NATIONAL DOCTORS TRAINING & PLANNING

Ophthalmology Medical Workforce in Ireland 2025-2040

An expert stakeholder informed review

HSE
National Doctors Training & Planning

Irish College of Ophthalmologists
Eye Doctors of Ireland
Protecting your Vision

Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

Contributors

Medical Workforce Planning Project Group

HSE National Doctors Training and Planning	Prof. Anthony O'Regan	Medical Director
	Dr. Hugo Nolan	Medical Workforce Planning
	Dr. Roisin Morris	Medical Workforce Planning Lead
	Dr. Tom Pierse	Medical Workforce Planning Data and Analytics Lead
	Dr. Consilia Walsh	Medical Workforce Planning Clinical Advisor
Trinity College Dublin Centre for Health Policy and Management	Dr. Bridget Johnston	Principal Investigator
	Prof. Sara Burke	Project Advisor
	Prof. Steve Thomas	Project Advisor
	Dr. Charlotte Myers	Postdoctoral Researcher
	Dr. Katharine Schulmann	Postdoctoral Researcher
	Ali McDonnell	Research Assistant
	Adrienne De Vore Merriman	Research Assistant
	Veronica Segerström	Research Assistant

Ophthalmology Specialty Stakeholder Group

Irish College of Ophthalmologists	Siobhan Kelly	CEO Irish College of Ophthalmologists
National Clinical Programme for Ophthalmology	Dr. Aoife Doyle	National Clinical Programme for Ophthalmology Lead Consultant Ophthalmic Surgeon

Table of Contents

List of Tables

List of Figures

Foreword: Clinical Director, National Doctors Training & Planning

It is my pleasure to announce the publication of this review of the specialist training requirements for the specialties of Ophthalmology in Ireland. This report is the result of collaboration between NDTP, the Irish College of Ophthalmologists, the National Clinical Programme for Ophthalmology, and the Centre for Health Policy and Management in Trinity College Dublin. My thanks to all who contributed to this review.

The principal focus of this report is to make recommendations around the number of training places at both basic and higher specialty training level in Medical Ophthalmology and Ophthalmic Surgery. Appropriately resourcing these training pathways will ensure the development of a future consultant workforce which is configured with the correct skill mix to serve the needs of the population in Ireland. Our goal is that the supply of consultants should be sustainable through the domestic training pipeline as much as is possible.

Medical Ophthalmology and Ophthalmic Surgery, while distinct specialties, are heavily intertwined with a shared workload and developments in one impacting the other. With this in mind, this review takes a comprehensive perspective of all ophthalmology services in Ireland. The estimates of future consultant demand are underpinned by demographic ageing, population growth, and, in particular, the Model of Care for Ophthalmology. The latter outlines the ongoing reconfiguration of public ophthalmology services in Ireland, an exercise which has yielded positive results in reducing waiting list volumes and times where it has been successfully implemented. Central to this is the development of multidisciplinary teams across the community and acute hospital settings which encompass the medical workforce and other healthcare practitioners. Of note, the establishment of Primary Eye Care Teams in Community settings requires significant expansion in the number of consultants in Medical Ophthalmology. Ophthalmic Surgery will require an increase in consultant workforce to serve the projected demand for acute or tertiary care. The recommendations in the number of trainees and future expansion of the consultant workforce in both Medical Ophthalmology and Ophthalmic Surgery reflects the challenges faced by each specialty, respectively.

This report recommends increasing Basic Specialty Training in Ophthalmology to an annual intake of 16, while the intake into Higher Specialty Training in Medical Ophthalmology and Ophthalmic Surgery should increase to 5 and 8, respectively, each year. In addition to increasing the scale of the training programmes, this review identified that it will be necessary to recruit some consultants from outside of the domestic training pipeline to offset anticipated age-related retirements and enable required service expansion in the short term.

While it is acknowledged that these are workforce projections and therefore may need to be adjusted over time, it is important, given that specialty training takes several years, that the NDTP works off such estimates in order to provide a self-sufficient domestic workforce pipeline as much as possible. We hope this work will be useful to clinicians and trainees, and we are committed to working with national clinical and training programmes in supporting training into the future.

Prof Anthony O'Regan

Medical Director, National Doctors Training & Planning

Foreword: National Clinical Programme for Ophthalmology

The NDTP's 2025–2040 report on the Ophthalmology Medical Workforce in Ireland highlights a critical and growing demand for services, driven by population growth and ageing, which will significantly increase the burden of cataract, glaucoma, and age-related maculopathy as well as other eye conditions. Current workforce capacity is inadequate, with just 2.38 ophthalmologists per 100,000 population—well below European and UK averages—and waiting lists exceeding 47,000 patients across adult and paediatric services.

The report reflects the reconfiguration of services to include consultant-led integrated eye care teams under Sláintecare, with complex care delivered in regional centres. The aim is to provide specialist eyecare in the community with a particular focus on the four main conditions: cataract, paediatric eye care, age related maculopathy and glaucoma.

To meet demand, the NDTP projects a required increase from 56 to 77 WTE Consultant Ophthalmic Surgeons and from 14 to 56 WTE Consultant Medical Ophthalmologists, accounting for retirements and role changes. Training numbers at both basic and higher levels will need to expand significantly to meet projected requirements across the public and private sectors, including growth in private consultant surgeons from 25 to 35 WTEs, while also accounting for attrition due to emigration, programme exits, and part-time work. The success of the model of care is further dependent on expanding the health and social care professional and ophthalmic nursing workforce, ensuring these teams work to the top of their licence under consultant supervision. As Consultant Medical Ophthalmologists are central to leading, supervising, and training these multidisciplinary teams, scaling up both the consultant and supporting workforce is essential to delivering sustainable, high-quality, and accessible eye care closer to home.

Ms Aoife Doyle

National Clinical Lead for Ophthalmology

Executive Summary

Aims

This report aims to inform intake into the specialty training programmes for Ophthalmology in Ireland and to facilitate a future consultant workforce that is equipped with the correct skill mix to serve population needs. Furthermore, this exercise outlines a potential recruitment roadmap to facilitate regional workforce planning which is aligned with future service configuration and population needs. This requires estimating the future demand for consultants through 2040, accounting for factors such as population growth, demographic ageing, and service reconfiguration. This expert-led process was informed through a consultative process with the National Clinical Programme for Ophthalmology (NCPO) and the Irish College of Ophthalmologists (ICO), in collaboration with the Centre for Health Policy and Management in Trinity College Dublin, following a standard methodology for specialty reviews carried out by National Doctors Training & Planning (NDTP). [1-3, 9]

This report encompasses both specialties of Ophthalmology, Medical Ophthalmology and Ophthalmic Surgery, which have separate training programmes but are integrated specialties in terms of service delivery with a single clinical organisational structure. [4] Consequently, estimation of demand for consultants and recommendations on training capacity were carried out in a single exercise and are summarised in this document.

As graduates from the Ophthalmology training programmes are expected to work as consultants in both the public and private healthcare sectors, projections are based on the combined public and private workforces serving the needs of the entire population.

Current Workforce

Baseline workforce data used in this work is for December 2024 and was sourced from NDTP's Doctors Integrated Management E-system (DIME), HSE National HR Census, and the Medical Council of Ireland (IMC). [5-7] A high level summary of qualified specialists working across Ophthalmology is shown in Table 1. Services in Medical Ophthalmology are currently provided by Consultants in Medical Ophthalmology and Community Ophthalmic Physicians (COPs). The COP role is currently being phased out to be replaced by Consultants in Medical Ophthalmology but is considered in the baseline workforce for this specialty. The current number of consultants per capita in Ireland (per 100k population) is generally lower than that observed in peer international jurisdictions with similarly configured healthcare systems (see Section 4.3).

Table 1: Current consultant workforce in Ophthalmology in Ireland, December 2024. [5-7]

	Medical Ophthalmology		Ophthalmic Surgery
Variable	**Consultant**	**COP**	**Consultant**
Headcount in HSE funded posts	15	33	69
WTE in HSE funded posts	13.8	25.3	56.2
Headcount private only consultants	8		27
WTE consultants in private sector	6.4		25.4
Consultants per 100k population (WTE)	0.85		1.53

Future Demand

Future demand for consultants across both specialties of Ophthalmology is driven by population growth, demographic ageing, and ongoing service reconfiguration. The Model of Care (MoC) for Ophthalmology, published by the NCPO, sets out hub and spoke regional networks whereby high-volume procedures addressing chronic conditions should be carried out in community clinical settings by Multi-Disciplinary Teams (MDTs) of eye care professionals, with clinical oversight and complex medical care provided by Consultant Medical Ophthalmologists. [8] In addition to replacing the COP workforce, Consultants in Medical Ophthalmology are expected to take on a more central role in the delivery and organisation of eye care in community settings as they are reconfigured in coming years. Surgical interventions and complex procedures will be carried out by Consultant Ophthalmic Surgeons in acute hospitals. Clear referral pathways and shared care protocols across both specialties will facilitate efficient alignment of hospital (hub) and community (spoke) services.

Implementation of this plan will require 55.6 WTE Consultants in Medical Ophthalmology and 77 WTE Consultant Ophthalmic Surgeons across HSE-funded services by 2040. Private healthcare capacity is expected to expand at a similar rate as the public sector in this time period.

Key Recommendations

In order to supply the future demand for consultants, both specialty training programmes in Ophthalmology will need to increase in intake over the next 5 years. Additionally, it will be necessary to recruit consultants from outside of the domestic training programmes in the immediate term to offset projected age-related retirements and satisfy service needs. In particular, a large portion of the COP workforce is aged 60 or older and are expected to retire in the coming years.

- Basic specialty training in Ophthalmology across both specialties (BMT/BST) should increase from current intake of 10 per year to 16 per year to ensure a sufficient pool of eligible candidates for higher the training programmes.

- Higher specialty training in Medical Ophthalmology (HMT) should build to a steady intake rate of 5 per annum. There are currently 2 trainees in Year 1 of this programme.

- Higher specialty training in Ophthalmic Surgery (HST) should build to a steady intake rate of 8 per annum. There are currently 5 trainees in Year 1 of this programme.

- In order to meet shorter term workforce demand there is a requirement for 12 Consultants in Medical Ophthalmology which will need to be recruited from outside of the domestic training programme in the next 3-4 years, principally to offset anticipated age-related retirements in the COP workforce.

- Service expansion requirements necessitate the recruitment of 17 Consultant Ophthalmic Surgeons to HSE-funded posts from outside of the domestic training programme in the coming years.

The roadmap outlined in this report is designed to build the consultant workforce across Ophthalmology to required levels by 2040, enabling further roll out of the MoC and addressing unmet demand for eye care. Nonetheless, it will be necessary to monitor consultant recruitment and workforce as service reconfiguration continues, with further periodic review of the required workforce to ensure that training and recruitment trajectories are aligned with future service requirements.

1. Introduction

1.1 HSE National Doctors Training and Planning

This report is the product of collaboration between HSE National Doctors Training & Planning (NDTP), the Centre for Health Policy and Management in Trinity College Dublin, the National Clinical Programme for Ophthalmology (NCPO), and the Irish College of Ophthalmologists (ICO). [1-3, 9]

Under the Medical Practitioners Act 2007, [10] NDTP is tasked with recommending the annual intake of post-graduate specialty medical trainees for each medical specialty in order to meet future demands for the medical workforce. To this end, NDTP works closely with stakeholders including National Clinical Programmes, National Specialty Directors, Postgraduate Training Bodies, and others to estimate the demand for consultants across the Irish healthcare system, both public and private. This information is then fed into the medical education and training role of NDTP via the commissioning of medical training to meet workforce needs, ensuring that the content and delivery is consistent and is responsive to the changing needs of the Irish healthcare system, and supporting the retention of doctors upon completion of their training.

This document is a summary of findings for the specialties of Ophthalmology. Due to the interlinked nature of work carried out by Medical Ophthalmologists and Ophthalmic Surgeons, as well as the overlap in training across the two specialties, the Ophthalmology specialist workload was considered as a standalone report. As the focus of the report is on informing the specialist training intake, the final step on the path to specialisation in a medical degree, a national approach is primarily taken.

Medical workforce planning in NDTP is broadly based on the following principles:

- Alignment with Government policy such as Sláintecare and the HSE Health Regions. [11, 12]
- The Irish Health Service should be self-sufficient in the production of medical graduates, in accordance with the WHO Global Code on the International Recruitment of Healthcare Professionals. [13]
- More patient care should be consultant-delivered, and more care should take place in the community.
- Workforce recommendations are for the entire population and across HSE and non-HSE funded (private) services.
- Recommendations should incorporate future health needs of the population, accounting for drivers such as demographic ageing, epidemiological changes, clinical models of care, and clinical/therapeutic innovations.
- Training capacity should match the recommended training numbers.

1.2 Aims and Objectives

The aims of this report are twofold; firstly, to recommend the required annual intake in the specialty training programmes of Medical Ophthalmology and Ophthalmic Surgery to meet consultant demand to 2040 and, secondly, to outline a potential annual recruitment roadmap aligned with regional workforce planning over this time period. The future workforce recommendations outlined in NDTP specialty review reports, for both trainees and consultants, are stakeholder informed and designed to meet the requirements of the Model of Care (MoC) for Ophthalmology. [8] The implementation of these recommendations lies outside the remit of NDTP and will be dependent on funding, available posts, training capacity, and available candidates.

2. Methodology

The approach taken in this report is broadly based on the methodological framework "NDTP Health Workforce Planning: A Stepwise Approach". [14] This forms the basis for all NDTP specialty workforce reviews, with adjustments made according to the needs of each unique specialty.

A multi-method approach to workforce planning was used which included the following steps:

- A review of Ophthalmology services in Ireland.
- A quantitative review of the Irish Ophthalmology workforce across public and private sectors to establish the baseline current workforce and related demographic variables.
- A review of policy documents to ensure the workforce plan is aligned with policy and strategy for the specialty and the wider health service.
- Stakeholder consultation to establish expert-informed baseline assumptions and scenarios to be used in modelling exercises.
- Quantitative simulation modelling of supply and demand statistics to establish the recommended annual increase in the supply of the consultant and trainee workforce numbers to meet the demand for consultants by 2040.
- Further engagement with stakeholders and refinement of modelling.
- Final recommendations on future trainee intake and consultant recruitment from outside the training pipeline to meet future consultant demand.

This general approach is outlined in Figure 1 below.

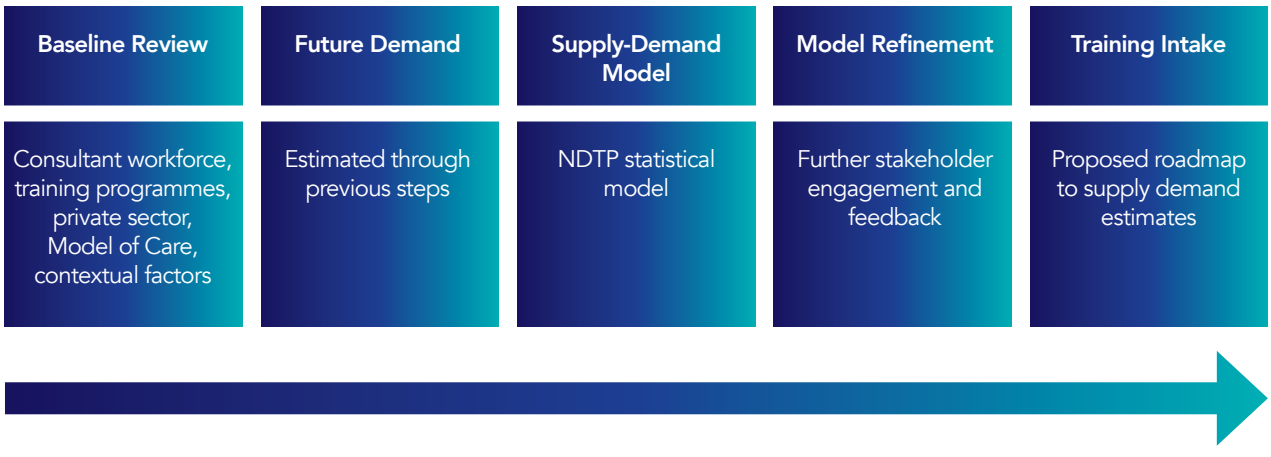

Figure 1: Process of engagement between NDTP and Specialty Stakeholders.

2.1 Data and Limitations

Analysis presented in this report is underpinned by multiple data sources, including the following:

- HSE NDTP Doctors Integrated Management E-System (DIME), which receives data from the Postgraduate Medical Training Bodies, the Medical Council of Ireland, and each clinical site that employs doctors in the public health system in Ireland. [5]

- HSE National HR staff census as recorded by the HSE's Strategic Workforce Reporting unit. [6] This report was used to determine the number of COPs working in acute and community settings, as these doctors are not captured by DIME. Stakeholder engagement highlighted possible limitations with the accuracy of this data.

- Hospital Inpatient Enquiry system (HIPE), which contains data on inpatient and day case activity in acute hospitals for HSE funded services. [15]

- HSE Business Intelligence Unit (BIU), which collates data on outpatient activity across acute hospitals funded by the HSE. [16]

- Community-based activity data sourced from frontline services.

- National Treatment Purchase Fund (NTPF), which collates waiting list data for HSE funded services in acute sites. [17]

- The Medical Council of Ireland (IMC), which collects data on private sector workforce numbers through its annual registration process. [7] This dataset is less up to date than what is available for HSE-funded services but represents the best-available data on private sector activity.

- The NCPO which produced the MoC for Ophthalmology and provided feedback on the medical workforce planning metrics and assumptions used in projecting supply and demand for consultants. [2, 8]

- Population projections from the Central Statistics Office (CSO, scenario M2) underpin all population-based calculations. [19]

- Health Atlas Ireland, managed by the HSE's Health Intelligence Unit, provides detailed information on demographics and boundaries of the HSE organisational geographies. [20]

- International health research groups and public health bodies, for example, Health Workforce Australia, the NHS in the UK, and equivalents in New Zealand and Canada.

DIME is dependent on clinical sites inputting details on their consultant workforce. The DIME data used in this report for consultants is for 31st December 2024, while data for Non-Consultant Hospital Doctors (NCHDs) is for 31st October 2024 and is reflective of the training year July 2024-July 2025. DIME data was accessed on 5th January 2025 and has been subject to a data validation exercise. As DIME is a live system, it must be noted that there can be variances in the figures published dependent on the run date of the report. In addition, some entries can be made with a retrospective date. Data on COPs was sourced from HSE National HR staff census, which is primarily used for payroll purposes. Consequently, the same granularity of data regarding clinical site and WTE commitments is not available as is the case with DIME.

2.2 Modelling

The statistical modelling used in this review simulates the supply of doctors into the health system on the basis of inputs such as training intake, retirement age, attrition, etc over the period 2025-2040. Medical Ophthalmology and Ophthalmic Surgery were modelled separately, given the separate specialty training programmes for each. Due to the long timeframe between an individual entering training and taking up a consultant post, increases in the training intake will only impact on consultant numbers in the later years of the model. The modelling approach used here is an extended version of a statistical simulation model developed by FÁS and Expert Group Needs, with distinct modules for supply and demand. [21] Although the principal aim of this workforce review is to estimate consultant demand in publicly funded posts, entire population needs must be considered, so the total public plus private workforce is considered in this supply model.

2.2.1 Supply Modelling

The supply module uses a stock-flow analysis of individuals progressing through the specialist training schemes and taking up consultant posts. Entrants into and exits from the training and consultant cohorts are modelled on an annual basis according to assumptions on gender profile and age, Less Than Full Time (LTFT) working patterns, attrition, and recruitment. These assumptions are outlined in Table 2. These assumptions were arrived at through NDTP analysis of DIME data and stakeholder engagement.

Table 2: Assumptions underpinning statistical modelling of consultant supply to 2040.

	Medical Ophthalmology	Ophthalmic Surgery	Source
Baseline workforce (WTE)	45.5	81.6	DIME & HSE National HR, IMC [5-7]
Post-CSCST attrition rate	25% initially, reducing to 18% over modelling period	15%	NDTP analysis & assumptions [22]
Age of retirement	62		NDTP analysis [22]
Non-retirement exits annually	0.5% (male) 0.8% (female)		Assumption
Years between CSCST and consultant post	2		Assumption
WTE rate (flexible/LTFT working assumptions)	92% initially, reducing to 85%	97% initially, reducing to 89%	Assumption
Private sector capacity	23% of total public + private workforce	25% of total public + private workforce	Assumption

Analysis of CSCST retention in Medical Ophthalmology is difficult as historically a very small number of individuals have completed this specialty training programme and it is not possible to determine which of these CSCSTs may have progressed into COP roles, given data limitations. An initial post-CSCST attrition rate of 25% was assumed in line with the overall trend across all specialties in the HSE. The establishment of new consultant posts in Medical Ophthalmology replacing the COP roles is expected to act as a driver for retention in coming years. Additionally, other factors such as the uptake of as Public Only Consultant Contracts (POCC) will act as a secondary driver for retention. A specific supply factor to consider for Medical Ophthalmology is building up consultant workforce capacity to meet demand as the COP workforce retires and the COP role transitions out of the public health system.

2.2.2 Demand Modelling

Estimating future consultant demand is a bespoke exercise which involves extensive engagement with specialty stakeholders including clinical programme leads and specialty directors. Demand estimates must account for population growth, demographic ageing, future service development as set out by the MoC, and broader reorganisation of the HSE such as implementation of Sláintecare and the HSE Health Regions. [12, 23] A detailed discussion of the drivers for demand for consultants in Ophthalmology is presented in Section 4 of this report.

The modelling approach used in this project integrates demographic projections with patient activity, workforce, and waiting-list data from acute and community services. This data underpins future consultant demand which is configured to support patient care and referral pathways across community and acute hospitals as set out in the MoC for Ophthalmology. The pathways set out in the MoC were successfully implemented in Community Health Organisation (CHO) 7 over 2020-2022 (see Section 3.3), resulting in an increase in monthly removals from waiting lists, more efficient patient referral processes, and an overall reduction in waiting volumes and times.

3. The Configuration of Ophthalmology Services in Ireland

3.1 Overview of the Specialties of Ophthalmology

Ophthalmology is the branch of medicine involved in the anatomy, physiology, disease, and care of the eye and ocular system. There are two specialties within Ophthalmology: Medical and Surgical, with both treating patients to preserve and prevent sight loss. Medical Ophthalmologists work in the acute and/or community settings with subspecialty expertise in glaucoma, paediatric ophthalmology, and medical retina. Ophthalmic Surgeons work in acute hospitals and often subspecialise in areas such as retinal surgery or glaucoma, oculoplastic, and nasolacrimal surgery. Ophthalmologists are trained to deliver care in both the public and private care setting after graduation, and later in their careers many ophthalmologists often combine a public HSE funded role with some private practice.

The Ophthalmology specialist workforce in Ireland currently consists of three different roles, all providing expert care in either Medical or Surgical Ophthalmology: Consultant in Medical Ophthalmology, COPs, and Consultant Ophthalmic Surgeons.

3.2 Ophthalmology Training Pathway in Ireland

Specialist training in Medical and Surgical Ophthalmology is delivered by the ICO and Royal College of Surgeons in Ireland (RCSI), respectively. Both pathways begin with a basic specialist training period of three years, followed by higher specialist training for an additional two (for Medical) or four (for Surgical) years, as illustrated in Figure 2.

Basic Training in Medical Ophthalmology (BMT) and the Basic Training in Surgical Ophthalmology (BST) function as a pipeline of trainees for the higher training programmes. Entry to Higher Specialist Training in Medical Ophthalmology (HMT) and Higher Specialist Training in Surgical Ophthalmology (HST) is competitive and includes successfully passing the Membership of the Royal College of Surgeons Ireland (MRCSI) Ophthalmology exam, an interview, and meeting other selection criteria.

To be eligible to apply for the Medical Ophthalmology training programme, medical graduates must be registered with the IMC and eligible for the trainee specialist division. BMT functions as a pipeline for entry to HMT. The higher training curriculum is outcomes-based and focuses on the three main sub-specialties of glaucoma, medical retina, and paediatric ophthalmology. To be eligible to apply for the Ophthalmic Surgery training programme, medical graduates must be registered with the IMC and eligible for the trainee specialist division. BST functions as a pipeline for entry to HST. The higher level of training curriculum is focused on the surgical sub-specialties of cataract, glaucoma, strabismus, anterior segment surgery, vitreo-retinal, oculoplastic, orbital, and nasolacrimal. [4]

<table>
<tr><th></th><th colspan="3">Basic Specialty Training</th><th></th><th colspan="5">Higher Specialty Training</th></tr>
<tr><td>Medical Ophthamology</td><td>BMT1</td><td>BMT2</td><td>BMT3</td><td rowspan="2">MRCSI</td><td>HMT1</td><td>HMT2</td><td>CSCST</td><td></td><td></td></tr>
<tr><td>Ophthalmic Surgery</td><td>BST1</td><td>BST2</td><td>BST3</td><td>HST1</td><td>HST2</td><td>HST3</td><td>HST4</td><td>CSCST</td></tr>
</table>

Figure 2: Training pathways for Medical and Surgical Ophthalmology.

3.3 Ophthalmology Services in Ireland

Ophthalmology care is delivered through primary, community, hospital, and tertiary services, as well as private service providers. Primary eye care in the community is delivered by General Practitioners (GPs), optometrists and ophthalmologists. These providers can be private or public employees working under a contract with the HSE.

The MoC for Ophthalmology recommends establishing multidisciplinary community Primary Eye Care Teams (PECT) to include other eye health professionals such as ophthalmic nurses, optometrists, ophthalmic technicians, and orthoptists and led by a Consultant Medical Ophthalmologist. These teams should be based in primary care locations across the country with standardised access to optimal facilities, equipment, and resources. [8] Care and patient referral pathways in PECTs are aligned with surgical centres in acute hospitals where surgical procedures and more complex interventions are carried out by Ophthalmic Surgeons. The implementation of this MoC has begun and PECTs are established in several community settings. Through establishing clear referral care pathways involving local optometry services and hospital ophthalmic services, patients are cared for in their locality, simultaneously freeing up theatre space and consultant appointments in hospitals and addressing the waiting list for elective surgery. [8, 24]

A successful example of the implementation of the MoC can be found in CHO 7, where the PECT model was implemented with tangible results in addressing acute and community waiting lists. It should be noted that as of the end of 2024, the CHO geographic organisational model within the HSE has been discontinued and community-based healthcare services merged into the HSE Health Regions. The Health Regions are further organised into sub-geographies known as Integrated Healthcare Areas (IHAs), which bring together acute and community services. The hub and spoke nature of the MoC for Ophthalmology will continue to operate within the structures of the Health Regions and IHAs. The location of consultants in acute and community services across the Health Regions as of the end of 2024 is summarised in Appendix 1.

CHO 7 (prior to 2024) was one of the largest CHOs in Ireland catering for approx. 15% of the national population with connections to four hospitals:

- Royal Victoria Eye and Ear (all specialties) (RVEEH)
- CHI Crumlin (paediatric ophthalmology)
- Tallaght University Hospital (neuro-ophthalmology, paediatric ophthalmology, general)
- St James (glaucoma, orbit and oculo-plastics, adult strabismus, general)

The PECT service opened gradually between 2020-2022 across two sites with one shared PECT, eventually providing services for glaucoma, cataract, medical retina, and paediatric ophthalmology patients. Upon inception, >7,000 historical paediatric records were inherited that required review as well as a case load of >1,000 patients waiting a long time for hospital paediatric care. The service grew gradually over the years despite significant challenges in recruitment, IT issues, and equipment and space requirements. Referrals into the service were added on a staggered basis, allowing for the service to grow organically. Specifically, the RVEEH reduced its wait time for new routine appointments from 36 months in 2019 to three months in 2023. [45] The average monthly number of patients seen in CHO 7 grew by 77% from 2021 to 2022. Over the same time period, the annual total number of referrals grew by 52% and the number of patients waiting more than 52 weeks was brought to zero.

As of 2025, the area formerly covered by CHO 7 is now covered by three IHAs (Dublin South City & West, Dublin South West, and Kildare West Wicklow) which are part of the Dublin & Midlands Health Region. [20] The integrated community care fundamentals of the MoC which were successfully implemented in CHO 7 will continue to be implemented nationally within the structure of the Health Regions.

3.4 Care Pathways for the Five Main Patient Groups

Approximately 70% of demand for Ophthalmology services is related to four chronic conditions: glaucoma, cataracts, Age-related Macular Degeneration (AMD), and Diabetic Retinopathy (DR), and children's services (see Table 3). [8] A well-established PECT, with appropriate equipment and clinical governance, is suited to managing these five groups in collaboration with hospitals. The remaining 30% of cases and more complex treatment of chronic conditions require treatment in acute hospitals.

Table 3: Patient groups identified as currently treated in acute hospitals which are suitable for treatment in the community setting via the PECT. [8]

Patient Group	Role of Community Setting	Role of Hospital Services
Age-related Macular Degeneration	Ongoing monitoring and treatment can be delivered in the community where medical retina expertise and appropriate equipment exist (OCT, angiography, cleanroom for injections).	Complex AMD cases. Patients requiring advanced investigation or specialist management.
Cataract	Pre-operative assessment in community. Routine post-operative review. Identification of comorbidities. Step-down care for stable patients.	Surgical treatment (cataract extraction). Post-operative care for complex cases.
Diabetic Retinopathy	Assessment following RetinaScreen referral. Monitoring of non-sight-threatening DR. Shared care with hospitals.	Sight-threatening DR requiring laser-Intravitreal injections Vitrectomy / surgical retina care. Pregnancy-related DR and paediatric DR.
Glaucoma	Follow-up and monitoring of stable glaucoma. Community assessment following optometrist referral. Virtual/tele-glaucoma clinics.	Complex/progressive disease. Laser interventions. Surgical glaucoma management. Subspecialist review.
Paediatric Eye Care	Routine surveillance and screening. Management of refractive errors, amblyopia, strabismus (initial phases). Orthoptics and optometry-led care. Ongoing triage and dilated fundoscopy where needed.	Surgical intervention (e.g., congenital cataract/glaucoma). Complex/non-refractive disorders. Children with additional medical or developmental needs.

Treating ophthalmological conditions in children requires a different set of skills than those required for treating adults. Children are often unable to clearly communicate subjective vision problems. In addition, a child's vision continues to develop up to approximately eight years of age. Routine vision surveillance and screening are essential to early identification of visual disorders in children. This ensures that a child will have healthy sight over the long-term and be referred to the appropriate eye care professional for further evaluation and treatment if necessary. Various eye care specialists are well placed to cater for paediatric conditions, such as refractive components (optometrist), amblyopia (orthoptist) and general triage of all referrals and specifically dilated fundoscopy (ophthalmologist). Surgical interventions, non-refractive disorders, and children with special needs should be referred into the hospital. Children can be referred out of community care if their need is for spectacle correction only; if they have completed amblyopia or strabismus treatment; or if they have no further medical eye disease, medical, or developmental problems. A local optometry service would be the suitable destination for that referral. [8]

4. Review of the Ophthalmology Workforce in Ireland

4.1 Consultants and Specialists

As previously discussed, Ophthalmology services in Ireland are provided by Consultant Medical Ophthalmologists, COPs, and Consultant Ophthalmic Surgeons. Although COPs do not have consultant status as per IMC criteria, stakeholders advised that they should be considered alongside consultants in this report as senior specialists in the provision of Ophthalmology services. The history and development of the COP is described in Appendix 4. The COP role is being phased out as this cohort retires over the coming years and the roles currently occupied by COPs will be replaced by Consultant Medical Ophthalmologists to maintain workforce capacity. To reflect these developments, the current number of COPs have been included in both the supply and demand modules.

4.2 Demographics of the Ophthalmology Workforce

4.2.1 Consultant Workforce

Table 4 below details the demographics of the consultant workforce in across both specialties of Ophthalmology. These parameters serve to review the current status of consultant workforce and provide input parameters for statistical modelling of supply which underpins all projections in this report. As previously described, the services in Medical Ophthalmology are delivered by two groups of specialists, Consultant Medical Ophthalmologists and COPs. The location of the Ophthalmology workforce broken down by clinical setting and Health Region is shown in Appendix 1.

Table 4: Ophthalmology consultant workforce December 2024. [5-7]

	Medical Ophthalmology		Ophthalmic Surgery
Variable	**Consultant**	**COP***	**Consultant**
Headcount in HSE funded posts	15	33	69
WTE in HSE funded posts	13.8	25.3	56.2
WTE rate	92%	76%	81.4%
Headcount private only consultants	8		27
WTE consultants in private sector	6.4		25.4
Total WTE specialists (public and private)	45.5		81.6
Proportion of WTE specialist workforce in private sector	14%		31%
Total number of approved public consultant posts	17		68
Vacant posts	2		4
% Consultant posts vacant for more than 18 months	11.8%		1.5%
Consultants Female	53.3%	63.6%	36.2%
Consultants aged >55	33.3%	68.4%	26.1%
Consultants working full time	80%	60.6%	66.7%
Consultants in permanent employment	86.7%	94%	82.6%
Consultants in temporary employment	6.7%	6%	10.1%
Consultants in locum posts	0.0%		7.2%
Number of HMTs	9		18
Number of NTSDs	42 (25 Reg, 17 SHO		1 (1 SHO)

**Stakeholder engagement highlighted potential limitations in data captured related to the workforce data, including overall capacity and distribution and the working patterns for COPs.*

When considering the clinical setting in which ophthalmologists in publicly funded services currently work, it was found that as, of December 2024, community settings were staffed by Consultants in Medical Ophthalmology and COPs, while acute settings were reportedly staffed by Consultants in Medical Ophthalmology, COPs, and (predominantly) Consultant Ophthalmic Surgeons. [5,6] This is summarised in Table 5, with greater detail presented in Appendix 1.

Table 5: Breakdown of consultant workforce across community and acute clinical settings by specialty, December 2024. [5,6]

Clinical Setting	Specialty*	Workforce (WTE)
Community	Medical Ophthalmology	21.3
Acute	Medical Ophthalmology	17.8
	Ophthalmic Surgery	56.2
	Acute Total	74

**Medical Ophthalmology here is taken to include both Consultants in Medical Ophthalmology and COPs.*

4.2.2 Non-Consultant Hospital Doctors

The overall NCHD workforce encompass those working in training and non-training (Non-Training Scheme Doctor, NTSD) roles. These are summarised in Table 6 below. Training roles within the specialties of Ophthalmology include BMT, BST, HMT, and HST. Additional training NCHDs such as Interns or GP trainees may rotate through Ophthalmology rotations, but these are not counted as Ophthalmology trainees when considering the pipeline specifically for consultants in Ophthalmology. Similarly, NCHDs working in Ophthalmology posts as part of the International Medical Graduates Training Initiative (IMGTI) are not counted towards the total number of Ophthalmology trainees in this exercise, as these individuals are not part of the domestic training pipeline to produce Irish-trained consultants.

Table 6: Ophthalmology NCHD workforce December 2024. [5]

Variable	Medical Ophthalmology	Ophthalmic Surgery	Total
Total NCHD (Training and Non-Training)*	88	19	107
Total BMT/BST	32		32
Total HMT/HST	9	18	27
Total NTSD	42 (25 Reg, 17 SHO)	1 (1 SHO)	43
NCHD/Consultant Ratio**			0.92

**This value includes NCHDs not explicitly counted in the following rows such as NCHDs working within the IMGTI.*
***This ratio is calculated on the basis of consultants and COPs working in HSE funded services. Private-only consultants are not considered.*

4.2.3 Trainee NCHDs

The breakdown of trainee NCHDs for the training year July 2024 – July 2025 is shown in Table 7. The training capacity of a specialty is an important consideration in workforce planning, particularly in the context of achieving self-sufficiency in supplying the future consultant workforce to align with Sláintecare implementation. Ophthalmology training is delivered across both specialty programmes by the HSE funded consultants (COP are involved in training at ICO level but are not directly supervising trainees in their teams). The two basic specialist training programmes (BMT and BST) are the pipeline supply into the higher specialist training programmes, though there is a competitive nature to advancement post MRCSI examination. Stakeholder feedback indicates that the large pool of trainers means that the specialty has good capacity to train and capacity to increase their training numbers from the current ratio of 0.62 trainees per trainer.

Table 7: Ophthalmology trainee numbers (training year July 2024-July 2025). [5]

	BMT/BST	HMT	HST	Total
Year 1	10	-	-	10
Year 2	12	-	-	12
Year 3	10	-	-	10
Year 4 (Year 1 HMT/HST)	-	2	5	7
Year 5	-	7	5	12
Year 6	-	-	4	4
Year 7	-	-	4	4
Total trainees	32	9	18	59
Total consultant trainers (WTE)				94.9
Trainee/trainer ratio				0.62

4.2.4 Non-Training Scheme Doctors

The number of NCHDs not in formal training posts (NTSDs) has grown by approx. 9.5% annually over the period 2020-2024 across the entire HSE. This workforce group is mainly employed at Senior House Officer or Registrar level, often on short term contracts and registered on the general or supervised register. Although it is HSE policy to have more NCHDs in training posts to support consultant delivered care, the expansion of the NTSD cohort may occur for a variety of reasons including plugging service gaps, to ensure European Working Time Directive 2003/88/EC (EWTD) compliance, lack of training posts in certain clinical sites, rostering restrictions, etc. [32] Ireland is an outlier internationally with this high dependence on NTSDs. One way to reduce dependence on NTSDs is to collaboratively identify suitable posts to be converted into training posts, thus further aligning Ophthalmology with the consultant-delivered care model. NDTP are currently tasked with supporting the realignment of the medical workforce away from the general overreliance on NTSDs across many specialties.

4.3 International Workforce Comparisons

The Royal College of Ophthalmologists (RCOphth) is the postgraduate training body for specialists in Ophthalmology across the UK. Trainees are medical doctors that will practice both as a physician and surgeon once fully qualified after the seven-year Ophthalmic specialist training programme is completed. [33]

The latest RCOphth Census report from 2022 identified staff shortages across the UK's National Health Service, as well as a large proportion of the workforce expecting to leave in the next five years or move into the private sector, exaggerating the waiting list numbers as well as affecting the increased future demand due to population ageing and improved treatment in e.g. age-related macular degeneration. [34] The RCOphth Census from 2018 included a section on workforce planning and the recommendation that emerged was 3-3.5 WTE consultant to 100k population would be the ideal. [35]

Comparing workforce data from Ireland with other similar, or aspirational, service regions is not without challenges. Several differences impact the comparison, such as the difference in size and age of the population, service delivery, IT infrastructure, MDT members, and the workload itself. Nonetheless, it can still be a useful exercise for contextualising the situation in Ireland. Table 8 summarises key metrics of the ophthalmology workforces per capita in Great Britain, Australia, Canada, and New Zealand. This illustrates the relative undersupply of Ophthalmology consultants in Ireland. The combined current Irish Medical and Surgical Ophthalmology workforce amounts to a population ratio of 2.38 WTE per 100k.

Table 8: Consultant international workforce comparison in WTE per 100k population.

	Ireland [5, 7, 19]	England [36, 37]	Scotland [37, 38]	Wales [37, 39]	Australia [40, 41]	New Zealand [42, 43]	Canada [44]
Medical Ophthalmologists	0.85*		0.15		3.77	3.28	3.11
Surgical Ophthalmologists	1.53	2.63	2.46	1.98			
Combined Ophthalmology	2.38	2.63	2.61	1.98			

Note that some jurisdictions (such as the UK nations) report Medical and Surgical Ophthalmology separately, but the number of registered Consultants in Medical Ophthalmology is very low. Other nations (Australia, NZ, Canada) only report on a single unified specialty of "Ophthalmology".
All values are WTE. Workforce data for Canada and NZ are provided in HC, an assumed WTE rate of 90% is used for comparative purposes here.
**This value includes the COP workforce.*


BQ 900

5. Drivers of Demand for Consultants

5.1 Demographic Ageing

Ireland's population is increasing and ageing and by 2040 is predicted to exceed 6 million, according to CSO projections. [19] Trends in utilisation reported by the Economic Social Research Institute show that in general, older people have a higher number of outpatient consultations than younger people. [25] This is reflected in acute hospital attendances for Ophthalmology in 2024 as shown in Table 9, which also summarises the projected population growth to 2040. [15,19] The largest population increase is projected in the 65+ age brackets and given that ophthalmic conditions are correlated with age, a large increase in service demand can be expected in these patient groups.

Table 9: Demographic profile of acute hospital attendances for Ophthalmology in 2024 and projected population growth 2024-2040. [15,19]

Demographic Group	Attendances per 1,000 Population 2024 [15, 19]	2024 Population [19]	2040 Population [19]	Population Growth Rate 2024-2040 [19]
0-15	1.1	1,072,252	877,439	-1.25%
16-30	1.3	998,240	1,078,880	0.49%
31-45	2.6	1,166,477	1,195,629	0.15%
46-60	8.8	1,053,876	1,248,188	1.06%
61-75	36.6	734,376	1,047,745	2.25%
76-85	101.3	253,668	423,410	3.25%
Over 85	124.9	76,499	177,009	5.38%
Total	**13.9**	**5,355,388**	**6,048,300**	**0.76%**

5.2 Increased Utilisation of Services

Age-weighted projected utilisation for inpatients and outpatients in acute settings indicates that attendances in acute hospital services are expected to grow by approx. 1.9% annually between 2024 and 2040, at current attendance patterns and care pathways. When also accounting for attendances in community clinics, overall attendances in Ophthalmology are expected to grow by 1.3% annually over this time period, as summarised in Table 10. The data outlined in this table underpins the future demand for consultants in both Surgical and Medical Ophthalmology. However, stakeholder input highlighted that this component of the statistical modelling must be considered in parallel with other drivers for demand, such as developments set out in the MoC, addressing unmet demand, and the need to replace the retiring COP workforce. While Table 10 breaks care demand down across community and acute services, new care pathways, once implemented, will drive more chronic care and paediatric screening into community settings. This in turn will allow for more complex care to be delivered in the acute setting. This is discussed in more detail in Section 5.4.

Table 10: Projected service utilisation across community and acute clinical settings for paediatric and adult age groups 2024-2040. [15, 19]

Year		2024	2025	2030	2035	2040
Paediatric population		1,072,252	1,058,369	972,011	911,593	877,439
Adult population		4,283,136	4,364,920	4,702,832	4,963,740	5,170,861
Community Attendances	Paediatric	66,594	65,731	60,368	56,616	54,494
	Adult	13,180	13,432	14,472	15,275	15,912
	Total	79,774	79,163	74,840	71,890	70,407
Acute Attendances	Paediatric	70,562	69,648	63,965	59,989	57,742
	Adult	187,991	193,771	223,446	254,037	287,131
	Total	258,553	263,419	287,411	314,026	344,873
Overall Total Attendances	Total	338,327	342,583	362,251	385,917	415,279

5.3 Current Unmet Demand

In addition to projected service demand underpinned by demographic ageing (see Section 5.1), there is a significant volume of current unmet demand in Ophthalmology, which is captured by the volume of patients on waiting lists awaiting services. For acute hospital services, this is captured in NTPF waiting lists. Additionally, stakeholders indicated large numbers of patients on referral and review waiting lists that are not captured in the NTPF data, but in separately recorded waiting lists for community services. These patients represent existing unmet need that is challenging to quantify due to data not being easily accessible from patient administration systems and not always validated. In addition, once seen, patients often cannot be discharged from acute hospitals to GP services for routine follow up. The patient care and referral pathways outlined in the MoC are configured to fulfil this discharge destination through more efficient patient transfer and discharge mechanisms. Thus, removing patients for acute service waiting lists as efficiently as possible.

5.3.1 Acute Hospital Waiting Lists

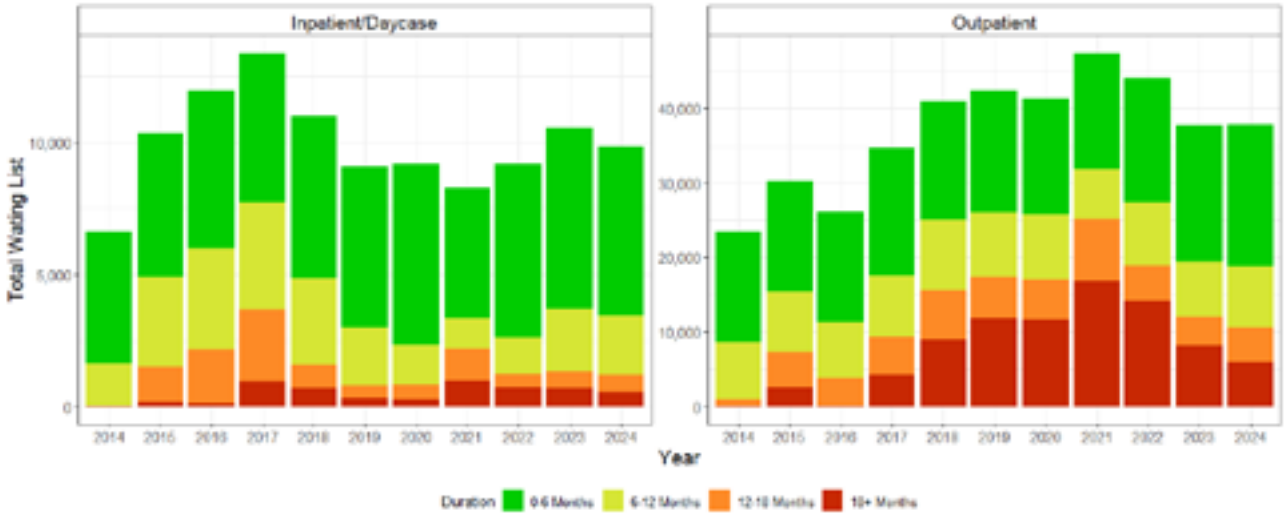

Figure 3: NTPF waiting list records for Ophthalmology for March of each year 2014-2024. Fill colour indicates the duration of time spent on waiting list. [17]

NTPF reports for national acute hospital waiting lists for Ophthalmology in March of each year from 2014-2024 are illustrated in Figure 3, with the duration of waiting time indicated by fill colour. While this data does not capture the number of patients awaiting community services, it is indicative of overall longitudinal trends in both waiting list totals and duration. This data highlights the impact of interventions carried out since the COVID-19 pandemic (such as the establishment of the PECT in CHO 7) which have had the impact of reducing both the total numbers on outpatient waiting lists and the duration spent waiting since a peak in 2021. A similar visualisation of outpatient waiting lists specifically for the RVEEH is shown in Appendix 3. This highlights the reduction in waiting times since the implementation of the PECT in this area. It is expected that the continued implementation of the MoC across Ireland and the increased capacity achieved through PECT service delivery will continue to have a positive impact on both the acute and community waiting lists. [8] Table 11 provides a detailed breakdown of national numbers awaiting adult and paediatric care across acute hospital inpatient and outpatient clinics as of the NTPF's report for December 2024.

Table 11: NTPF Waiting list data for Ophthalmology, December 2024. [17]

Wait time	Adult Inpatient	Paediatric Inpatient	Adult Outpatient	Paediatric Outpatient	Total
0-6 months	5,945	422	16,977	2,185	**25,529**
6-12 months	1,939	298	7,387	799	**10,423**
12-18 months	485	202	4,280	342	**5,309**
18+ months	433	94	5,459	452	**6,438**
Total	**8,802**	**1,016**	**34,103**	**3,778**	**47,699**

The 2024 Waiting List Action Plan published by the Government identified Ophthalmology as one of the three high volume outpatient waiting list to be targeted. [29] The specific targets set include:

- Roll-out 80% of a central management system across six high volume hospitals: University Hospital Waterford, RVEEH, South Infirmary Victoria University Hospital (SIVUH), Mater Misericordiae University Hospital (MMUH), University Hospital Galway, and Tallaght University Hospital. This facilitates a standardised waiting list management of referrals, appointments, outcome and follow up. It also manages 'did not attend', 'could not attend' and hospital cancellations to reduce numbers in line with the Outpatient National Waiting List Protocol 2022.

- Deliver 90% <15 months for out-patient department by the end of 2024.

- Increased private outsourcing above the NTPF capacity as part of the HSE Outpatient Framework.

In addition to the specific targets above identified for Ophthalmology, the NTPF carries out administrative validation every year to remove inappropriate additions to the waiting lists and procures both outsourced and insourced capacity from the private sector.

5.3.2 Community Waiting Lists

Specialist community ophthalmology services are separately recorded across all Health Regions. This information was historically captured by the various CHOs and reported accordingly. These services are focused on pre/post operative care, paediatric screenings, and ongoing care of chronic eye diseases. As the establishment of PECTs and the implementation of the MoC proceeds nationally, standardised comprehensive and accurate waiting list data will be captured.

Summary community waiting list data for CHO 7 over 2021-2022 is shown in Table 12. The data for CHO 7 was validated over the course of implementing the MoC structures and PECT. The total number of patients awaiting community services was significantly reduced, with no patients awaiting services for more than a year by the end of 2022. This reduction in waiting list volumes was achieved with a corresponding increase in the number of patient attendances over this period. In parallel, the total number of new patients referred for services increased, indicative of the efficient integrated referral pathways established with acute hospital services linked with CHO 7. Taken together, this indicates that the number of patients removed from community waiting lists in this CHO increased more than threefold over 2021-2022. The success of this pilot is evidence that a national consultant workforce configured to support the implementation of the MoC integrated patient care pathways will continue to address unmet demand for services, in addition to service increased demand due to demographic ageing.

Table 12: Summary statistics and dynamics for CHO 7 community waiting lists 2021-2022.

Waiting List Metric	2021	2022	Change 2021-2022
Total waiting list volume (December value)	1,401	327	-77%
Total waiting >52 weeks (December value)	773	0	-100%
Annual patient attendances	3,186	5,647	77%
Annual new patient referrals	856	1,298	52%
Average monthly waiting list removals	48	198	311%

5.4 Model of Care

The MoC for Ophthalmology sets out several ambitions to modernise care pathways which will impact demand for consultants in Ophthalmology, in addition to increased patient attendances driven by demographic ageing and population growth. As discussed in Section 3.3, the PECT model was successfully piloted in CHO 7 over 2020-2022 with positive outcomes in terms of reduction in both the volume of and time spent on waiting lists in both community and acute settings.

The diagnosis and treatment of the chronic eye conditions discussed in Section 3.4 is currently delivered in public acute hospitals. These treatments could in part, or in full, be delivered in the primary care setting in a decentralised model underpinned by the PECT.

This will act as a driver for demand for consultant work in community settings away from acute clinical sites. The PECT requires additional essential eye care specialists in addition to Consultant Medical Ophthalmologists and an adequate supply of these professionals is essential, however these considerations are outside the scope of this report.

Acute hospital activity data for 2024 indicates that 60-70% of recorded inpatient and daycase attendances fall into the five patient categories outlined in Section 3.4 which could be managed in community settings by the PECT. [15]

The remaining cases will require access to acute or tertiary care delivered by Consultant Ophthalmic Surgeons. Examples include retinal detachment, perforating eye injury, endophthalmitis, intraocular malignancy, temporal arteritis, corneal ulcers, and uveitis. Hospital-based ophthalmologists work in close collaboration with other specialists including diabetologists, rheumatologists, neurologists, otolaryngologists, maxillofacial surgeons, paediatricians, geneticists, and oncologists to address a variety of eye conditions.

The coming years will see increased demand for Consultant Medical Ophthalmologists, in particular, as the community care pathways set out in the MoC are established across the country and the current cohort of COP roles are replaced by consultant posts. In addition to work in acute hospitals, Consultant Medical Ophthalmologists' duties also include community outreach and supporting staff in smaller hospitals. Demand for Consultant Ophthalmic Surgeons will also grow in the coming years to ensure appropriate staffing levels and capacity in acute surgical hospitals.

5.5 Health Service Reform

The service reconfiguration outlined in the MoC for Ophthalmology is aligned with the ambitions set out in the report published by the Oireachtas Committee on the Future of Healthcare, also known as the "Sláintecare Report". [23] This set out a strategic 10-year plan to reform the Irish health service into a universal access, single-tier system. Several subsequent action plans and progress reports have since been published outlining the implementations planned and executed to date to deliver a population-health based integrated service model. [27, 28] This service model aims to shift healthcare away from hospitals and closer to the patients through expansion of primary, community and social care. Integrated care pathways are being developed to facilitate a cohesive patient transition through primary, secondary, and tertiary providers.

A key ambition of Sláintecare is the recommended maximum wait time for in-patient procedures is within 12 weeks from referral, while out-patient appointments should be within 10 weeks from referral. As highlighted in this report, Ophthalmology has been identified as one of three targeted high-volume specialties in the Waiting List Action Plan - 2024, owing to having the 5th largest outpatient waiting list in 2023, with 46,028 people recorded on the waitlist as of December 2023. [29]

A further consideration on workforce demand is the roll out of the Public-Only Consultant Contract as of March of 2023 (POCC 23). As of the end of 2024, 55% of HSE employed consultants have accepted this contract. 48% of all consultants in Ophthalmology services hold the POCC 23 contract (66.7% of consultants in Medical Ophthalmology, 43.5% in Ophthalmic Surgery). This contract outlines the Sláintecare recommendation to increase capacity in public hospitals by transitioning away from private care delivery in public hospitals. As of the latest available data, the private workforce in Ophthalmology is approximately 25% the size of the publicly funded workforce, based mainly in Surgical Ophthalmology. Stakeholder engagement highlighted an expected increase in surgical consultants opting for a 0.5 WTE POCC contract to facilitate private sector work, which has been corroborated in other countries, such as Australia. Future revision of this workforce plan should review the uptake of the contract within the current consultant workforce. Nonetheless, this workforce review considers the combined public plus private workforce, so the specific proportion of public/private will not change the overall population-based calculations.

In March 2024, the HSE was restructured into six HSE Health Regions led by Regional Executive Officers, with direct responsibility for delivery of health and social services across the geographical region. [12] As a result of this restructure, CHOs have been phased out alongside the hospital groups in favour of Health Regions and IHAs.

Localised service delivery aligns with the MoC roll out of consultant Medical Ophthalmology-led community care teams and ophthalmology services are already established within the former CHO structure. Surgical Ophthalmology is represented nationally but stakeholders have highlighted the importance of strengthening workforce capacity and service delivery for Medical Ophthalmology. This includes capacity at Cork University Hospital (CUH), which is a Level 4 service, an additional trauma centre should provide coverage for the Limerick region, and also the two national tertiary referral hospitals Royal Victotria Eye and Ear Hospital (RVEEH) and MMUH. The RVEEH serves the largest local population and has a remit that stretches across HSE Dublin & Midlands and HSE South East health regions.

Lastly, investment in information technology, including electronic patient records, was one of the key recommendations as outlined by the MoC. Ideally, this will be addressed by the electronic health record and associated shared care record dataset as outlined in the Irish Government's Digital Health Framework. [30] An electronic patient record will facilitate access to the medical history of each patient to all care providers throughout the care pathway, which is essential as ophthalmology patients are transferred between acute and community care, with consultation with various multi-disciplinary medical professionals.

The key drivers for future demand for consultants in Ophthalmology are summarised in Table 13.

Table 13: Drivers of future demand for Medical and Surgical Ophthalmology Services.

Increased demand for services due to demographic ageing and population growth, as summarised in Table 9. The considerable growth among the older adult population with associated increased risk of development of chronic eye conditions leads to projected annual growth inpatient and outpatient attendances in acute hospitals of 1.9% to 2040, based on existing treatment pathways. Across all age cohorts and services (acute inpatient, acute outpatient, and community attendances), an average annual growth in demand for services of 1.3% is projected to 2040.
Implementation of the MoC for Ophthalmology and associated care pathways. The overall aim is to establish national coverage of community services with a PECT led by a Consultant Medical Ophthalmologist which will be linked with local surgical units.
HSE Health Region implementation and the resulting restructure of CHO and hospital group formations into IHAs and Health Regions.
Addressing unmet demand and waiting list management by aligning with the Sláintecare goal of maximum wait times of 10 weeks for outpatient and 12 weeks for inpatient appointments.
Alignment of workforce planning to Government of Ireland and international policies, such as Sláintecare, EWTD & Organisation of Working Time Act, and the World Health Organisation Global Code of Practice on the International Recruitment of Health Personnel. [11, 13, 31]
Alignment of workforce capacity with international healthcare systems where comparable to the Irish health service delivery and training system.
Sustainable workforce rostering and minimum safe staffing numbers. Stakeholder engagement informed the allocation of consultant workforce across the eight former CHOs and associated surgical hospital located within the HSE Health Regions.
More flexible training and working conditions, including LTFT working and a move towards greater work/life balance across the consultant and NCHD workforce.
Replacement of COP positions with Consultant Medical Ophthalmologists. As of December 2024, there are 33 COPs throughout Ireland, however all positions will phase out largely due to retirement in the coming years. Therefore, it is essential to consider building workforce capacity to address the replacement of these positions.

5.6 Future Demand

As outlined in Section 5, the ageing population in Ireland is expected to drive increased demand for Ophthalmology services across community and acute settings. This increased demand and the unmet demand for services (outlined in Section 5.1) will be addressed through restructuring of services as outlined in the MoC, the implementation of which will move treatment of chronic conditions to community-based services and supports enhanced referral pathways between community and acute care settings. Accordingly, national workforce demand projections are modelled on this staffing and service configuration.

Growing the overall consultant workforce (community and acute services) in line with increased utilisation due to demographic ageing alone results in a projected national demand of 117 WTE by 2040 across Medical and Surgical Ophthalmology. However, consideration must be given to projected growth in demand for community services as treatment of chronic conditions and paediatric screening will be moved community settings, where possible.

Analysis of acute hospital inpatient and daycase attendances for 2024 reveals that 65% of attendances were paediatric or related to one of the four chronic conditions discussed in Section 3.4. [15] This pattern is consistent with what is set out in the MoC. [8] Accounting for demographic ageing and population increase, paediatric/chronic disease attendances are projected to grow by 3% annually to 2040, while all other attendances are projected to grow by 1.9% over this time period. The MoC for Ophthalmology states that much of the former can be moved to community settings, with treatment of only the most complex cases remaining in acute hospitals. Thus, the number of attendances to community settings is estimated to grow by 3% annually to 2040, while attendances to acute hospitals are estimated to grow by 1.9% annually to 2040. These growth rates applied to the baseline workforce working community and acute settings, respectively, result in an estimated demand for approx. 33 WTE consultants in community settings and approx. 100 WTE consultants in acute hospitals, giving a total consultant demand in public funded services of approx. 133 WTE. This is summarised in Table 14 below.

Table 14: Future demand scenarios to estimate consultant demand in publicly funded Ophthalmology services.

Demand Scenario	Comment	Baseline Workforce 2024 (WTE)*	Projected Annual Growth Rate	Projected Consultant demand 2040 (WTE)
Demographic Ageing	No consideration for restructuring of services.	95.3	1.3%	117
Demographic Ageing + MoC Implementation	Integrated community-acute referral pathways, chronic conditions treated in community.	Community: 20.9 Acute: 74.4	Community: 3% Acute: 1.9%	Community: 33 Acute: 100

**Baseline workforce is the combined workforce of consultants in Medical and Surgical Ophthalmology and COPs working in either acute or community settings as of December 2024, as recorded by DIME and National HR, respectively. [5, 6]*

The growth of consultant demand across publicly funded community and acute settings from 2024-2040 is outlined in Table 15.

Table 15: Projected growth profile for consultants in publicly funded community and acute clinical settings 2024-2040.

Clinical Setting	2024	2030	2035	2040
Community	20.9	25	29	33
Acute	74.4	83	91	100
Total	**95.3**	**108**	**120**	**133**

The balance between Medical and Surgical Ophthalmology in the future overall consultant workforce reflects the service pathways outlined in the MoC and is informed by expert stakeholder input. The total demand for Consultants in Medical Ophthalmology in publicly funded services was estimated as 55.6 WTE, based in community settings or linked with regional or supra-regional units. These will lead a team of health and social care professionals to provide community based eye care linked with acute hubs such as RVEEH, SIVUH, MMUH, and University Hospitals Cork, Waterford, Limerick, and Sligo. Whilst primarily community based, a portion of their work will be in the acute hub with clinical governance and continuing professional development provided by acute regional hubs. Demand for Consultant Ophthalmic Surgeons in public services was estimated at 77 WTE. The 100 WTE overall demand for acute services outlined above comprises the consultant workforce in Ophthalmic Surgery and the portion of the Medical Ophthalmology consultant workforce based in acute hubs. Overall, the national consultant workforce will be split approx. 40/60% across Medical Ophthalmology and Ophthalmic Surgery, respectively, across community and acute services.

With assumptions on private sector capacity outlined in Section 2.2, consultant demand across public and private services was estimated as 72.1 WTE and 112 WTE in Medical Ophthalmology and Ophthalmic Surgery, respectively. This is summarised in Table 16. These workforce values would equate to a combined Ophthalmology consultant workforce of approx. 3 WTE per 100k population across public and private services by 2040, broadly in line with RCOphth recommendations discussed in Section 4.3. Supply modelling was configured to match these values in the following section. The precise distribution of these total workforces is dealt with later in this report.

Table 16: Estimated future demand for consultants in Medical Ophthalmology and Ophthalmic Surgery across public and private sectors in 2040.

	Medical Ophthalmology (WTE)	Ophthalmic Surgery (WTE)
HSE-funded services	55.6	77
Private sector	16.5	35
Total	**72.1**	**112**

Expanding surgical services nationwide is necessary to complement the Consultant Medical Ophthalmologist and the work carried out in the community by the PECT. This estimated demand also considers the need to expand tertiary surgical services, in both Dublin (including Children's Health Ireland, CHI) and CUH. SIVUH is linked with CUH and should also cover paediatric, neuro-ophthalmology, ocular plastics and trauma, whilst the RVEEH in Dublin is a national referral level 4 service which also caters for ocular plastics, neuro-ophthalmology, medical retina, glaucoma, cataract, and paediatric cases.

The drivers for and estimates of future demand are summarised below.

Demand Driver	Impact
Demographic ageing	Service utilisation projected to grow by 1.9% annually across all acute services and 1.3% across combined acute and community services.
Epidemiology	Growth in chronic eye disease prevalence.
Population benchmark	3-3.5 WTE per 100k population (RCOphth standards).
Care pathways (MoC)	Integrated patient and referral pathways across community and acute settings to address unmet demand (waiting lists).
Activity redistribution	Chronic eye disease and paediatric screening care routed through PECT and out of acute hospitals. Up to 70% of current acute attendances suitable for community care.
Growth in community and acute activity	Following activity distribution: Attendances in community services projected to grow by 3% annually. Attendances in acute hospitals projected to grow by 1.9% annually.
Total consultant demand	133 WTE consultants nationally across all public ophthalmology services; acute and community settings.
Community settings	Approx. 33 WTE Medical Ophthalmologists in community settings
Acute hospitals	Approx. 100 WTE consultants in acute hospitals. 77 WTE Ophthalmic Surgeons supported by 20-23 WTE Medical Ophthalmologists linked with acute hubs.
Consultant demand (public + private)	55.6 WTE in Medical Ophthalmology 77 WTE in Ophthalmic surgery

6. Recommendations To Meet Consultant Demand

Achieving the required consultant workforces across Medical and Surgical Ophthalmology by 2040 will require increased intake in the specialty training across both specialties. Additionally, there will be a requirement in the short term to recruit consultants from outside of the domestic training pipeline. This will serve to offset a number of anticipated age-related retirements in the immediate term and serve to expand the workforce while the training pipeline is increasing in capacity. The recommendations around training intake and additional recruitment are summarised Table 17 and Table 18, respectively.

6.1 Training Intake Recommendations

Training intake values for 2024 shown in Table 17 are actual recorded training numbers and are included as reference values. Training intake values from 2025 onwards are recommendations to meet consultant demand. While the principal focus of this exercise is to recommend intake into HMT and HST, it will be necessary to increase intake into BMT/BST to provide a steady supply of eligible candidates to ensure that intake to the higher programmes is consistently met. Note that some year-to-year deviations from the values outlined here may occur due to factors such as availability of eligible candidates, but the overall trend will remain largely unchanged.

Table 17: Recommended Intake to Ophthalmology specialty training.

Training Stage	2024*	2025	2026	2027	2028	2029	2030
BMT/BST	10	10	12	14	16	16	16
HMT	2	2	4	4	4	4	5
HST	5	7	7	8	8	8	8

*Intake for 2024 are actual values for the training year 2024-2025. 2025 onwards are recommended numbers.

6.2 Additional Recruitment Recommendations

To bridge the gap between consultant supply and demand in the short term, it will be necessary to recruit consultants from outside the domestic training pipeline. It will be necessary to recruit approx. 12 such consultants to Medical Ophthalmology and 17 to Ophthalmic Surgery. Table 18 summarises an annual recruitment profile for such consultants, with actual numbers of newly appointed consultants for 2023 and 2024 who trained outside Ireland included for context. The inclusion of this data serves to demonstrate the scale of recruitment required in the short term to replace anticipated retirements. The additional recruitments required in Medical Ophthalmology are primarily to replace retiring COPs (many of whom are currently working past the assumed age of retirement) in the immediate term while the HMT programme gradually increases in output. In the latter portion of the projection period, consultant demand is serviced sustainably through the domestic training programmes. This short-term additional recruitment will also serve to fill consultant posts which are currently vacant, as outlined in Table 4. Practical considerations such as availability of suitable candidates and the pace of recruitment process may have an impact on the number of consultants who can be recruited in a given year. Nonetheless, over the course of the projection period the target workforce will ultimately be met.

Table 18: Additional recruitment external to thedomestic training pipeline.

Specialty	2023	2024	2025	2026	2027	2028	2029	2030
Medical Ophthalmology	4	0	3	3	3	2	1	0
Ophthalmic Surgery	0	1	2	5	5	5	4	0

Values for 2023 and 2024 are actual numbers of consultants recruited from outside the training programme. See main text. Values for 2025 onwards are recommended numbers of consultants to be recruited who trained outside of Ireland.

6.3 Detailed Supply Summaries

Detailed supply scenarios to align with the training intake and recruitment roadmaps outlined above are summarised in Table 19 and Table 20 below. The total recruitment is split according to the requirements for replacing projected age-related retirements and requirements for service expansion. Additionally, the projected entrants to the workforce are separated according to the number of Irish-trained CSCSTs and those who trained elsewhere. Should the annual intake Year 1 trainees or number of consultants appointed to posts differ from the profile outlined here, the annual total consultant workforce will be correspondingly affected. Nonetheless, provided overall training and recruitment numbers are achieved over the duration of the projection period, workforce targets will ultimately be met.

Table 19: Detailed supply summary for Medical Ophthalmology.

	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040
Consultant Supply (WTE) (@ year-end)	45.5	45.5	47.3	51.2	52.5	52.9	53.9	55.8	57.8	60.0	62.0	63.9	65.9	67.2	69.1	70.9	71.9
Replacement posts (WTE) (Retirements & Exits)		3.9	4.0	4.1	2.7	2.7	2.7	1.9	1.9	1.8	1.8	1.8	1.8	2.5	1.9	1.9	2.9
New Posts (WTE) (Service Expansion)		0.0	1.0	3.0	0.4	0.0	0.1	1.0	1.1	1.2	2.0	2.0	2.0	1.3	1.9	1.9	0.9
Total recruitment (WTE)		3.9	5.0	7.1	3.0	2.2	2.8	2.9	3.0	3.0	3.8	3.8	3.8	3.8	3.8	3.8	3.8
Irish CSCST Graduates (WTE)		1.5	2.5	4.6	1.3	1.4	2.8	2.9	3.0	3.0	3.8	3.8	3.8	3.8	3.8	3.8	3.8
Additional Overseas Recruitment (WTE)		2.4	2.5	2.5	1.7	0.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Percent female		59.6%	62.3%	62.2%	63.9%	64.6%	65.1%	65.5%	66.0%	65.6%	64.9%	64.1%	63.5%	62.9%	62.7%	62.6%	62.3%
Estimated Headcount (HC)		55	57	61	61	61	61	62	63	65	67	69	71	72	74	76	77

Table 20: Detailed supply summary for Ophthalmic Surgery.

	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040
Consultant Supply (WTE) (@ year-end)	81.5	82.3	84.0	87.8	91.5	94.6	95.0	96.1	97.1	98.7	100.3	101.9	103.5	105.8	107.8	109.9	111.9
Replacement posts (WTE) (Retirements & Exits)		6.5	2.1	2.1	2.2	2.5	2.5	2.5	3.3	3.3	3.3	3.2	3.2	3.2	3.5	3.5	3.6
New Posts (WTE) (Service Expansion)		0.8	2.2	4.4	4.3	3.8	1.2	1.8	1.7	2.4	2.4	2.4	2.4	2.3	2.0	2.0	2.0
Total recruitment (WTE)		7.3	4.3	6.6	6.5	6.3	3.7	4.3	5.0	5.7	5.7	5.6	5.6	5.6	5.6	5.6	5.6
Irish CSCST Graduates		4.6	0.8	3.0	3.0	3.7	3.7	4.3	5.0	5.7	5.7	5.6	5.6	5.6	5.6	5.6	5.6
Additional Overseas Recruitment		2.7	3.6	3.5	3.5	2.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Percent female		36.1%	36.5%	37.3%	37.9%	37.9%	37.9%	37.2%	37.1%	37.0%	37.0%	37.4%	38.3%	38.8%	39.2%	39.5%	39.8%
Estimated Headcount (HC)		93	95	100	105	109	111	113	115	118	121	124	126	129	132	134	137

6.4 Trainee/Trainer Ratios

An important consideration in expansion of the Ophthalmology training programmes is the availability of sufficient consultants to acts as trainers. Table 21 summarises the projected number of trainees and consultants across Medical and Surgical Ophthalmology on an annual basis, with corresponding trainee/consultant ratios. For the purposes of this calculation, only consultants in HSE-funded services are considered as trainers. As the intake into the various training programmes increases, the corresponding number of trainees per consultant increases slightly before returning to initial levels as the consultant workforce expands. COPs participate in training in the ICO but do not typically act in a direct supervisory role for trainees. This cohort are projected to retire and be replaced by Consultant Medical Ophthalmologists in the immediate future, thus ensuring that an appropriate number of trainers are available.

Table 21: Annual summary of total trainees and public consultants in post across Medical and Surgical Ophthalmology.

Training Stage	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040
Total BMT/ BST	32	36	38	42	42	42	42	42	42	42	42	42	42	42	42	42	42
Total HMT	9	4	6	8	8	8	9	10	10	10	10	10	10	10	10	10	10
Total HST	18	21	25	28	31	32	32	32	32	32	32	32	32	32	32	32	32
Total Trainees	59	61	69	78	81	82	83	84	84	84	84	84	84	84	84	84	84
HMT per Medical Consultant (WTE)	0.23	0.11	0.16	0.20	0.19	0.19	0.21	0.23	0.22	0.21	0.21	0.20	0.19	0.19	0.18	0.18	0.18
HST per Surgical Consultant (WTE)	0.32	0.34	0.4	0.42	0.45	0.45	0.45	0.44	0.44	0.43	0.42	0.42	0.41	0.40	0.39	0.38	0.38
Overall Trainee per Consultant (WTE)	0.62	0.63	0.68	0.72	0.73	0.73	0.73	0.72	0.71	0.69	0.68	0.66	0.65	0.63	0.62	0.60	0.59

6.5 Geographic Distribution of Consultant Workforce

Drawing on available data and expert stakeholder input, the proposed distribution of the consultant workforce in 2040 across is summarised in Table 22. The workforce demand for Consultants in Medical Ophthalmology is allocated across the Health Regions to facilitate the replacement of the outgoing COP workforce, establishing PECTs in community care facilities, and supporting ophthalmology services in regional and supra-regional acute hubs. Community services are linked to specific surgical units. The Ophthalmic Surgeon workforce is based in surgical units in acute hospitals. The HSE Dublin and Midlands and HSE Dublin and South East regions are jointly considered for the purposes of assigning the Ophthalmology workforce, due to the national tertiary referral status of the RVEEH and Waterford UH covering parts of both Health Regions. A more detailed roadmap of the regional workforce throughout the projection period is presented in Appendix 2.

Table 22: Proposed geographic breakdown of consultant workforce in 2040.

Health Region	Workforce (WTE)	Population Ratio (WTE/100k)	Workforce (WTE)	Population Ratio (WTE/100k)
	Medical		Surgical	
HSE Dublin & Northeast	10.7	0.76	16.1	1.14
HSE Dublin & Midlands*	19.3	0.78	30	1.21
HSE Dublin & Southeast*				
HSE Southwest	8.6	1.00	11.8	1.39
HSE Midwest	6.4	1.36	6.4	1.36
HSE West & Northwest	10.7	1.26	12.8	1.5
HSE Subtotal	**55.6**	**0.92**	**77**	**1.27**
Private	16.5		35	
Total	**72.1**	**1.19**	**112**	**1.85**

*The workforce of Dublin & Midlands and Dublin & Southeast are considered together due to the surgical unit of the RVEEH for South Dublin covering the midlands and Waterford UH covering parts of both Health Regions. This combined workforce also includes that allocated to CHI.

7. Conclusions and Recommendations

- Medical Ophthalmology and Ophthalmic Surgical are intertwined specialties, both requiring expansion in the coming years owing to population growth and demographic ageing, proposed service reconfiguration, and waiting list management. The supply and demand estimates for future consultant workforce outlined in this report are informed by current data and discussions with stakeholders including the NCPO and the ICO. Given ongoing service and workforce developments across the public health system, growing population need and global challenges in medical workforce recruitment, and uncertainty in available data sources, it will be important to review these estimates of projected supply and demand within five years to ensure they continue to accurately reflect actual supply and demand.

- The estimated requirement for the public consultant workforce is 133 WTE to meet demand by 2040 across both specialties of Ophthalmology to provide care in community and acute clinical settings in accordance with the MoC. With anticipated private sector capacity of 51.5 WTE, the total Ophthalmology consultant workforce would increase to 184.1 WTE overall.

- These estimates reflect a scenario where the current COP positions (n=33) are replaced by Consultants in Medical Ophthalmology as the COP workforce retires. However, increases in the workforce cannot be achieved quickly.

- To meet demand for consultants in 2040, the training programmes in Ophthalmology should increase annual intake as follows:

    - BMT/BST intake should increase to an average of 16 per annum.
    - HMT intake should increase to a steady rate of 5 trainees per annum.
    - HST intake should increase to a steady rate of 8 trainees per annum.

- In addition to increased training intake, it will be necessary to recruit consultants in the immediate term to replace anticipated retirements and satisfy service expansion demands. Medical Ophthalmology requires approx. 12 consultants, while Ophthalmic Surgery requires approx. 17 such consultants be appointed in the coming years.

- Ophthalmology services are well established nationally and include coverage in the two major trauma centres as well as two national referral hospitals covering adult and paediatric services. As the integrated eye care teams are established, it is anticipated that they will alleviate pressure on acute services and waiting lists by addressing both new and review appointments.

- Recruitment and retention are identified challenges across the health service and Ophthalmology is no exception. The PECT requires additional essential eye care specialists outside the scope of this report.

- Whilst the increased capacity to tackle the ~70% of chronic care in the community is welcomed, 30% of cases are complex and require acute surgical care, resulting in review appointments. Thus, due to the two specialties being intertwined, demand in one often exacerbates demand for the other.

Appendix 1. Location of Ophthalmology Services 2024

Table 23 below outlines the profile of the workforce across Ophthalmology services as of the end of 2024 by HSE Health Region, with WTE commitments summarised by clinical setting (community/ acute) and specialty (Medical/Surgical Ophthalmology).

Table 23: Location of HSE-funded Services in Ophthalmology (WTE) by specialty and Health Region, December 2024. [5, 6]

Health Region	Clinical Setting	Medical Ophthalmology			Ophthalmic Surgery[2]	Total
		Consultant in Medical Ophthalmology	Community Ophthalmic Physician	Medical Ophthalmology Subtotal	Consultant Ophthalmic Surgeon	Total
HSE Dublin & North East	Acute	1.9	3.1	4.9	11.1	**21.6**
	Community	2.5	3	5.5		
HSE Dublin & Midlands[1]	Acute	0.4	3.3	3.7	16.5	**21**
	Community	0.8		0.8		
HSE Dublin & South East	Acute		4.3	4	8.1	**15.8**
	Community	0.4	3	3.4		
HSE South West	Acute	3		3	7	**12**
	Community		2	2		
HSE Midwest	Acute				4	**5**
	Community		1	1		
HSE West & North West	Acute	0.2	2	2.2	9.5	**19.9**
	Community	4.6	3.6	8.6		
Total		**13.8**	**25.3**	**39.1**	**56.2**	**95.3**

1: The total workforce in Dublin & Midlands include those consultants working in CHI.
2: Ophthalmic Surgeons have a small commitment to academic institutions (0.7 WTE nationally), which has not been summarised separately in this table.

Appendix 2. Regional Workforce Roadmap

A proposed regional roadmap for workforce expansion to 2040 is outlined in Table 24 below. This is aligned with the national workforce supply modelling in Table 19 and Table 20 the requirements to roll out the MoC for Ophthalmology. This will inform regional recruitment in accordance with the regional organisation structure introduced as part of the HSE Health Regions. [12] Note that rate of expansion is not anticipated to be uniform across all health regions throughout the projection period, reflecting the priorities involved in establishing equitable services aligned with the MoC across the country. Furthermore, the profile of the regional workforce in Medical Ophthalmology over 2024-2040 as shown in Table 24 does not account for changing configuration of the consultant workforce across community and acute settings within a given Health Region. The implementation of the MoC in the coming years is a matter for the NCPO and the specifics may evolve over time, resulting in some variation from the timelines and regional distribution outlined here.

Table 24: Regional workforce roadmap for HSE-funded services in Ophthalmology to 2040.

Health Region	Medical Ophthalmology (WTE)			Ophthalmic Surgery (WTE)		
	2024*	**2030**	**2040**	**2024**	**2030**	**2040**
HSE Dublin & North East	10.5	10.6	10.7	11.1	12.8	16.1
HSE Dublin & Midlands**	11.5	13.2	19.3	24.6	25.0	30
HSE Dublin & South East**						
HSE South West	5	5.9	8.5	7	9.4	11.8
HSE Midwest	1	4.4	6.4	4	5.1	6.4
HSE West & North West	10.8	10.8	10.8	9.5	10.2	12.8
Total	**38.8**	**43.9**	**55.6**	**56.2**	**62.1**	**77**

2030 and 2040 regional workforce distribution matches supply modelling and is aligned with implementation of the MoC for Ophthalmology.
**Baseline 2024 Medical Ophthalmology includes Consultant Medical Ophthalmologists and COPs.*
***The workforce of Dublin & Midlands and Dublin & Southeast are considered together due to the surgical unit of the RVEEH for South Dublin covering the midlands and Waterford UH covering parts of both Health Regions. This combined workforce also includes that allocated to CHI.*

Appendix 3. Royal Victoria Eye & Ear Hospital Waiting Lists

Outpatient waiting lists for the RVEEH for March of each year from 2014-2024 are visualised in Figure 4, with fill colour indicating the duration of time spent on these waiting lists. Note that data collection and reporting for 2023 was impacted by the HSE cyber-attack which took place in May 2022, highlighting some limitations with waiting list data. Nonetheless, full reporting had resumed by 2024.

Prior to the establishment of the HSE Health Regions, the RVEE was linked with CHO 7, where the PECT was piloted and expanded between 2020-2022, in accordance the MoC for Ophthalmology, as discussed in Section 3.3. This service delivery model is designed to optimise the care pathway among acute and community patients. The data shown here illustrates the impact on acute hospital outpatients following the establishment of the MoC structures in linked community settings, with attendances for glaucoma, cataract, medical retina, and paediatric ophthalmology cases routed through the community services in CHO 7 and integrated referral pathways established between CHO 7 and affiliated acute services, including the RVEEH. This data indicates that the waiting times for outpatients in the RVEE reduced dramatically in the short time since the development of the PECT in CHO 7. There were a peak of >7,000 outpatients on waiting lists for more than 18 months in 2021, and only 23% of patients waiting 6 months or less. By 2024, the number waiting more than 18 months had reduced to <2,000 and 48% of total patients were waiting 6 months or less.

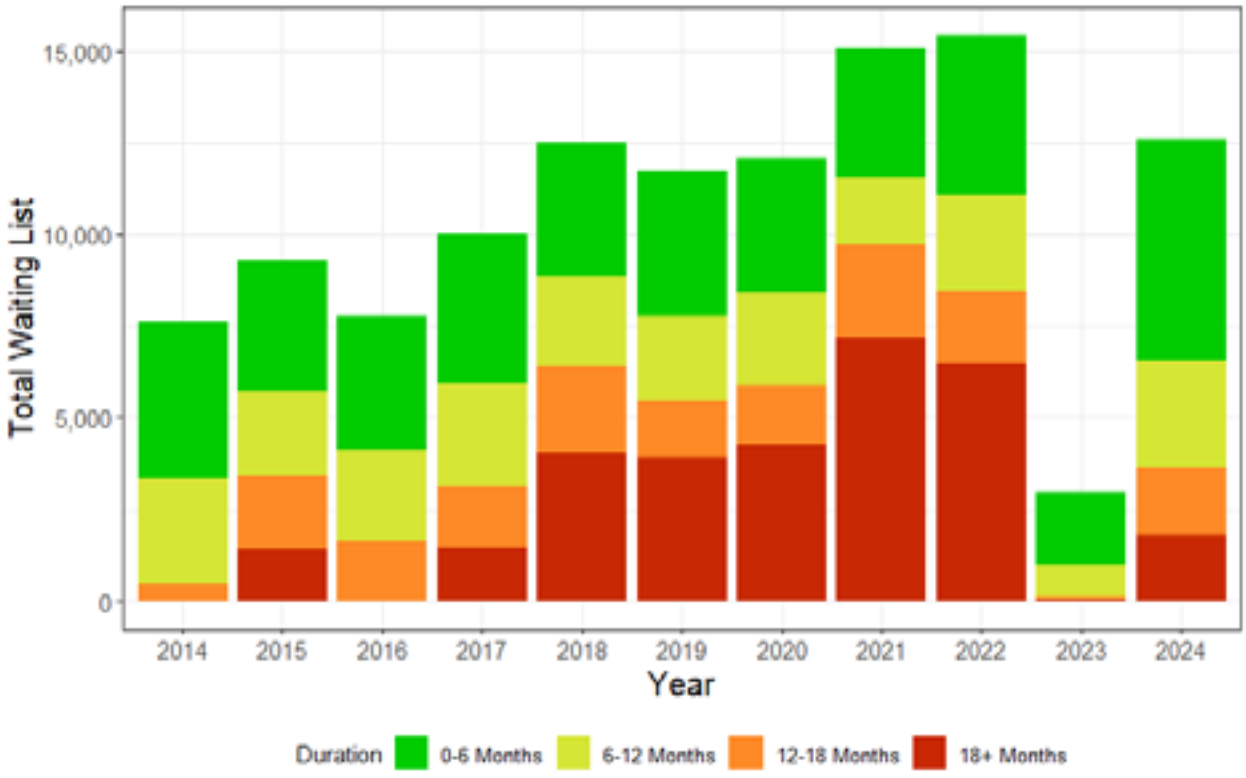

Figure 4: Outpatient waiting list numbers for the RVEE in March of each year 2014-2024. Fill colour indicates waiting duration. Data for 2023 is likely impacted by the HSE cyber-attack in April 2022. [17]

Appendix 4. Development of Medical Ophthalmology Specialists

The community service in Ophthalmology has been provided by the COP since the 1980s. The role was reviewed in the late 1990s when it was agreed that the role would be entitled to a CSCST and registration on the Medical Register for Specialist Training depending on training and experience. [46]

In early 2017 both the Primary Care Eye Services Review Group (PCESRG) Report and the MoC for Ophthalmology were published [8, 24]. The reviews called for the establishment of a PECT in each CHO. The PCESRG noted that the team should be led by a COP and include various other eye care professionals, such as optometrists and orthoptists, while the MoC indicated that a Medical Ophthalmologist should serve as the lead clinician. The PCESRG also specifically notes that "the grading of posts may be modified as implementation progresses and the detail of staff roles are further agreed" (Section 6.5, note 5, page 90). Following the publication of the PCESRG, the Irish Medical Organisation (IMO) initiated contact with the HSE to discuss the creation of a new contract and salary for the proposed change in role and responsibility of the COP.

In July of 2018, the National Medical Ophthalmology programme was initiated, which comprises of three core training years followed by a MRCSI qualification and two years of subspecialty training. Thus, the common training pathway previously available as Medical and Surgical Ophthalmology was replaced, requiring students to decide between Medical and Surgical Ophthalmology specialty at the beginning of their training.

In March of 2019, the IMO and HSE agreed to a review of the COP post and commissioned a review published by Conal Devine and Associates in February 2020. [46] While the review was in progress, the IMO and HSE continued to negotiate and by October 2019 they came to an agreement: the HSE established a designated 'Medical Ophthalmologist' role. An associated job description tied to consultant contract (2008) Type B was agreed, and three posts were advertised in the autumn of 2019. A job description for the 'Medical Ophthalmologist' grade including reporting responsibility to a Consultant Medical Ophthalmologist was also agreed, as well as a job description for the COP who was not eligible for a consultant post. The parallel development of these roles (COP/Medical Ophthalmologist and Consultant Medical Ophthalmologist) was a source of discussion and clarification during the review, as well as the HSE announcement in 2019 to restructure nine CHO and seven hospital groups into six Integrated Service Areas.

As the PCESRG review report made its recommendations based on the current CHO structure, the review report followed suit and did the same. The review recommends:

- An enhanced 'Medical Ophthalmologist' role and illustrates competencies and recommended salary scale. This role would be an option for current COP employees who matched the criteria.

- Posts where the specialist wished to remain in a COP contract, the position would be red circled as such and advertised and filled according to the Medical Ophthalmologist role when vacant.

- A clear career pathway for NCHDs in training, or current Medical Ophthalmologists to progress, should they wish to, to a Consultant Medical Ophthalmologist role.

In July 2020, the IMO issued a notice to its members that the HSE would contact all COPs with the aim of determining individuals' preferences for having their post assessed for potentail transfer to a 'Medical Ophthalmologist' contract. It's important to note that the 'Medical Ophthalmologist' post

would be a new post with a different skill set required and would in some cases require additional training to achieve the requisite skills and competencies. In April 2021, the IMO reported ongoing efforts to negotiate the implementation of the Devine report with HSE and the Department of Health (DoH).

The public service agreement 'Building Momentum - A New Public Service Agreement 2021-2022' was published in December 2020. The IMO adopted the view that the employer was in breach of pay adjustments for Area Medical Officers, COPs, Specialist Occupational Health Physicians, and Sexual Assault Treatment Unit doctors. In May 2022, the IMO approached the HSE and DoH to address the outstanding pay adjustments for these roles as well as the implementation of the Devine report. Progress was made throughout the year, but later ceased, and sectorial bargaining was initiated by the IMO as a means of dispute resolution. In early 2023, the matter was heard by the Workplace Relations Commission and was referred in February 2023 to the Labour Court. In October that same year the Labour Court recommended the proposals as accepted by the IMO, Department of Health and the HSE regarding COPs be implemented without further delay, as provided for in the Sectoral Bargaining clauses of Building Momentum. [47]

Glossary

AMD	Age-Related Macular Degeneration
BIU	Business Intelligence Unit
BMT	Basic Training in Medical Ophthalmology
BST	Basic Training in Surgical Ophthalmology
CHI	Children's Health Ireland
CHO	Community Health Organisation
COP	Community Ophthalmic Physician
CSCST	Certificate of Satisfactory Completion of Specialist Training
CSO	Central Statistics Office Ireland
CUH	Cork University Hospital
DIME	Doctors Integrated Management E-System
DR	Diabetic Retinopathy
EWTD	European Working Time Directive 2003/88/EC
HIPE	Hospital In-Patient Enquiry System
HMT	Higher Specialist Training in Medical Ophthalmology
HSE	Health Service Executive
HST	Higher Specialist Training in Surgical Ophthalmology
ICO	Irish College of Ophthalmology
IHA	Integrated Healthcare Area
IMC	Medical Council of Ireland
IMO	Irish Medical Organisation
MDT	Multi-Disciplinary Team
MMUH	Mater Misericordiae University Hospital
MoC	Model of Care
MRCSI	Membership of the Royal College of Surgeons in Ireland
NCHD	Non-Consultant Hospital Doctor
NCPO	National Clinical Programme for Ophthalmology
NDTP	National Doctors Training & Planning Unit of the HSE
NTPF	National Treatment Purchase Fund
NTSD	Non-Training Scheme Doctors
PCESRG	Primary Care Eye Services Review Group
PECT	Primary Eye Care Team
POCC	Public-Only Consultant Contract
RCOphth	Royal College of Ophthalmologists
RCSI	Royal College of Surgeons in Ireland
ROP	Retinopathy of Prematurity
RVEEH	Royal Victoria Eye and Ear Hospital
SIVUH	South Infirmary Victoria University Hospital
WTE	Whole Time Equivalent

References

[1] Irish College of Ophthalmologists, 2025, https://www.eyedoctors.ie/.

[2] Health Service Executive, *National Clinical Programme for Ophthalmology,* 2025, https://www.hse.ie/eng/about/who/cspd/ncps/ophthalmology/.

[3] Health Service Executive, *National Doctors Training & Planning (NDTP),* 2025, https://www.hse.ie/doctors.

[4] Irish College of Ophthalmologists, *Ophthalmology Specialty Training Programmes,* 2025, https://www.eyedoctors.ie/trainees/.

[5] Health Service Executive, *Doctors Integrated Management E-system (DIME)*, Dublin, 2024, https://www.hse.ie/eng/staff/leadership-education-development/met/database/.

[6] Health Service Executive, *Strategic Workforce Reporting*, 2024, https://www.hse.ie/eng/staff/resources/our-workforce/workforce-reporting/.

[7] Medical Council of Ireland, Dublin, 2024.

[8] Health Service Executive, *National Clinical Programme for Ophthalmology - Model of Eye Care*, Dublin, 2017, https://www.hse.ie/eng/about/who/cspd/ncps/ophthalmology/moc/.

[9] Trinity College Dublin, *Centre for Health Policy and Management,* 2025, https://www.tcd.ie/medicine/health-policy-and-management/overview/.

[10] Oireachtas Éireann, *Medical Practitioners Act*, Dublin, 2007, https://www.irishstatutebook.ie/eli/2007/act/25/section/47/enacted/en/html#sec47.

[11] Department of Health, *Committee on the Future of Healthcare - Sláintecare Report*, Dubln, https://www.oireachtas.ie/en/committees/32/future-of-healthcare/.

[12] Department of Health, *Organisational Reform: HSE Health Regions*, Dublin, 2023, https://www.gov.ie/en/publication/4eda4-slaintecare-regional-health-areas-rhas/#hse-health-regions-implementation-plan.

[13] World Health Organization, *WHO Global Code of Practice on the International Recruitment of Health Personnel*, Geneva, 2010, https://www.who.int/publications/i/item/wha68.32.

[14] Health Service Executive, *Medical Workforce Planning Ireland: A Stepwise Approach*, Dublin, 2016, https://www.hse.ie/eng/staff/leadership-education-development/met/plan/medical-workforce-planning-ireland-a-step-wise-approach.pdf.

[15] Healthcare Pricing Office, *Hospital Inpatient Enquiry,* 2024, https://hpowp.com/hipe-home/.

[16] Health Service Executive, *Business Intelligence Unit,* 2024.

[17] Health Service Executive, *NTPF National Waiting List Data,* 2024, https://www.ntpf.ie/home/nwld.htm.

[18] National Clinical Programme for Ophthalmology, *Model of care Ophthalmology*, Dublin, 2017, https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/model-of-eye-care.pdf.

[19] Central Statistics Office, *Population and Labour Force Projections 2023-2057*, 2024, https://www.cso.ie/en/releasesandpublications/ep/p-plfp/populationandlabourforceprojections2023-2057/.

[20] Health Service Executive, *Health Atlas Ireland*, 2024, https://www.healthatlasireland.ie/.

[21] FÁS, *A quantitative tool for workforce planning in healthcare: example simulations*, Dublin, 2009, http://www.skillsireland.ie/media/egfsn090617_healthcare_report.pdf.

[22] Health Service Executive, *Medical Recruitment and Retention Report 2024*, Dublin, 2025, https://www.hse.ie/eng/staff/leadership-education-development/met/plan/.

[23] Department of Health, *Committee on the Future of Healthcare Sláintecare Report 2017*, Dublin, 2017, https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/committee_on_the_future_of_healthcare/reports/2017/2017-05-30_slaintecare-report_en.pdf.

[24] Health Service Executive, *Primary Care Eye Services Review Group Report*, Dublin, 2017, https://www.eyedoctors.ie/Health-Policy/HSE-Primary-Care-Eye-Services-Report.asp.

[25] The Economic and Social Research Institute, *Projecting the Impact of Demographic Change on the Demand for and Delivery of Health Care in Ireland*, Dublin, 2009, https://www.esri.ie/publications/projecting-the-impact-of-demographic-change-on-the-demand-for-and-delivery-of-health.

[26] *Projecting the impact of demographic change on the demand for and delivery of health care in Ireland*, Dublin, Ireland, 2009.

[27] Department of Health, *Sláintecare Action Plan 2023*, Dublin, 2023, https://www.gov.ie/en/publication/49c5c-slaintecare-action-plan-2023/.

[28] Department of Health, *Sláintecare Implementation Strategy and Action Plan 2021-2023*, Dublin, 2021, https://www.gov.ie/en/publication/6996b-slaintecare-implementation-strategy-and-action-plan-2021-2023/.

[29] Department of Health, *Waiting List Action Plan - 2024*, Dublin, 2024, https://www.gov.ie/en/publication/f4944-waiting-list-action-plan-2024/.

[30] Department of Health, *Digital for Care: A Digital Health Framework for Ireland 2024-2030*, Dublin, 2024, https://www.gov.ie/en/publication/0d21e-digital-for-care-a-digital-health-framework-for-ireland-2024-2030/.

[31] European Parliament and of the Council of the European Union, *Directive 2003/88/EC of the European Parliament and of the Council of 4 November 2003 concerning certain aspects of the organisation of working time*, 2003, https://eur-lex.europa.eu/eli/dir/2003/88/oj.

[32] Department of Health, *National Taskforce on the Non-Consultant Hospital Doctor (NCHD) Workforce: Final Recommendations Report*, Dublin, 2024, https://www.gov.ie/en/department-of-health/publications/national-taskforce-on-the-non-consultant-hospital-doctor-nchd-workforce-final-recommendations-report/.

[33] The Royal College of Ophthalmologists, *Curriculum for Ophthalmic Specialist Training*, London, 2024, https://curriculum.rcophth.ac.uk/curriculum/ost/.

[34] Royal College of Ophthalmologists, *The 2022 census of the ophthalmology consultant, trainee and SAS workforce*, 2023, https://www.rcophth.ac.uk/news-views/rcophth-census-2022-report/.

[35] The Royal College of Ophthalmologists, *Workforce Census 2018*, London, 2019.

[36] National Health Service, *NHS Workforce Statistics - December 2024*, London, 2025, https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/december-2024.

[37] Office for National Statistics, *Population estimates for the UK, England, Wales, Scotland and Northern Ireland: mid-2023*, London, 2024, https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/mid2023.

[38] National Health Service Scotland, *NHS Scotland Workforce,* 2023, https://turasdata.nes.nhs.scot/data-and-reports/official-workforce-statistics/all-official-statistics-publications/07-march-2023-workforce/dashboards/nhs-scotland-workforce/.

[39] StatsWales, *NHS Medical and Dental Staff 2024,* 2025, https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Staff/Medical-and-Dental-Staff.

[40] Australian Bureau of Statistics, *Population clock and pyramid,* 2023, https://www.abs.gov.au/statistics/people/population/population-clock-pyramid.

[41] Department of Health and Aged Care, *National Health Workforce Dataset,* 2025, https://hwd.health.gov.au/datatool/.

[42] Stats NZ Tatauranga Aotearoa, *2023 Census*, Wellington, 2024, https://www.stats.govt.nz/2023-census/.

[43] Medical Council of New Zealand, *The New Zealand Medical Workforce in 2024*, Wellington, 2025, https://www.mcnz.org.nz/about-us/our-data/.

[44] Canadian Institute for Health Information, *The state of the health workforce in Canada, 2023*, Ottowa, 2024, https://www.cihi.ca/en/health-workforce-in-canada-overview.

[45] Irish College of Ophthalmologists, *IECT Meeting April,* 2023, https://vimeo.com/showcase/10128708.

[46] Irish Medical Organisation, *Independent Review of Community Ophthalmic Physician Salary, Terms and Conditions*, Dublin, 2020, https://www.imo.ie/i-am-a/armycopother/imo-update-copmedical-oph/.

[47] The Labour Court, *Labour Court Recommendation 22841,* 2023, https://www.workplacerelations.ie/en/cases/2023/november/lcr22841.html.

NATIONAL DOCTORS TRAINING & PLANNING

doctors@hse.ie

hse.ie/doctors

/company/national-doctors-training-planning/

@ndtp_hse

@ndtp_hse