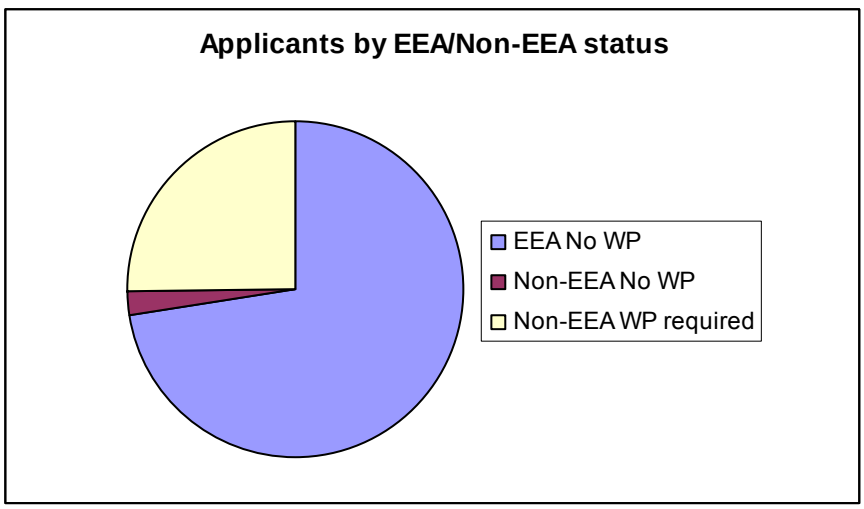
E1.3 EEA / Non-EEA status of applicants

Table 2

EEA – no work permit required	409	72.4%
Non-EEA & no work permit required*	13	2.3%
Non-EEA & work permit required	143	25.3%

*In some circumstances, non-EEA nationals do not require a work permit due to their immigration status. References to "non-EEA" throughout relate to those applicants who are non-EEA nationals and who require a work permit. For the purposes of matching applicants to posts, non-EEA applicants who did not require a work permit were included with EEA nationals, in order to comply with EU Community Preference and the work permit system.

Fig. 2

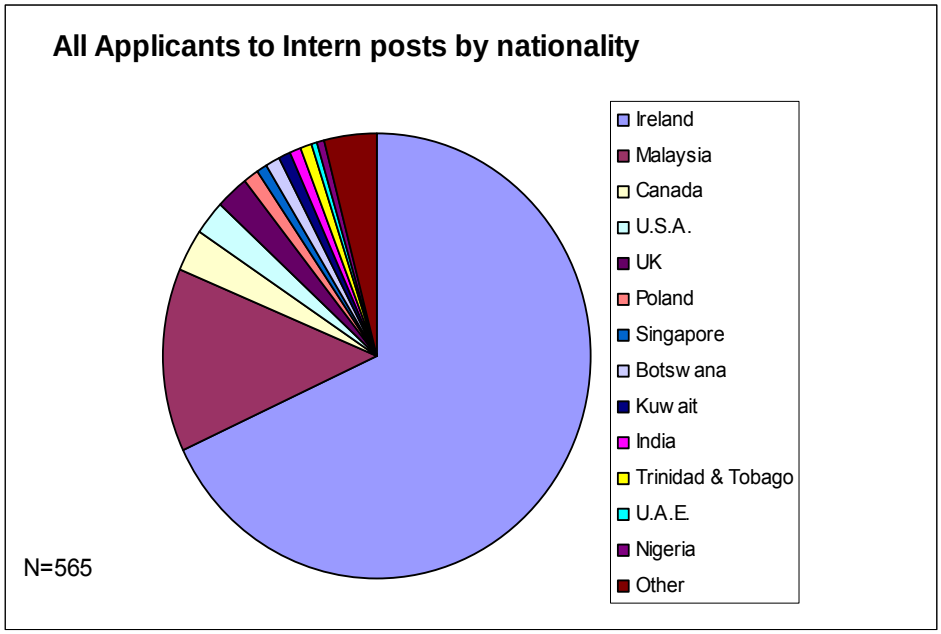


E1.4 Nationality of applicants

Table 3

Ireland	385	68.1%
Malaysia	75	13.3%
Canada	17	3.0%
U.S.A.	15	2.7%
UK	13	2.3%
Poland	6	1.1%
Singapore	6	1.1%
Botswana	6	1.1%
Kuwait	5	0.9%
India	4	0.7%
Trinidad & Tobago	4	0.7%
U.A.E.	4	0.7%
Nigeria	3	0.5%
Norway	2	0.4%
Indonesia	2	0.4%
Mauritius	2	0.4%
Oman	2	0.4%
Australia	2	0.4%
Other (Bahrain, France, Germany, Iran, Italy, Jordan, New Zealand, Saudi Arabia, South Korea, Sweden, Tanzania, Zambia)	12	2.1%

Fig. 6

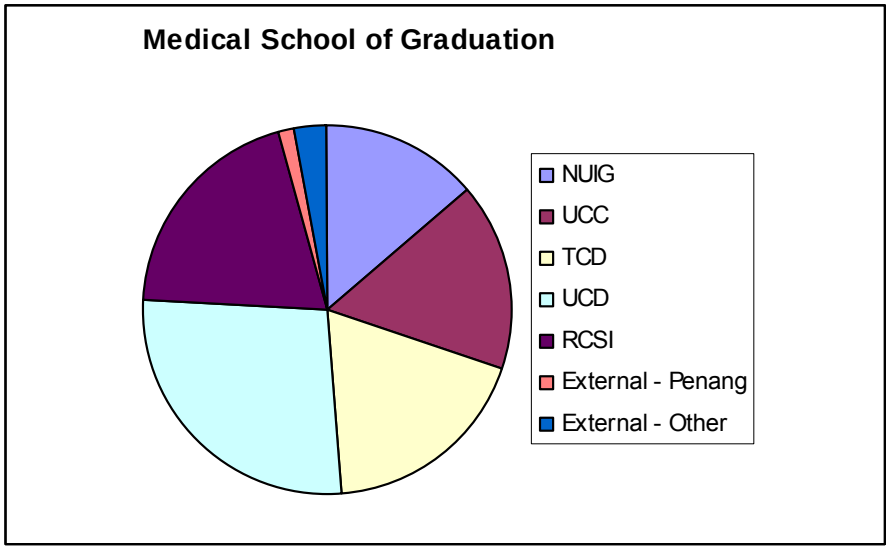


E1.5 Medical School of Graduation of all applicants

Table 4

	EEA	Non-EEA	Total	% of total
NUIG	56	22	78	14%
UCC	67	26	93	16%
TCD	90	14	104	18%
UCD	131	22	153	27%
RCSI	67	47	114	20%
External - Penang	0	7	7	1%
External - Other	11	5	16	3%
	422	143	565	

Fig. 7



"External – Other" refers to applications received from Schools outside Ireland other than Penang[5]. Applications in this cohort were received from graduates of the following Schools:

- Cardiff University, Wales
- Queen's University, Belfast
- Poznan University, Poland
- Jagiellonian University, Poland
- St. George's University, London
- Bart's and the London Medical School
- Medical University of Bialystok, Poland

[5] Medical School in association with RCSI/UCD. NUI degrees are currently awarded to graduates of Penang.

E1.6 Medical School & Nationality of Applicants

Table 5

Applicants' Nationality	UCD	TCD	RCSI	NUIG	UCC	Penang	Other External	Total
Ireland	126	80	57	54	63		5	385
Malaysia	7	6	16	18	20	7	1	75
Canada	8	3	5	1				17
U.S.A.	2	6	6		1			15
UK	4	5	1	1	2			13
Poland							6	6
Singapore	2	1		1	2			6
Botswana	2			3	1			6
Kuwait		1	1		3			5
India			3				1	4
Trinidad & Tobago			4					4
U.A.E.			4					4
Nigeria							3	3
Norway			2					2
Indonesia			2					2
Mauritius	1	1						2
Oman			2					2
Australia			2					2
Bahrain			1					1
France					1			1
Germany		1						1
Iran			1					1
Italy	1							1
Jordan			1					1
New Zealand			1					1
Saudi Arabia			1					1
South Korea			1					1
Sweden			1					1
Tanzania			1					1
Zambia			1					1
Total	153	104	114	78	93	7	16	565

Note: data above relates to applicants for intern posts from the above Schools and does not represent total graduating classes of these Schools.

E2. Preferences of Applicants

Each applicant was required to list in their application form their top 20 preference posts of the 521 available and to rank each of the five available Intern Training Networks in order of preference.

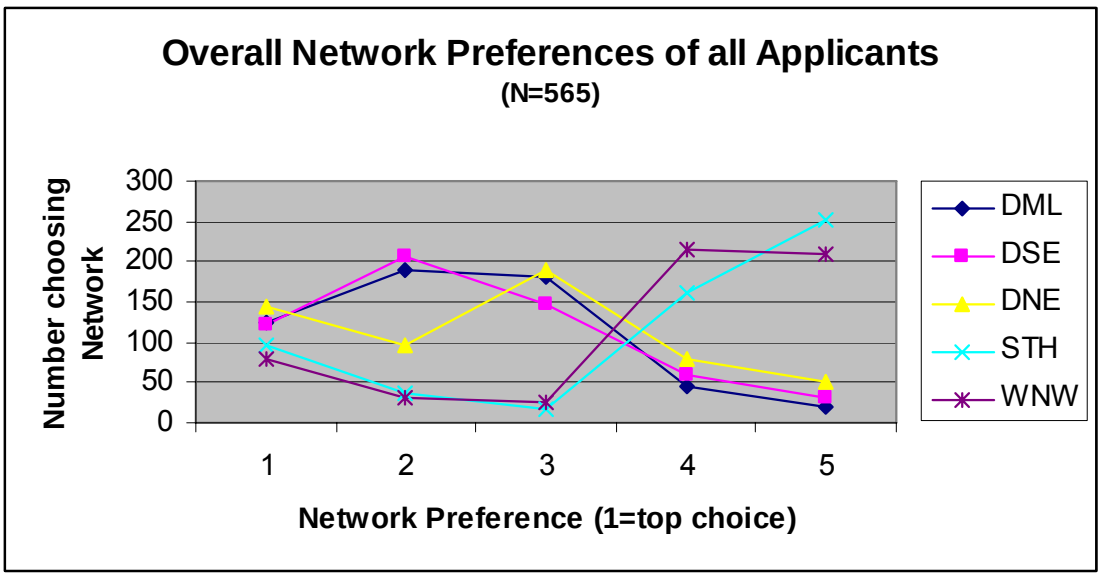
Most applicants chose posts that were within the Intern Training Network associated with their own medical school. Overall, 75% of applicants from the Irish medical schools chose only posts in their own network, although UCD was significantly lower than others in this regard, with UCD graduates more likely to consider posts outside their own network. In cases where applicants included in their top preferences a mixture of posts across networks, there was a clear specialty bias, with these applicants concentrating on being matched to a post with rotations in their preferred specialty, rather than being concerned with location. A small number of applicants chose no posts from their own network.

Table 6

School of graduation	% that chose only posts from own network	Number that chose no posts in own network
UCD	50%	6
TCD	81%	1
RCSI	85%	0
UCC	85%	5
NUIG	85%	1

In relation to the preferential ranking of the five available Intern Training Networks, overall, 90% of applicants from the five Irish medical schools listed as their first choice the Intern Training Network associated with their own medical school. The tendency of applicants to choose their own network first was largely consistent, ranging from 78% amongst UCD applicants network to 98% amongst RCSI applicants. Figure 8 below illustrates that, overall, most applicants listed the three Dublin-based networks in their top three choices. The South and West were more likely, overall, to be in the latter preferences for a majority of applicants.

Fig. 8

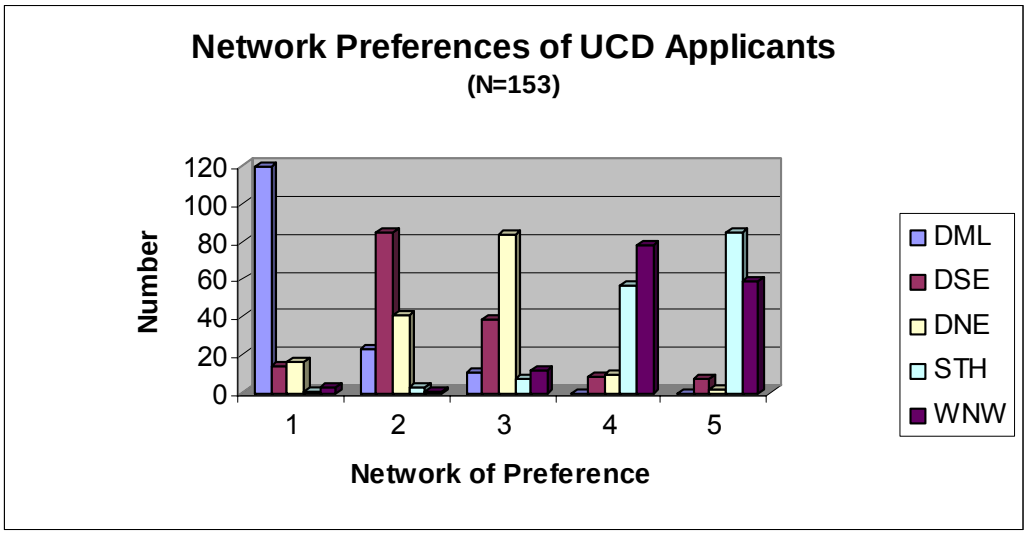


Numerically, the Dublin / Northeast (RCSI) Intern Training Network was the most popular first choice network, with 26% listing this network as their top preference, followed by Dublin/Mid-Leinster (22%), Dublin/Southeast (21%), South (17%) and West (14%)

External applicants were mixed in their preferences for Networks, although there was a marked tendency towards the three Dublin-based networks.

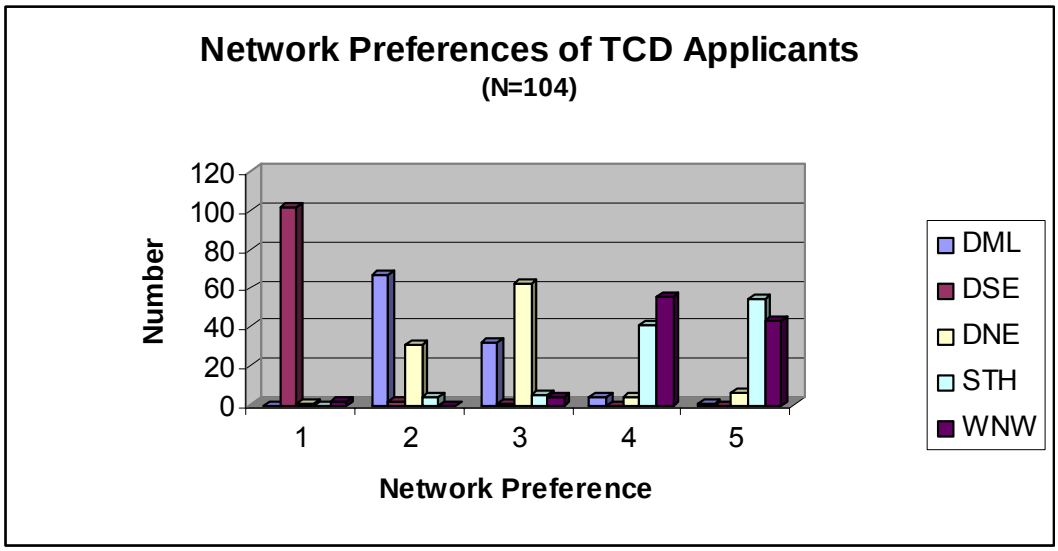
The graphs below illustrate the network preferences of applicants from each medical school and those of external applicants to intern posts in 2010.

Fig. 9



78% of applicants from UCD chose the Dublin / Mid-Leinster (UCD) Network as their top preference network. Amongst these applicants, the two other Dublin-based networks were the next most popular, with 82% of applicants choosing either Dublin / Northeast or Dublin / Southeast as their second preference network. 19% of UCD listed Dublin / Southeast or Dublin / Northeast as their first preference network, while small numbers chose the West/Northwest Network (2%) or South Network (1%) as their top preference network.

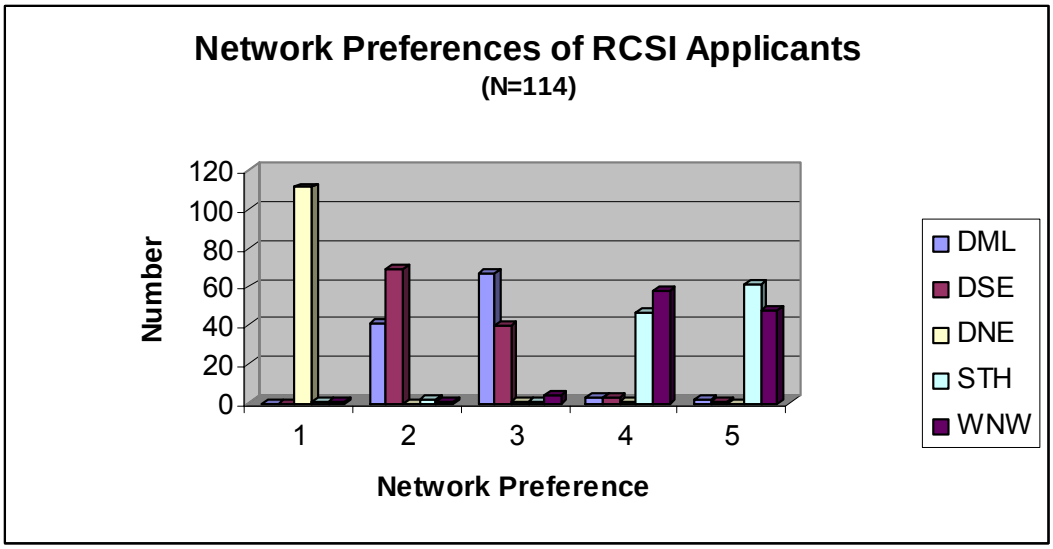
Fig. 10



97% of applicants from Trinity College chose the Dublin / Southeast (TCD) Intern Training Network as their first preference. As with applicants from the other Dublin schools, the other Dublin-based

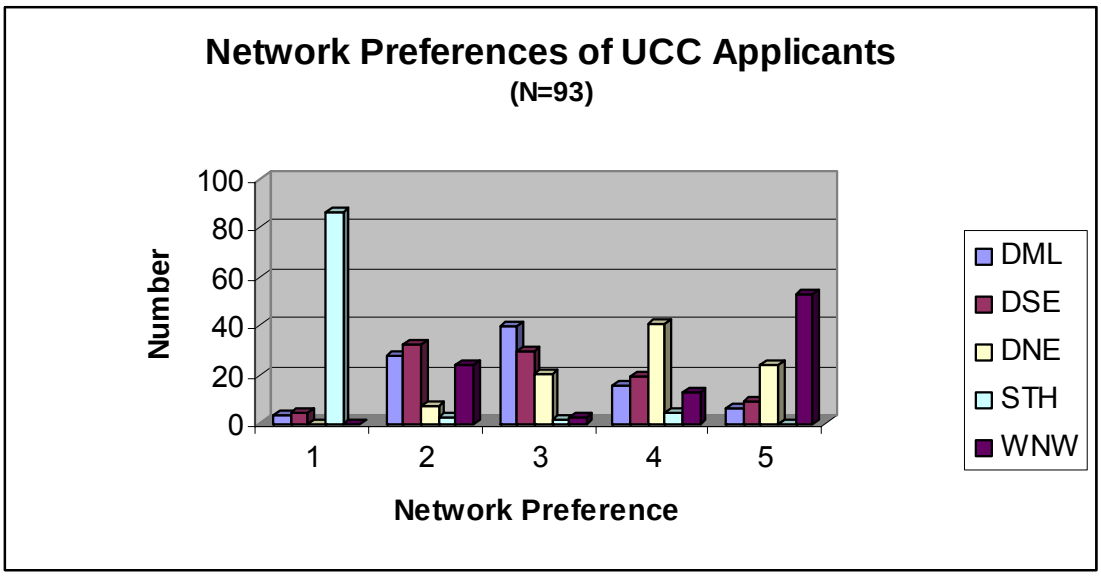
networks were the next most popular amongst Trinity students. 64% of TCD applicants chose the Dublin / Mid-Leinster (UCD) network as their second choice, while 30% indicated a second preference for the Dublin / Northeast (RCSI) network. Most Trinity students listed the South and West / Northwest networks as their fourth or fifth choices.

Fig. 11



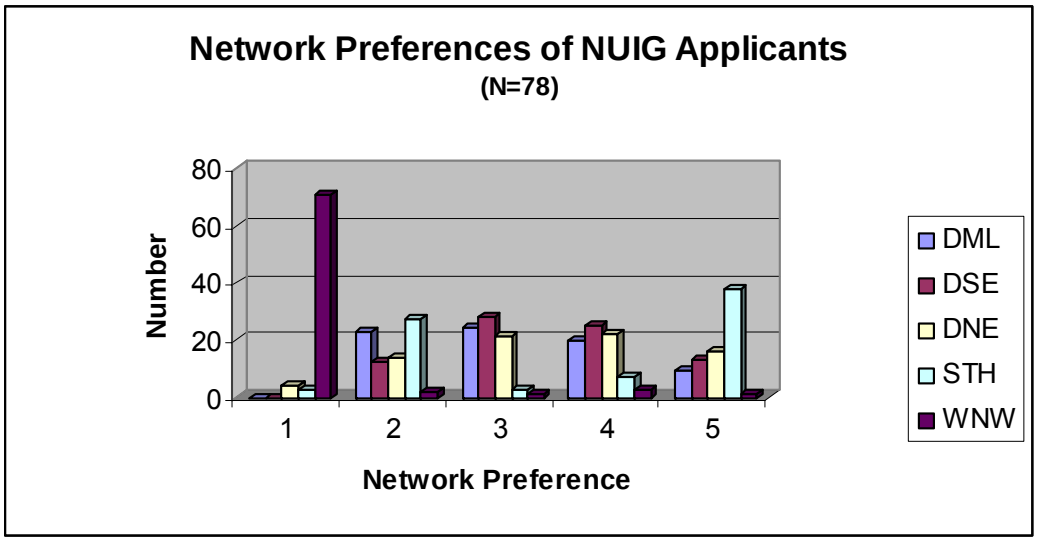
98% of RCSI applicants chose the Dublin / Northeast (RCSI) network as their first preference. The other two Dublin networks (Dublin Southeast & Dublin Mid-Leinster) were significantly favoured above the West and South in subsequent choices. 1% of RCSI applicants chose the South as their first preference, with a further 1% choosing the West / Northwest as their top preference.

Fig. 12



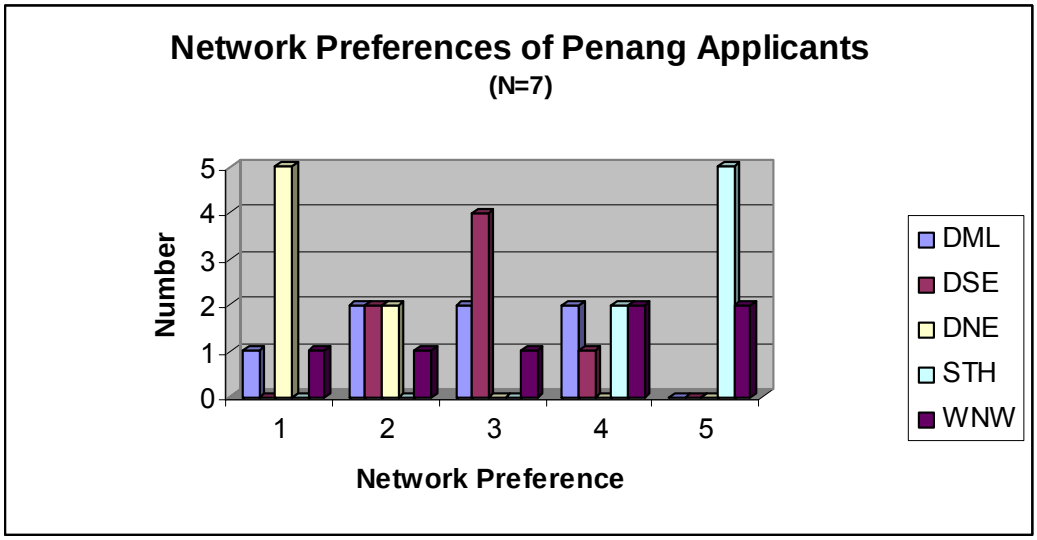
92% of applicants from UCC indicated a top preference to the South Intern Training Network, with Dublin / Southeast and Dublin / Mid-Leinster being the top choice for 4% and 3%, respectively, of UCC applicants. Subsequent choices amongst UCC applicants were more generally mixed than in the case of applicants from the Dublin-based schools, with 34% indicating a second preference for the Dublin / Southeast network, 30% choosing the Dublin / Mid-Leinster network as their second choice, and 26% choosing to go to the West in second choice. Overall, 57% of UCC applicants listed the West/ NW as their fifth preference network.

Fig. 13



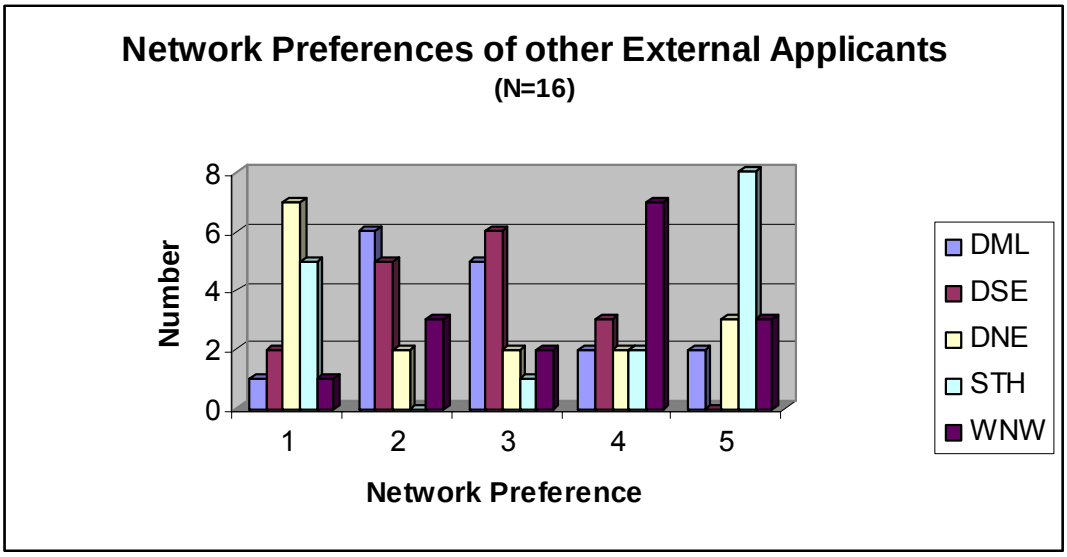
91% of NUIG applicants chose the West / Northwest Intern Training Network as their top preference. Other networks which were favoured as first preferences amongst NUIG applicants were Dublin / Northeast (5%) and the South (4%). 63% of NUIG applicants listed one of the Dublin-based networks as their second choice. Overall, the South was the Network most likely to be listed in last place by NUIG graduates, with 49% listing this network as their fifth and final choice.

Fig. 14



Given that the Penang Medical School is linked to RCSI and UCD, it is not surprising that the networks associated with these two schools were popular among Penang applicants. The Dublin / Northeast (RCSI) Network was by far the most popular, with 71% (N=7) of Penang applicants indicating their first preference for this network and 14% choosing the Dublin / Mid-Leinster (UCD) network first. The least favoured network among this cohort of applicants was the South.

Fig. 15



As might be expected, there was greater diversity in the preferences of external (excluding Penang) applicants. The Dublin / Northeast (RCSI) network was the most popular, with 44% choosing this as their top preference, followed by the South (31%) and Dublin / Southeast (13%).

E3 Centiles of Applicants

The centile system compares an individual applicant's position in the graduating class, relative to their peers in their own class; the formula used does not refer to actual marks obtained and therefore does not compare the marks of applicants from different Schools with different degree structures, marking systems etc. Centiles are expressed in descending order, with higher centiles achieved by applicants who ranked highly in their graduating class.

E3.1 Comparison of centiles of EEA / Non-EEA applicants

Fig. 16

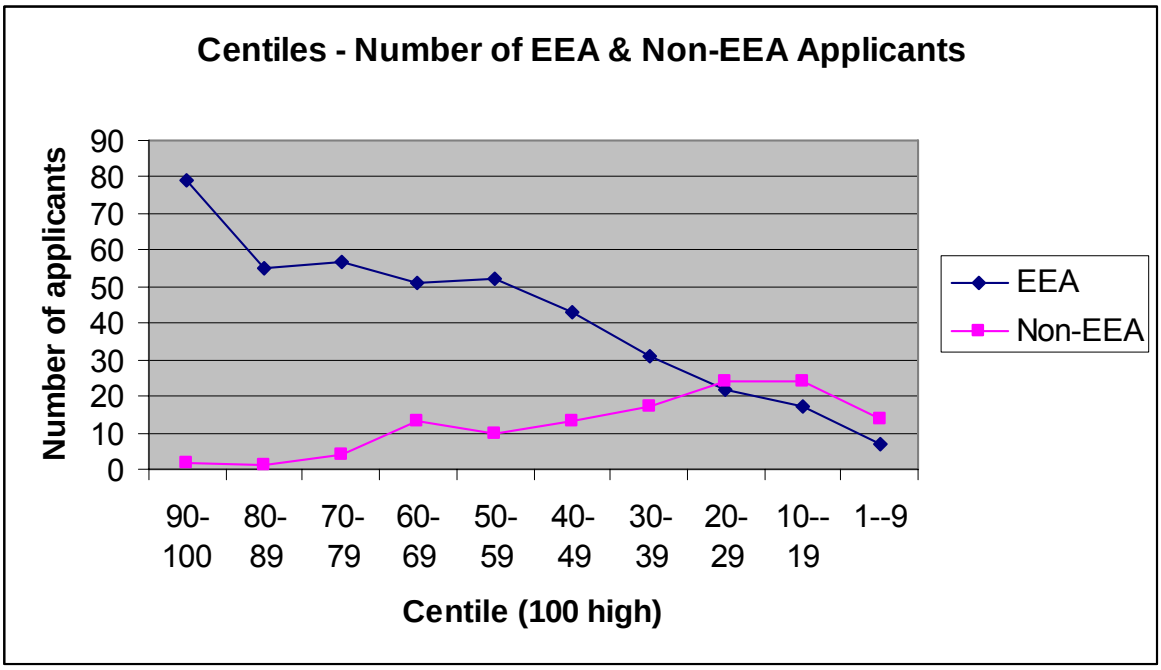
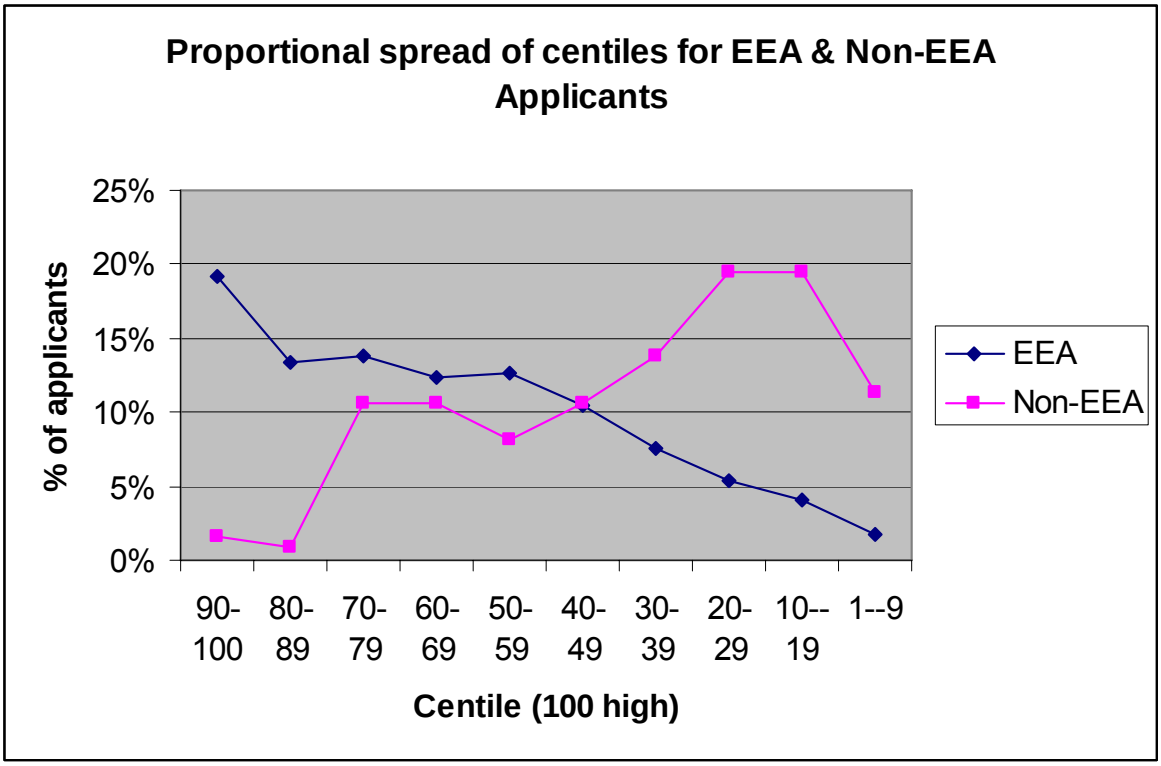


Figure 16 above compares – by number of applicants – the centile levels of EEA versus non-EEA applicants. There were 422 applicants classed as "EEA" for the purposes of the matching process, including 13 who were non-EEA applicants but did not require a permit to work in Ireland owing to their immigration status. [Note: top centile 100; lowest 1]

Figure 17 overleaf compares the same data on a proportional basis. 19% of EEA applicants had centiles of 90 or higher, compared with 2% of non-EEA applicants in this bracket. At the other end of the centile scale, 51% of non-EEA applicants had centiles of 29 or lower, compared with 11% of EEA applicants in this bracket.

Fig. 17


Proportional spread of centiles for EEA & Non-EEA Applicants
% of applicants
25%
20%
15%
10%
5%
0%
90-100
80-89
70-79
60-69
50-59
40-49
30-39
20-29
10--19
1--9
Centile (100 high)
EEA
Non-EEA

E4. Matching Process

E4.1 Order of filling of Intern Training Networks

The matching process commenced with the top ranked candidate being matched to their top preference post and continued until all posts had been filled on order of merit. In line with EU Community Preference, EEA / non-work permit required applicants were matched first, followed by non-EEA / work permit required applicants. The following was the order in which the Networks were filled during the matching process:

Table 7

	Name of Network	Centile range of matched applicants
1st Network to fill	Dublin Mid-Leinster (UCD)	100-19
2nd Network to fill	Dublin Southeast (TCD)	100 -16
3rd Network to fill	Dublin Northeast (DNE)	100 – 2
4th Network to fill	West Northeast (NUIG)	100 – 10
5th Network to fill	South (UCC)	100 - 10

E4.2 Matching of applicants to post preferences

25% of applicants were matched to their first preference post. When it is taken into consideration that most intern posts are grouped with the same rotations in different orders, the actual number of applicants who were matched to their top "type" of post was even higher.

55% of applicants were matched to a post in their top 5, 71% in their top 10 and 80% in their top 15.

Figures 18 & 19 below illustrate the number of applicants matched centrally to their preference posts and the distribution of those matched locally by their order of preference for Networks.

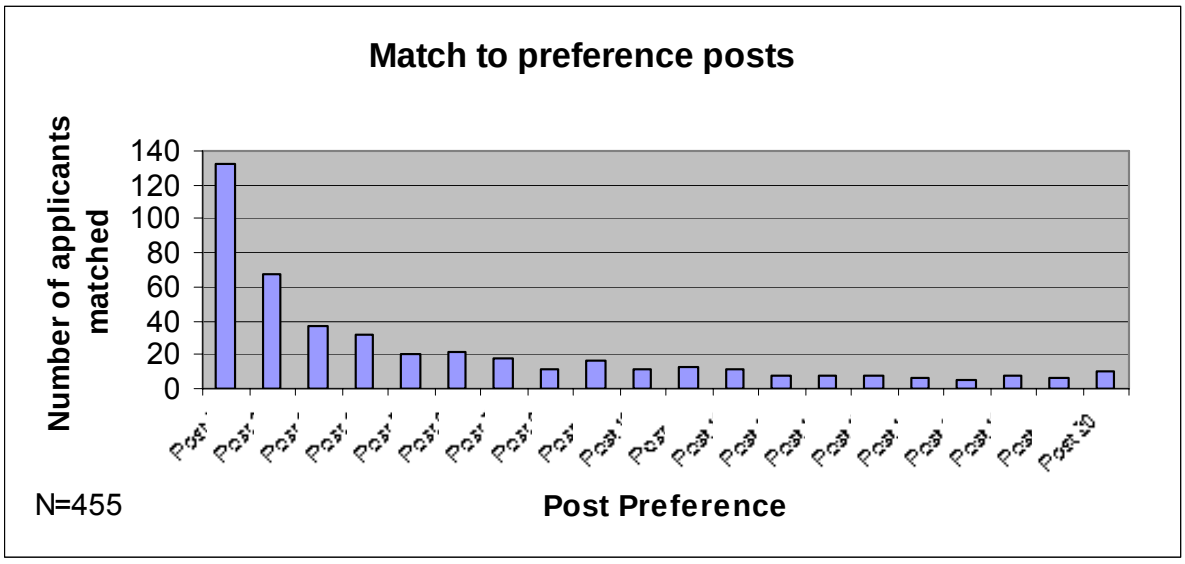
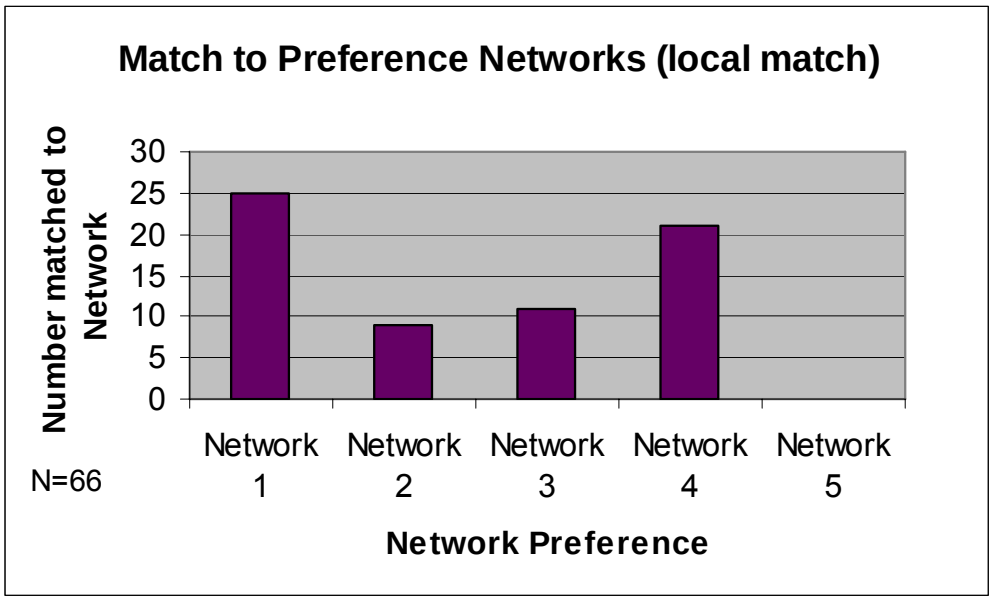


Fig. 19



Note: the above data relate to the actual number originally matched to the 521 available intern posts; actual filling of posts differs slightly owing to the decline of posts by a small number or applicants.

E4.3 Central matching & local matching

The central matching process completed by the HSE's MET Unit resulted in 88% of applicants and posts being matched centrally. The remaining 12% of posts were matched locally by the Intern Training Networks. The number of posts remaining for local match ranged from 6 to 19 and were distributed to the Intern Training Networks as follows:

Table 8

Local match of intern posts / applicants

Network	Number of posts & applicants for local match	Range of centiles
Dublin Mid-Leinster (UCD)	8	64 - 21
Dublin Southeast (TCD)	6	43 - 16
Dublin Northeast (RCSI)	17	93 - 2
West Northwest (NUIG)	14	27 - 12
South (UCC)	19	51 - 11

Note: the above information is based on the position at the time of the matching process; actual appointment to intern posts differs based on decline of posts by a number of applicants.

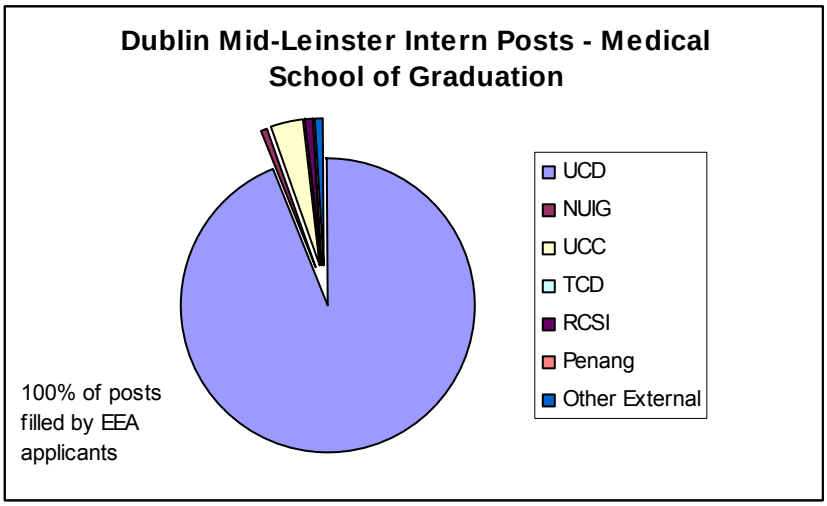
E5. Filling of Intern posts by Intern Training Network

E5.1 Filling of posts in each Intern Training Network by Medical School of Graduation

The following charts illustrate the filling of intern posts in each of the Intern Training Networks by Medical School of graduation.

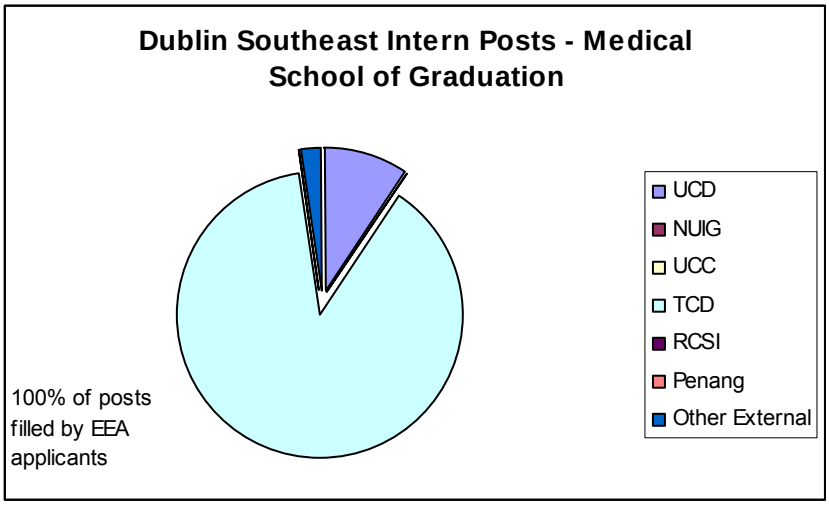
Note: the details below relate to filled intern positions at September 1st 2010 and reflect the actual position rather than the position following the completion of the matching process. The details below exclude any vacant posts as at September 1st 2010.

Fig. 20



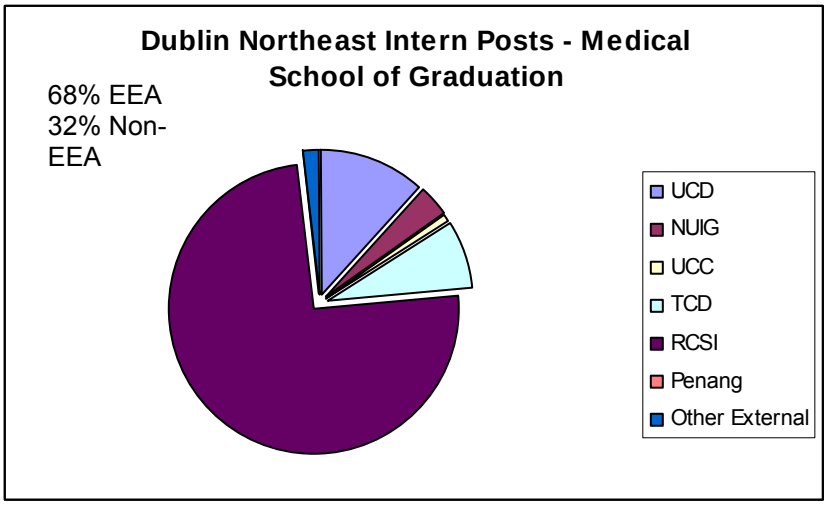
94% of posts in the Dublin Mid-Leinster Intern Training Network (which is associated with UCD) were filled by graduates of UCD.

Fig. 21



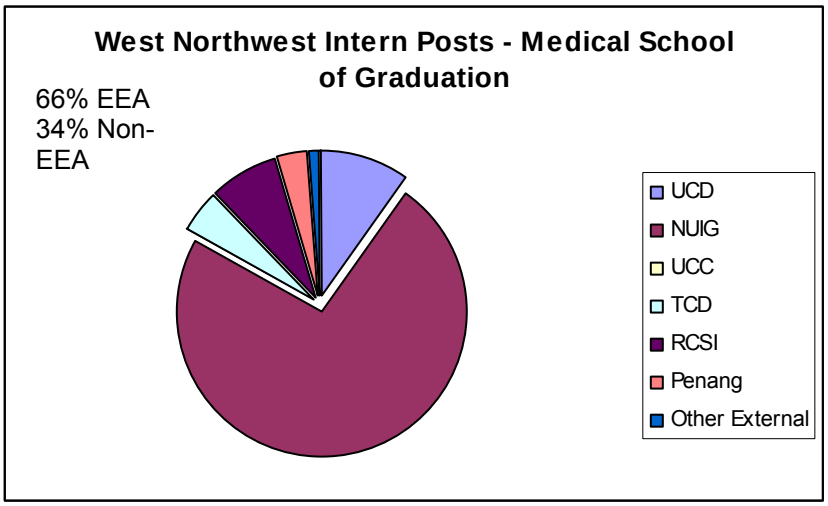
88% of posts in the Dublin Southeast Intern Training Network (which is associated with TCD) were filled by Trinity College graduates.

Fig. 22



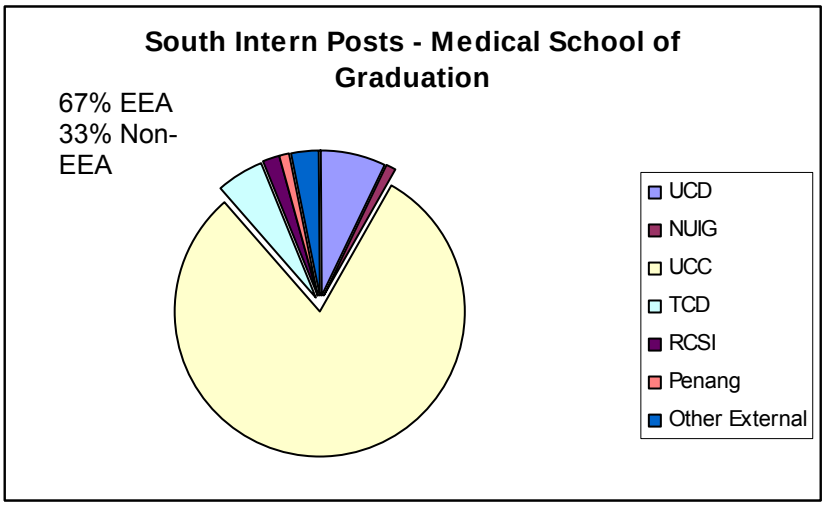
75% of posts in the Dublin Northeast Intern Training Network (which is associated with RCSI) were filled by RCSI graduates.

Fig. 23



73% of posts in the West/Northwest Intern Training Network (which is associated with NUIG) were filled by NUIG graduates.

Fig. 24



80% of posts in the South Intern Training Network (which is associated with UCC) were filled by UCC graduates.

E 5.2 Placement of Applicants by Medical School

Table 9 below details the placement of applicants by Medical School. The distribution of applicants from each School is illustrated in the charts that follow.

Table 9

	UCD	TCD	RCSI	NUIG	UCC	Penang	Other External	Total
DML post	106	0	1	1	4	0	1	**113**
DSE post	9	85	0	4	0	0	2	**100**
DNE post	14	9	88	0	1	0	2	**114**
WNW post	9	3	8	65	0	3	3	**91**
STH post	7	5	2	1	78	1	1	**95**
Ineligible	4	2	4	3	8	3	7	**31**
Declined offer	4	0	10	3	1	0	0	**18**
No-shows / resignations	0	0	1	1	1	0	0	**3**
	153	104	114	78	93	7	16	**565**

Fig. 25

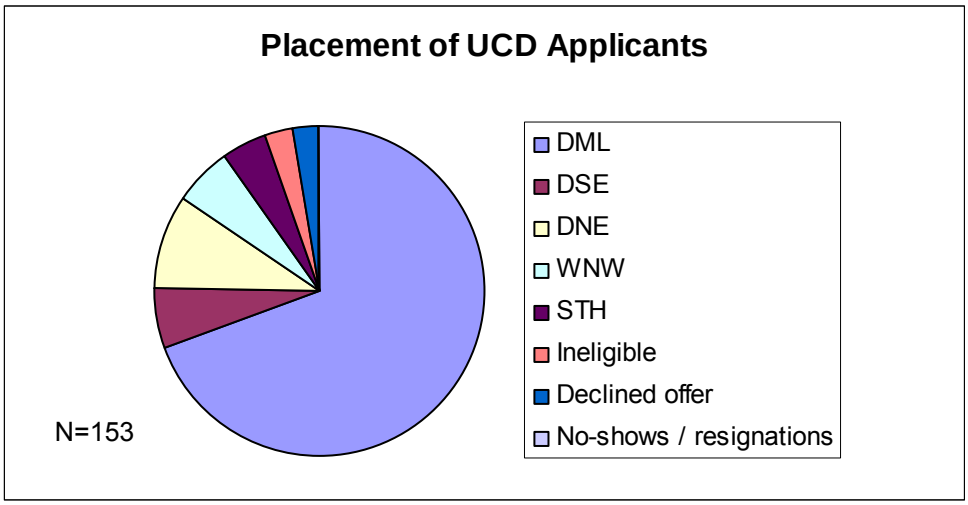


Fig. 26

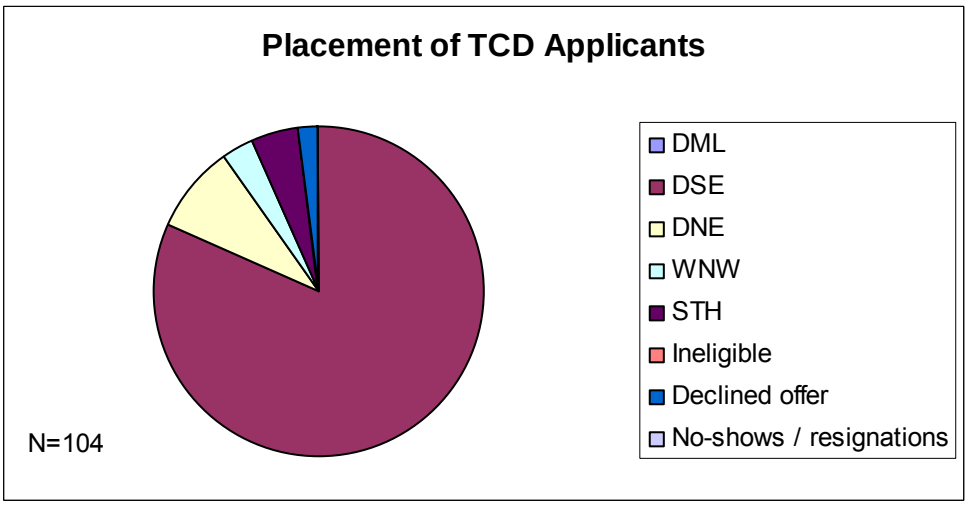


Fig. 27

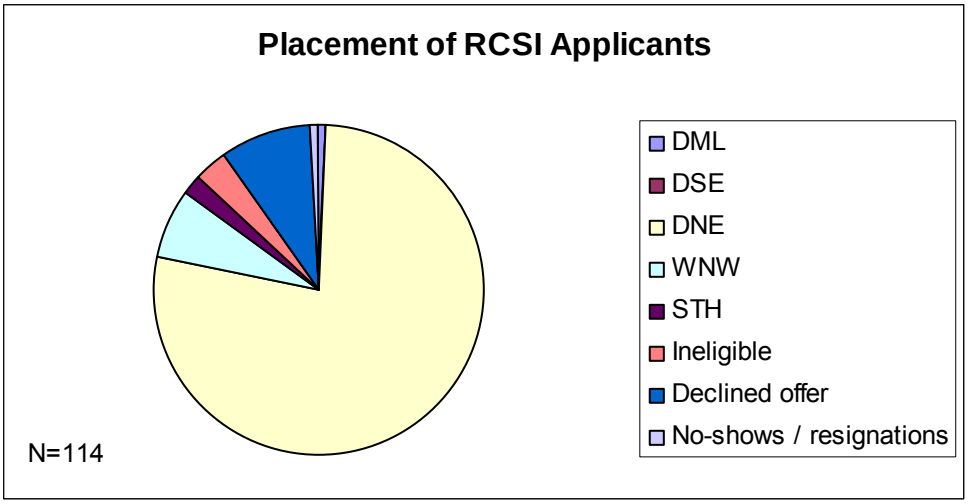


Fig. 28

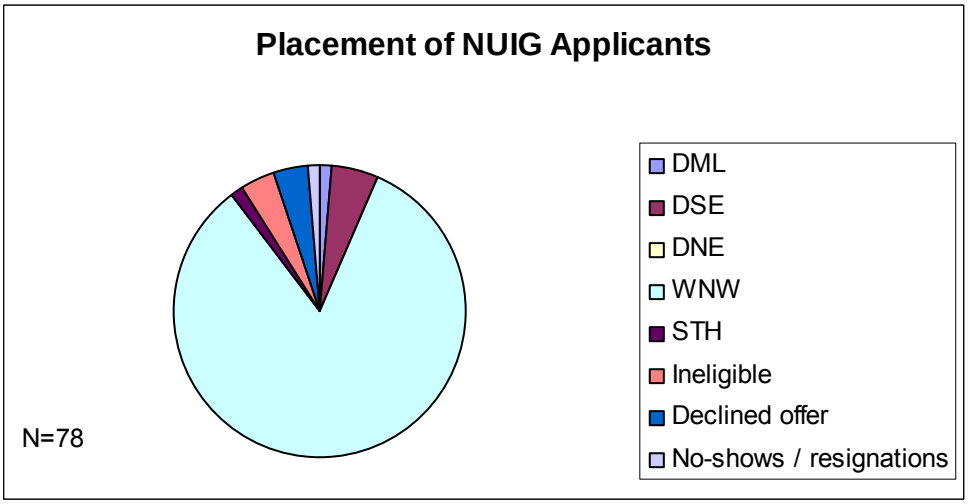


Fig. 29

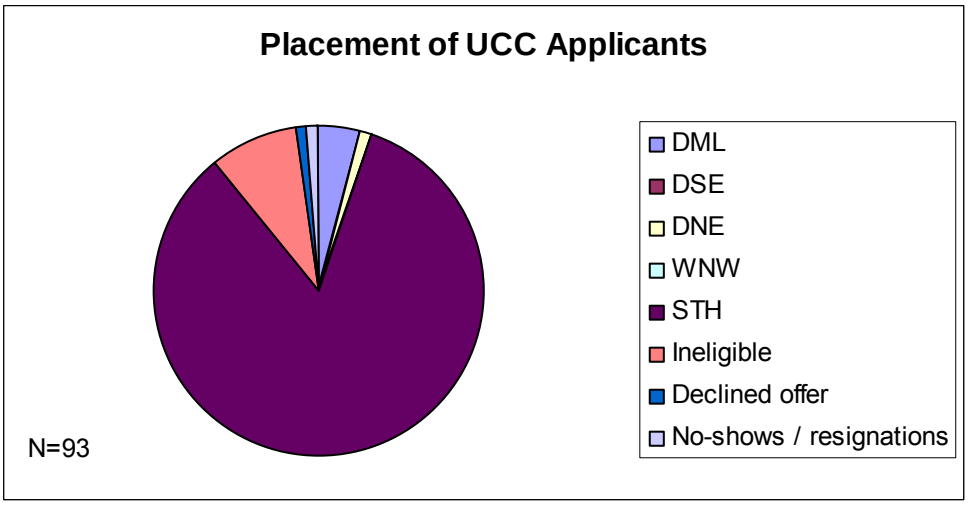


Fig. 30

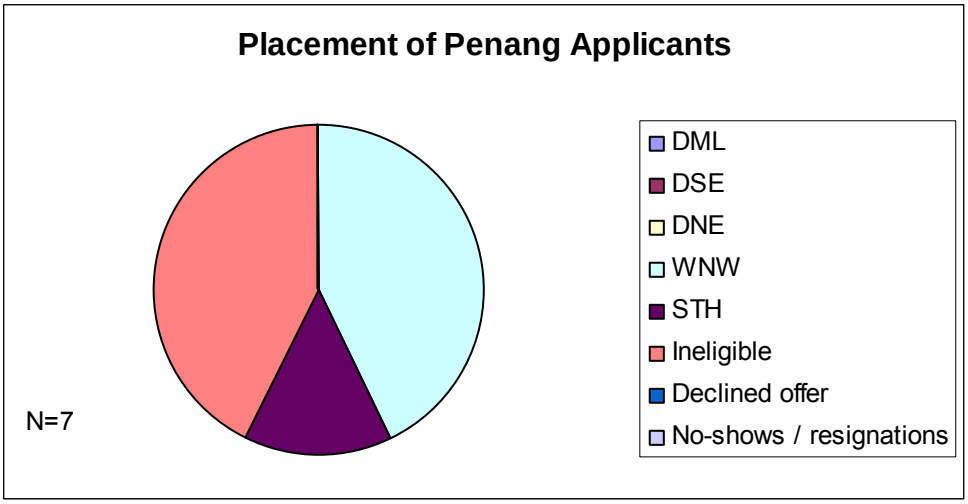
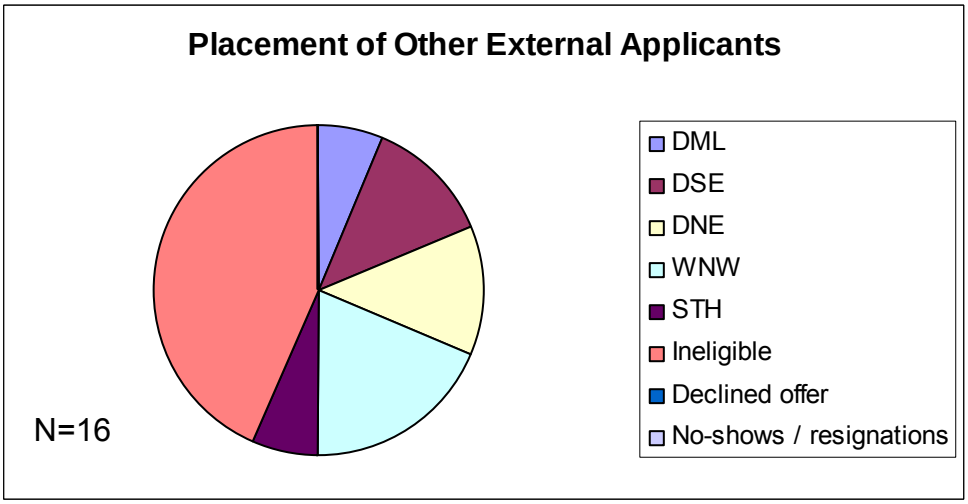


Fig. 31



E5.3 Filling of intern posts by EEA / Non-EEA

The details provided below reflect filled intern posts as at September 1st 2010; this reflects the position after all candidates on the reserve list had been offered positions. Every eligible applicant, including every eligible non-EEA applicant, eventually received an intern post allocation offer.

Table 10

	Number in post	Proportion of filled intern posts
EEA	413	81%
Non-EEA	99	19%

Number of filled posts: 512. Other posts declined and filled by "existing" interns and / or locally.

E5.4 Analysis of filling of intern posts in a sample of hospitals

Table 11 below reflects the status of intern posts in five different hospitals, comparing the proportion of EEA / Non-EEA nationals in intern posts in each of the hospitals listed and the range of centiles of applicants matched to posts in these hospitals. Higher proportions of EEA nationals were seen in the larger teaching hospitals listed and, as is often the case at other grades of NCHD, higher proportions of non-EEA applicants are employed at intern level at the smaller hospitals identified here.

Table 11

Posts with rotations in ↓	EEA interns (%)	Non-EEA interns (%)	Centile range
Mater Hospital	62 (100%)	0	99 - 19
St. James's Hospital	50 (100%)	0	99 - 22
Cork University Hospital	57 (79%)	15 (21%)	100 - 9
Our Lady of Lourdes Hospital Drogheda*	11 (28%)	28 (72%)	69 - 1
Letterkenny General Hospital	13 (54%)	11 (46%)	92 - 7

*One post declined filled by (non-EEA) existing intern