Department of Health
An Roinn Sláinte
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DEPARTMENT OF HEALTH
NORTHERN IRELAND EVIDENCE

THE REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION

January 2023

Contents

Section 1 - 50TH Report – Observations and Recommendations

The Department of Health welcomed the recommendations and observations from the Report.

The then Minister for Health recommended the acceptance of the recommendations in full in July 2022. But unfortunately due to the collapse of the Executive the pay award could not be approved and implemented at that time as there was no agreed Executive budget or pay policy in place. At the end of November 2022 the Secretary of State for Northern Ireland issued a Written Ministerial Statement on the Budget which set the context for pay and meant that the 22/23 pay award of 4.5% (plus arrears) will be paid to the relevant staff groups prior to the end of the 2022/23 financial year. While an earlier implementation would be preferred, the system of government in Northern Ireland, which requires Executive approval for additional funding requirements, and Department of Finance approval for pay remits, impacts greatly on the Department's timescales.

Section Two – General Economic Context for Northern Ireland

2.1 Economic Overview

As a small open economy, Northern Ireland (NI) is particularly vulnerable to national and international conditions outside of its control. The NI economy is in the midst of the worst cost of living crisis seen in decades, alongside recovering and rebuilding from the severity of the Covid-19 pandemic.

The cost-of-living crisis is having a profound impact on households and families, who are facing significantly higher day to day costs on essential items such as food and energy; where CPI inflation stood at 10.7%[1] in November 2022. Although the CPI rate eased from 11.1% in October 2022, the recent rates are the highest observed for over 40 years. The Bank of England expects inflation to remain elevated at over 10% in the near term[2]. At the same time however, average wage growth (which increased by 7.5% over the year to November 2022[3]) has struggled to keep pace with the sharp rises in inflation, meaning discretionary income is being eroded for many. The ASDA income tracker for example shows discretionary income contracted by 28.7%[4] in NI over the year to Q3 2022, the largest annual contraction for any region of the UK.

Looking forward, local forecasters are uncertain as to how the cost-of-living crisis is likely to unfold over the coming months, and consumer confidence is falling sharply[5]. Business confidence has also continued to fall, with predictions of further declines in activity over the year ahead[6]. In what is also a very constrained fiscal environment, there are certainly challenging times ahead for the NI economy.

2.2 Labour Market[7]

Although the suite of labour market indicators showed resilience in the aftermath of the COVID-19 pandemic, it is not yet known what the full impact of the cost-of-living crisis will be on the local labour market. Online job listings, as reported by the Department for the Economy, decreased by 28% from October to November 2022 to

[1] ONS - Consumer price inflation, UK: December 2022 (November data)
[2] Bank of England – Monetary Policy Report - November 2022
[3] NISRA NI Labour Market Report – December 2022 – HMRC PAYE statistics
[4] ASDA Income Tracker – October 2022 Report
[5] Danske Bank – Consumer Confidence Index – Q3 2022
[6] Ulster Bank PMI Report – December 2022 (November data)
[7] NISRA NI Labour Market Report – December 2022

12,800[8]; while annual confirmed redundancies of 850 (December 2021 to November 2022) were 72.3% less than in the previous 12 months.

According to the latest Ulster Bank PMI[9], employment continued to increase in November, the 21st consecutive month of growth. At the same time, businesses continue to report ongoing difficulties sourcing suitable staff within the context of a very tight labour market.

In addition, the number of people on the claimant count in November 2022 was 36,200 people or 3.8% of the workforce – an increase of 1.2% (or 400 claimants) over the month. Whilst for the period August-October 2022, the unemployment rate in NI decreased over the quarter by 0.2 percentage points (pps) and 1.2pps over the year to 2.4%[10].

Looking at the employment rate for NI for the same period, it increased by 1.7pps over the quarter and 2.9pps over the year[11] to 71.3% - the second-lowest of the twelve UK regions and 4.3pps lower than the UK average (75.6%).

NI also continues to have the highest level of economic inactivity in the UK at 26.7 % - 5.2pps higher than the UK average (21.5%). Transitioning people from inactivity to actively participate in the labour market has been a long-standing challenge for NI.

2.3 Public Expenditure

The Spending Review outcome for 2022-25 was published and the Executive had issued a draft Budget for consultation however given the COVID-19 position and the significant pressures facing the Resource Budget, a number of Departments indicated significant resource constraints that potentially may put at risk even "business as usual" activities. Following the resignation of the First Minister there was no Executive to take further decisions on the 2022-25 budget and this created additional uncertainty around both the 2022-23 budget and future years' budgets. The 2022-23 Budget was set via Written Ministerial Statement by the Secretary of State for Northern Ireland on 24 November 2022. The 2022-23 Budget provided a Resource outcome that required

[8] Department for the Economy- Online Job Posting Trends - November 2022
[9] Ulster Bank PMI Report – December 2022 (November data)
[10] Unemployment Rate: Quarterly change not statistically significant. Annual change was statistically significant.
[11] Employment Rate: Quarterly change was statistically significant. Annual change not statistically significant.

a £332 million call on the HMT reserve for 2022-23. This will require to be repaid from the 2023-34 NI spending envelope.

The outcome of these changes means that the amount available for Resource DEL allocations for 2023-24 will be some £529.5 million less than the NI DEL used for the 2022-23 Budget announcement. The Resource DEL budget outcome for 2023-24 will require departmental budgetary reductions even before taking account of inflationary pressures.

The high proportion of Government expenditure accounted for by pay means that trends in public sector pay costs have significant implications for the availability of resources to support staff and deliver public services in Northern Ireland.

2.4 The Public Sector Workforce

The public sector in NI employs 221,590 people[12] or 27.6% of all employee jobs in NI, a significantly higher share compared to 17.6%[13] for the UK as a whole – however, such comparisons should be treated with caution given the different structure and coverage of the public sector workforces. The NI figures show an increase of 2.5% (or 5,380 jobs) over the year (September 2021- Septmeber2022), although this is 2.9% (6,580 jobs) fewer NI public sector jobs than the series peak in September 2009.

2.5 Public Sector Pay

Public sector pay in Northern Ireland accounts for a significant share of the Departmental Expenditure Limit (DEL) budget. Department of Finance (DoF) estimates for the 2021-22 financial year indicate that pay costs accounted for approximately 54.2% of departmental non-ring-fenced Resource DEL.

The NI median gross full-time public sector employee earnings for April 2022[14] was £708 per week and was higher than the UK overall median at £695. Similarly public sector employee earnings were 30% higher than the median gross full-time private sector earnings (£544) – representing the smallest gap in the last 20 years. That said, private sector weekly earnings increased by 7.3% over the year, whilst public sector

[12] NISRA Northern Ireland Quarterly Employment Survey – Published December 2022 (September 2022 Data)
[13] ONS Public sector employment, UK, December 2022 (September 2022 Data)
[14] Source: NISRA Annual Survey of Hours and Earnings – October 2022

weekly earnings increased by 3.1% - with earnings falling in real terms (adjusted to take account of inflation) across all FT employees by 4.5% in NI. The data show earnings for public sector workers have not increased in real terms over the last decade. Headline comparisons of median earnings however can, to varying extents, reflect differing workforce structures and activities between the sectors (see below).

Prior to the COVID-19 pandemic, the UUEPC was commissioned (in November 2019) by the Department of Finance (DoF) to analyse recent trends in public and private sector wages in Northern Ireland. The report was published on 24th March 2020 (https://www.ulster.ac.uk/__data/assets/pdf_file/0003/542586/UUEPC-Public-and-private-sector-pay-270220-FINAL.pdf). The findings from this paper indicated that NI public sector wages were on par with other UK regions, apart from London. In contrast, NI private sector wages were the lowest in the UK. The paper also noted analysis undertaken by the Institute for Fiscal Studies (IFS) which found that headline public sector pay then remained significantly higher than private sector pay, but this differential was significantly reduced when controlled for workers characteristics such as working time, occupational structure, qualifications, and demographic factors. When taking these characteristics into account, the premium on NI public sector pay (on an hourly basis) fell from a headline differential of approximately 30% to 10% for 2016-18.

2.6 Northern Ireland Executive Pay Policy for 2022/23

The draft budget for consultation, issued in December 2021, proposed a 3-year Public Sector Pay Policy for 2022/23 onwards.

In the context of a constrained budget position, the proposed Public Sector Pay Policy for 2022-23 to 2024-25 was to be a flexible one. A flexible 3-year policy would have enabled longer-term pay awards to be negotiated, which ideally, could be used to advance reform and efficiency initiatives.

Unfortunately, the collapse of the Executive meant no agreed Executive budget or pay policy guidance could issue.

On 24th November 2022 the Secretary of State for Northern Ireland issued a Written Ministerial Statement on the Budget. This set the context for pay, ‘this budget

recognises the cost-of-living challenges that our frontline workers are facing by increasing public sector pay and ensuring the Living Wage threshold is met. I appreciate that these pay awards will not go as far as many workers would wish. Until there is the right level of income to NI Departments, this position on public sector pay is the most that can be afforded within the budget available and without cutting into important front line services.'

Following this FD 08/22 (FD (DoF) 08/22 - Pay remit approval process and guidance 2022/23 (finance-ni.gov.uk)) was issued on 8th December 2022. This noted that the approach for 2022/23 is 'that awards must be affordable in the context of each Department's Budget settlement for this year as set out in the Secretary of State for Northern Ireland's (SoSNI) 24th November 2022 Written Ministerial Statement (WMS) on the Budget, so that public sector employment and essential public services can be sustainably funded going forward. In addition, employers should also be mindful of legal entitlements of individual staff groups; have cognisance of national pay arrangements where appropriate; and the established principles in previous years' pay guidance in relation to fairness and giving due regard and consideration as to how awards can be targeted to address low pay and the payment of the Living Wage as calculated annually by the Resolution Foundation and overseen by the Living Wage Commission.'

This also notes that, 'any Pay Remit submitted to DoF for consideration must be accompanied by an assurance and confirmation from the departmental Permanent Secretary that as Accounting Officer for the Department, they are content that the pay award proposed in the remit is affordable within their Department's budget.'

2.7 Financial Position – Funds Available for 2023/24 Pay Award

As there is no NI Executive in place no Budget has been agreed for 2023/24. The Secretary of State for Northern Ireland announced a 2022/23 budget for Health of some **£7.3 billion** on 24th November 2022. While the budget did provide additional funding above our baseline this is primarily and necessarily being spent on recurrent commitments to cover historic pay awards, price inflation and to maintain Rebuild and Transformation requirements at current spending levels.

The Department had been forecasting an overspend in 2022/23, including the expected cost of the 2022/23 pay recommendations and while the budget will provide us with a fighting chance of breaking even in year, this is only because we have already taken action to bear down on costs as far as possible without impacting front line services already on the ground. It is likely that the funding provided in year will be at the expense of next year's budget.

The future funding position was already under intense pressure and it is anticipated that next year's financial position will now be even more challenging, with less money available to the NI Block than is now being spent in 2022/23.There will be no capacity to afford a pay uplift in 2023/24 in this context without implementing corresponding cuts to expenditure on services or additional funding being made available in-year, the latter then perpetuates the funding issue into the future. The Department will need to manage our ongoing response to Covid against this financial backdrop and will continue to focus on efficiency and savings measures but are likely to be faced with some difficult decisions to determine what can be funded from the allocation available. The high proportion of Health expenditure accounted for by pay (around 50%) means that trends in pay costs continue to have significant implications for spending on service delivery.

Section 3 – Policy Context

3.1 The Longer-term Direction of Travel and Aspiration for Health Services In Northern Ireland

NI has some of the longest waiting times of all the regions in the UK. In response, the Elective Care Framework (ECF) was originally published in June 2021. The Framework was developed as a strategic tool to tackle the backlog of patients waiting for assessment and treatment across Northern Ireland.

The Framework sets out a detailed plan for addressing hospital waiting lists. It covers 55 actions to reduce our waiting lists and to increase capacity across the elective care system.

The improved outcomes described in the Elective Care Framework will only be achieved with significant sustained investment to address the central issue of demand outstripping the current capacity of our system. Capacity in this context is a byword for expanding and upskilling our workforce and implementing new and flexible ways of working.

The Framework sets two five-year targets, together with an underlying ambition to increase productivity and to improve performance

Subject to a commitment from the NI Executive that the necessary backlog funding will be made available, the Department's clear aim is that, by March 2026, no-one should wait more than 52 weeks for a first outpatient appointment and inpatient/day case treatment; or, 26 weeks for a diagnostics appointment.

Subject to a commitment from the NI Executive that the necessary capacity funding will be made available, the Department's clear aim is that, by March 2026, we will have eradicated the gap between demand and capacity for elective care.

An essential prerequisite for expanding capacity and delivering the Actions of the Framework is the availability of a skilled and well-equipped workforce. Workforce reform addresses not only the numbers of available staff but all targeting skills mix and making the most effective use of available resources.

In consequence, there are 14 separate Actions contained within the ECF directed at workforce improvements. These include measures to: stabilise and expand workforce

in particular areas; ensure development of robust workforce plans; continuation of international recruitment plan; development of training facilities; enhancing roles in some specialties; more effective use of staff across different specialities; and enhancement and development of core roles to maximise the benefit of nursing to perioperative care and treatment. Progress on these actions is variable. Progress has been hampered, not only by the continuing pressures on the service, but by current uncertainty around funding.

Without an effective, well equipped, fully trained and fit for purpose workforce it is not possible to deliver the Framework. This is not just about numbers, it is about different ways of working to get the best service for patients from all available resources and having the right staff with the right skills mix, to do that.

Progress continues to be made across a range of services in a short period of time. There have been some very significant developments here, including: the establishment of megaclinics; regional planning of services; expansion of elective care centres; better use of existing resources; cross border reimbursement scheme and greater flexibility in engagement with the independent sector.

Each of these measures has the potential to reduce the number of people on HSC waiting lists and improve how services are delivered through better ways of working. It is only through a continuous and parallel focus on ensuring effective implementation of all these arrangements alongside driving efficiency and productivity that improvement will be made.

It is also clear that the ongoing pressures facing the system currently, including uncertainty around budget allocations, has the potential to further delay progress across many of these actions. In the absence of an Executive and an agreed budget, we strive to deliver high quality Health and Social Care services for the public with the resources we have available.

3.2 Workforce Strategy

The Department of Health published the comprehensive *Health and Social Care Workforce Strategy 2026: Delivering for Our People* in May 2018, with an aim 'by 2026, we meet our workforce needs and the needs of our workforce'.

The Strategy, which covers the period 2018 to 2026 was developed by the Department's Workforce Policy Directorate through detailed engagement with health and social care colleagues across the HSC and independent, voluntary and community sector healthcare providers and trade unions.

The Workforce Strategy Second Action Plan was published on 15th June 2022. This identifies an ambitious range of strategic actions for progression over the next three years (2022/23 to 2024/25) The action plan contains a range of actions relating to pre- and post-registration training, attraction, recruitment and retention across all healthcare professions including doctors and dentists. Implementation structures have been developed to progress delivering over the life of the action plan including the establishment of a forum for Chief Professional Officers to support collaborative working and sharing of best practice in the implementation of these identified actions.

Lead organisations have been assigned to each action to facilitate implementation. Workforce Policy Directorate are in the latter stages of engagement with each of these lead organisations to establish the implementation structures for delivery.

3.3 Workforce Planning

Effective workforce planning is complex and challenging but is essential in order to contribute to ensuring services across Northern Ireland are both sustainable and delivered to the appropriate standard. The range of challenges faced by the health and social care system has reinforced the need to ensure that the workforce is balanced correctly in terms of numbers and skills. At its simplest, effective workforce planning ensures a workforce of the right size, with the right skills, organised in the right way, delivering services to provide the best possible care for service users within available resources.

The Department has accepted the Skills Six Step Methodology as the tool for all workforce planning. All workforce reviews consider the purpose, scope and ownership of the plan at the outset. It identifies the Goals/benefits of change. Collates the current baseline data, highlights drivers for change e.g. MDT, work life balance/family friendly policies etc. Agrees working models going forward and scenario sets against the working models for future planning. Analysis is carried out of the activities undertaken, types of roles and numbers required, productivity and new ways of working. This help

identify skill sets and levels of interventions for service users and facilitates new ways of working. An example being the introduction of Pharmacists/Nurse Practitioners in GP practices to facilitate multi-disciplinary working.

In order to project the future workforce requirements analysis of the demographics alongside the supply chain is examined in great detail thus informing the need for commissioned numbers of undergraduates for the medical and dental school and speciality post graduate training. Managing the changes required is complex and challenging and often has significant financial implications. This is a key challenge: it is much easier to assess workforce need than to implement the measures (including recruitment and training) necessary to ensure workforce supply. For each workforce review, an implementation plan is developed to oversee and monitor the implementation of the review recommendations. Our recruitment processes endeavour to reflect the growing diversity of Northern Ireland society, including increasing participation of women and minority ethnic communities in the workforce.

The Minister works alongside his Executive colleagues to secure the funding required to implement the recommendations of workforce reviews.

A rolling programme of medical and speciality workforce reviews is ongoing, including a Workforce Review for Dental Services. Governance arrangements are in place to ensure that all workforce reviews are considered by the Department and seek the approval of Minister thus ensuring a robust process in place.

The Department has moved away from sole reliance on uni-professional workforce reviews. Increasingly, in future, a Programme of Care approach will be taken to workforce planning (for example, in areas such as Diabetes, cancer and Stroke) which endeavours to map the patient journey through the service. This will significantly progress multi-disciplinary working and will be used to build optimum workforce model for future services across health and social care as envisaged by the Workforce Strategy – see attached agreed work programme for strategic workforce reviews for medical specialties (under review) and the overall programme of ongoing and planned strategic workforce reviews.

The Workforce Strategy Second Action Plan also contains a range of actions aimed at addressing attraction, recruitment and retention across all professions including

medical and dentistry which have been allocated to the respective Chief Professional Officers to progress alongside HSC employers. A forum has been established for Chief Professional Officers to support collaborative working and sharing of best practice and experience across professions in these areas with view to developing profession specific initiatives to attract and retain staff.

The Department published in January 2019, the Medical Student Places Review, which sought to inform how the supply of Northern Ireland medical students should grow to meet the anticipated need for the medical component of healthcare over the next 10 years. The commencement of the new Graduate Entry Medical School at Ulster University in 2019 met 70% of the recommended growth in medical student places. Further consideration is being given as to how the remaining 30% of assessed need may best be met in a value for money and affordable way. This will include measures beyond simply growing overall NI medical student places; for example, increasing retention in the local medical education and training system or encouraging a greater proportion of NI domiciled medical graduates to progress the next stages of their medical careers here.

Then Medical Student Places Review advocated a mid-term review after 5 years (effectively 2023/24). This need has probably been attenuated by the legacy of the Covid 19 pandemic. The Department is now considering how / when such a review might be progressed.

3.4 Legislative Framework

3.4.1 Mental Capacity Act

Northern Ireland is the only part of the United Kingdom where practitioners are potentially subject to individual criminal liability for any service user deprived of their liberty who is not detained in accordance with the requirements of the MCA or other relevant statute. This is causing significant anxiety amongst various staff groups as the Trusts endeavour to work through the implementation across all relevant settings.

3.4.2 Duty of Candour

Trusts fully support the recommendation for a statutory organisational Duty of Candour within Justice O'Hara's report and welcome that this will bring Northern Ireland into line with health and social care organisations in other nations.

However whilst there is full commitment to achievement of an open and just culture it is not felt that the policy options for the individual Duty of Candour would achieve this aim. The proposed individual criminal sanctions for breach are causing anxiety amongst all staff groups and Trusts are concerned about the impact that this might have on the attractiveness of careers in health and social care in the longer term and the impact it could also have on retention.

Section Four – General Medical Practitioners

4.1 Introduction

GP-led care plays a key role in Northern Ireland's health and social care system. General Practice is the first point of contact for the majority of patients and has an important role in promoting health and well-being as well as providing treatment, care and support to patients.

GP-led services in Northern Ireland continue to face a number of challenges. These include the increasing demand for GP services (including out of hours services) and a growing and ageing population.

Mid-year Population Estimates published by the Northern Ireland Statistics and Research Agency (NISRA) in June 2021[15], showed that the population in Northern Ireland continues to age. In the year to mid-2020, the number of people aged 65 or more increased by 1.7 per cent to 319,900 people. By mid-2020, one in six people in Northern Ireland were aged 65 and over. The proportion of the population aged 65 or more has increased from 13.0 per cent in mid-1995 to 16.9 per cent in mid-2020.

In contrast, the proportion of the population aged 0 to 15 years decreased from 25.3 per cent in mid-1995 to 20.9 per cent in mid-2020. The population aged 85 and over increased by 1.9 per cent (from 38,700 to 39,500) between mid-2019 and mid-2020, representing 2.1 per cent of the population.

Interim Population Projections published by the Northern Ireland Statistics and Research Agency in January 2022[16] indicated that the population aged 65 and over is projected to increase by 50.5 per cent by mid-2045, with almost 1 in 4 people in Northern Ireland projected to be aged 65 and over.

In addition, the prevalence of long-term conditions is also increasing and as the population ages, people are living with an increasing number of co-morbidities. First results from the Northern Ireland Health Survey 2021/22[17], indicate that around two-

[15] Statistical Bulletin - 2019 Mid-year Population Estimates for Northern Ireland (nisra.gov.uk) NI Statistics and Research Agency published June 2021.

[16] 2020-based Interim Population Projections for Northern Ireland | Northern Ireland Statistics and Research Agency (nisra.gov.uk)

[17] Health survey Northern Ireland: first results 2021/22 | Department of Health (health-ni.gov.uk)

fifths of respondents (40%) reported a physical or mental health condition or illness expected to last 12 months or more. This increased with age from a quarter (25%) of those aged 16-24 to two-thirds (66%) of those aged 75 and over. Almost a third (30%) of respondents reported having a long-standing illness that reduces their ability to carry out day-to-day activities (similar to 2020/21 level).

There are also challenges in public sector finances in Northern Ireland which have been exacerbated by the significant and ongoing impact of the COVID-19 pandemic, as well as the political context where there has been no functioning Executive in Northern Ireland since February 2022 and no Ministers in post since 28 October.

A further significant change during the past year has been the closure of the Health and Social Care Board (HSCB) with effect from 1 April 2022. As a result, HSCB functions were transferred into the Department of Health to become the Strategic Planning and Performance Group (SPPG). An effect of this is that GMS contracts which were held by the HSCB are now held by the Department.

4.2 Response to Recommendations Of The 50th DDRB Report – July 2022

In 2021-22, in response to the recommendations in the report of the Review Body on Doctors' and Dentists' Remuneration (DDRB), a 3.0% uplift was applied for GP pay and practice staff expenses and a 2.4% uplift for other expenses. This represents an investment of £7.114million.

The 50th report of the Review Body on Doctors' and Dentists' Remuneration (published in July 2022) recommended a 4.5% GMS uplift. When the DDRB report was published, the then Health Minister indicated that he accepted the recommendations made by the pay review bodies but that he was unable to move forward without an agreed budget. Implementation of the pay uplift will follow receipt of the necessary public sector pay remit and any necessary approvals from the Department of Finance. Whilst it has not yet been possible to make payments at this time, the Department is committed to moving ahead with this as quickly as possible.

4.3 General Practice and Covid-19

The COVID-19 pandemic presented unprecedented challenges across health and social care in Northern Ireland. General Practice reacted quickly to this and moved to put in place working arrangements to respond to the pandemic and protect the public and staff.

The Department of Health, in partnership with the then Health and Social Care Board[18], took a number of actions to support General Practice during the course of the pandemic. To facilitate COVID workload, in March 2020, some elements of the GMS contract were reduced/suspended to reduce demands on practices. Practices were also supported through additional funding for telephony, IT support for remote working, Mask F.I.T Testing and guidance on infection prevention/control. Financial support was provided for the disposal of clinical waste, additional infection control procedures, and measures to support patient flow in the practice. Education and guidance were provided via webinars and an information sharing and educational website.

All of these actions helped to support GPs to maintain the majority of their services despite the impact of COVID-19.

4.4 Primary Care Covid-19 Centres

An early step in the COVID response was the establishment of COVID Centres in April 2020. This was a GP-led innovation that was an urgent and immediate response to the challenges posed by the COVID-19 pandemic. The Centres ensured that primary care services were able to be maintained, by enabling patients with COVID-19 symptoms to be treated separately from other patients, thereby safeguarding practices and patients. In total, 10 primary care COVID-19 Centres were in place across Northern Ireland with the final two sites closing at the end of March 2022

GP leaders from across Northern Ireland played a key role in the design, implementation and ongoing management of the Centres with the BMA, NI General Practitioners' Committee and the Royal College of General Practitioners (NI)

[18] WEF 1 April 2022, the Health and Social Care Board (HSCB) was dissolved and its functions were transferred into the Department of Health (to become the Strategic Planning and Performance Group (SPPG). GMS contracts which were held with the HSCB are now held by the Department.

represented on the Project Board that oversaw them. Staffing of the Centres was managed locally by GP Federations, in line with demand.

As noted, COVID Centres have now been stood down and GP Practices are providing their own services for both COVID positive and suspected COVID positive patients, either face to face or remotely, supported by updated Public Health Agency Infection Prevention and Control guidance.

As we have emerged from the pandemic, the Quality and Outcomes Framework has also been phased in over the 2022/23 year. To support this, and in recognition of pressures facing practices, modifications were made to lower the achievement thresholds for some indicators and extend the window on others. The 2022/23 QOF guidelines include indicators that are intended to improve services for patients and quality improvement.

4.5 Challenges Facing General Practice

4.5.1 GP Practices

There were 319 GP Practices in Northern Ireland at 31 March 2022. This is a reduction of 2 practices since 2021 and a reduction of 31 (8.9%) since 2014. The number of GP Practices per 100,000 population (15.8 at March 2022)[19] has decreased across all GP Federations since 2017 with a reduction of 8.7% at Northern Ireland level during this time.

Currently, 16 practices are judged as at risk of closure. Rural areas have signalled particular difficulty and some GP practices have handed their contracts back to the Department of Health[20]. The potential of practice closures represents a significant risk to the wider Health and Social Care system given the key role of primary care as a cornerstone of healthcare provision.

GP practices across Northern Ireland remained open throughout the pandemic to provide services, including face-to-face appointments for patients where appropriate.

[19]Family Practitioner Services Statistics for Northern Ireland 2020/21 (Business Services Organisation June 2022) FPS - General Medical Statistics Annual Report (hscni.net)

[20] WEF 1 April 2022, the Health and Social Care Board (HSCB) was dissolved and its functions were transferred into the Department of Health (to become the Strategic Planning and Performance Group (SPPG)). GMS contracts which were held with the HSCB are now held by the Department.

GP services were already experiencing sustained, high levels of demand before the COVID-19 pandemic. Figures in 2019 indicated patient contacts were almost 15 million per year up from an estimated 12.7 million in 2014.

The increased demand on General Practice has led to practices adapting how services are delivered. The General Practice telephone first consultations allow patients to seek timely medical advice from their GP for both routine and urgent problems. This approach helps GPs to appropriately manage, treat and support the large number of people who seek clinical support and advice. It has allowed practices to maintain the majority of GP services and has enabled GPs to appropriately manage, treat and support a greater number of people than would otherwise have been the case. With the level of pressure on the service continuing to rise, telephone consultation is part of a wider strategic move to make better use of technology to deliver services, in the face of increasing demand on primary care services.

Primary Care's response to the COVID-19 pandemic has accelerated the implementation of new and innovative ways of working, including making greater use of technology and telephony. One of the challenges is to make sure the potential of technology is being maximised to deliver the best possible quality of service to patients.

Whilst practice teams are averaging over 200,000 patient consultations per week, with a mix of face to face and remote consultations (on a ratio of approximately 50:50), there is a sense of public frustration about access to services. Patients feel they struggle to contact their practice, have to make multiple call backs, or find that no appointments remain available when they get through.

To address these concerns, the Department has established a Working Group to explore issues around access to GP services, including demand for services, limitations of infrastructure, and staffing and resourcing issues. Membership includes GPs, those with lived experience and Departmental officials.

Initial assessment has highlighted that call demand is not being met, not all calls answered require a GP appointment, and whilst there may be shorter waits for appointments, difficulties getting through to practices have led to an increase in hostile behaviours towards General Practice staff.

In moving this work forward, the next steps will include further analysis needed to better understand the nature of demand both met and unmet, how to optimise telephony provision, how to improve patient experience and how to work with patients to manage demand.

4.5.2 GP Workforce

The Business Services Organisation (BSO) Family Practitioner Services Information Unit publishes an annual report on GP statistical information. The report provides high level summary information in relation to General Practitioners, GP Practices and registered patients including registration activity in Northern Ireland. The most recent report was published in June 2022[21].

The report shows there were 1,419 active GPs (headcount) across Northern Ireland at 31 March 2022[22]. This is a 0.6% increase in the number of GPs since 2021 and a 20.3% increase since 2014. It should be noted that not all GPs work full-time hours so changes in headcount may not reflect the change in full time equivalent GPs. Quality-assured information on GP working patterns is not currently unavailable for active GPs. However, unpublished management information, sourced from the Northern Ireland Medical and Dental Training Agency (NIMDTA)[23] which provides an analysis of GP appraisals, suggests that the increase in headcount has not been replicated in terms of whole-time equivalent (WTE) GPs and the total number of GMS sessions provided compared to 2014 has decreased. It should be noted that this is based on self-reported working patterns by GPs collected as part of the appraisal process. Where GPs have not completed all sections of the application form this data is incomplete.

GP appraisal was disrupted due to the COVID pandemic with full restart from 1 April 2021. NIMDTA information based on 2021/22 GP appraisals (again self-reported) indicates that just over 67% of the 1,639 GPs appraising in Northern Ireland were GP Principals (1,107), this is a fall from the figure of 70% that had been largely unchanged

[21] FPS - General Medical Statistics Annual Report (hscni.net)
[22] GP figures include Principal, Salaried and Retainer GPs but exclude Locums
[23] The Northern Ireland Medical and Dental Training Agency (NIMDTA) is commissioned to deliver appraisal to General Practitioners in Northern Ireland

since 2014/15 (when 1,083 out of 1,517 were GP Principals). Approximately 13% of appraising GPs in 2021/22 were salaried (208). This compares to approximately 5% in 2014/15 (76 salaried). There were 272 sessional GPs undertaking appraisal in 2021/22 (approximately 16%) compared to 318 in 2014/15 (21%).

In terms of the gender and age profile of GPs, the Business Services Organisation's report[24] notes that 59% are female and 41% are male. Since 2014, there has generally been a gradual downward trend in the number of male GPs with a steeper increase in the number of female GPs. The number of male GPs is 9.5% lower than in 2014, while the number of female GPs has increased by more than half (55.9%) during the same period.

In terms of age profile, the BSO report notes that the average age of Northern Ireland GPs is 45 years. 21% of the GP workforce on average are in the 55 years+ age group and therefore may be likely to retire within 5 years. Over half of GPs in the 55-59 and 60+ age-groups are male, while there are more female GPs in the younger age groups. Almost two fifths of female GPs (37.4%) are in the 25-39 age band compared to just under a quarter of male GPs (23.8%).

Conversely only 3.5% of female GPs are aged 60 and over compared to 13.7% of male GPs. The 25-39 age band is made up of 30.8% male and 69.2% female GPs.

4.5.3 Patient Registrations

BSO statistics also show that at 31 March 2022, there were just over 2,022,000 individuals on the index of patients registered with a GP Practice. compared to 2,007,000 patients registered with a GP practice in 2021 – an increase of 0.75%.

During 2021/2022, GP Practices in Northern Ireland registered 91,000 patients. This comprised 52,000 new patients (first time registrations in NI) and 39,000 patients transferring from another Northern Ireland GP Practice. Whilst there was a significant drop observed during 2020/2021, in large part driven by the impact of Covid-19 on registration services and population movement, the number of registrations processed

[24] Information taken from Family Practitioner Services Statistics for Northern Ireland 2020/21 (Business Services Organisation June 2022 - FPS - General Medical Statistics Annual Report (hscni.net)

in 2021/2022 is more in line with 2019/2020 (91,000) when there were no atypical external factors influencing the processing of registrations

The average practice list size in Northern Ireland at Quarter 2, 2022/23 was 6,360 compared to 6,318 at Quarter 2 in 2021/22[25].

The BSO General Medical Services Report 2021/22 shows that at 31 March 2022 there were 15.8 GP practices per 100,000 registered patients in Northern Ireland. There were 70.2 GPs per 100,000 registered patients - GP Practices will vary in size in terms of the number of GPs attached to each. At Northern Ireland level, 97.4% of the population live within five miles of a GP Practice whilst at least 86.8% of the population live within a three mile radius of a GP Practice.

There have been a number of practice amalgamations over recent years following the retirement of several single-handed practitioners. The move towards fewer but larger practices is likely to continue, particularly in rural areas where there are more single-handed practices and the challenge of recruiting GPs is more acute.

4.6 Responding to The Challenges

4.6.1 Primary Care Multi-disciplinary Teams (MDTs)

In October 2016, the Department published '*Health and Wellbeing 2026 – Delivering Together* - a 10-year approach to transforming health and social care published in response to the '*Systems, not structures: changing health and social care'* report produced by an Expert Panel led by Professor Rafael Bengoa, which was tasked with considering the best configuration of Health and Social Care Services in Northern Ireland.
https://www.health-ni.gov.uk/sites/default/files/publications/health/health-and-wellbeing-2026-delivering-together.pdf

Delivering Together identified primary care as one of the four key building blocks for healthcare in Northern Ireland. It set out a vision for an enhanced primary care service that requires moving away from a system based on GPs working largely independently with some input from other disciplines to a genuinely multi-disciplinary way of working. Key to this is the introduction of Multi-disciplinary teams, expanding the range of

[25] https://hscbusiness.hscni.net/pdf/FPS%20GMS%20Quarterly%20Series%2022-23%20Q22.xlsx

professions available in GP practices and facilitating access to a wider range of services closer to home.

The Primary Care Multi-disciplinary Teams (MDT) model has introduced new mental health, physiotherapy and social work roles into General Practice, complemented by increased levels of district nursing and health visiting staff. It aims to move from a system of treating illness to holistically supporting positive physical and mental health, and social wellbeing.

The composition of the MDT model was designed with stakeholders from across the wider HSC and informed by an analysis of demand in GP practices and a review of best practice in the UK and Ireland, and further afield.

The MDT model is currently in place or in development in 7 of the 17 GP Federation areas in Northern Ireland. As of October 2022, there were 341.26 whole time equivalent frontline staff working across 101 GP practices.

In total, over 644,000 citizens now have access to physiotherapy, social work or mental health services in their local GP practice and benefit from enhanced levels of district nursing and health visiting. 170,000 of those have access to all 4 MDT roles in their local GP practice.

In keeping with the model and vision set out in Delivering Together, multi-disciplinary teams (MDTs) are playing a key role in improving population health and wellbeing, as well as developing care pathways and services to meet population needs. MDTs focus on providing access to diagnosis, support, appropriate care and where appropriate interventions at the earliest stage, in primary care settings, and improving the overall health and well-being of the local population. Services users have quick and convenient access to highly qualified and experienced professionals, providing the right support in the right place at the earliest possible stage.

Since its launch in 2018, the Department has allocated over £79m to the MDT Programme, with £23.5m invested in the MDT Programme in 2022/23. Since 2018, a £11.9m capital investment in MDT roll out areas has also been made to facilitate MDTs and other primary care services through internal refurbishment and extensions.

In March 2022, the then Health Minister published a ‘road map’ for the full roll-out of the model across all GP Federation areas. The MDT model has played a key role in

stabilising and strengthening primary care services to ensure they can continue to provide high quality care to our people, now and into the future.

Whilst it has not been possible to expand the roll-out of the MDT model as quickly as desired due to the absence of a budget, it was directed that an additional £1.5m be invested in 2022/23. The speed at which MDTs can be rolled out will depend on the availability of appropriate funding (including capital funding) and suitably qualified and experienced staff.

MDTs are not the only way in which we are seeking to support primary care and build GP teams. All practices now have access to the services of a General Practice Pharmacist, working with existing practice staff to ensure effective medicines management for patients and optimising medicines use.

To complement the MDT model, the Department of Health has also been investing in Advanced Nurse Practitioners (ANPs). The introduction of this highly skilled role has released GP time, increased overall capacity in General Practice and contributed to improved patient outcomes.

Investment has also enabled additional nursing staff to be recruited into the General Practice workforce to enhance capacity to meet the needs of patients in the community setting. Subject to available funding, it is the Department's intention to continue to increase the nursing workforce which helps release GP time, increase overall capacity in general practice and contribute to improved patient outcomes.

As services are rebuilt following the pandemic, it is recognised that care will need to be delivered differently, with greater collaboration across care sectors to better deliver services for patients.

4.6.2 Support for General Practice

The Department is very conscious of the pressures on General Practice across Northern Ireland and continues to work with GP representatives to address the challenges facing the service. With the issue of practice closure being prominent over recent months, the Department has sought to work with practices to support them to remain open, and to fund new GPs to take on the contracts where practices do hand back their contracts.

The Department recognises that GP Practices are coming under increasing pressure, especially in areas where recruitment has traditionally been challenging. In response to this, the Department has developed a package to support primary care and to target support to where it is most needed, to help vulnerable practices and avert the risk of practices returning their contracts.

In September 2022, the then Health Minister announced a £5.5m package of support measures. This includes funding for targeted help to parts of the service that are most under pressure by investing £1m in a new *Attract, Recruit, Retain* scheme to help attract GPs in hard-to-recruit areas. Although the details of the scheme are still being finalised, additional funding will be made available to GP practices in Northern Ireland to encourage recruitment of GPs in their area, however practices will have to satisfy a range of criteria in order to be eligible for any payment.

In order to qualify for an *Attract Recruit Retain* payment, a doctor would be required to take up a post as a GP Partner or Salaried GP where there is evidence, specific to the local area, of significant difficulties around the recruitment and retention of GPs within that practice.

The package also included an additional £680k for the GP Crisis Response Team. The Crisis Support Team supports 'at risk' GP Practices to develop and implement an effective Practice Recovery Plan to ensure delivery of their contractual obligations to their registered patients. This support includes advice on practice management issues and GP clinical cover. The CRT incorporates:

- expert General Practice managerial support at short notice for practices at high risk or in a crisis;
- improved access to clinical GP cover at short notice for practices at high risk or in a crisis.

As part of winter planning, a Northern Ireland Local Enhanced Service has also been put in place making £3m of funding of available to GP practices to develop plans to manage increases in demand and provide additional clinical patient care to help with winter pressures. Under this initiative, this funding will be distributed to all practices on a capitation basis where they have contracted to provide the enhanced service.

The package also includes up to £800k additional investment in Out of Hours services; and a commitment to progress work to address the issue of GP Indemnity.

4.6.3 GP Training

Strengthening the GP workforce is a critical part of helping to address the pressures in GP services. The Department has continued to invest in our GP workforce and has increased the number of GP trainees by over 70% from 2015 levels.

A Task and Finish Group of officials from the Department, the then Health and Social Care Board, and the Northern Ireland Medical and Dental Training Agency was established in 2021 to consider evidence relating to the number of GPs in Northern Ireland, trends in the GP workforce, and the demand for GP services in order to assess the need for additional GP training posts over the next 5 years.

Whilst this work is still progressing, in March 2022, the then Health Minister directed that for 2022/23, the number of training places be increased by an additional 10 places, bringing the total number of GP training places to an all-time high of 121 places for the August 2022 intake. The number of GPs in training August 2021-August 2022 was 377.

4.6.4 GP Federations

There are 17 GP Federations in Northern Ireland established as not-for-profit community interest companies. Federations have a role to play in helping to address capacity and workload issues. They also provide additional resilience to GP practices and have been instrumental in the development of elective services in primary care. Federations also provide opportunity for the pooling of resources and skills to increase the range and quality of services offered by GPs and to support smaller and/ or rural practices.

4.6.5 GP Induction and Refresher Scheme

Arrangements are in place which aim to encourage and support GPs to return to or remain in general practice. The GP Induction and Refresher Scheme (I&R Scheme) provides an opportunity for GPs who have previously been on the General Medical Council's GP Register and on a UK Performer's List, to safely return to general practice following a career break or time spent working abroad.

It also ensures that GPs who have qualified outside the UK or who have not practised in the UK for more than 2 years, can be appropriately inducted and have the necessary skills for the provision of General Medical Services.

In October 2022, the former Minister of Health announced further steps to support GP recruitment and retention by streamlining the processes for GPs qualified in the Republic of Ireland, Australia, Canada, New Zealand and South Africa to take up roles in Northern Ireland.

Under the new process, GPs who qualified in the Republic of Ireland in the last two years will be exempt from sitting the MCQ knowledge test. This is a pragmatic step that recognises the similarities between GP training in Northern Ireland and the Republic of Ireland and removes an unnecessary barrier to qualified GPs practising in Northern Ireland.

Northern Ireland will also be participating in a new UK-wide scheme where GPs who have trained in Australia, Canada, New Zealand and South Africa are able to use a streamlined process - the Certificate of Eligibility for GP Registration (CEGPR SP) - if certain conditions around their training and professional experience have been met. The new scheme will make it easier for GPs who have trained in these countries to work in Northern Ireland, potentially making it easier for doctors who left Northern Ireland to undergo GP training abroad to now return home.

4.6.6 GP Retainer Scheme

The GP Retainer Scheme commenced in June 2018 and is designed to assist in the retention of GPs in primary care in Northern Ireland. It provides stable work in a practice and includes some out-of-hours sessions with a mandatory funded CPD programme to assist with appraisal and revalidation.

4.6.7 NIMDTA GP Mentoring Scheme

A GP mentoring pilot scheme administered by NIMDTA ran between 2018 and 2021 has continued as the GP mentoring scheme. The scheme provides mentoring support to GPs on the Northern Ireland performers list who have completed their GP training. All of the mentors in the scheme are GPs with a broad range of experience.

To avail of the GP mentoring programme, GPs must have completed their GP training, gained their CCT and be on the Northern Ireland Primary Medical Performers List.

GPs who wish to avail of mentoring can have access to up to five mentoring sessions free of charge with sessions generally held on a monthly basis. Web based resources are also available to help mentors offer guidance and support.

4.7 Investment in General Practice in Northern Ireland

In October 2022, the Department of Health published a report on investment in general practice and the reimbursement for drugs dispensed in general practices in Northern Ireland from 2016/17 to 2021/22.

Investment in general practice report, Northern Ireland 2017/18 to 2021/22 | Department of Health (health-ni.gov.uk)

The report draws on information from the financial reporting system of the Health and Social Care Board[26] and other published data on reimbursement and remuneration for dispensing activity. The data also contain some financial flows which do not reach GP Practices, but contribute towards overall General Medical Services investment. These include payments for Information Management and Technology and out-of-hours services.

Previously country level information from all 4 UK countries was available via the annual *Investment in General Practice* report produced by NHS Digital, which provided UK-level figures and was intended to facilitate comparison of spending across the countries. However, changes to General Practice contractual arrangements in each country over recent years mean the payment categories and spending practices are no longer comparable. As a result, it was agreed that from 2020, each country will produce and publish its own report. It should be noted therefore that figures between individual country reports will not be comparable due to the differing contractual arrangements which have led to the UK-level report being discontinued.

In 2021/22, the total investment in general practice, including the reimbursement of drugs dispensed in general practice, was £377,874million. This represents an increase

[26] From 1 April 2022, the Health and Social Care Board was dissolved and its function transferred into the Department of Health

in the total investment in GP practices of 2.85 percent in Northern Ireland. In real terms this equates to an increase of 3.07 per cent.

It is not known at this stage what Departmental budget allocations will be for 2022/23. However, the health and social care system faces significant challenges and demand on funding and the requirement to live within constrained budget means that difficult decisions are having to be made on how best to use the resources available.

4.8 Trends in The Earnings And Expenses Of GMPs

The *GP Earnings and Expenses Estimates 2020/21*, published by NHS Digital[27] on 1 September 2022 provides a range of information on both a UK and country specific basis.

Northern Ireland Contractor and Salaried GPs were analysed separately for the first time in 2015/16. In previous years, salaried GPs could not be identified separately and Northern Ireland Contractor GP figures may therefore have contained a small number of salaried GPs. In light of this, NHS Digital have advised that direct comparison with previous years before this change is not applicable. The tables below are based on data from the NHS Digital GP Earnings and Expenses Estimates 2020/21.

Table A below highlights the changes in gross earnings, expenses and income before tax for the average GMP in NI during the period 2012/13 to 2020/21. In 2020/21, income before tax for the average GMP was £112,000 . This is 12.5% higher than the 2019/20 figure of £99,600. The average gross earnings for contractor GPs in Northern Ireland in 2020/21 was £246,800 228,000 compared to £228,000 in 2019/20, an increase of 8.2per cent.

The average total expenses for contractor GPs in Northern Ireland in 2020/21 was £134,800 compared to £128,400 in 2019/20, an increase of 5 per cent.

[27] GP Earnings and Expenses Estimates, 2020/21 - NHS Digital

Table A - Gross Earnings, Expenses and Income before Tax for the Average GMS Contractor GPs in NI - 2012/13 to 2020/21 (cash terms) – All practice types

	Income Before Tax	Expenses	Gross Earnings
2012/13	£92,200	£99,000	£191,100
2013/14	£96,500	£103,300	£199,800
2014/15	£93,100[1]	£102,300	£195,400[1]
2015/16	£92,000	£103,500	£195,600
2016/17	£90,500	£104,700	£195,200
2017/18	£93,400	£112,400	£205,700
2018/19	£92,300	£116,200	£208,400
2019/20	£99,600	£128,400	£228,000
2020/21	£112,000	£134,800	£246,800

[1] 2014/15 Income before tax and gross earnings figures were re-calculated since the publication of the 2014/15 GP Earnings and Expenses Report in September 2016 using updated adjustments for superannuation contributions

Table B sets out the ratio of gross earnings to practice expenses for GMS contractor GPs in Northern Ireland. The expenses to earnings ratio decreased by 1.7 percentage points from 2019/20 to 2020/21.

Table B - Trends in the Ratio of Gross Earnings to Expenses for NI GMS Contractor GPs 2012/13 to 2020/21 – All practice types

Financial year	Gross Earnings	Expenses	Expenses as a % of Gross Earnings
2012/13	£191,100	£99,000	51.8%
2013/14	£199,800	£103,300	51.7%
2014/15	£195,400[1]	£102,300	52.4%
2015/16	£195,600	£103,500	52.9%

2016/17	£195,200	£104,700	53.6%
2017/18	£205,700	£112,400	54.6%
2018/19	£208,400	£116,200	55.7%
2019/20	£228.000	£128,400	56.3%
2020/21	£246,800	£134,800	54.6%

[1] 2014/15 Income before tax and gross earnings figures for Northern Ireland were re-calculated since the publication of the 2014/15 GP Earnings and Expenses Report in September 2016 using updated adjustments for superannuation contributions

In Northern Ireland, the average income before tax for Salaried GPs in 2020/21 was £61,300 compared to £56,500 in 2019/20 – an increase of 8.5%. Salaried GPs could not be identified in the NI data prior to 2015/16.

4.9 GP Indemnity

GPs in Northern Ireland are ordinarily indemnified by one of three Medical Defence Organisations operating in Northern Ireland. Work is ongoing to review arrangements for the provision of indemnity cover for GPs in Northern Ireland. A range of options are under consideration from the status quo to alternatives such as the state backed systems adopted in England and Wales.

4.10 GMP Pension Arrangements

The HSC Pension Scheme forms an important part of the overall GMP reward package.

Until 31 March 2022, GMPs had a Career Average Pension arrangement in which their pensionable earnings were re-valued by an annual up-rating factor. This process was known as “dynamisation”. From April 2008 the HSC Pension Scheme re-valued GMP earnings for pension purposes by the Retail Prices Index plus 1.5%.

A new pension scheme came into operation from 1 April 2015, and following a Court of Appeal ruling in 2018, all members of the HSC Pension Scheme (including GMPs) were moved in to the new 2015 scheme with effect from 1 April 2022. GPs now earn pension on an annual basis at 1/54th of their pensionable earnings, with the annual pension earned each year revalued by CPI plus 1.5%.

Pension benefits earned up to 31 March 2022 remain payable under the previous (pre-2015) scheme rules.

Many GPs have been impacted by the HMRC taxation rules on pensions which can impact on the number of sessions GPs are working, particularly in GP Out of Hours, as the increased tax liability is a significant disincentive to working additional sessions.

The Department of Health has set up a working group (consisting of representatives from the Department, HSC employers and the BMA) to consider possible options to address this issue.

The Department is currently working on guidance to allow HSC employers to introduce flexibilities such as employer contribution recycling. Employer contribution recycling is where, when a member drops out of the scheme, either entirely or for one contract, they receive the money which their employer would have spent on employer pension contributions as income.

Concerns have also been raised for GPs and other HSC Pension Scheme members, this year, regarding the interaction of significantly increased CPI and the operation of the system meant to strip purely inflation driven defined benefit pension growth out of the calculation for Annual Allowance (AA) charges. The members most likely to be affected are those with high pensions or salaries.

HMT have proposed the best solution is to move scheme revaluation dates to ensure that the same rate is used for opening and closing values. For this to happen DoF would be required to amend their revaluation order, this is currently being considered.

Section Five – General Dental Practitioners

5.1 Introduction

The current General Dental Services (GDS) arrangements in Northern Ireland were introduced in 1990 and pay General Dental Practitioners (GDPs) using a blended system of remuneration. Items of Service (IoS) payments account for approximately 60% of GDP income; 20% comes from capitation payments and the remaining 20% comes from allowances, reimbursements, initiatives and other payments. The Statement of Dental Remuneration (SDR) is issued on an annual basis by the Department of Health (DoH) setting out the Dentist Fee levels for more than four hundred Items of Service payments and the conditions that claims must fulfill in order to be valid.

The primary mechanism by which DDRB recommendations are reflected in GDS payments is in respect of the uplift to the items of service fee levels in the SDR. The level or rate of payment for other GDS payments is determined separately.

5.2 GDS Pay Uplift for 2022/23

Significant challenges in public sector finances in Northern Ireland remain and have been exacerbated by the significant and ongoing impact of the COVID-19 pandemic and the political context. Before leaving his post, the previous Minister accepted and approved a 4.5% net increase to fees and allowances, in line with DDRB recommendations, and a 4.5% increase in dental expenses, with an overall recurring increased investment in GDS of approximately £4.84m per annum.

The previous Minister also announced, in October 2022, a 25% enhancement to the fees for dentures from Q4 2022/23 subject to the approval of the relevant business case. This would see an additional recurring investment of £1.2m in GDS.

In terms of the implementation of pay uplifts, we acknowledge that the time taken continues to cause practitioners concern. While we are pleased to have been able to show improvements in this area over the last three years, we know more improvement is necessary and intend to continue work to improve the turnaround time. However, in terms of the 2022/23 uplift, the political reality and budget uncertainties in Northern

Ireland significantly complicate the process. The previous Minister was unable to announce the immediate implementation of the 2022/23 pay awards, as Northern Ireland still does not have an agreed Executive Budget for 2022/23 nor an agreed public sector pay remit. Whilst elements of the pay uplift are outside the control of the Department of Health, we will do everything possible to implement as soon as possible.

5.3 COVID Response

Whilst the impact of the pandemic has significantly reduced, further financial support has continued in 2021/22 and 2022/23.

The GDS Financial Support Scheme, which supported GDPs based on previous earnings, provided activity targets were met, was replaced by the GDS Rebuilding Support Scheme (RSS) in 2022/23. Under the RSS practitioners could avail of a 25% enhancement to their Item of Service (IoS) claims each month during Q1 and Q2 of 2022/23.

In September 2022, with the impact of the pandemic significantly reduced and most restrictions removed, the justification for ongoing COVID-specific support was also reduced. However, as the impacts had not entirely receded with inefficiencies created by increased "Did Not Attends" and associated staff absences, the RSS was extended until the end of 2022/23 with a 10% enhancement on IoS payments.

5.4 General Dental Practitioners

As of 31 March 2022, there were 1,146 GDPs working in 365 practices in Northern Ireland compared with 1,108 GDP's working 5 years ago (2017) and 1,015 working 10 years ago (2012).[28] Since 2014, the number of practices has decreased by 15 (-4%), while the number of dentists has increased by 9% during this time and in March 2022 there were an average of 3.1 dentists per practice, compared with 2.8 in 2014. There are now 60 dentists per 100,000 resident population in Northern Ireland compared with 42.9[29] in England.

[28] General Dental Statistics Publication 2020-21 (hscni.net)
[29] https://files.digital.nhs.uk/02/C7E663/nhs-dent-stat-eng-21-22-anx1.xlsx (Table 8d)

Dentistry was previously a male dominated profession but that has changed rapidly in recent years. In particular, the majority of new dentists are female, with 71% of dentists aged under 35 being female while the reverse is true in the older age groups with 63% of dentists aged 50 and above being male. Naturally with this pattern, there has been a shift in the overall makeup of the workforce and since 2013, the number of female dentists has exceeded males with almost three fifths (59%) of the workforce now being female in 2022

5.5 Dental Access & Registration

The access issues which had previously been a problem in Northern Ireland over a decade ago, had been largely resolved prior to the pandemic. However the pandemic has created new access issues, with capacity in the GDS not yet up to pre-pandemic levels.

The number of patients registered with a GDP has grown to 1.289 million,[30] 67% of the total population[31] compared with 63% in 2013.[32] Children are more likely to be registered with a health service dentist than adults (72% compared to 66%). 94% of the population in Northern Ireland live within five miles of a dental practice.

	2017	2018	2019	2020	2021	2022
Number of dentists	1,108	1,137	1,139	1,147	1,142	1,146
Number of practices	376	377	376	372	368	365
Patient Registrations	1.187m	1.203m	1.213m	1.219m	1.246m	1.289m
Registration Rate	63.5%	64.0%	64.0%	64.1%	65%	67%

Table 1 – GDS supply & registrations[33]

[30] General Dental Statistics Publication 2020-21 (hscni.net)
[31] 2021 Mid-Year Population Estimates for Northern Ireland (1.91m)
[32] Northern Ireland patients are registered for 25 months
[33] General Dental Statistics Publication 2020-21 (hscni.net)

Once registered with a dentist, the patient will remain on their dental list for two years unless they visit another dentist. If they do not attend during that 25-month period, they will become deregistered.

Due to the Covid-19 pandemic, dental registrations due to end during 2020/21 and 2021/22 were extended at various points during these two years. As such any registrations due to expire at any point in the last two years have been extended. This was done to prevent large numbers of patient registrations lapsing as a result of individuals being unable to obtain a dental appointment due to the reduced capacity within GDS. As restrictions have reduced we are now in a position were a return to the normal schedule of 25 month registration periods is appropriate. To avoid the scenario where a large number of patient registrations lapse at once, the GDS regulations have been amended so that registrations are scheduled to lapse at the same rate as they would normally.

5.6 Dental Activity

Due to the rebuilding of dental services following the Covid-19 pandemic, the number of dental treatments carried out in 2021/22 increased markedly compared to 2020/21. Patients seen were up to 58% in 2021/22 of pre-pandemic figures and up to 75.1% in 2022/23 (November 2022).

5.7 General Dental Services funding - 2021/22

2021/22 was another year where the Covid-19 pandemic impacted health service dentistry. Dentists continued to face restrictions on seeing patients and incurred additional costs. Because of this, additional support payments were made to dentists in 2021/22 to support them during periods of restricted ability to practice as well as to fund additional costs incurred, for example PPE. The net cost of primary care dental services in Northern Ireland not including these additional support payments was £87 million with an additional £13.1 million in patient contribution for treatments. Both these figures are down from pre-pandemic years with the net cost of services in 2019/20 being almost £105 million and £26 million in patient charges. The additional Covid-19 payments in 2021/22 were £43.7 million, bringing the total gross cost of services in that year to £143.8 million, a 9% rise on the previous year (see Table 6.1). Excluding patient payments, the cost in 2021/22 was 5% higher than in 2020/21.

	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Total GDS Payments	£121.4m	£121.2m	£125.1m	£130.9	£131.7m	£143.8m
Patient Payments	£23.6m	£24.5m	£25.6m	£26m	£7.1m	£13.1m
COVID-19 Support Payment	N/A	N/A	N/A	N/A	£51.9m	£43.7m
Net Cost (Excluding COVID-19 support)	£97.8m	£96.7m	£99.5m	£104.9m	£72.7m	£87m

Table 2 – General Dental Services – Costs[34]

Table 3 below provides a breakdown of GDS payments in 2021/22 with Gross Fees accounting for 78% of the total.

GDS Payments	2021/22(£m)
Gross Fees (Item of Service, FSS, Continuing Care, Capitation)	101.9
Allowances (Practice & Seniority)	10.5
Expense / Reimbursements (Rates, IT, Sickness, Maternity etc)	1.9
Training & Development (Vocational Training, Trainers Grant & Trainee Salary)	2.0
Clinical Initiatives / Good Practice (Clinical Audit, QA, Hygiene)	0.9
Other Payments (Superannuation, Relief of Pain, Oral Surgery Pilot & Patient Refunds)	11.0
TOTAL	**130.6**

Table 3 – General Dental Services – Payments[35]

[34] General Dental Statistics Publication 2020-21 (hscni.net)
[35] Sum may not add to total due to rounding.

Further details on the other main items are set out below.

5.7.1 Practice Allowance Payments

The Practice Allowance was introduced in 2005 to provide support for the provision of Health Service dentistry in Northern Ireland by giving financial assistance to Health Service committed dental practices to address practice requirements in relation to the provision of high-quality premises, health and safety, staffing support, and information collection and provision, and to improve equality of access to Health Service dental care and treatment.

The spend on this allowance in 2021/22 was £10.1m. It is payable to a designated dentist at 2 different rates. A payment equal to 11% of the practice's gross Health Service earnings is made twice a year and is currently made where each dentist in a practice has:

a) at least 500 patients registered for care and treatment under capitation and continuing care arrangements. 100 of these patients must be fee paying adults (though patients who are partially exempt from paying fees are included here); and

b) average gross earnings of at least £50k per dentist.

For specialised dental practices such as orthodontic or oral surgery practices, different criteria are applied in order for these practices to be paid the allowance at the 11% rate.

If a practice does not meet these criteria, they may still receive a lower award of 4% of the practice's gross earnings. In addition, where dentists are unable to meet the criteria, for example because they work low hours, these can be waived if the dentist verifies that at least 85% of their work was conducted in the Health Service.

5.7.2 Capitation and continuing care payments

Capitation and continuing care payments are made to dentists for each patient they have registered. Under the current GDS arrangements these are calculated on the basis of five broad age bands, a weighting for those electoral wards with higher levels of decayed, missing or filled teeth and an enhanced fee for those meeting special needs criteria.

5.7.3 Reimbursement of Non-Domestic Rates

Dentists are able to seek reimbursement of non-domestic rates (Council Tax) payable on their dental practices. These non-domestic rates are reimbursed in full for practitioners who are at least 85% committed to the Health Service. Other practitioners receive an amount that is abated in line with their commitment to the Health Service, as certified by their accountant.

5.7.4 Other Payments

Dentists can also receive payment towards the cost of removal of clinical waste from their practices. These payments are made on submission of invoices to the Department and are abated on the basis of the number of patients registered with the practice.

Allowances are also available for practitioners participating in the Dental Foundation Training scheme and for undertaking clinical audit and continual professional development activities.

5.8 GDP Earnings & Expenses

The most recent Dental Earnings and Expenses Estimates 2020/21 report, published by NHS Digital, shows that the average taxable NHS and private dentistry income for Principal dentists in Northern Ireland was £122,000 in 2020/21 (a 23% increase on the previous year), whilst that for Associate dentists was £59,500 (a 4% increase on the previous year). The earnings of dentists in Northern Ireland are broadly on a par with those in Scotland, England & Wales.

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Principal	£117,600	£99,200	£116,000	£104,400	£99,200	£122,000
Associate	£54,200	£59,100	£52,300	£58,700	£57,200	£59,500

Table 4 – GDP Taxable Income

Taxable income is calculated as Gross Earnings minus Expenses. Table 5 below shows that the total expenses of Principal dentists has decreased by 9.4% since 2015/16 and decreased for Associates by 30% over the same period.

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Principal	£218,400	£215,500	£231,100	£229,700	£213,700	£197,900
Associate	£44,700	£45,700	£33,600	£39,400	£39,000	£31,300

Table 5 – GDP Expenses[36]

5.8.1 GDS Payment Analysis

In March 2019 the Health and Social Care Board (HSCB) commissioned a report as a one-off exercise to examine the trends in GDS payments from 2011/12 to 2018/19.

The report was published in February 2021 and found that between 2011/12 and 2018/19, the average total payment for GDS dentists decreased by 3%. However, there has been a decrease in health service clinical working days over the last eight years which has resulted in a 5% increase over this time from £575 to £606 per health service clinical day worked[37].

Table 6 below outlines the respective pay awards in the GDS sector in Northern Ireland over the last 5 years.

	2017/18	2018/19	2019/20	2020/21	2021/22
DDRB Recommendation	1%	2%	2.5%	2.8%	3%
GDS Uplift	1%	2%	2.5%	2.8%	3%

Table 6 – GDS Pay Uplifts[38]

5.9 Future Developments

5.9.1 Contract reform

For a number of years there has been a desire to change the GDS contract Northern Ireland to a model focused more on prevention than treatment. Indeed, this was the primary focus of the Department prior to the pandemic, which unfortunately halted efforts temporarily. In the wake of this disruption, the current focus of the Department

[36] Dental Earnings and Expenses Estimates, 2020/21 - NHS Digital
[37] GDS Payments Report.pdf (hscni.net)
[38] Review Body on Doctors' and Dentists' Remuneration on doctors' and dentists' pay in England, Wales, Scotland and Northern Ireland – reports relating to GDP Pay:2017/18 – 2021/22

has been to rebuild General Dental Services so that the immediate oral health needs of the public are met. In parallel, the GDS Contract Reform Group, established in December 2021, is exploring options to ensure that Health Service dentistry is sustainable and delivers for both patients and the profession.

5.9.2 Prior Approval Limit

The Department has also recognised the necessity to review and adjust the current Prior Approval Limits (PAL) contained within the dental regulations. Following consultation with the British Dental Association (BDA), the Department has now amended the General Dental Services Regulations (Northern Ireland) 1993 (S.R. 1993 No. 326) to move the PAL into the Statement of Dental Remuneration (SDR). This means that amendments to the PAL are now solely within the gift of the Department of Health, without requiring a change in regulations. This amendment will facilitate a proactive ability to adjust the PAL in line with the SDR that provides payment for dental services, facilitate timeous treatment and improve administrative efficiency.

Section Six - Hospital Medical and Dental Staff

6.1 Introduction

Health and Social Care across Northern Ireland, and indeed the UK, continues to face significant challenges in recruiting and retaining clinical staff. Despite constant recruitment activity, vacancy levels remain high in our Medical and Dental workforce, and there is a continued reliance on temporary staff and agency workers to support service delivery.

Trusts have advised that they are experiencing significant shortages across all specialty groupings, which generates additional pressures and workloads on wards and departments within their organisations. They have found over the years that services provided by locum doctors do not provide the same level of stability and consistency in our services and they are much more expensive than substantive staff.

Selection and recruitment material has been updated to reflect the HSC Values and Behaviours. In addition work has been on going to establish an HSC 'Branding' to make the HSC an employer of choice for potential candidates. Employing organisations have used a number of methods to attract suitable candidates, such as advertising on social media platforms, attending career fairs, promotional videos, as well as recruiting candidates through the international recruitment project.

6.1.1 Recruitment and retention challenges associated with rural location and land borders

One Trust in particular challenges are compounded by the geographical location and rurality of the Trust. The Western Trust, serves a mainly rural and dispersed population, with acute hospitals in Fermanagh, and Londonderry, both far removed from Belfast where many clinicians prefer to practice and where many students prefer to train. This results in positions becoming less attractive where exposure to larger acute service hospitals with multiple specialities on site, is often a professional preference for doctors and trainees.

The Western Trust shares a border with counties Donegal, Cavan and Monaghan in the Republic of Ireland (ROI), which adds to its recruitment challenges in filling their vacancies and competing for staff. Often the terms and conditions for health service

staff are significantly more attractive in ROI. This also increases the risk of staff leaving to work in ROI and of students choosing to take up posts in ROI following completion of their training.

Western Trust is geographically considered to be remote from Belfast for students who study in Belfast. This presents a significant challenge in terms of service provision and not all specialties will be represented at each hospital site.

6.2 Impact of Covid-19

There remains a severe impact on the medical and dental workforce following the Covid pandemic including: impact on planned (non-cancer-related) surgery due to significant workforce shortages across a number of clinical groups in ward and theatre departments; and impact on training of surgical trainees (especially Trauma and Orthopaedic Surgery) due to lack of exposure to planned / elective surgical procedures.

Whilst employers are trying to return to business as usual, the impact of Covid remains a challenge with complex patients with multiple co-morbidities who have experienced delayed access to primary care and specialist treatment throughout the pandemic. The Trust is continuing to increase the throughput of patient care, particularly outpatient care with additional outpatient clinic and continuation of virtual patient care (phone / video consultations) to address back log and to ensure patients have an initial assessment at the earliest opportunity.

The impact of Covid 19 has also had an immense effect on the health and wellbeing of Trust's medical and dental workforce and continues to be felt in the current post-covid recovery and rebuild phase. Trusts continue to work hard to collectively support its entire staff.

Although Trust's are now in the post-Covid phase, the impact of Covid still remains on our workforce, especially with staff experiencing Long Covid.

6.2.1 Effect of Long Covid

The Occupational Health Service provides Consultant clinics to specifically see staff with Covid-related issues. Staff can be diagnosed with Long Covid via this route. Additionally, the Occupational Health Manager liaises with Trusts and suitably

diagnosed staff meeting the criteria can be referred. This is a new service which is in early development and was set up late in 2021 for the referral of patients with Long Covid.

6.2.2 Doctors and Dentists in Training

Training systems have tried to reduce the impact of the pandemic by introducing online recruitment, online ARCP panels, online exams and online education and training events The temporary derogations to medical and dental education and training due to the disruption caused by the COVID-19 pandemic remains in place until September 2023.

In relation to training progression, during the COVID pandemic, the General Medical Council, the Academy of Royal Medical Colleges and the four UK Statutory Education Bodies agreed college and faculty derogations to curricula and decision aids for ARCPs. Some trainees continued to progress into the next training year while accumulating increased numbers of areas still to be completed. There were fewer Outcome 10s issued during the 2021/22 training year (COVID Outcomes 10.1 & 10.2 which can be applied in place of Outcome 2 & 3 respectively, where the acquisition of competencies/capabilities have been delayed due to COVID-19 and there are no serious concerns about the trainee. The aim is to enable trainees to progress to the next stage of their training or complete their programme where possible).

Training opportunities have decreased particularly in relation to craft specialties and outpatient clinic exposure. Use of the independent sector to rebuild service has not provided significant training capacity.

Trainees and other members of staff are increasingly reporting high levels of burnout. We would want to be able to better support trainees returning into their programme after a period of absence similar to England and have submitted a proposal for these trainees to be able to shadow on return and access more support courses in advance of starting.

Within England money was provided by the Department of Health to HEE to give to HSC Trusts to support training recovery. This has been used to provide support for trainees and trainers to enhance training after the pandemic disruption. Similar funding has not been available in NI to support retention and progression of trainees.

6.3 Workforce Data

6.3.1 Staffing Numbers

HSC Medical & Dental staff

31st March 2022	Full-Time	Part-Time		Total	
	Headcount	Headcount	WTE	Headcount	WTE
Consultant	1,666	396	262.8	2,062	1,928.8
Associate Specialist	58	34	22.7	92	80.7
Specialty Doctor / Staff Grade	344	202	128.0	546	472.0
Specialty / Specialist Registrar [2]	1,197	210	152	1,407	1,348.6
Foundation Year 1 & 2	513	13	8	526	521.4
Hospital/Medical Practitioner [1]	31	55	15	86	45.9
Dental Officer/Practitioner	38	69	40	107	77.9
Other Medical & Dental / GP Educator / Medical students (covid)	133	96	19	229	151.8
GP trainees [3]	147	66	46	213	193.4
Table Total	4,127	1,141	693.3	5,268	4,820.3

Source: Human Resource, Payroll, Travel & Subsistence system

[1] No longer includes Out of Hours GPs that are on the system purely for payment purposes.

[2] Includes locum/trust appointments for service/training on registrar pay scales.

[3] includes GP trainees working in Trusts only.

Trend of HSC Medical & Dental staff split by female and male

	Female	Male	% Female	% Male
Mar-12	1,924	1,995	49.1%	50.9%
Mar-13	1,959	2,073	48.6%	51.4%
Mar-14	2,096	2,172	49.1%	50.9%
Mar-15	2,181	2,163	50.2%	49.8%
Mar-16	2,228	2,150	50.9%	49.1%
Mar-17	2,281	2,200	50.9%	49.1%
Mar-18	2,329	2,271	50.6%	49.4%
Mar-19	2,411	2,317	51.0%	49.0%
Mar-20	2,525	2,400	51.3%	48.7%

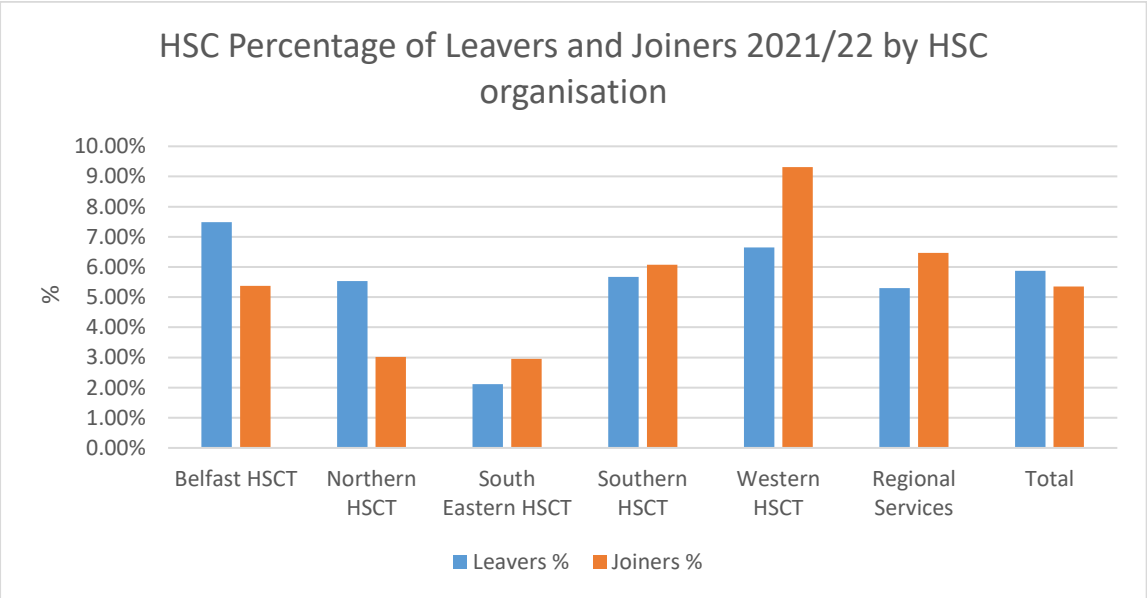
Mar-21	2,688	2,563	51.2%	48.8%
Mar-22	2,740	2,528	52.0%	48.0%

6.3.2 Vacancies Data

For overall vacancy statistics, including shortages and turnover for HSC please see Annex 1

6.3.3 Retirements and Leavers Data

6.3.3.1 Leavers & Joiners



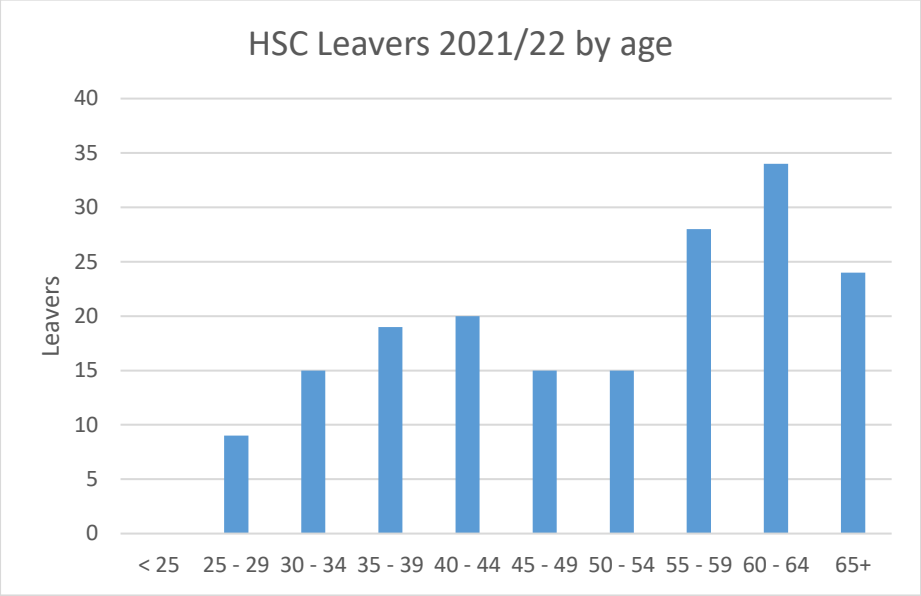
Excludes doctors in training

Includes leavers from and joiners to Health & Social Care only, will not include movements between or within organisations.

Medical & dental staff have experienced an increased turnover this year, similar to the Trust as a whole.

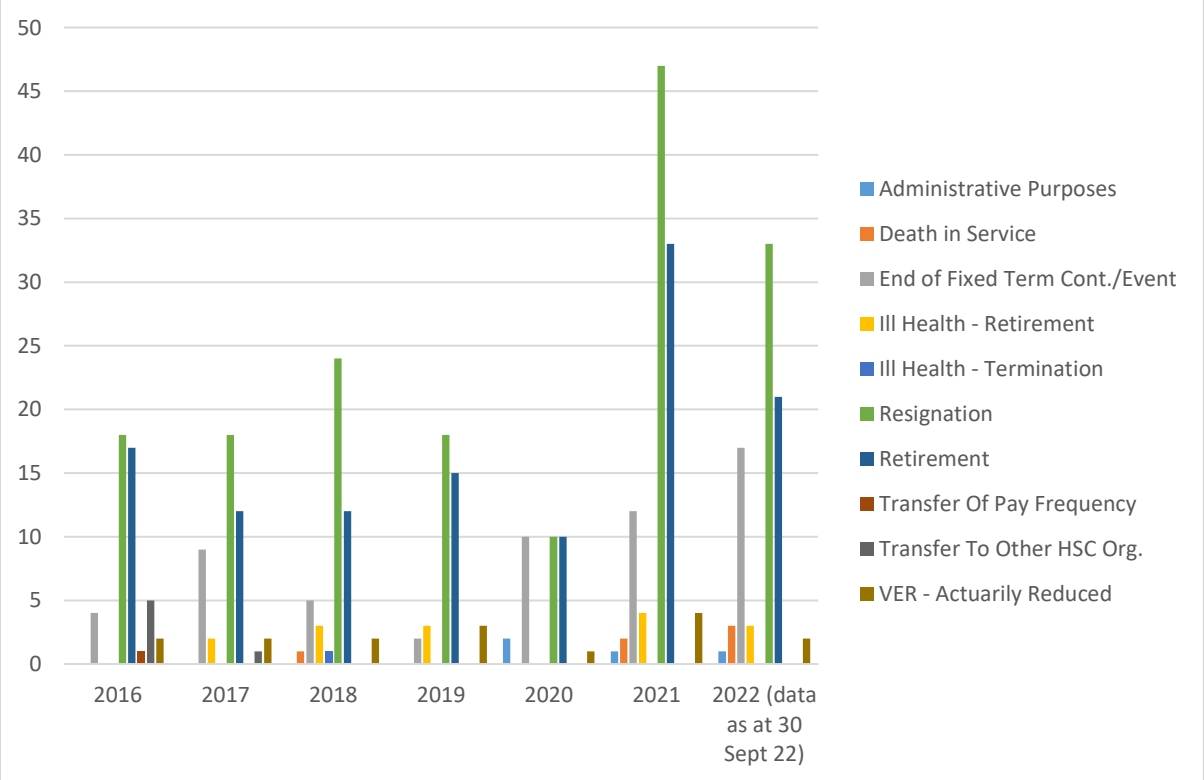
Higher levels of turnover can have immediate and lasting consequences: loss of valuable knowledge and experience, increase cost in recruitment, decrease in productivity, and loss of morale for those remaining.

HSC Medical & Dental Leavers 2021/22 by age



The main reasons for permanent leavers was resignations followed by retirements for medical and dental staff.

Information from the largest local Trust has been provided which demonstrates analysis over the last 5 years on reasons for leaving



6.3.3.2 Retirement Data

Information from the largest local Trust has been provided which demonstrates analysis over the last 5 years on the average retirement age overall and also broken down by medical grade.

Retirement age trends

	2016	2017	2018	2019	2020	2021	Overall
Average Retirement Age	**61**	**62**	**60**	**61**	**62**	**62**	**61**

Average Retirement Ages over the last 5 years by Medical Grade

Associate Specialist	61
Specialty Doctor	62
Consultant	61

An issue that has been highlighted by Trusts that seems to be increasing the number of leavers is the combined effects of pension tax issue on senior consultants, senior SAS doctors and Associate Specialists, leading to a number of them retiring from the Service early. There is real concern that we will lose proportionately many more than normal. This is discussed in more detail at 6.6.2.

6.4 Vacancies & Shortages

Workforce shortages within Health & Social Care are significant with high vacancy levels and as a consequence a high reliance on locum agencies. There are shortages across a range of specialities, and mostly at both junior doctor and consultant level.

The hardest to fill specialities at present at consultant level are in Care of the Elderly, Psychiatry, Paediatrics, Microbiology, Cellular Pathology, Emergency Medicine and Acute and General Medicine. One Trust has had to temporarily withdraw emergency general surgery services from one of their hospitals as despite repeatedly advertising for general surgeons over recent years there has been very limited success.

Another trust has indicated that their medical and dental permanent vacancy rate is currently sitting at 51%.

There is a range of hard to fill posts or staff shortages in a number of hospital settings across the employing organisations. In part these are due to insufficient training

grades in specialty coming through the education system. The shortages of workforce, coupled with the younger generation's life style choices to travel and desire for flexible working arrangements including reduced hours due to family friendly policies, create a significant challenge for the service.

Employers continue to feel the combined effects of workforce shortages, arguing that there is a need for a more proactive regional workforce planning to consider the increasing demands made on medical and dental staff which result in this group of staff working more intensely. This is evidenced by retention difficulties, rising banding supplements for many trainees and increasing programmed activities for other medical staff.

6.4.1 Impact of Vacancies and increased work loads

All grades are reporting burnout, staff shortages plus the impact of Covid 19 has led to significant pressure for all staff.

Onerous on call rotas and the age profile - as doctors progress in their careers, some find Out of Hours Working and on call arrangements difficult to maintain. Some doctors are removed from the rotas due to health and medical reasons, which means increased frequency and burden for others.

Due to small teams and recruitment difficulties there is limited flexibility to allow senior doctors to reduce on call duties. There is a view that on call work is poorly remunerated under existing terms and conditions and does not offer an incentive to remain on the on call rota.

Other reasons for staff burn out include the impact of the pensions cap means a reduction in ability to work additional hours or take on management roles, which attract higher allowances. Despite the changes made to the Annual Allowance and Lifetime Allowance more recently, doctors continue to report pensions taxation as an area of great concern.

6.4.2 Vacances for Post-graduate doctors and dentists in training

There is currently a vacancy rate of 11% which has been an increase from 8% in August 2021. The vacancy fill rate provides a summary of current training posts by HSC Trust and also Specialty.

August 2022 - Vacancies

Vacancies by Trust

	Overall Posts	Overall Fill	Unfilled via recruitment	Programme vacancies	Overall %Vacant
Belfast Trust	802	89%	6%	5%	11%
SE Trust	243	95%	4%	1%	5%
Southern Trust	221	90%	4%	6%	10%
Northern Trust	236	85%	10%	6%	15%
Western Trust	230	87%	8%	5%	13%
	1732	**89%**	**6%**	**5%**	**11%**

**** "Mid Programme gaps" include Statutory leave, Out of Programme & Resignations***

Vacancies by Specialty Group

Specialties	Overall Posts	Overall Fill	Unfilled via recruitment	Programme vacancies	Overall %Vacant
Foundation	537	96.5%	0.0%	3.5%	3.5%
GP Training	159	89.9%	5.7%	4.4%	10.1%
Anaesthetics	142	98.6%	0.0%	1.4%	1.4%
Emergency Medicine	73	83.6%	15.1%	1.4%	16.4%
O&G	78	87.2%	10.3%	2.6%	12.8%
Paediatrics	120	90.8%	6.7%	2.5%	9.2%
Radiology	54	92.6%	0.0%	7.4%	7.4%
Histopathology	19	63.2%	26.3%	10.5%	36.8%
Internal Medicine Training	181	89.5%	0.6%	9.9%	10.5%
Group 1 Medical Specialties	126	82.5%	7.1%	10.3%	16.7%
Group 2 Medical Specialties	71	76.1%	18.3%	5.6%	23.9%
Public Health	11	81.8%	0.0%	18.2%	18.2%
Core Psychiatry Training	52	80.8%	11.5%	7.7%	19.2%
Psychiatric Specialties	13	100.0%	0.0%	0.0%	0.0%
Core Surgical Training	88	62.5%	35.2%	2.3%	37.5%
Surgical Specialties	138	84.8%	11.6%	3.6%	15.2%

Some specialties do not attract local applicants currently (e.g. neurology). This may be due to specific local factors – e.g. public inquiries. Plans to expand the NI Foundation Programme would potentially facilitate the rotation of more trainees through those less popular specialties with the hope that would develop an interest in them.

Consideration is being given to local (as opposed to UK-wide) recruitment where it is considered that this has the potential to improve fill rates (e.g. Core Surgery). However, due to changes in recruitment processes as a result of the pandemic this has become more resource dependent (admin staff and consultants) producing challenges in its delivery. Many of the applicants are also applying to England.

Any vacancies in training grades due to a lack of suitable applicants impacts on the other trainees in that team due to rota gaps, daytime service to cover and consequent loss of time for training opportunities.

NIMDTA has previously indicated concerns about the impact local dental pay scales are having on recruitment, morale and retention in NI. There is now some evidence emerging that this differential is affecting fill rates in NI.

6.5 Recruitment

Attracting and recruiting appropriately skilled employees remains a key priority for the Trusts.

6.5.1 Local and National Recruitment

One Trust has introduced a Recruitment Strategy on 2021, supported by an Action Plan for 2021 – 2024. They have launched a recruitment campaign, with the aim to strengthen and build the medical team within the Medicine and Emergency Medicine division. The campaign included a TV advertisement featuring medical staff showcasing why they love working in Causeway Hospital. The TV advertisement was picked up by a number of local news stations, including BBC News and BBC Radio Ulster. Link attached https://www.youtube.com/watch?v=lOBPUDYgM4Y. Despite this high profile campaign, there were no applicants for any of the four available posts. This highlights the difficulty in attracting medical staff to smaller hospital sites away from cities.

6.5.2 International Medical Recruitment (IMR)

Along with domestic recruitment, employers within Northern Ireland have focused on international medical recruitment as another viable recruitment channel for highly skilled medics to help counter the pressures on the current workforce.

To date 31 placements have been made via regional International Medical recruitment. Progress was hindered by the pandemic and work is now ongoing between the HSC Project Team and HSC Trusts to move forward under a new framework. There are now five agencies on this framework to source doctors immediately internationally. A Regional IMR group has been established to focus on International Medical Recruitment and this will help to instil new vigour to recruiting in this manner in 2023

Currently Trusts will consider applicants via the international medical recruitment regional project for any vacancies they have not been able to fill via domestic recruitment.

However, Trusts have noted a significant increase in international doctors, especially junior doctors, entering the system (either via training or non-training posts) having no previous NHS/UK experience. This continues to be a challenge as there is currently no regional support/training mechanism or funding packages in place to facilitate successful integration into our medical workforce. New junior doctors rely on the Trust to help with integrating them into the workplace and local area.

With a worldwide shortage of doctors, the NHS faces major uphill struggle to retain the doctors it has when there are better paid jobs overseas. This is being experienced at Trust level like never before.

6.5.3 Job Fairs

Employing organisations attend job/careers fairs throughout the year. These events enable the Trusts to showcase the various opportunities and career pathways that are on offer within health and social care. Moreover, Trusts have been working in partnership with local councils and Jobs and Benefits Offices to support those in the community who may be facing unemployment, redundancy or who are unsure about their next steps in their career.

6.5.4 Recruitment and Retention Premia (RRP)

A regional approach has been taken in NI as to the application of any Consultant RRP, very limited RRP applications have been approved. HSC Trusts do not believe the regionally agreed rate of 10% is sufficient to attract doctors into the service in NI. A review of the RRP process was timetabled to start in 2020, however this has been delayed due to the Covid 19 response and ongoing pressures. It is anticipated that the review will be progressed in 2023.

There are currently no recruitment and retention premiums for medical and dental consultants in acute settings throughout Northern Ireland.

6.6 Renumeration

Challenges are exacerbated by the inability of Trusts to meet the expectations of the emerging medical and dental workforce. Medical graduates are also now less attracted by the existing pay, terms and conditions offered by employing organisations, instead opting to work through non-contract locum agencies.

Remuneration via this route is often substantially greater than that offered under Medical and Dental terms and conditions, and the flexibility of locum shifts often outweighs the attractiveness of security of employment. This presents financial challenges to employing organisations, as the cost of non-contract agencies exceeds the funded staffing establishment. The attractive nature of locum engagements continues to drive doctors away from rotational training schemes, particularly after FY2. Employers would like to see a regional strategy to address this imbalance and would benefit from a regional focus to develop in-house locum banks and regional control/monitoring on locum rates of pay.

Agency rates make it attractive for doctors to not take up a substantive role, and therefore create pay inequities in the system. Many doctors also elect to register with agencies not on the Medical and Dental Framework Agreement who offer higher rates of pay than contracted agencies.

While increased rates of pay for medical and dental staff would go some way in assisting, these must be fully funded by HM Treasury. In an ever increasingly difficult financial environment, pay increases which are unfunded by central government will result in service deficiencies.

6.6.1 Rate of Pay

There is often wide variation across the health service in the amount paid for additional/non contracted work. The BMA has developed and promoted a minimum rate card which purports to achieve uniformity, fairness and consistency in remuneration for its members.

The BMA is now advising all NHS / HSCNI consultants to ensure that such extra-contractual work is paid at the BMA minimum recommended rate and to decline the offer of extra-contractual work that doesn't value them appropriately. This rate card is being raised by Trust Doctors in relation to rates of pay. These rates have been established by the BMA with no consultation or input from the Department of Health or employers and as such are not supported by the Department. Additional clinics may only be run within existing funding; affordability is key, and the number of interventions possible is dictated by the overall cost.

6.6.2 Pension Issues

Pension issues have the potential to adversely impact our retention of existing staff. The annual allowance is a threshold which restricts the amount of pension savings doctors are allowed each year before tax charges apply.

Due to the complexities of both annual allowance and lifetime allowance rules there is a concern that there will be multiple early retirements, with the Trusts potentially losing valuable staff due to the financial impact of the annual and lifetime allowances. It is reported anecdotally, that Consultants are now receiving a yearly annual allowance charge in excess of £10,000.

It is considered that a Consultant could be expected to reach the lifetime allowance before the age of 55. This means that ongoing employment within the HSC will be financially unsustainable for experienced staff over the age of 55 due to very high taxation.

In the absence of significant central pension reform it is expected by staff that these retirements will begin in the next 2 years and accelerate afterwards.

The pension scheme view is that the long term return on investment in the HSC pension scheme is valuable enough that, even with tax charges, the vast majority of

members are benefitting from membership. The immediate effect of the charges can however lead to senior consultants refusing extra management responsibilities or extra clinical work due to the tax implications.

Employers can offer a number of flexibilities to help manage tax charges and the Department is currently working to introduce guidance to allow HSC employers to offer flexibilities including contribution recycling. Employer contribution recycling is where, when a member drops out of the scheme, either entirely or for one contract, they receive the money which their employer would have spent on employer pension contributions as income. This payment is net of the extra national insurance costs incurred by the employer and is received as gross income i.e. liable to employee national insurance and income tax. Leaving the scheme also means that the employee can lose other benefits in relation to ill health or death.

Concerns have been raised for HSC Pension Scheme members, this year, regarding the interaction of significantly increased CPI and the operation of the system meant to strip purely inflation driven defined benefit pension growth out of the calculation for Annual Allowance (AA) charges. The members most likely to be affected are those with high pensions or salaries.

HMT have proposed the best solution is to move scheme revaluation dates to ensure that the same rate is used for opening and closing values. For this to happen DoF would be required to amend their revaluation order, this is currently being considered.

6.6.2.1 Withdrawals from the NHS Pension Scheme

Table below is the opt out figures for Medical Staff for year 01/04/2021 to 31/03/2022

Pay Level	Opt Outs
£0 to £50,00	82
£50,000 to £70,000	16
£70,000 to £100,000	13
£100,000 to £150,000	18
£150,000 +	0
Total	129

Table below is the opt out figures for Medical Staff for year 01/01/2022 to 31/10/2022

Pay Level	Opt Outs
£0 to £50,00	112
£50,000 to £70,000	16
£70,000 to £100,000	25
£100,000 to £150,000	50
£150,000 +	0
Total	203

It should be noted the overall numbers this current year are higher due to auto enrolment, the increase in opt outs is to be expected.

Total Number of Hospital Doctors/Consultants retired on VER for period 01/04/2021 to 31/03/2022 is 8.

Total Number of Hospital Doctors/Consultants retired on VER for period 01/01/2022 to 31/10/2022 is 7.

6.7 Independent Sector

A perceived demand for private health care provision, on foot of growing waiting lists has attracted doctors to the independent sector where patients are seeking more timely interventions. This means many doctors will opt to decline additional PAs in Trusts and will opt to work in the independent sector instead. These employers also offer higher rates of remuneration to doctors and dentists. There is also the concern the pension taxation concerns are also pulling medical staff towards the independent and private sector, this is particularly evident in Radiology and Surgical specialties.

6.8 Locums

6.8.1 Use of Locums

Employers feel that the services provided by Locums do not provide the same level of stability and consistency in Trust services and are more expensive. Locum recruitment is also considerably more challenging due to the physical separation of Northern Ireland from the remainder of the UK and therefore the main source of locum doctors are those doctors working outside their normal contracted NHS hours. This

then limits the pool of locums and thus creates significant shortages across all speciality groups.

The increasing use of locum and agency medical staff continues to present huge challenges. The attractive nature of locum engagements continues to drive doctors away from rotational training schemes, particularly after FY2. It is felt that a regional strategy to address this imbalance and would benefit from a regional focus to develop in-house locum banks and regional control/monitoring on locum rates of pay.

The escalation of locum rates is presenting precarious challenges, greater than ever before for covering services. Local agreements agreed across the UK are also having an impact –as is the BMA consultant and SAS doctor's non-contractual rate card. There is a need to ensure NI contractual rates of pay are attractive.

6.8.2 Locum Spend

The key aim of expenditure on agency and bank staff has been to ensure that safe and effective services are sustained and maintained.
A key factor in tackling the issue of agency/locum expenditure is transformation of HSC and the need for long-term investment in our HSC workforce.

The Bengoa report made clear that rising locum and agency costs are due to the current configuration of services and that "changing the model of care" is the only solution.

The Department fully recognises the impact rising agency/locum costs are having on the Health & Social Care budget and this is not sustainable, particularly at a time of serious financial pressures right across the public sector.

Transformation of health and social care in Northern Ireland is a key priority. The Department has undertaken significant work to try and alleviate the workforce pressures across HSC and it is examining all potential options, and the implications, as to how to address the issues of rising locum expenditure.

The use of off-contract agencies has contributed significantly to an increase in agency staff expenditure over the last decade. Off-contract agencies are typically more expensive than their on-contract counterparts.

In 2021/22, expenditure on off-contract locum staffing was £33.6m accounting for 33% of all locum expenditure.

The Minister for Health made his announcement on 21 October ahead of the open competition for the new regional procurement of agency staff being advertised. The procurement is aimed at eliminating the use of off-contract agencies - only those agencies successful on being placed on the new framework will be able to compete for business at agreed maximum rates.

The drive to reduce agency spend will run in parallel with ongoing initiatives to build the health service workforce. These include additional investment to expand the number of places and undergraduate and post-graduate medical training.

The sustained drive to reduce agency costs will be accompanied by reform of the HSC Trusts' Staff Banks to make them a more attractive option for staff wishing to work additional hours. Though this reform isn't directly related to medical and dental, it is an example of what the Department are planning on doing to resolve the issue across all professions within the HSC.

Agency Cost Key Facts:

- Locum spend continues to rise year on year. For the 21/22 financial year HSC Trusts' expenditure on medical and dental locum staff was £103m (Annex A), up from £99m in 20/21, a rise of 4%;
- 5-year trend - Expenditure on medical and dental Locum costs in 21/22 was £103m a rise of £30m or 41% on 17/18 (£73m);
- 10-year trend – Expenditure on medical and dental Locum costs in 21/22 was £103m a rise of £71m or 222% on 2012/13 (£32m);
- In 21/22 Medical and Dental expenditure totalled £102.7m, a rise of £4m or 4.0 % (costs: £98.7m in 21/22);
- Medical & Dental Agency expenditure accounted for 32% of the overall agency spend;
- Of the £102.7m, £33.6m or 32.7% was off-contract spend;
- Total medical and dental Bank spend for 21/22 was £44k (Annex B).

6.9 Terms and Conditions of Employment

6.9.1 Consultants

6.9.1.1 Consultant Contract Reform

There has been no real progress made regarding the consultant contract reform.

6.9.1.2 Clinical Excellence Awards

The Clinical Excellence Award scheme in Northern Ireland scheme has been on pause for a number of years, with no new awards being made; existing awards continue to be paid where applicable.

The Department is currently working with the BMA to co-design a new revised government scheme. The underlying principle of the scheme is to reward excellence. This excellence will be over and above the standard normally expected of a consultant in post. The impact of the consultant's work will be taken into account in the new scheme as well as innovation. The draft objectives of the proposed new scheme are:

i. reward consultants who deliver local/national impact above the expectation of their job role or other paid work.
ii. encourage consultants to help develop and deliver a high-quality service and/or provide improvement to service
iii. encourage excellence, innovation, leadership to include training and people development with the emphasis being on the local/national impact of the achievements
iv. encourage and attracts new staff and retains current staff by promoting innovation and excellence for the benefits of service users and/or the service
v. produce a fit for purpose flexible scheme for now and the future to reflect the differing and changing priorities for Health and Social Care in Northern Ireland.
vi. be a fair and transparent scheme for all those eligible

6.9.1.3 Pensions

Employers continue to feel the combined effects of the pension tax issue on senior consultant staff, a number of whom have retired from the service early with many others considering leaving next year. There is real concern that we will lose proportionately many more than normal. Many consultants express worry and concern

about the impact of remaining in the HSC and /or taking on additional sessions. Consultants are also seeking more flexibility in their working patterns, sabbatical leave, and the ability to opt out of on-call work if they wish to later on in their careers.

6.9.2 Specialty Doctors and Associate Specialists Contract

SAS doctors make up at least 25% of the permanent hospital medical workforce but still information about this career path is not included in undergraduate or post-graduate education, resulting in some trainees deciding to leave medicine or move to another country to practise, as they do not consider this option if they find local training programmes unsuitable.

The Covid pandemic has resulted in more isolation both within the workplace and also for those working from home, with a lack of the usual social supports and contacts, compounding the already reported lack of support for SAS doctors identified in the first GMC SAS and LED survey (2020). Despite this, SAS staff have been very flexible e.g. covering absent colleagues, changing working patterns e.g. covering community or inpatient wards as required, often necessitating more travel. SAS doctors have stepped up to provide cover in Covid wards, on rotas during the pandemic and new ways of working e.g. one stop hubs in Cardiology and Urology run by SAS staff. SAS doctors have been widely acknowledged as pivotal to the success of these new hubs in feedback from colleagues to the SAS Lead.

6.9.2.1 SAS Contract Reform 2021

The new contract and terms for SAS doctors has been implemented in Northern Ireland. Whilst 94% of SAS staff voted for the new SAS contract in Northern Ireland and a significant number of SAS doctors expressed an interest only a very small number of doctors decided to proceed and move to the new contract during the window of opportunity. It is not anticipated many more will move to the new terms given the recommendation of the DDRB of a 3% pay uplift for all medical and dental staff in 2021 and 4.5% in 2022.

As these uplifts did not include those on agreed multi-year deals, an unintended consequence has made the pay framework within the new 2021 contract a much less attractive option for these doctors in the short term.

All new starts are placed on the new contract terms, this may result in less movement between organisations as SAS doctors chose to remain on the 2008 pay framework rather than move to a new post.

The process for recruiting the first Specialist posts within Trusts has commenced with some posts being successfully filled. It is felt though that with this limited progress on Specialist posts, there could be a negative impact on SAS recruitment, retention and morale; already the most likely cohort of medical staff to leave medicine (GMC). The opportunity for career progression was the main reason SAS doctors voted for the new contract, so if this is not realised, SAS staff will perceive this as a lack of recognition of their knowledge, skills and experience. It is therefore important these posts are funded, which will highlight SAS as a positive career choice.

6.9.2.2 Valuing SAS

SAS doctors have been meeting online monthly in the SAS Interdisciplinary Training Forum for education and peer support over the past year. SAS doctors have a SAS intranet webpage to improve the sense of connection and belonging in SEHSCT and medical HR have facilitated the development of a Pagetiger resource for SAS doctor induction, which had been identified as an issue during the pandemic as usual induction processes were not possible. This resource is used by all SAS Doctors with development opportunities now also included within it. Medical Induction 21-22 - SAS Medical Induction and Information Pack (pagetiger.com)

The first national SAS week was held from 10-14 October 2022 and daily meetings with themes of SAS contract, SAS charter and careers; Specialist post; SAS leadership and extended roles; SAS Advocate and wellbeing and SAS Equality and Diversity Issues were held, with good attendance. In one Trust a SAS lunch was organised, funded by BMA, and attended by the Chief Executive, Chair of Board and Associate Medical Director. ‘SAS Doctor Star’ nominations were held in this trust, with 53 SAS doctors being nominated by 100 of their colleagues, this provided a great morale boost and highlighted the excellent work SAS staff are doing across the trust in clinical work, service development, quality improvement, education, research and leadership.

6.9.2.3 SAS Career Development

The Department of Health has provided regional funding for the development of SAS doctors and Dentists, this has enabled SAS staff to access online leadership, management and other training as well as wellbeing support e.g. time management, networking and coaching since 2020, this was following the employment of SAS Leads in 2019.

Training was well attended and has had a significant impact in improving SAS morale, with excellent feedback. Courses offered in 2022 include:

- SAS Doctors' and Dentists' Programme – SAS Conference
- SAS Doctors' and Dentists' Programme – Job Planning
- SAS Doctors' and Dentists' Programme – Creating and delivering a presentation
- SAS Doctors' and Dentists' Programme - Leading Local Service Development
- SAS Doctors' and Dentists' Programme – Leadership and Change Management
- SAS Doctors' and Dentists' Programme – Introduction to Quality Improvement
- SAS Doctors' and Dentists' Programme – Creating psychological safety
- SAS Doctors' and Dentists' Programme – Re-imaging healthcare in post Covid - the role of data and AI
- SAS Doctors' and Dentists' Programme - Being an emotionally intelligent colleague and leader
- SAS Doctors' and Dentists' Programme - Entrepreneurship - Lesson for Leadership
- SAS Doctors' Leadership Programme - Managing Conflict in the Workplace
- SAS Doctors' Leadership Programme – Creating Psychological Safety

Courses planned for the first quarter of 2023 include:

- SAS Doctors' and Dentists' Programme - Mindfulness & Resilience
- SAS Doctors' and Dentists' Programme - CESR
- SAS Doctors' and Dentists' Programme - Appraisal, reflective practice and revalidation for appraisees

- SAS Doctors' and Dentists' Programme - Being assertive and negotiating
- SAS Doctors' and Dentists' Programme - Managing difficult colleagues
- SAS Doctors' and Dentists' Programme - Career development
- SAS Doctors' and Dentists' Programme - Personal Effectiveness & Time Management
- SAS Doctors' and Dentists' Programme - SAS Career Development
- SAS Doctors' and Dentists' Programme - Taking clinical responsibility and autonomy
- SAS Doctors' and Dentists' Programme - Specialist post preparation course
- SAS Doctors' and Dentists' Programme - Clinical Governance incorporating Audit
- SAS Doctors' and Dentists' Programme - Patient Safety and learning from incidents
- SAS Doctors' and Dentists' Programme - Human Factors

The Department has funded 2 PAs on a non-recurrent basis for 5 SAS leads. SAS staff have fed back about the importance of having a SAS Lead in position to have a voice within medical leadership. Improvements that this has led to includes that SAS doctors will now be able to apply to become appraisers, with appropriate remuneration, and that more leadership and educational positions are open to SAS staff.

In addition the Department is working closely with the SAS Leads and NIMDTA to establish a part-time SAS Associate Dean, who will co-ordinate the work of the SAS Leads as well as being the regional lead for SAS doctors development, it is hoped this will be in place in 2023.

Employers and the Department are also working towards introducing an additional SAS Advocate role which is hoped to be in place also in 2023. This may help address some of the issues identified in the GMC SAS and LED survey (2020) and improve wellbeing, which is strongly associated with working conditions, especially opportunities for autonomy, sense of belonging and maintaining competence.

6.9.2.4 Pensions

The annual allowance charges on HSC pensions has started to impact senior SAS doctors, with some already planning to retire within the next year and others making

the decision to reduce PAs to avoid these charges, in a similar way Consultants have been affected. This will continue to have an increasing impact on provision of service, unless similar arrangements to those made for judges are implemented.

6.9.3 Post graduate doctors and dentist in training Contract

A single employer for Doctors and Dentists in Training has been introduced and fully implemented in NI.

The key benefits aimed to deliver through the single employer model are:

- A single contract for doctors and dentists in training for the entire duration of their training programme
- A single sign-on for doctors and dentists for their programme in relation to pay and pension.
- Reduced complications for trainees with respect to pay and taxes.
- Standardised interpretation of terms and conditions for doctors and dentists in training
- Less duplication of effort for trainees and for HSC Trusts
- Improved information sharing in respect of statutory leave and performance concerns.

Trainees in Northern Ireland remain on the 2002 New Deal TCS, BMA have approached the Department informally to commence initial discussions around the potential for new local contract negotiations.

Employers are increasingly feeling the impact of the difference in pay scales (and contracts) between Northern Ireland and our UK counterparts, many trainees joining the Northern Ireland training scheme from the UK face a significant drop in pay due to the differing pay frameworks – making Northern Ireland a less attractive career option.

Trends in average working hours for doctors and dentists in training.

Percentage and total of trainees working on a Less Than Full Time (LTFT) basis:

WTE	Count	Percentage
LTFT	271	14.20%

Full Time	1638	85.80%

Breakdown per WTE:

WTE	Count	Percentage
0.3	1	0.05%
0.4	2	0.10%
0.5	14	0.73%
0.6	96	5.03%
0.65	1	0.05%
0.7	15	0.79%
0.8	141	7.39%
0.9	1	0.05%
1	1638	85.80%

There are also currently 114 trainees on parental leave and 66 Out of Programme (OOP) for Training (OOPT), Experience (OOPE), Research (OOPR) or Career Break (OOPC).

The Department of Health re-activated the Strategic Group to Enhance the Quality of Medical Education in Northern Ireland (SGEQMENI) in February 2022. With representation from the Department, NIMDTA, Queen's University Belfast, Ulster University and HSC Trusts, this Group aims to enhance the quality of undergraduate and postgraduate medical education in Northern Ireland by strategic planning, collective working as a system and innovative approaches in order to make Northern Ireland an attractive place to learn and practise medicine and to ensure that Northern Ireland has the medical workforce to meet the needs of the population.

A number of recommendations have been made by the Group to improve the experience of doctors in training in Northern Ireland, make a difference to the life of trainees, increase morale and reduce the risk of burn out:

1. Recommendation 1: Dedicated time for education and personal development

Each HSC Trust should facilitate mandatory dedicated education and personal development time for all doctors in training, with time split as 80% for clinical work and 20% for personal development each week.

2. Recommendation 2: Work schedules and rotas

Each HSC Trust should appoint a rota organiser with responsibility for the oversight of rotas for all medical specialties, ensuring that all rotas are distributed a minimum of six weeks in advance and that rotas are designed in a compassionate and thoughtful way.

3. Recommendation 3: Working conditions and facilities

Each HSC Trust should adopt, in full, the BMA's 'Fatigue and Facilities Charter', and appoint a member of staff with responsibility for the oversight of this to ensure standards are achieved and maintained.

4. Recommendation 4: Welcome and inclusion

Each HSC Trust should appoint a lead for junior doctor engagement and inclusion, with responsibility for engaging with trainees, improving inclusion and monitoring trainee satisfaction.

5. Recommendation 5: Feeling part of a team

Each HSC Trust should ensure trainees work in teams as opposed to being assigned to clinical areas.

6. Recommendation 6: Trainee wellbeing and support

Each HSC Trust should appoint a senior doctor on each hospital site to act as a pastoral care lead with responsibility for trainee wellbeing, who will link with already established wellbeing work streams and act as a point of contact for trainees requiring additional support or mentoring.

7. Recommendation 7: Improving workload

Each HSC Trust should appoint a safe working guardian to review the workloads of doctors in training (across all specialties) and ensure upskilling/utilisation of other health professionals to undertake tasks that are of limited educational value for doctors in training.

The Group is now looking at how best to implement these measures. Many are focused on local management practices.

The Group also focused on the issues and challenged faced by trainees who are new to Northern Ireland (N2NI). However, a proposal to offer a period of working in a supernumerary capacity to support these trainees' integration into the HSC will be subject to the identification of suitable funding.

6.9.4 Prison Healthcare

Prison Healthcare is delivered on a regional basis by the South Eastern Health and Social Care Trust. One of the key vacancy challenges in South Eastern Trust is recruiting for the prison dental service, part of the provision of prison healthcare within Northern Ireland, which falls under the remit of the trust.

There have been long term vacancies creating pressure on current staff. The recruitment of the prison dental staff has been conducted at a local level. In the past number of years, there has been a high turnover of staff for various reasons, illness, suspension and career progression.

Unfortunately, there are few opportunities for career progression in prison or community dentistry which accounts for higher staff turnover.

An issue which is raised on a routine basis for medical and dental staff working in prisons who are dealing with the same emotional and challenging behaviours of prisoners but do not receiving any financial differentiation, comparable to AFC prison healthcare staff who receive a RRP allowance. Given the recognised security issues arising from prisons in Northern Ireland, this is seen as a bar to recruitment.

6.9.5 Community Dentists

Within the Community Dental Service is a small group of mostly female staff who are responsible for treating very challenging dental patients, which general dental practitioners are unable to treat. The majority of staff are female – maternity leave contributes to further workforce pressures. The utilisation of training budgets is improving. Unfortunately, there are few opportunities for career progression in Community Dentistry which accounts for higher staff turnover due to a lack of senior posts and training pathways.

The COVID-19 pandemic has significantly impacted NHS dentistry and this has resulted in significant access issues across the profession. A considerable increase in referrals from General Dental Services has had a knock on impact and put additional strain on staff. There is also reduced access to theatre time which has led to increased waiting lists and challenges in managing these vulnerable priority groups. The lack of Special Care Dental Consultant posts in N. Ireland makes this even more difficult.

Increased PPE for patients on a Respiratory pathway requiring an AGP makes the practice of dentistry more challenging – this has had a detrimental and physical impact on staff resulting in increased stress levels and a sense of disillusionment. As a result, staff have left the profession and there has been an increase in early retirement.

It has been recognised by the Department of Health that the TCS of community dentists did not have any rates of pay for the out of hours period, as it was never foreseen that this would be a requirement. During Covid 19 emergency Directions were issued to allow community dentists to be paid time and third for any out of hours work undertaken, this is comparable with both the Consultant and SAS contracts. The Department is keen to seek approval for a single item negotiation to have this issue addressed and added to the Community Dentists contract.

6.10 Job Planning and Appraisal

Most employers have reported that job planning and appraisal have been of areas of particular focus, with performance in these areas significantly improving.

6.10.1 Appraisals

All Trusts have previously advised that the appraisal year January to December 2020 presented a huge challenge, the pandemic combined with the temporary suspension

of the appraisal process by the GMC were contributory factors. The appraisal year covering the period January 2021 to December 2021 continues to present a challenge and is currently 90% due to deferments during the covid-19 restrictions of 2020 and 2021.

One Trust has developed a new Appraisal and Revalidation Governance Policy which has included consultation with the BMA. This document will now be presented to the Policy Committee before issue.

Another Trust has implemented an on-line Regional Appraisal System for all medical and dental staff with an emphasis of a similar on-line system for job planning, which they believe with enhance the governance regulation and facilitate better access for doctors, making reporting and monitoring more reliable. Other Trusts have advised that they are continuing to work with regional colleagues with the further enhancement of the medical electronic medical appraisal system they have agreed to contribute towards the funding of a regional lead for three years commencing 2022.

6.10.2 Job Planning

Job planning was only undertaken on an ‘as required’ basis during the pandemic. However routine job planning, has recommenced throughout the 2022/23 period.

There is a low rate of consultants accessing the Job Planning Appeal process and this remains indicative of the strong partnership working with professional bodies such as the BMA in seeking to resolve differences without recourse to the formal process.

An up-to-date job plan must be included in all appraisal documentation in order for the appraisal process to be completed.

One Trust is currently giving consideration to piloting an electronic job planning system within medical specialties. This will facilitate a more effective job planning process with more robust objectives and activity reporting mechanisms.

6.11 Health and Well Being

The impact of Covid-19 on the health and wellbeing of the medical and dental workforce has been immense and employers have worked hard to collectively support its entire staff through the pandemic by innovation and flexibly.

Examples of some of the Covid 19 related initiatives include:

- Dedicated helplines for staff continues to be provided, operated by Trust Psychology Services. The helplines continue to provide psychological support and opportunities for reflective practice for individuals and teams. Specific COVID-19 related advice from Occupational Health, increased promotion of Inspire Workplaces and spiritual support from chaplaincy services;
- Dedicated psychological 1-1 and team support sessions;
- Increased Trust communications around where to find information on digital platforms such as the Trust intranet, Health and Wellbeing platform Livewell and the Trust App
- Constant communication and reiteration of safe working measures.
- The Occupational health led Contact Tracing team continues to support managers and staff with any identified links/outbreaks due to Covid 19 and instigates outbreak management and help protect staff.
- Psychological Support Helpline; Team Staff Support Sessions; A Space For You – individual support sessions; Psychological Safety and Staff Wellbeing Webinars for Managers; Psychological PPE wellbeing sessions for FY1 doctors; development of a paper “Managing Anxiety in Uncertain Times”.

All Trusts have strategies in place which indicate that the health and wellbeing of their people is a priority.

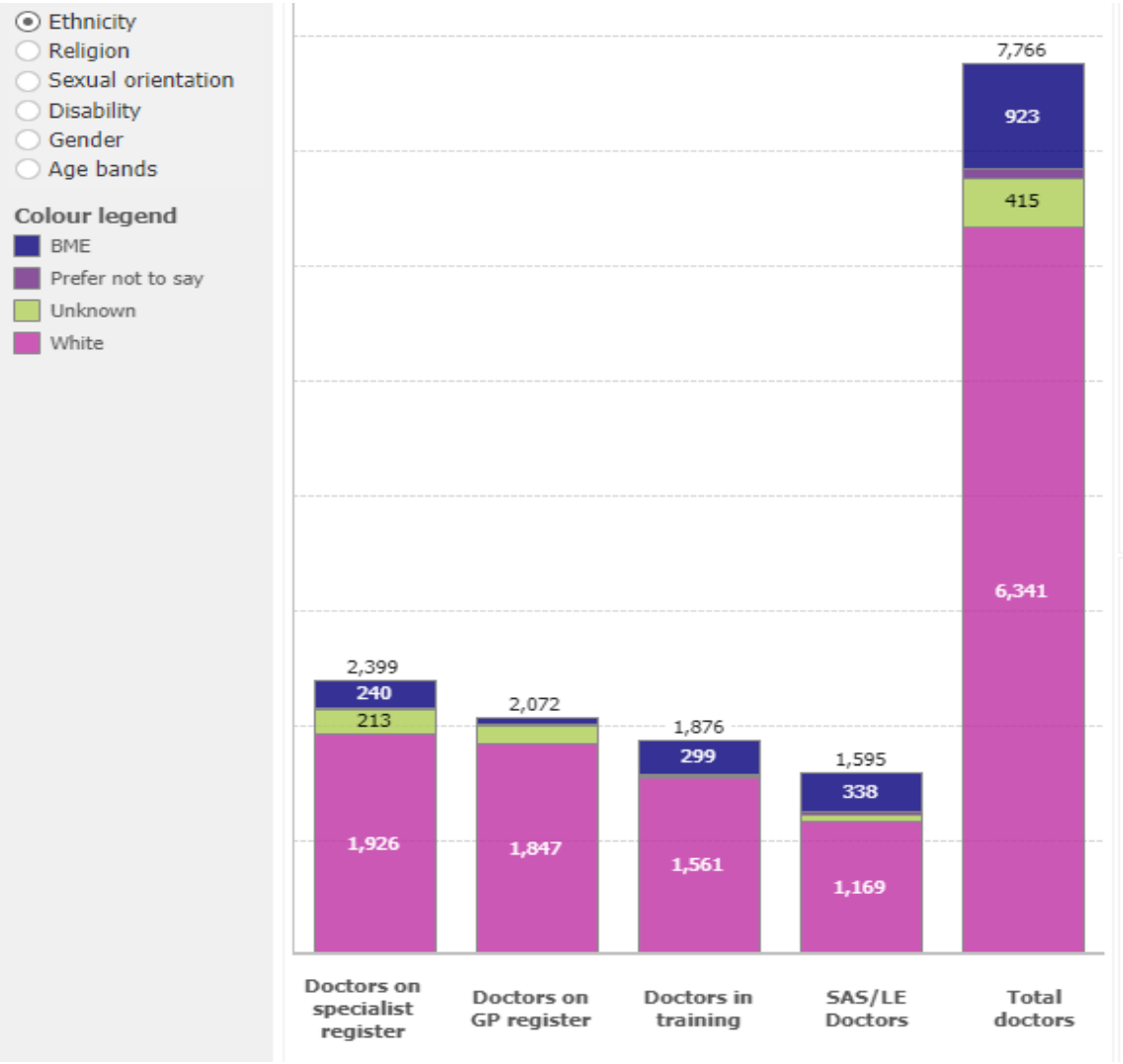
Examples of some of the initiatives in this area include:

- Staff health & wellbeing is part of Corporate Welcome and Induction Programmes to ensure this new group of staff are welcomed and informed from when they start what services and supports are available.
- Focusing on key areas like Equality, diversity & inclusion (EDI); Promoting healthy living; Promoting healthy working lives; Psychological wellbeing
- Health & wellbeing funding has been made available for staff to take time out to Reflect Relax and Reconnect, there has been excellent feedback from the teams who availed of this opportunity.
- A partnership model has been established with the aim of encouraging medical staff to avail of Trust Coach Approach. The aim of the coaching is to provide a safe supportive space to discuss with a peer/colleague what is important to them.

- Medical and dental staff have availed of the ‘Important Conversations’ training which discusses how relationships are built on holding important conversations to achieve the required results.
- Staff Confidential Wellbeing helpline remains an invaluable support service to staff.
- An innovative website has been set up which provides advice and support to staff and their families
- A number of helplines have been established, including a confidential psychological support helpline, which has been communicated widely with staff. Staff have also been provided with guidance on looking after their mental health by the Trust’s Psychology and Occupational Health teams.
- Trust runs concentrated flu campaigns every autumn/winter and this specifically targets key front line clinical staff like doctors and dentists to ensure they have received their flu vaccination. In addition to this, staff had the opportunity to receive their Covid vaccination and booster within one of the vaccination centres.

6.12 Equality Matters

Robust data on the whole HSC Medical & Dental workforce by ethnicity is not available. Alternative: GMC Registrants with a licence to practice with a Northern Ireland location by ethnicity. Source: GMC Explorer generated on 15/11/22. https://data.gmc-uk.org/gmcdata/home/#/reports/The Register/Stats/report



During the recent Covid pandemic there was an emerging concern regarding a potential disproportionate impact on staff from Black, Asian and Minority Ethnic (BAME) backgrounds. Recognising that this may be a worrying time for the staff members and their families, the South-Eastern Trust has established its Multi-Cultural Forum for all staff, including medical and dental, and their advocates. This Forum continues to be held on a quarterly basis and is well attended. The Trust continues to support the Multi-Cultural Forum for staff post-Covid.

The Trust has recently developed 'Drop-In' clinics for Multi-Cultural staff to attend to have confidential conversations where they have an opportunity to raise any challenges they may be experiencing with the Co-Chair of the Forum and the Equality Officer. Drop-In clinics are available to all staff, including medical and dental, and their advocates.

The Trust has completed the pilot of the 'Reverse Mentoring' initiative and guidelines are currently being developed. Feedback from pilot has redefined the title of the program to 'Mutual Mentoring'. In order to build their capacity, mentors are offered the opportunity to attend 'Important Conversations' training before the start of the partnership. The program is currently being rolled out across the Trust.

The Trust continues to regularly encourage all staff to update their personal details to enable the Trust to have an accurate picture of our staff profile.

6.13 Learning and Development Support

Learning & Development opportunities offered across Trusts are open to staff working across all Directorates and Professions (including Medical and Dental).

This would include e.g.

- Corporate Induction/Corporate Welcome
- Coaching e.g. ILM5 Coaching, Coaching for Collective Leaders
- Difficult Conversations
- Leadership & Management Development
- Health & Wellbeing initiatives

SAS doctors and consultants have the option to complete ILM level 5 Coaching and Mentoring training, and can then form part of coaching pools to provide support for Trust staff, including Medical & Dental staff.

Regional training for Medical and Dental staff is provided by the HSC Northern Ireland Leadership Centre and includes sessions on Interview Skills, Confident Communications, Human Factors in Patient Safety, Difficult Conversations and Mentoring.

Annex A Northern Ireland HSC DATA

Staff Numbers HSC Medical & Dental staff

Foundation training:

The first column relates to recruitment into the 2 year programme (i.e. over 500 posts in total F1 and F2 in a training year).

	Total F1 posts being recruited to	F1 Posts filled at August	% posts filled (of those which were advertised for this intake)	F2 Posts filled at August	% posts filled (of those which were advertised for this intake)
2013	252	252	100.00%	251	99.60%
2014	252	251	99.60%	252	100.00%
2015	252	250	99.20%	247	100.00%
2016	267	259	97.00%	262	98.12%
2017	252	239	94.84%	256	95.89%
2018	252	250	99.20%	239	94.84%
2019	252	251	99.60%	249	98.80%
2020	252	255*	103.70%	248	98.40%
2021	252	254*	100.80%	258	98.00%
2022	259	273*	98.00%	259	95.00%

* Total including oversubscription. Includes 19 additional posts from UKFPO reserve list Aug 22.

Specialty training

	Total posts being recruited to (incl CT/ST/LAT)	Posts filled at August	% posts filled (of those which were advertised for this intake)
2013	455	382	83.90%
2014	434	376	86.60%
2015	403	355	88.00%
2016	480	380	79.00%
2017	498	380	76.30%
2018	487	369	76.00%
2019	479	393	82.05%
2020	402	364	91%
2021	383	348	91%
2022	399	361	90%

Overall vacancy position:

	Posts vacant at August (total training posts inc Foundation & Specialty programmes)	% posts vacant (of total posts)
2013	73	4.40%
2014	104	6.20%
2015	133	7.80%

2016	179	10.20%
2017	179	10.00%
2018	163	9.00%
2019	157	8.61%
2020	135	7%
2021	158	8%
2022	191	11%

Source: NIMDTA

Vacancies are defined as NIMDTA Unsuccessful Recruitment or Trainee Resignation and also Trainee Out of Programme (due to maternity leave, sick leave, pursuing out of programme clinical experience, pursuing out of programme training, pursuing out of programme research, career break etc).

Note that there was a lower intake for specialty training – this related to the impact of COVID in that some specialties did not recruit due to change in process or uncertainty regarding progression of their current trainees.

Other demographics

Medical & Dental staff as at 31st March 2022 by age range (headcount)

	<35	35-44	45-54	55+	Total
Consultant	79	789	755	439	2,062
Associate Specialist	5		38	49	92
Specialty Doctor /Staff Grade	107	221	163	55	546
Specialty Registrars [1]	1,082	288	26	11	1,407
Foundation Year 1 & 2	507	19		0	526
Hospital/Medical Practitioner	12	35	22	17	86
Dental Officer/Practitioner	23	23	40	21	107
GP Educator	0	39	28	23	90
GP trainees [2]	163	39	11		213
Other Medical & Dental / Medical students (covid)	119	14	6		139

1 Includes locum/trust appointments for service/training on registrar pay scales.
2 includes GP trainees working in Trusts only.
Source: Human Resource, Payroll, Travel & Subsistence System.

Medical & Dental staff as at 31st March 2022 by gender (headcount)

	Female	Male
Consultant	829	1233
Associate Specialist	58	34
Specialty Doctor / Staff Grade	360	186
Specialty Registrars [1]	791	616
Foundation Year 1 & 2	302	224
Hospital/Medical Practitioner	46	40
Dental Officer/Practitioner	84	23
GP Educator	58	32
GP trainees [2]	141	72
Other Medical & Dental / Medical students (covid)	71	68
Total	2740	2528

1 Includes locum/trust appointments for service/training on registrar pay scales.
2 includes GP trainees working in Trusts only.

Source: Human Resource, Payroll, Travel & Subsistence System.

Vacancy data

Definition of a vacancy

A vacancy is any position that is currently with the recruitment team and being actively recruited to. This will include those going through pre-employment checks, up to the point of a start date being agreed. Once a start date has been agreed with both parties (i.e. manager and applicant) this will no longer be classed as a vacancy. Vacancies that are on hold by managers are not included

This information represents the number of vacancies actively being recruited to and does not indicate the whole time equivalent (WTE) for these positions.

The data includes both permanent and temporary positions. Vacancy rates are expressed out of the staff in post position at the mid-point of the year.

These figures do not include posts not actively being recruited to at the specific point in time, including those outside the bounds of the definition e.g. those that have not reached recruitment stage yet.

Staff Group	Number of vacancies actively being recruited to at									
	31-Mar-20	30-Jun-20	30-Sep-20	31-Dec-20	31-Mar-21	30-Jun-21	30-Sep-21	31-Dec-21	31-Mar-22	30-Jun-22
Consultant	101	127	88	120	126	133	117	119	153	167
Specialty Doctor	53	42	40	36	40	52	53	46	72	65
Doctors in training (core trainees, specialty registrars, foundation doctors)*	18	10	6	4	7	10	11	2	1	7

Other Doctor	29	65	57	20	42	66	19	23	92	132
Dental Officer	1	3	0	0	2	2	6	11	5	2
Total	**202**	**247**	**191**	**180**	**217**	**263**	**206**	**201**	**323**	**373**

Source: HSC Trusts & ALB's

*relates to Trust recruitment

**Excludes NIMDTA doctors in training recruitment vacancies, see next worksheet

Staff Group	**Vacancy Rate at**									
	31-Mar-20	**30-Jun-20**	**30-Sep-20**	**31-Dec-20**	**31-Mar-21**	**30-Jun-21**	**30-Sep-21**	**31-Dec-21**	**31-Mar-22**	**30-Jun-22**
Medical & Dental staff	3.9%	4.6%	3.6%	3.3%	4.0%	4.8%	3.7%	3.6%	5.8%	6.7%

Consultant Vacancies in HSC Trusts

	Number of vacancies actively being recruited to at									
Specialty	**31-Mar-20**	**30-Jun-20**	**30-Sep-20**	**31-Dec-20**	**31-Mar-21**	**30-Jun-21**	**30-Sep-21**	**31-Dec-21**	**31-Mar-22**	**30-Jun-22**
Acute/General Medicine	7	6	3	5	4	2	1	5	7	3
Acute Orthophysician	1	0	0	0	0	0	0	0	0	0
Addictions	0	1	0	0	0	0	0	0	0	0
Anaesthesics, ICU, Critical Care Medicine and Retrieval Medicine	8	10	10	7	3	8	8	13	11	13
Cardiology	1	2	1	1	3	4	3	0	2	2
Cardiology with sub specialty in heart failure	0	0	0	0	1	0	0	0	1	0
Care of the Elderly	2	9	4	2	5	4	1	5	3	6
Child and Adolescent Mental Health	0	0	1	0	1	0	0	0	2	2
Dermatology	2	1	0	0	1	2	2	0	0	0
Ear, Nose and Throat	0	0	0	2	2	0	0	3	1	3
Elderly Care with Stroke Interest	0	0	0	0	1	0	0	1	3	0
Elderly Frielty	0	0	0	0	0	1	0	0	0	0
Emergency Medicine	1	3	3	2	9	5	5	4	3	3
Endocrinology/Diabetes	2	3	2	1	3	1	3	3	2	2
Gastroenterology	0	2	1	2	3	6	2	5	2	3
Gastroenterology & General Medicine	0	1	0	0	0	0	0	0	0	0
General Internal Medicine	0	0	0	0	0	0	0	0	0	1
General Internal / Geriatric Medicine	0	0	0	0	0	0	0	0	0	1
Genito-Urinary Medicine	0	0	0	0	1	0	0	0	0	0
Geriatrics	0	0	2	2	2	5	4	2	5	0
Geriatric / Acute Care at Home	0	0	0	0	0	0	0	0	0	1
Haematology	1	2	0	1	2	4	2	1	1	1
Hepatology	0	0	0	0	0	0	0	0	2	2
Histopathology / Cytopathology	1	1	0	0	0	0	1	1	1	0

Imaging	0	0	0	0	0	0	0	2	1	0
Infection	0	0	0	0	0	3	0	0	0	0
Learning Disability	0	0	0	0	0	0	0	1	0	0
Cellular Pathology	5	4	0	0	0	5	2	2	1	1
Chemical Pathology	0	0	0	0	1	0	0	0	0	1
Pathology	0	3	2	2	2	1	1	0	1	0
Medical Microbiology	2	1	3	0	0	0	0	0	1	0
Mental Health	0	0	0	0	0	1	0	0	0	0
Mental Health Liaison Service	0	0	0	0	0	0	0	0	0	1
Microbiology	0	1	1	2	2	0	2	2	1	1
Medical/Clinical Oncology	3	4	6	6	4	3	3	0	7	7
Neonatal	0	0	0	0	0	0	0	0	1	0
Nephrology	0	1	0	0	4	1	0	0	0	0
Neurology	1	1	0	0	1	8	2	1	3	3
Neurosciences	0	8	3	13	0	0	0	0	0	0
Northern Ireland Specialist Transport & Retrieval (NISTAR)	0	0	0	0	0	0	0	0	1	0
Obstetrics & Gynaecology	4	2	3	3	1	1	2	3	8	19
Occupational Medicine	1	1	1	0	0	0	0	0	0	0
Oncology	0	0	0	0	0	0	0	2	0	0
Ophthalmology	0	0	2	2	0	1	1	0	0	0
Oral and Maxillo-Facial Surgery Head & Neck Oncology	0	0	0	0	0	1	0	0	0	0
Oral and Maxillo-Facial Surgery Orthognathics	0	0	0	0	0	1	0	0	0	0
Oral & Maxillofacial (Orthogriathics)	0	0	0	0	0	0	0	0	0	1
Orthodontics	0	0	0	0	0	1	1	1	0	0
Orthopaedics	0	0	0	0	0	4	3	2	0	0
Otolaryngology	0	0	0	0	2	0	0	0	0	0
Paediatrics	9	8	3	6	9	9	9	8	6	8
Palliative Medicine	3	2	1	1	1	0	2	2	1	0

Psychiatry	9	11	9	16	11	16	18	18	23	24
Radiology	17	14	2	6	11	4	6	3	17	8
Rehabilitation Medicine	0	0	0	0	0	0	0	0	0	1
Renal Medicine	0	0	0	0	0	0	1	0	0	0
Respiratory Medicine	1	0	0	3	2	0	1	2	3	5
Rheumatology	1	3	0	0	0	2	1	0	0	1
Sexual Health & HIV	0	1	1	0	0	0	0	0	0	0
Stroke Medicine	0	0	0	0	1	0	0	0	0	0
Substance Use and Dependance	0	0	0	0	0	1	0	0	0	0
Surgery	10	4	3	14	4	4	7	4	10	9
Trauma & Orthopaedics	0	0	2	1	1	1	0	2	6	7
Urology	0	0	2	1	6	4	4	2	4	3
Vascular	0	0	0	0	2	0	1	0	0	0
Virology	0	0	1	1	1	0	0	0	0	0
Total	92	110	72	102	107	114	99	100	141	143
Source: HSC Trusts										

* Excludes vacancies in Regional Services

Direct Employment Locum Consultant Vacancies in HSC Trusts

	Number of vacancies actively being recruited to at									
Specialty	**31-Mar-20**	**30-Jun-20**	**30-Sep-20**	**31-Dec-20**	**31-Mar-21**	**30-Jun-21**	**30-Sep-21**	**31-Dec-21**	**31-Mar-22**	**30-Jun-22**
Acute Medicine	0	0	0	0	0	1	0	0	0	0
Anaesthetics	1	1	0	4	3	3	2	0	0	1
Intensive Care Medicine and Anaesthesia	1	0	0	0	0	0	0	0	0	0
Cardiology	0	0	0	1	0	0	0	2	0	0
Care of the Elderly	0	0	0	0	0	1	4	1	1	0
Clinical Oncology	1	0	0	0	0	0	0	0	0	0
Chemical Pathology	0	0	0	0	0	0	0	0	1	0

Dentistry	1	0	1	0	0	0	0	0	0	0
Dermatology	0	0	0	0	0	0	0	0	1	0
Ear, Nose and Throat	0	0	0	0	0	0	1	1	1	1
Elderly Care with Stroke Interest	0	0	0	0	0	0	0	0	0	0
Emergency Medicine	2	2	0	0	3	1	1	1	1	0
Endocrinology/Diabetes	0	0	0	0	0	0	0	0	0	0
Gastroenterology	0	0	0	0	0	0	0	1	1	0
General Medicine	0	0	0	1	0	0	0	0	0	0
Geriatrics	0	0	0	0	0	0	0	0	0	0
Labs	0	0	0	0	0	0	0	0	1	0
Microbiology	0	0	0	0	1	1	0	0	0	0
Neonatal	0	0	0	0	0	1	0	0	0	1
Neurology	0	0	0	0	1	1	0	0	0	1
Obstetrics & Gynaecology	0	0	0	1	1	0	2	1	1	2
Oncology	0	0	0	0	0	0	0	4	1	5
Orthopaedics	0	0	0	0	0	2	1	0	0	0
Ophthalmology	0	0	0	0	2	0	1	0	0	0
Paediatrics	0	8	4	2	3	4	3	7	2	3
Palliative Medicine	0	0	0	1	1	1	0	1	0	1
Psychiatry	1	0	1	2	2	3	2	0	1	0
Radiology	0	1	0	1	0	0	1	0	0	0
Respiratory	0	0	0	0	1	0	0	0	0	0
Surgery	2	3	1	1	0	0	0	0	0	1
Trauma & Orthopaedics	0	0	3	0	0	0	0	0	0	8
Urology	0	0	1	1	0	0	0	0	0	0
Total	**9**	**15**	**11**	**15**	**18**	**19**	**18**	**19**	**12**	**24**

Source: HSC Trusts

* Excludes vacancies in Regional Services

SAS Doctor Vacancies in HSC Trusts	Number of vacancies actively being recruited to at									
Specialty	**31-Mar-20**	**30-Jun-20**	**30-Sep-20**	**31-Dec-20**	**31-Mar-21**	**30-Jun-21**	**30-Sep-21**	**31-Dec-21**	**31-Mar-22**	**30-Jun-22**
Acute Care at Home	1	0	0	3	1	2	2	4	5	2
Acute Medicine	0	1	0	1	1	2	0	1	0	0
Acute & Ambulatory Care	0	0	0	0	0	0	0	1	0	0
Acute & Ambulatory Paediatrics	0	0	0	0	0	1	1	0	1	2
Acute & Critical Care	0	0	0	0	0	0	0	1	0	0
Addiction	0	0	0	0	0	0	0	0	1	0
Ambulatory Medicine	0	0	0	1	1	0	0	0	0	0
Ambulatory & Geriatric Medicine	0	0	0	0	0	0	2	0	0	2
Anaesthetics	4	3	2	3	4	3	5	3	8	7
Cardiology DAU	2	0	0	0	1	0	0	0	0	0
Cardiology	0	3	1	2	2	3	0	0	1	1
Care of Elderly (Outreach)	1	0	0	0	0	0	0	0	0	0
Care Of Elderly	0	2	0	0	1	0	2	1	1	2
Child and Adolescent Mental Health	0	1	2	2	3	1	3	2	2	2
Dentistry	1	2	2	0	0	0	0	0	0	0
Dermatology	0	0	0	0	0	0	0	0	1	1
Direct Assessment Unit	10	6	3	2	0	2	2	1	1	1
Ear, Nose and Throat	1	1	0	1	0	1	1	0	1	0
Emergency Medicine	1	3	3	0	3	8	1	1	3	1
Endocrinology/Diabetes	0	0	1	1	2	4	4	3	3	2
Gastroenterology	0	0	0	0	0	2	3	3	3	1
General Medicine	4	1	0	3	1	2	0	0	0	0
General Internal Medicine & Acute Critical Care	0	0	0	0	0	0	1	0	0	0
Geriatric Medicine	0	0	1	0	1	0	1	3	3	1

Haematology	1	1	0	1	3	3	2	2	3	0
Medical Microbiology	0	0	0	0	0	0	0	0	1	0
Mental Health	0	0	0	0	0	0	1	0	1	0
Mental Health Liaison Service	0	0	0	0	0	0	0	0	0	1
Microbiology	0	0	0	1	0	0	1	0	1	1
Neonatology	0	0	0	0	0	1	0	0	0	0
Nephrology	1	1	0	0	0	0	0	0	0	0
Neurology	2	1	0	0	0	0	4	1	2	0
Obstetrics & Gynaecology	1	0	4	2	0	0	0	2	2	7
Occupational Health	0	0	0	0	0	1	2	1	1	0
Oncology	2	0	1	0	2	0	1	1	3	3
Opthalmology	0	0	1	0	0	0	0	0	0	0
Orthopaedics	0	0	0	0	0	0	0	1	0	0
Paediatrics	11	4	5	6	3	3	8	6	9	12
Palliative Care	0	0	1	1	1	0	0	1	0	0
Plastic Surgery	0	2	0	1	0	0	0	0	0	0
Psychiatry	6	5	6	2	4	3	0	4	7	9
Renal Medicine	0	1	0	0	0	0	0	0	0	0
Respiratory Medicine	1	1	0	1	3	4	2	2	3	2
Respiratory & Ambulatory Medicine	0	0	1	0	2	1	0	0	0	0
Rheumatology	0	1	1	0	0	1	2	0	1	1
Sexual & Reproductive Healthcare	0	0	1	0	0	0	0	0	0	0
Stroke Medicine	0	1	1	1	1	0	1	0	1	0
Surgery	2	1	3	1	0	1	1	1	2	1
Trauma & Orthopaedics	0	0	0	0	0	0	0	0	1	3
Thoracic	0	0	0	0	0	2	0	0	0	0
Urology	1	0	0	0	0	1	0	0	0	0
Total	**53**	**42**	**40**	**36**	**40**	**52**	**53**	**46**	**72**	**65**

Source: HSC Trusts

HSC Medical & Dental Leavers (1st April 2020 - 31 March 2021)

	Headcount	Leaving Rate
Consultant	68	3.42%
Associate Specialist / Staff Grade	12	11.54%
Specialty Doctor	22	4.36%
Hospital/Medical Practitioner	9	9.28%
Dental Officer/Practitioner	3	2.65%
GP Educator	6	7.32%
Other Medical & Dental	12	19.35%
Total	132	4.47%

Excludes doctors in training

Includes leavers from Health & Social Care only, will not include movements between or within organisations.

HSC Medical & Dental Leavers (1st April 2021 - 31 March 2022)

	Headcount	Leaving Rate
Consultant	95	4.64%
Associate Specialist / Staff Grade	7	7.22%
Specialty Doctor	41	7.64%
Hospital/Medical Practitioner	11	12.50%
Dental Officer/Practitioner	9	8.74%
GP Educator	3	3.37%
Other Medical & Dental	13	15.12%
Total	179	5.87%

Excludes doctors in training

Includes leavers from Health & Social Care only, will not include movements between or within organisations.

Note there was an increase in the number of temporary staff leaving in 21/22, possibly related to those temporary additions to the workforce to assist with the Covid-19 pandemic response.

HSC Medical & Dental Joiners (1st April 2020 - 31 March 2021)

	Headcount	Joining Rate
Consultant	70	3.52%
Associate Specialist / Staff Grade	55	9.03%
Specialty Doctor		
Hospital/Medical Practitioner	23	23.71%

HSC Medical & Dental Joiners (1st April 2021 - 31 March 2022)

	Headcount	Joining Rate
Consultant	76	3.71%
Associate Specialist / Staff Grade	49	7.73%
Specialty Doctor		
Hospital/Medical Practitioner	3	3.41%

Dental Officer/Practitioner	2	1.77%
GP Educator	7	8.54%
Other Medical & Dental	14	22.58%
Total	171	5.79%

Excludes doctors in training, from headcount and rate

Includes new joiners to Health & Social Care only, will not include movements between or within organisations.

Dental Officer/Practitioner	8	7.77%
GP Educator	27	15.43%
Other Medical & Dental		
Total	163	5.35%

Excludes doctors in training, from headcount and rate

Includes new joiners to Health & Social Care only, will not include movements between or within organisations.

Agency Spend, 2021/22 Q1 -Q4

		Belfast HSC Trust	Northern HSC Trust	Northern Ireland Ambulance Service	South Eastern HSC Trust	Southern HSC Trust	Western HSC Trust	Total
Medical & Dental (excludes directly employed locums)	Contract Only spend	17,563,092	8,256,209	0	2,841,218	14,704,098	15,708,560	69,073,177
	Off-Contract	7,507,953	12,519,579	0	12,315,188	4,357,273	6,902,061	33,602,053
	Total	**25,071,045**	**20,775,788**	**0**	**15,156,406**	**19,061,371**	**22,610,620**	**102,675,230**

Bank Staff 2021/22 Q1-Q4

	Belfast HSC Trust	Northern HSC Trust	South Eastern HSC Trust	Southern HSC Trust	Western HSC Trust	Total
Medical & Dental	0	0	0	43,953	0	43,953