

**DEPARTMENT OF HEALTH**

**NORTHERN IRELAND**

**EVIDENCE**

**THE REVIEW BODY ON DOCTORS' AND DENTISTS'**

**REMUNERATION**

**2027/28 PAY ROUND**

**October 2026**

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## **Section One – DDRB 54th Report – Observations and Recommendations**

Following publication of the 54th Report of the Doctors' and Dentists' Remuneration Body (DDRB) on 25 March 2026, the Minister for Health welcomed the report and the recommendations relevant to Northern Ireland.

The Department remains committed to constructive engagement with the DDRB process and recognises the important role of the Review Body in supporting the recruitment, retention and motivation of doctors and dentists. The Department has carefully considered the recommendations contained within the 54th Report and continues to progress those recommendations applicable to Northern Ireland

### **1.1 Overview of Recommendations**

The DDRB recommended:

**A 3.5 per cent increase to the pay ranges and the pay element of contracts from 1 April 2026. This applies to: resident doctors and dentists; consultants; SAS doctors and dentists; locally employed doctors; contractor general medical practitioners; and salaried GP pay ranges.**

**A 3.75 per cent increase to the pay element of dental contracts and to pay for salaried dentists working in Community Dental Services and the Public Dental Service.**

Despite the absence of an agreed Budget for 2026/27, the Health Minister accepted the recommendations. Given the affordability challenges facing the Department, a Ministerial Direction was issued on 10 July 2026 to implement the recommended 2026/27 HSC pay award. Ministerial Directions of this nature require approval by either the Department of Finance or the Executive before they can be implemented. The Ministerial Direction has been referred to the Northern Ireland Executive, by the Department, for consideration and decision and, at the time of writing, the Department is awaiting the outcome of that process.

**The four governments work with dentists' representatives to develop an index of dental costs in each nation. These indices should then be used to determine the expenses element of dental contract uplifts in each nation.**

The Department recognises the importance of ensuring that future contract uplifts appropriately reflect the costs associated with delivering Health Service dentistry. A General Dental Service Cost of Service Review was published<sup>1</sup> on 16 September 2026, with practice expenses included within its scope. The Department will consider the findings of this review alongside ongoing work relating to the reform and sustainability of General Dental Services

**Governments review pay and progression for salaried dentists working in Community and Public Dental Services to assess whether the reward structure is appropriate to support recruitment, retention, and service delivery.**

The Department is currently considering this recommendation and continues to engage with counterparts in the other UK nations, as well as the British Dental Association Northern Ireland, to better understand the workforce challenges facing the Community Dental Service and the potential options available to address them.

## **1.2 Financial Position – Funds Available for 2026/27 Pay Award**

The 2025-26 medical and dental pay awards were implemented only following the receipt of additional in-year funding and access to a Reserve Claim. These measures were provided on a non-recurrent basis and do not resolve the underlying affordability challenges associated with future pay awards.

Minister Butler has committed to implementing the 2026/27 pay awards in line with the independent pay review body recommendations.

However, at the time of writing, Northern Ireland departments do not have the benefit of an Executive agreed budget within which to plan or operate for 2026-27 and beyond. Any pay award for 2027/28 must therefore be considered within the context of future agreed departmental spending limits and the wider affordability position facing both the Department and the Northern Ireland Executive.

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<sup>1</sup> General Dental Services in Northern Ireland Cost of Service Review | Department of Health

### **1.3 Departmental Approach to Pay Award 2026/27**

The Department remains committed to engaging fully with the independent pay review process and recognises the importance of pay in recruiting, retaining and motivating doctors and dentists.

However, the financial outlook remains extremely challenging. It is anticipated that the future funding position will not significantly improve, with next year's financial position equally as challenging and there is a risk that the position may worsen if the overspends currently forecast in 2026-27 materialise, and future budgets are reduced as a consequence.

In this context, the Department has little capacity to fund a pay uplift in 2027/28. Affordability will be dependent on making significant savings in other areas or the provision of additional funding from the Executive. The latter will be constrained by the financial pressures faced by all Executive departments. There is also a risk that any additional Executive funding is provided from in year easements meaning it is non recurrent thereby perpetuating the funding issue in the future.

The Department continue to pursue efficiency and savings measures wherever possible. However, the need for financial savings must be balanced against the potential for an adverse impact on services..

Pay accounts for more than half of Health expenditure in Northern Ireland, and as a result, pay awards continue to have significant implications for overall affordability and the funding available to support frontline service delivery.

### **1.4 Affordability of pay uplifts**

In the absence of an Executive agreed Budget, and associated Budget Act, for 2026 - 27 the Department is currently operating under the legal authority provided by the DoF Permanent Secretary, using the contingency powers granted to him in the Government Resources and Accounts Act (NI) 2001 and the NI Act 1998. However, as the amount which can be authorised in this way is limited to 95% of the preceding year the amount DoF has indicated will be authorised for DoH is lower than its opening 2025-26 budget. The contingency planning envelope does not constitute a formal Budget settlement, rather it reflects a prudent estimate of the level of funding that could reasonably be expected to inform a future Budget position for Executive consideration.

The Department faces a range of significant unavoidable pressures and current estimates indicate that cash-releasing savings of between 6 per cent and 9 per cent would be required in 2026/27 simply to address these pressures. Taking account of these challenges, the Department is forecasting a funding gap of approximately £800 million. Even with maximum efforts to deliver efficiencies and savings, it is unlikely that financial balance can be achieved without additional financial support.

The Department recognises the importance of competitive pay in supporting the recruitment, retention and motivation of Health and Social Care staff. However, workforce expenditure represents the largest component of Health spending, meaning that pay settlements must be considered alongside other significant pressures and priorities, including workforce expansion, waiting list recovery, service transformation and the maintenance of core services. The affordability of pay awards remains the most significant constraint affecting future workforce investment. In the absence of additional funding, any pay award must be met from within the Department's overall resource allocation. As a result, decisions on pay cannot be considered in isolation but must be balanced against other demands on the Health budget. This creates unavoidable trade-offs between investment in pay and the resources available to support wider service delivery, workforce growth and system improvement. The Department therefore considers it essential that recommendations on pay take account of both workforce considerations and the broader financial sustainability of the Health and Social Care system.

## **1.5 Conclusion**

The Department remains committed to supporting the recruitment, retention and wellbeing of the medical and dental workforce and recognises the important role of the independent pay review process in maintaining morale, supporting workforce sustainability and ensuring that the Health and Social Care system remains an attractive place to work. This submission is, however, presented against a backdrop of significant financial constraint, increasing demand for services, workforce shortages and continuing affordability pressures. The absence of a sustainable funding settlement, combined with wider financial challenges facing the Health and Social Care system, continues to place considerable pressure on available resources.

The Department recognises the importance of competitive pay as part of the overall employment offer. However, workforce sustainability is influenced by a broader range of factors, including workforce supply, education and training capacity, retention, staff wellbeing, career development opportunities and service transformation. The evidence presented throughout this submission demonstrates both the scale of these challenges and the actions being taken to address them.

While the Department remains committed to implementing DDRB recommendations, future pay awards must be considered within the context of the wider financial position facing Health, Social Care services and public service as a whole in Northern Ireland. The Department therefore considers it essential that pay recommendations take account of both workforce considerations and affordability, recognising the need to balance investment in pay with wider service delivery, workforce growth and transformation priorities. The remainder of this submission sets out the economic, workforce and service delivery context that will inform the Department's position for the 2027/28 pay round.

## **Section 2 – 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.

CPI inflation stood at 3.1% in the 12 months to August 2026, up from 2.9% in July<sup>2</sup>. The Bank of England reported that CPI inflation was 2.6% in June, above the Monetary Policy Committee's (MPC) 2% target. While there are clear signs that underlying price and wage pressures have continued to ease, that has been offset by higher global energy prices as a result of the conflict in the Middle East, which have led to higher motor fuel prices for UK consumers. The MPC cannot influence global energy prices so it is setting monetary policy to make sure that the effects of the shock do not become embedded so that inflation falls back to the 2% target and stays there<sup>3</sup>. At the same time median wage growth in NI increased by 4.9 % over the year to June 2026<sup>4</sup>. The ASDA income tracker has reported that growth has slowed to 3.4% in August 2026, its weakest since March<sup>5</sup>.

While earnings growth has picked up slightly, it has been outpaced by inflation which accelerated to 3.1% in August and is expected to stay above 3% in the near term. This has also seen discretionary income fall by 0.5% in August 2026. The lowest income quintile was the only group to see its discretionary income deteriorate over the year seeing a decline of 1.9% from August 2025. All other quintiles recorded positive annual growth. The tracker reports that price volatility due to the ongoing conflict in the Middle East has taken expected interest rates cuts off the table for 2026, increasing the possibility of rate hikes before the end of the year, which is likely to impact discretionary incomes for UK households heading into the New Year. Average household spending power for Northern Ireland amounted to £134 per week as of August 2026. This remains the lowest level amongst the UK's regions and nations<sup>6</sup>.

Whilst inflationary pressures have eased compared with the peaks experienced in recent years, household finances remain under pressure. This continues to form part

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<sup>2</sup> ONS - Consumer price inflation, UK: August 2026

<sup>3</sup> Bank of England – Monetary Policy Report – July 2026

<sup>4</sup> NISRA NI Labour Market Report – July 2026 – HMRC PAYE statistics

<sup>5</sup> ASDA Income Tracker – September 2026 Report

<sup>6</sup> ASDA Income Tracker – September 2026 Report

of the wider context in which the Department must consider recruitment, retention and motivation across the medical and dental workforce.

## **2.2 Labour Market**

Online job listings, as reported by the Department for the Economy, increased by 10% compared with the previous month. There were 11,700 new job postings in August 2026, an increase of 39% compared to August 2025<sup>7</sup>. In addition, latest Ulster Bank PMI<sup>8</sup>, signalled a first rise in employment in five months as growth of output and new orders was sustained.

The latest data also pointed to a marked intensification of inflationary pressures amid higher fuel costs due to war in the Middle East. Meanwhile, business confidence has eased. The headline Business Activity Index signalled a rise in business activity for the third month running amid sustained growth of new orders. As was the case in February, only London posted a faster expansion in output than Northern Ireland in March. Activity increased across all four monitored sectors, led by retail. Meanwhile, the rate of growth in the service sector eased markedly and was only marginal.

The number of people on the claimant count in June 2026 was 33,800 – a decrease of 1.8% over the month. This is 47.4% less than the recent peak in May 2020 and 13% more than the pre-pandemic count in March 2020.

Looking at the employment rate, over the last 15 years, the rate in NI has been consistently below the UK rate. The most recent NI employment rate (aged 16 to 64) for the period March-May 2026 was estimated at 72.1%. This was an increase of 0.8pps over the quarter (not statistically significant) and an increase of 0.1pps over the year (not statistically significant).

The rolling 12-month total of confirmed redundancies is 1,670, 23% lower than for the previous year's figure of 2,170. The Department for the Economy were notified of 2,860 proposed redundancies over the last 12 months up to the end of June 2026. This was over 5% less than the figure for the previous year (3,030).

Finally, a significant issue in NI is that over the last 15 years, economic inactivity in NI has been consistently higher than the UK average, with more variability in economic

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<sup>7</sup> Department for the Economy- Online Job Posting Trends – August 2026

<sup>8</sup> Ulster Bank PMI Report – March 2026

inactivity in NI than the UK. The NI economic inactivity rate (aged 16 to 64) of 26.5% was 5.6pps above the most recent UK rate of 20.9%. This is the highest of the twelve UK regions.

Although labour market conditions have softened in some sectors, Northern Ireland continues to operate within a highly competitive labour market for professional and specialist occupations, including healthcare staff.

## 2.3 Public Expenditure

On 11 June 2025, the Chancellor announced Phase 2 of the Spending Review providing the Executive with a multi-year funding envelope for the period 2026-27 to 2028-29 for Resource plus an additional year to 2029-30 for Capital. This was further updated at Autumn 2025 Budget and Spring 2026 Forecast. The revised position is set out in the table below. Please note this is subject to change.

**Table 1: Autumn Budget and Spring Forecast**

|                                       |                        |                |                |                | £million       |
|---------------------------------------|------------------------|----------------|----------------|----------------|----------------|
| <b>Control Total</b>                  | <b>2025-26 Budget*</b> | <b>2026-27</b> | <b>2027-28</b> | <b>2028-29</b> | <b>2029-30</b> |
| <b>Resource DEL</b>                   | 16,148.5               | 16,707.8       | 16,929.8       | 17,481.6       | -              |
| <b>Capital DEL</b>                    | 2,154.2                | 2,351.7        | 2,394.8        | 2,306.7        | 2,330.9        |
| <b>Financial Transactions Capital</b> | 57.4                   | 91.7           | 92.6           | 118.6          | 140.7          |

\* 2025-26 position is included for comparison

*Source: Department of Finance*

Whilst overall the Spending Review outcome provides the Executive with additional funding when compared to 2025-26, the position remains extremely challenging as this must be viewed in the context of rising demand and the increasing cost of delivering public services. However, the additional funding available to the Executive must be considered alongside inflationary pressures, increasing demand for public services and the rising cost of delivering health and social care services. As a result, affordability remains a significant consideration for future pay awards.

Intensive work is continuing on progressing a multi-year budget including continued engagement with the UK Government on sustainable funding for public services in Northern Ireland.

In the absence of an agreed Budget for 2026-27 the DoF Permanent Secretary has provided Departmental Accounting Officers with Contingency Planning Envelopes to assist them in assessing spending plans. In the absence of a Budget Act, departmental expenditure is currently authorised by the DoF Permanent Secretary under the contingency powers provided to him by the NI Act 1998 and the Government Resources and Accounts Act (NI) 2001. The amounts that can be authorised under these powers is limited to 95% of the sums authorised for 2025-26 in the Budget Act 2026. They are therefore a short-term contingency measure.

## **2.4 Public Sector Workforce**

The public sector in NI employs 235,380 people<sup>9</sup> or 27.4% of all employee jobs in NI, a significantly higher share compared to 18%<sup>10</sup> 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.

Northern Ireland has consistently had a higher proportion of public sector jobs per population than the whole of the UK.

The size of the public sector workforce reflects the structure of the Northern Ireland economy, which continues to be more reliant on public sector employment than many other UK regions. This means that public sector pay decisions can have wider implications for both public expenditure and labour market competitiveness.

## **2.5 Public Sector Pay**

Public sector pay in Northern Ireland accounts for a significant share of the Resource Department Expenditure Limits (DEL) budget. Provisional outturn figures for the 2025-26 financial year indicate that pay costs accounted for approximately 60% of departmental non-ring-fenced Resource DEL<sup>11</sup>.

Public sector pay therefore represents one of the most significant areas of departmental expenditure. Decisions relating to pay awards must be considered

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<sup>9</sup> NISRA Northern Ireland Quarterly Employment Survey – June 2026

<sup>10</sup> ONS Public sector employment, UK, June 2025 (March 2025 Data)

<sup>11</sup> Open Book Review of Northern Ireland Executive Budget – June 2026

alongside wider affordability pressures and the need to maintain the delivery of public services within available funding allocations.

## **2.6 Northern Ireland Executive Pay Policy**

The Minister of Finance set out the approach to Public Sector Pay Policy for 2026-29 in the draft Budget 2026-29 when it was published for consultation in January 2026. While the Finance Minister's draft Budget was not agreed, the approach to public sector pay policy remained largely unchanged from that in recent years. The overarching principles remain that pay must be affordable within each department's budget settlement (once agreed); and awards should be targeted to address low pay, and where possible, the payment of the real Living Wage.

## **2.7 Total Health Expenditure**

Total Department of Health expenditure in 2025/26 was £8.9 billion. In the absence of an agreed budget for 2026-27 the Department has been provided with a funding limit which is less than the 2025-26 total expenditure. Workforce costs continue to represent the largest area of expenditure, with pay accounting for more than 50% of overall Health spending. Consequently, decisions relating to pay awards, workforce expansion, education commissioning and retention initiatives have a material impact on overall affordability and the Department's ability to invest in other service priorities.

## **2.8 Health and Social Care Paybill**

The total HSC paybill was £4.54 billion in 2025/26, of which approximately £0.84 billion relates to medical and dental staff. The estimated pay bill for 26/27 for the HSC is £4.85 billion of which approximately £0.88 billion relates to medical and dental staff. Workforce costs therefore continue to represent a substantial proportion of overall Health expenditure and are a key consideration in assessing the affordability of future pay awards. As pay expenditure accounts for more than half of total Health spending, relatively small percentage changes in pay awards create significant recurring cost pressures. Consequently, affordability considerations remain central to decisions regarding workforce growth, training commissions, service expansion and future pay awards

## **2.9 Conclusion**

Northern Ireland continues to face a challenging economic and fiscal environment characterised by inflationary pressures, constrained public expenditure and increasing demand for public services. While labour market conditions have softened in some areas, competition for skilled professionals remains significant. These factors provide important context for considering the recruitment, retention and motivation of doctors and dentists, as well as the affordability of future pay awards. Affordability considerations therefore remain central to workforce planning, workforce growth and consideration of future pay awards. While workforce investment remains essential to support service delivery, the pace at which investment can occur continues to be influenced by the Department's financial position.

## **Section Three – Policy Context**

### **3.1 Strategic Direction of Health and Social Care in Northern Ireland**

#### **3.1.1 Cancer Strategy for Northern Ireland**

The Cancer Strategy for Northern Ireland 2022-2032 was launched in March 2022 and sets out 60 recommendations across four strategic themes to transform cancer services over the next decade. While progress has been made, implementation has been significantly constrained by funding pressures.

Since 2024/25, £10.6 million of recurrent funding has supported delivery of the Strategy. However, this falls considerably short of the investment levels envisaged in the original Funding Plan, which projected £55.7 million recurrent funding by Year 4, increasing to £145 million by Year 10, alongside £73 million in one-off capital investment. As a result, delivery has progressed more slowly than anticipated. Achieving the Strategy's full range of intended outcomes will require substantial additional investment, alongside increased workforce capacity and the appropriate skills mix to support sustainable service delivery.

In line with a Programme for Government commitment to cut waiting times, the Northern Ireland Executive earmarked funding for elective care and waiting list activity in 2025/2026, with £85m for red flag cancer and other time-critical treatments. This investment has supported key areas of cancer diagnostics and treatment, including £13m for endoscopy, £12m for diagnostics, £5m each for breast surgery and dermatology, and £3.5m for gynaecology. A further £1m was allocated to a Cancer Charities Grant Scheme, matched by Macmillan Cancer Support, to provide practical support services for cancer patients and families closer to home.

Although £80m has been ringfenced for elective waiting lists and capacity building in 2026/27, there is currently no additional identified funding to support full implementation of the Cancer Strategy.

As a result, a significant number of planned actions have been delayed or are unable to progress at this time. Funding and workforce pressures have also delayed a number of Cancer Strategy initiatives, impacting service development across cancer care, including palliative care and community-based "closer to home" cancer services.

Workforce shortages, particularly among Allied Health Professionals, are currently restricting delivery of prehabilitation and rehabilitation programmes, while plans to expand seven-day acute oncology services, workforce training and development have also been impacted, creating longer-term risks to service sustainability and quality of care.

These challenges also place additional pressure on existing staff and highlight the importance of maintaining a sustainable workforce able to support increasing demand for cancer services over the coming years. Delivering the ambitions of the Cancer Strategy will require not only continued investment in services, but also sufficient workforce capacity across medical, nursing, allied health professional and diagnostic disciplines.

Despite lower investment levels than initially anticipated, there are a number of areas where implementation of the Cancer Strategy has progressed well. The Cancer Progress Report<sup>12</sup>, published on 2 July 2026, provides a comprehensive assessment of implementation during the Strategy's first four years, highlighting achievements to date.

### **3.1.2 Elective Care Framework and Waiting List Recover**

Waiting times for elective care services in Northern Ireland are among the worst in the UK. They have significantly increased in recent years due to the challenging financial situation, the residual impact of COVID-19 and an increasing health service capacity and demand gap.

The Department of Health's Elective Care Framework<sup>13</sup>, updated in May 2024, sets out the strategic direction for the development and implementation of the changes necessary for effective sustainable elective care services in Northern Ireland over the next five-year period. It sets out a thematic plan designed to reduce waiting lists and increase capacity across the elective care system.

In-house and IS capacity is used to address some of the longest waiters for assessments and treatments across a number of general specialties and/or procedures. Funding is also being targeted at some of those specialist procedures

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<sup>12</sup>[Cancer Strategy for Northern Ireland Progress Report March 2022 - March 2026.pdf](#)

<sup>13</sup> [Elective Care Framework - May 2024.pdf](#)

where there are long waits impacting women or children as per the recent Elective Care Framework.

The establishment of the Waiting List Reduction Reimbursement Scheme helped facilitate the transfer and treatment of long waiting patients, without impacting on core or local IS capacity. The Scheme offers patients the choice of treatment in the Republic of Ireland, and other parts of the European Union. To ensure the maximum impact on waiting times, this Scheme is limited to those patients who have been waiting at least 12 months for their procedure.

Mega Clinics are being undertaken in all Trusts and cover a range of specialties including; ophthalmology, orthopaedics, general surgery and ENT. Mega clinics may also be utilised to undertake large scale administrative and clinical validation as this will represent value for money.

Given the current long waits for routine assessment, it is not uncommon for a patient's clinical condition to change. Undertaking regular validation of the waiting list is important to ensure accuracy of waits and reduce the risk of patient cancellations or Did Not Attends (DNAs). Ensuring accurate and up to date waiting lists will enable more efficient scheduling of activity and help reduce DNAs and cancellations, thereby improving the overall service productivity. Historically, between 5-10% of contacts via validation results in a removal from a waiting list. This helps ensure that clinical capacity is directed towards patients who continue to require treatment, supporting more effective use of available resources and improving overall productivity.

Building core HSC capacity will be paramount to sustainably reducing waiting times. The funding identified through the ECF has allowed this work to start and capacity is being expanded across a range of specialties.

In May 2025, the Minister for Health, published an Elective Care Framework Implementation and Funding Plan<sup>14</sup> for 2025/26, detailing how £215m earmarked funding from the Programme for Government would be invested in waiting list activities across expanding capacity to reduce the red flag/time critical capacity gap, increasing core routine capacity, and non-recurrent funding to tackle the backlog of patients waiting.

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<sup>14</sup> ECF Implementation and Funding Plan

Significant achievements were realised in 2025/26 using this funding, notably:

- over 313,000 patients received an outpatient/AHP assessment, diagnostic test or treatment;
- over four-year waits for colonoscopy, laparoscopic cholecystectomy and tonsillectomy down by 100%;
- over four-year waits for primary hip and knee replacements and hernia procedures down by between 95% and 99% respectively; and
- over 12,000 elective appointments carried out in a primary care setting.

In July 2026, the Minister published an Elective Care Framework Funding and Implementation Plan<sup>15</sup> for 2026/27 to build on work already achieved in 2025/26 through regional elective care services, increased diagnostic capacity, elective care centres, waiting list initiatives and stronger collaboration across the HSC system. It details how the £165m ringfenced allocation in the 2026/27 Northern Ireland Health Budget for waiting list activities will be invested across expanding capacity to reduce the red flag/time critical capacity gap, increasing core routine capacity and continuing to tackle the backlog of patients waiting.

Achievements in Quarter 1 of 2026/27 include:

- over 36,800 patients receiving outpatient/AHP assessment, diagnostic test or IP/DC;
- a 72% reduction in the endoscopy backlog since its peak in June 2022;
- 4,721 appointments delivered through the Primary Care Elective Service;
- a 25% reduction in long waits for a number of targeted procedures including tonsillectomies, hip and knee replacements and paediatric scopes; and
- outpatient validation of almost 40,000 patients.

Sustainable reductions in waiting times will depend not only on additional funding and service reform, but also on securing sufficient workforce capacity across key specialties. Workforce shortages and recruitment challenges continue to constrain the pace at which additional activity can be delivered in some areas, reinforcing the importance of long-term workforce planning and investment.

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<sup>15</sup> [Elective Care Framework - Funding and Implementation Plan - July 2026](#)

### **3.1.3 Pandemic Recovery and Elective Care Backlogs**

The Department's approach to reducing waiting lists, building sustainable capacity and addressing backlogs arising from pandemic-related disruption is outlined in Section 3.1.2 (Elective Care Framework and Waiting List Recovery).

In relation to the longer-term approach to address backlogs, the Elective Care Framework (ECF) (originally published in June 2021 and updated in May 2024) remains the roadmap for change. It sets out a five-year plan to systematically tackle the backlog of patients waiting, and to invest in and transform services to meet the population's demands in future.

Positive achievements have been made through the development of elective care centres, rapid diagnosis centres and mega clinics. In addition, service reviews have been completed across a number of specialities, subsequently leading to improvements. The Department of Health continues to work with Trusts to increase productivity and efficiency through the use of a wide range of best practice service improvements.

Reducing waiting lists will not be a quick fix and it will not be resolved in a year or two. Investment at this level or higher will need to be sustained for up to five years to bring hospital waiting times down to acceptable levels.

### **3.1.4 Multidisciplinary Teams and Managing Long-Term Demand Growth**

The increase in demand for Primary Care services cannot be met solely by increasing the number of GPs. In terms of the wider primary care workforce, the Department has continued to boost its capacity by investing £25million per year in the Primary Care MDT Programme.

Additionally, a successful bid for £61m was made to the Transformation Fund, to support the further rollout of the MDT Programme across the five-year span of the Transformation Fund.

The Primary Care Multi-disciplinary Teams (MDTs) Programme has introduced new physiotherapy, social work, and mental health roles into General Practice, working alongside the existing practice team and enhanced levels of nursing.

MDT practitioners are working with patients of all ages to ensure they have access to timely assessment and appropriate support to address their individual needs. There is a strong focus on prevention and early intervention to help patients self-manage a variety of issues.

The MDT Programme has already delivered a range of positive outcomes across a variety of areas. By focusing on wellbeing rather than just sickness and proactively managing patient need in their local GP practice setting through a multi-disciplinary early intervention approach, patient outcomes are being improved, reducing the need for referrals and appointments elsewhere, and ultimately easing pressure on GP and hospital services.

The MDT model remains the key to stabilising and strengthening vital Primary Care services to ensure they can continue to provide high-quality care to people, now and into the future.

In July 2025, the Minister for Health, published the MDT Implementation Plan. The Plan set out how the MDT model will be rolled out in full across all areas of Northern Ireland over the next 8 years. Implementation will proceed in two phases:

- Phase 1, supported by £61m Transformation Funding, will run from 2025/26 – 2028/29 and will see MDT completed in the seven existing Federation areas where implementation has already commenced, and expansion to a further 5 Federation areas.
- Phase 2 will run for a further four years from 2029/30 and will see MDT complete in the remaining 5 GP Federation areas.

At the end of Q1 (June 2026) the programme is reporting the following progress:

- Over 1.3m citizens now have access to physiotherapy, social work or mental health services in their local GP Practice.
- The percentage of GP practices with an element of MDT has increased by 35 percentage points to 87% of target GP practices. There are currently over 412 wte front line MDT staff supported by the programme, including 297.41 WTE core patient-facing MDT staff working across 194 GP practices in 12 GP Federation areas.

MDT teams are providing vital additional capacity in general practice settings, often without the need for a patient to first see a GP. During 2025/26 an additional 354k consultations were provided by MDTs. These consultations represent additional capacity delivered without requiring a corresponding increase in GP numbers, demonstrating how multidisciplinary workforce models can improve productivity and help manage increasing demand within existing resource constraints.

Patients can see a member of the MDT without first having to be assessed by a GP. With ongoing challenges in relation to GP retention and recruitment across Northern Ireland, MDT practitioners are key in helping to meet rising demand in the Primary Care setting.

The MDT model demonstrates how workforce transformation can support the delivery of services in a sustainable manner. By ensuring that patients are seen by the most appropriate professional at the earliest opportunity, MDTs help maximise available workforce capacity, reduce pressure on GPs and support the long-term sustainability of primary care services.

It is estimated that once fully rolled out, the programme could provide around a million consultations each year in General Practice. Progress towards this ambition continues, with MDTs providing 99,601 consultations by the end of Quarter 1 2026/27, representing 24.5% of the annual additional consultations target. This additional capacity will become increasingly important as demographic change, population ageing and increasing service demand continue to place pressure on primary and community care services. Feedback from senior GPs in existing MDT areas indicates that these practice-based MDT roles have been critical in stabilising GP services in these areas and averting further practice closures to date. Of the GP contracts that have been returned over the past two years, none have been from practices with the full MDT in place. This suggests that MDTs are not only improving access to services but may also contribute to the stability and resilience of GP practices facing increasing workload and workforce pressures.

The introduction of new roles such as Advanced Nurse Practitioners, additional General Practice Nurses and General Practice Pharmacists is also making a difference to the capacity of primary care services and how those services are delivered and is contributing to improved patient outcomes.

While it has been difficult to fully assess the impact on appointments for GP's the MDT programme staff in post have provided treatment to over 73% of their patients within primary care, and therefore with no need for referral to secondary care.

The percentage of patients managed in an MDT primary care setting, with no need for an onward referral was 84.5%.

The continued rollout of MDTs represents a key component of wider health service reform and provides an important mechanism for addressing increasing demand, improving access to services and supporting the long-term sustainability of primary care in Northern Ireland.

### **3.1.5 HSC Reset Plan and Service Transformation**

The Department's Health and Social Care Reset Plan<sup>16</sup>, published on 9 July 2025, made a commitment to develop a neighbourhood model of care by March 2026. The HSC Reset Plan remains the overarching framework for stabilising, reforming and delivering a more sustainable health and social care system in Northern Ireland. The Reset Programme also reflects the reality that additional funding alone is unlikely to be sufficient to address long-term demand pressures. Sustainable improvement will require service transformation, improved productivity and more efficient deployment of workforce resources alongside future workforce growth.

The programme is focused on addressing the long-term challenges facing health and social care, including increasing demand, workforce pressures, financial sustainability and service transformation. The successful delivery of the Reset Programme will depend on maintaining a sustainable, skilled and adaptable workforce capable of supporting new models of care, increasing service demand and ongoing system transformation.

While significant challenges remain, the Reset programme is progressing with key priorities including establishing the neighbourhood care model, optimising workforce planning, virtual and digital enablement, a strong focus on prevention and on reducing unwarranted variation in care delivery, all underpinning our journey towards financial and operational sustainability.

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<sup>16</sup> [Health and Social Care Reset plan](#) | Department of Health

The System Financial Management and Reset Group (SFMRG) provides system oversight for both financial sustainability and delivery of Reset priorities.

Dedicated system-level governance arrangements have been established within the Department of Health for the Reset Programme, including financial management, workforce and digital transformation, offering clear accountability for the delivery of the Programme.

#### 3.1.5.1 Neighbourhood Model

The Reset Plan prioritises a shift towards neighbourhood-centred care, bringing services closer to people's homes, supporting earlier intervention and improving outcomes through stronger integration between health, social care and community services.

Integrated Neighbourhood Teams (INTs) have been identified as the key delivery mechanism to support this ambition. The development and implementation of the Neighbourhood Model is outlined in more detail at 3.1.6.

#### 3.1.5.2 Prevention

Prevention remains a core element of Reset and is increasingly recognised as essential in helping managing demand on our Health Service and supporting long-term sustainability.

Through *This Is Our Health*, work is underway to strengthen the relationship between citizens and services and support people to become active partners in improving and maintaining their own health and wellbeing.

Adult Social Care Reform is also progressing with a particular emphasis on prevention, early intervention, technology-enabled care, self-directed support and community-based alternatives to traditional models of care.

These approaches are intended to support long-term service sustainability by reducing avoidable demand on health and social care services and making better use of available workforce capacity.

### 3.1.5.3 Sensible Care

Through the Sensible Care programme we are seeking to reduce unwarranted variation, improve consistency and ensure patients receive the right care, at the right time and in the right setting.

Six regional catalyst programmes are now being taken forward: Heart Failure at Home; Pathology Demand Optimisation; Cardiovascular-Kidney-Metabolic; Radiology Diagnostic Imaging; Virtual Wards; and Effective MDT Working to Improve the Patient Journey.

These programmes have been selected because they demonstrate significant potential to support the core goals of our reset contribute to a more sustainable health and social care system.

The programme now has strong clinical engagement across the HSC. These programmes provide an important opportunity to test, refine and scale approaches that could subsequently be adopted across the wider HSC system.

### 3.1.5.4 Digital, Data and Innovation

Digital, data and innovation are recognised as fundamental enablers of the Reset agenda rather than standalone programmes. A dedicated system-level governance arrangement has now been established to support prioritisation, assurance and delivery of digital, data and innovation activity. Current priorities include supporting neighbourhood health, workforce planning, virtual wards, AI-enabled opportunities, better use of data and wider system transformation.

### 3.1.5.5 Research, Innovation and Investment

Reset is also focused on maximising opportunities arising from research, innovation and investment.

Through the newly established Academic Health and Economic Partnership, the Department is working with academia, industry and investors to accelerate innovation adoption, improve patient outcomes and support economic growth. There is growing external interest in supporting delivery of Reset priorities, including potential investment through the Macmillan Neighbourhood Transformation Fund, a respiratory pathway partnership with AstraZeneca and an Innovate UK funded obesity pathway

innovation project. Collectively, these initiatives aim to support service transformation, improve patient outcomes and create more sustainable models of care that make effective use of the available workforce.

### **3.1.6 Neighbourhood Model of Care**

The Department has been working at pace to deliver on the commitment in the Reset Plan. *A Policy Framework - A Vision For Neighbourhood Health And Wellbeing In Northern Ireland*, including a high-level operating and funding model, was published on 31 March 2026.<sup>17</sup>

The Neighbourhood Model of Health and Wellbeing Policy Framework sets out the vision and design principles for the Neighbourhood approach. It is the first step in a long-term reform programme that will reshape how services are planned, how resources are allocated, and how professionals work together with voluntary and community sector partners and the public

The Neighbourhood Model will mean a significant change in the way primary care is delivered in communities and is a key enabler for the Department's objective to shift the focus of health and social care provision from secondary care to primary and community care. It will ensure better access for patients to the services and support they need and will facilitate a more preventative approach to health and social care by identifying individuals and groups with specific needs and providing targeted support and interventions at an earlier stage. This will help to manage demand, which in turn will reduce pressure on services. In doing so, the model is expected to contribute to the longer-term sustainability of health and social care services by ensuring that increasing demand can be managed more effectively through community-based and preventative approaches.

The successful delivery of this model will require a workforce that is increasingly multidisciplinary, flexible and able to work across organisational boundaries. Workforce planning and workforce development will therefore be fundamental to supporting implementation of the Neighbourhood Model over the coming years.

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<sup>17</sup> [Neighbourhood Model of Health and Wellbeing in Northern Ireland - Policy Framework - March 2026](#)

Implementation of the new model has recently commenced through the phased establishment of 17 Integrated Neighbourhood Teams (INTs), bringing together Community Pharmacy, GPs and their Federations, Voluntary and Community organisations, HSC Trusts, independent providers, other statutory bodies and Local Government.

The role of the Community and Voluntary (C&V) sector remains an important component of the neighbourhood approach. Through the MDT Programme, close collaboration has already been established with C&V partners across rollout areas. During 2025/26, in addition to more than 354,000 consultations delivered by MDT teams within general practice settings, over 26,477 patients benefited from 68,830 contacts delivered through more than 439 targeted community initiatives supported by MDT Social Work Seed Funding and delivered in partnership with the C&V sector. For appropriate patients, these approaches can provide effective alternatives to hospital referral or prescription-based interventions. During 2025/26, approximately 2.35% of patients seen by MDTs were referred onwards to community and voluntary sector services. As the MDT model continues to expand, there will be further opportunities to strengthen referral pathways and develop innovative partnerships with community-based organisations across Northern Ireland.

These INTs will have a clear focus: identifying need earlier, improving access, preventing avoidable deterioration, and supporting people to stay well at home. The initial focus of the new model will be on the needs of older people. This reflects the increasing impact of population ageing and growing complexity of need, both of which are expected to place significant pressure on health and social care services in future years. By identifying need earlier and supporting people at home, the aim is to reduce unnecessary admissions, missed appointments and escalation to crisis care.

The Neighbourhood Model represents a key element of the Department's longer-term reform agenda. By supporting prevention, earlier intervention and better integration of services, it aims to improve outcomes for patients while helping ensure that health and social care services remain sustainable in the face of increasing demand and workforce pressures.

### **3.1.7 Conclusion**

The strategic direction of Health and Social Care in Northern Ireland continues to focus on reform, prevention, service transformation and the delivery of care closer to home. Programmes such as the Cancer Strategy, Elective Care Framework, MDT Programme, HSC Reset and Neighbourhood Model of Care are intended to improve outcomes for patients, manage increasing demand and support the long-term sustainability of health and social care services.

Whilst progress has been made across a range of these strategic priorities, delivery continues to be influenced by financial constraints, increasing demand and workforce pressures. The successful implementation of these reforms will depend upon maintaining a sufficiently skilled, flexible and sustainable workforce, supported by effective workforce planning, workforce transformation and investment in education, training and staff development.

The Department remains committed to delivering these reforms and ensuring that the workforce is equipped to support the changing needs of the population and the future direction of health and social care services in Northern Ireland.

## **3.2 Workforce Strategy**

The Health and Social Care Workforce Strategy 2026<sup>18</sup>, published in May 2018, provides the overarching framework for workforce planning, development and reform across Health and Social Care in Northern Ireland. The Strategy was developed in response to increasing service demand, workforce shortages, demographic change and the need to ensure that the workforce is equipped to support the transformation of health and social care services.

The Strategy's vision was that by 2026 Northern Ireland will meet both its workforce needs and the needs of its workforce through a sustainable approach to workforce supply, workforce development, staff experience and workforce planning. The Strategy recognises that workforce capacity, capability and wellbeing are critical enablers of service transformation and the long-term sustainability of health and social care services.

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<sup>18</sup> [Health and Social Care Workforce Strategy 2026](#)

While the Strategy was originally due to conclude in 2026, the impact of the COVID-19 pandemic and the scale of progress achieved during implementation led to a decision to extend the Strategy until March 2028. A third action plan has been published setting out priorities for the remaining implementation period.

The Workforce Strategy continues to provide the strategic framework through which the Department and HSC organisations are addressing workforce supply, recruitment, retention, staff wellbeing, workforce planning and workforce transformation to support the future delivery of health and social care services.

### **3.2.1 Implementation of the Health and Social Care Workforce Strategy**

Significant progress has been made in delivering the aims and objectives of the Strategy to ‘meet our workforce needs and the needs of our workforce’, with a clear focus on translating policy development to tangible delivery. This progress has been driven through coordinated system-wide implementation, supported by DoH led governance structures, dedicated workstreams, and active staff involvement.

Implementation activity has focused on strengthening workforce supply, enhancing recruitment and retention, improving workforce wellbeing and supporting the development of a modern, sustainable workforce. Key achievements include:

- Delivery of a ***comprehensive rolling programme of strategic workforce planning*** to identify workforce need across health and social care professional group over a five-to-ten-year horizon. This considers service configuration, service (population) demand and workforce supply to arrive at recommended levels of training required to deliver workforce supply in each area. Work has also commenced to scope the feasibility of developing and introducing a statistical model to produce comprehensive workforce projections for each healthcare professional group based on an analysis of service demand and workforce supply.
- The Department of Health has fully utilised available budgets to ***significantly increase the numbers of pre- and post- registration training places commissioned*** since publication of the Strategy. This includes:
- A 40% increase in medical school training places, with 367 in 2025/26 compared to 262 in 2019/20.

- an increase in commissioned GP training numbers to 121 places per year since 2022/23.
- An **HSC Employer brand 'Be Proud, Be Part of it'** and associated toolkit has also been developed to support HSC Employers in their attraction and recruitment of staff.
- A **Review of the HSC recruitment model and process** was completed in September 2022 with a series of recommendations identified to achieve a shorter time to recruit and an improved experience for candidates and recruiting managers. A dedicated programme of work is ongoing to implement and embed the recommendations of this review.
- Exploring alternative training pathways into a career in health and social care, the Department has commissioned **a pilot apprenticeship programme in diagnostic radiography** which commenced in January 2026. This will inform the Department for the Economy's policy consideration of a viable funding model for Public Sector Apprenticeships here and also the suitability of apprenticeship programmes to HSC more broadly.
- A **Regional Medical and Dental Locum Reduction project** has been established with the aim of reducing unsustainable agency and locum spend.
- A **Multi-disciplinary HSC Staff Retention Framework** is currently under development. Comprehensive engagement with staff across health and social care will be undertaken over the coming months to shape development of this framework which will also feature the wide range of retention initiatives already in place across HSC. The framework, which will be launched in early 2027, will be a valuable resource to assist health and social care employers in developing initiatives to enhance staff retention.
- **'Strengthening our Core: A Regional Framework for HSC Staff Health and Wellbeing in the Workplace'** was launched in September 2024. Over 1,000 members of staff from across health and social care were engaged in the development of this framework which has primary focus on prevention and early intervention, creating a culture which promotes health and wellbeing and places a particular emphasis on constructing a healthy working environment. The

framework is currently being implemented and provides a valuable resource to HSC employers as they continue to build upon the range of health and wellbeing initiatives being delivered across the service.

- A dedicated regional **HSC Equality, Diversity and Inclusion workstream** has been established and has developed a five-year (2024 -2029) Equality and Disability Action Plan for delivery by all HSC employers. This plan outline actions and initiatives to address section 75 inequalities, improve equality of opportunity, promote positive attitudes for disabled people and improve their participation in public life.
- Recognising the importance of occupational health services in supporting our workforce, a **Review of HSC Occupational Health Services** was completed in October 2023. The recommendations of this review are currently being implemented including an assessment of the funding required to create robust, sustainable and regionally consistent Occupational Health Services across HSC. The review recognised the importance of multi-disciplinary stepped care HSC Occupational Health Services and work is due to conclude shortly on an agreed service model for the region. Recognising the need to deliver a multi-disciplinary Occupational Health workforce, the Department recently re-established the Occupational Health Medicine training programme at NIMDTA with a third trainee due to commence this programme in 2027. The Department is also minded developing a post-registration occupational health training programme for nurses and allied health professionals with scoping on the feasibility of such a programme underway.
- **Joint Negotiating and Consultation Forums** are in place within each HSC organisation to ensure information flows freely across organisations and that employees are kept abreast of developments.
- As part of a four nations approach, HSC organisations completed a **HSC wide review of flexible working practices in Northern Ireland**, in partnership with staff and Trade Unions, resulting in the development of a policy for flexible working applications within HSC organisations.

- A ***new Learning Management System ‘Learn HSCNI’*** has been developed and is now live across all HSC Organisations enabling learning, development and training to be delivered in a comprehensive, accessible and timely manner.

These initiatives demonstrate a continued focus on strengthening workforce supply, improving recruitment and retention, enhancing workforce wellbeing and supporting the development of a skilled and sustainable workforce capable of meeting future service needs.

### 3.2.2 Impact of the Workforce Strategy

A full update on implementation is outlined above. This strategic approach to health and social care workforce development has supported a 20.3% (+11,538) increase in whole time equivalent staff in post across the HSC in Northern Ireland reported between March 2018 (56,803) and March 2026 (68,341).

This includes a 32.3% (+1,356 wte) increase in medical and dental staff. This growth reflects sustained investment in workforce supply and training over recent years and has contributed to increasing workforce capacity across a number of medical and dental staff groups. Increased workforce numbers have supported service delivery and resilience across a range of specialties, although workforce shortages and vacancy pressures remain in a number of key areas

**Table 2 – HSC Workforce (Whole Time Equivalent) by staff group 31 March 2018 to 31 March 2026**

| Staff Group                                        | 2018  | 2026  | Difference | % Difference |
|----------------------------------------------------|-------|-------|------------|--------------|
| <b>Consultant</b>                                  | 1,693 | 2,147 | +454       | 26.8%        |
| <b>SAS Doctor</b> (Specialist or Specialty Doctor) | 475   | 738   | +263       | 55.4%        |
| <b>Resident Doctor</b>                             | 1,879 | 2,374 | +495       | 26.3%        |
| <b>Other Doctor</b>                                | 77    | 217   | +140       | 182%         |
| <b>Dental Officer</b>                              | 75    | 78    | +3         | 4.3%         |
| <b>Total</b>                                       | 4,199 | 5,555 | +1,356     | 32.3%        |

*Source: Information & Analysis Directorate, Department of Health*

Workforce growth has also occurred across all medical and dental staff groups, particularly SAS doctors, Consultants and Resident Doctors. This increased workforce

capacity has supported service delivery and transformation. While this growth is encouraging, workforce demand continues to increase and significant challenges remain in a number of specialties and professions. Continued investment in workforce supply and retention will therefore remain essential to support service sustainability and transformation.

### **3.2.3 Conclusion**

The Health and Social Care Workforce Strategy continues to provide the overarching framework for workforce reform, workforce supply and workforce sustainability across Northern Ireland. Progress has been made in expanding training capacity, increasing workforce numbers, supporting staff wellbeing and strengthening workforce planning arrangements. While these achievements are significant, workforce demand continues to grow and a range of recruitment and retention challenges remain. Continued investment in workforce supply, retention and development will therefore remain essential to support the transformation and long-term sustainability of health and social care services.

## **3.3 Workforce Planning**

### **3.3.1 Long-term workforce demand in Northern Ireland**

The Department of Health is responsible for strategic medium to longer term HSC workforce planning aimed at securing workforce supply across the entire HSC over a five-to-ten-year horizon. This responsibility is currently fulfilled through a comprehensive rolling programme of strategic workforce reviews with the aim of providing a system wide view of workforce requirements across a reformed health and social care system.

This is not an individual Departmental Workforce Plan document, but rather an organic and responsive tool which brings together the workforce need identified through this rolling programme of regional strategic workforce reviews coordinated by the Department's Workforce Policy Directorate. Workforce planning is becoming increasingly important as health and social care services respond to demographic change, population ageing, increasing service complexity and rising demand. These factors are expected to continue increasing demand for health and social care services over the coming decade and have reinforced the need for robust long-term workforce

planning arrangements. All workforce planning follows the principles of the Regional HSC Workforce Planning Framework and takes the needs of the population and current workforce availability into consideration in their formulation.

Strategic workforce planning reviews undertaken since 2015 are outlined in Annex 1. Once accepted, strategic workforce planning review reports are published on the Department's website<sup>19</sup>.

The outputs of such system wide strategic workforce planning are required to provide a sound evidence base for the commissioning of pre- and post-registration training by the Department to ensure the most appropriate numbers and types of healthcare professionals are trained within available budgets to provide the optimal talent pool from which HSC organisations can recruit going forward. This ensures the most efficient use of the Departments training budget, however, it continues to be the case that due to financial constraints, the number of pre- and post- registration training places commissioned each year falls significantly below what has been identified as required by these strategic workforce planning reviews. This creates an ongoing risk that future workforce supply may not fully align with projected service demand, particularly in professions and specialties already experiencing workforce pressures. This approach helps ensure that decisions relating to education, training and workforce supply are aligned with future service requirements, supporting the long-term sustainability of the health and social care workforce.

The third action plan of the Health and Social Care Workforce Strategy contains a specific commitment to further enhance HSC Workforce Planning (Action 3.9).

The Senior Leadership Team within DoH have provided approval to introduce a new cross HSC structure to oversee all aspects of the continued development of operational and strategic workforce planning across health and social care. The work of this group will also align with policy proposals informing the development of Safer and Effective Staffing Legislation which were approved by the NI Executive on 16 April 2026. The Department is currently progressing development of this bill with a view to Minister Butler seeking approval from Executive colleagues in October 2026 to introduce the bill to the NI Assembly at the earliest opportunity thereafter.

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<sup>19</sup> [Workforce Planning: Workforce Review Reports | Department of Health](#)

One of the key aspects of this work relates to the development of a ***statistical modelling system to produce comprehensive workforce projections for each healthcare professional group based on an analysis of service demand, including population demographics, and workforce supply.*** The development of such a model is considered key to making HSC strategic workforce planning more efficient and agile. The model will support more informed workforce decisions by helping to identify future workforce requirements, potential supply gaps and emerging workforce pressures at an earlier stage.

Work has already commenced on scoping the feasibility of developing and introducing such a model for the HSC. This work will be progressed under the new cross HSC structure outlined above.

The Department continues to strengthen its workforce planning arrangements to ensure that future workforce supply is aligned with long-term service requirements and supports the sustainability of health and social care services.

### **3.3.2 Workforce Planning Processes and Long-Term Workforce Requirements**

The Minister and the Department remain committed to implementing the recommendations of all accepted strategic workforce reviews and the Minister and the Department remain committed to implementing the recommendations of all accepted strategic workforce reviews and continue to make the case for the funding necessary to support this essential long-term investment in the workforce. However, the implementation of these recommendations is dependent on the availability of financial resources and, given the significant pressures on budgets, difficult prioritisation decisions are required to ensure that limited funding is directed towards the highest priority areas.

In the meantime, officials will continue to consider opportunities for recommended expansions in each annual review of education and training commissioning.

While significant progress has been made in strengthening workforce planning arrangements, the ability to fully implement workforce review recommendations remains dependent on the availability of funding. This continues to represent one of the most significant constraints on aligning future workforce supply with projected service demand.

### **3.3.3 Planning for a Changing Medical and Dental Workforce**

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. Workforce planning arrangements must also respond to changing workforce expectations. Increasing uptake of flexible working arrangements, portfolio careers and less than full-time working patterns, particularly amongst younger clinicians, has implications for future workforce supply and training requirements. These trends are increasingly being considered within workforce planning assumptions.

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. Medical and dental workforce planning presents particular challenges because training pathways are lengthy and workforce decisions made today may take many years to translate into increases in workforce supply. Effective long-term planning is therefore essential to ensure that future workforce capacity aligns with anticipated service demand.

The Department and the wider HSC has accepted the Skills for Health Six Step Methodology as the tool for all workforce planning. This is reflected in the *Regional HSC Workforce Planning Framework*, which provides the principles that underpin workforce planning at operational and strategic levels.

Operational workforce planning is a responsibility of employers; either HSC organisations or independent, voluntary, community or private sector organisations from whom services are commissioned. This includes service delivery and safe staffing levels, operational vacancy management and recruitment, skill mix/band mix changes, career progression pathways and workforce design to support new models of care within organisations.

All strategic workforce reviews consider the purpose, scope and ownership of the plan at the outset. Each identifies the goals/benefits of change. It collates the current baseline data, highlights drivers for change e.g. multi-disciplinary teams, work life balance/family friendly policies etc. It 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 helps identify skill sets and levels of interventions for service users and facilitates new ways of working. This approach helps ensure that workforce planning keeps pace with changing service models and supports the development of a workforce capable of delivering future models of care.

In order to project the future workforce requirements, analysis of the demographics alongside the supply chain is examined in great detail. This informs the need for commissioned numbers of undergraduates for the medical and dental school and specialty post graduate training. Managing the changes required is complex and demanding and often has significant financial implications. If a workforce review report recommends an increase in the number of Whole Time Equivalent medical or dental staff, the impact of increasing numbers of doctors and dentists training and working less than full-time hours must be recognised in a proportionate expansion in actual training or staff numbers, to deliver the required increase in WTE staff. An action plan is developed to oversee and monitor the implementation of each workforce review's recommendations. Our workforce planning processes endeavour to reflect the growing diversity of Northern Ireland society, including the increasing participation of women and people from minority ethnic backgrounds in the workforce.

The Workforce Strategy Third *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 a view to developing profession specific initiatives to attract and retain staff.

In January 2019 the Department published 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. However, funding constraints have meant that the full recommendation has not yet

been implemented and the annual number of medical student places remains below the level recommended by the Review. 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 Northern Ireland medical student places; for example, increasing retention in the local medical education and training system or encouraging a greater proportion of Northern Ireland domiciled medical graduates to progress the next stages of their medical careers here. Improving retention within Northern Ireland's education and training system is increasingly recognised as an important component of workforce supply alongside the expansion of training places.

As workforce demographics, working patterns and service requirements continue to evolve, workforce planning must remain responsive and adaptable. Ensuring that education, training and workforce supply arrangements are aligned with future service needs will remain critical to the long-term sustainability of the medical and dental workforce in Northern Ireland.

### **3.3.4 Medical and Dental Education, Training and workforce Supply**

The Department undertakes comprehensive assessments of education and training commissioning requirements to inform future workforce supply. Recommendations arising from workforce reviews are translated into prioritised and costed commissioning plans where funding is available and where they can be accommodated within wider departmental priorities and financial constraints.

While workforce requirements have been identified through strategic workforce reviews, implementation remains dependent upon the availability of funding to support additional education and training places. This remains a significant constraint on expanding workforce supply at the pace required.

The Department continues to progress medical specialty workforce reviews and work closely with service commissioners, employers and training providers to identify emerging workforce pressures and develop targeted training and recruitment responses. Work is also underway to explore more sustainable approaches to funding education and training expansion, including opportunities arising from reductions in agency and locum expenditure.

The delivery of medical and dental workforce supply remains dependent upon sustained investment in education and training. Given the length of medical and dental training pathways, decisions relating to workforce supply require a long-term perspective and failure to invest at the appropriate level today increases the risk of workforce shortages emerging in future years.

### **3.3.5 Workforce Diversity and Future Workforce Characteristics**

Workforce planning must also consider the changing characteristics of the future workforce. The Department has observed an increasing proportion of female entrants to medical education in Northern Ireland, alongside changes in the socio-economic profile of applicants entering medical training.

These changing workforce characteristics are increasingly reflected within workforce planning assumptions. The Department recognises that future workforce supply will be influenced by a range of factors including increasing workforce diversity, the growing proportion of female clinicians, continued reliance on international recruitment and increasing uptake of flexible and less-than-full-time working arrangements. Workforce planning methodologies therefore consider not only headcount requirements, but also the impact of changing working patterns and workforce demographics on whole-time equivalent workforce capacity. This is particularly important in medical and dental workforce planning, where training pathways are lengthy and changes in workforce participation can significantly influence future workforce supply requirements.

The Department also recognises the importance of widening participation and ensuring that pathways into medical and dental careers remain accessible to individuals from a broad range of backgrounds. Future workforce planning activity will continue to consider workforce diversity, workforce participation and workforce sustainability alongside projected service demand and population need.

Understanding these trends is important to ensuring that future workforce planning, education pathways and recruitment strategies reflect the changing composition of the medical and dental workforce. Further consideration of these issues will form part of the planned update to the Medical Student Places Review.

### **3.3.6 Monitoring and Evaluation of Workforce Planning**

Operational workforce planning is the responsibility of HSC organisations and other providers of health and social care services. This includes workforce deployment, vacancy management, recruitment, workforce design, safe staffing and the development of new roles and service models.

Monitoring and evaluation of operational workforce planning is undertaken through local governance arrangements within each organisation, supported by workforce, operational and financial reporting mechanisms appropriate to the planning timescale being considered.

At a strategic level, workforce planning is undertaken through a programme of strategic workforce reviews. Progress in implementing recommendations is monitored through established workforce governance arrangements.

The Workforce Planning Team seeks annual updates on implementation progress and these are incorporated into wider reporting arrangements through the Workforce Strategy Programme Board.

Together, these arrangements provide oversight of workforce planning activity across the health and social care system and help ensure that workforce planning remains aligned to future service requirements, workforce supply challenges and strategic priorities.

#### 3.3.6.1 Workforce Intelligence and Longitudinal Workforce Data

The Department recognises the value of longitudinal workforce intelligence in supporting workforce planning and workforce sustainability. Such information can help improve understanding of progression from education and training into employment, workforce retention patterns, movement between workforce groups and longer-term career outcomes.

At present, the Department does not maintain a fully integrated longitudinal dataset linking medical and dental education records, postgraduate training data, professional registration information and employment records across the Health and Social Care system. While relevant information is held across a number of organisations and systems, these datasets are not currently linked in a way that allows comprehensive tracking of workforce journeys from training through to employment and career progression.

The Department recognises that enhanced workforce intelligence would support future workforce planning, workforce modelling and workforce sustainability assessments and will continue to consider opportunities to strengthen workforce data and analytical capability as part of wider workforce planning developments.

### **3.3.7 Conclusion**

Workforce planning remains fundamental to ensuring that Health and Social Care services in Northern Ireland are able to respond to increasing demand, demographic change, evolving workforce expectations and future service transformation. Through strategic workforce reviews, workforce modelling, education and training commissioning, and strengthened governance arrangements, the Department continues to develop a more sustainable approach to workforce supply

While significant progress has been made in strengthening workforce planning arrangements, financial constraints continue to affect the pace at which workforce review recommendations can be fully implemented. Continued investment in workforce supply, education and training will therefore remain critical to ensuring that sufficient medical and dental workforce capacity is available to support future service delivery and the long-term sustainability of health and social care services in Northern Ireland.

## **3.4 Digital Transformation and Innovation**

### **3.4.1 Digital Transformation in Health and Social Care**

Digital transformation is a key enabler of the Department's strategic ambition to improve access to services, enhance patient outcomes and support the delivery of sustainable health and social care services. As outlined within the Health and Social Care Reset Plan, digital technology has an important role in supporting service redesign, improving productivity and enabling new models of care across hospital, community and primary care settings.

Significant investment continues to be made in digital infrastructure, systems and data capabilities to support the modernisation of healthcare delivery. These investments are intended to improve the availability and quality of information, strengthen decision-making, reduce administrative burdens and support a more integrated approach to patient care across the Health and Social Care system.

Collectively, these investments represent some of the most significant digital transformation programmes undertaken within Health and Social Care in Northern Ireland and are intended to provide the digital foundations necessary to support future service reform, workforce sustainability and productivity improvement.

### **3.4.2 Encompass**

Encompass represents one of the most significant digital and service transformation programmes ever undertaken within Health and Social Care (HSC) in Northern Ireland. The programme has introduced a single, integrated Electronic Patient Record (EPR) across all HSC Trusts, replacing multiple legacy information systems and paper-based records with a unified digital care record. The programme was implemented through a phased regional rollout, commencing with the South Eastern HSC Trust in November 2023 and concluding with the Southern and Western HSC Trusts on 8 May 2025, when Encompass became operational across all five HSC Trusts.

Encompass provides a single digital care record for every citizen who receives health and social care services in Northern Ireland. The system enables healthcare professionals to access patient information through a single platform and supports the sharing of information across organisational and care boundaries. By bringing together information previously held within separate systems, Encompass supports improved continuity of care, more informed clinical decision-making and enhanced coordination between services. The completion of the regional rollout has established a common digital platform across HSC, supporting greater consistency in clinical and operational processes and reducing variation in the management of patient information.

The transition from paper-based processes to a fully digital patient record is intended to improve the quality, accessibility and security of clinical information. The system provides health and social care professionals with access to the right information at the right time, reducing reliance on paper records and supporting more consistent data capture across the region. In addition, Encompass helps minimise duplication of tests and investigations, supports safer medicines management and provides higher quality data to inform service improvement and future planning.

From a workforce perspective, Encompass is expected to deliver significant productivity benefits through the reduction of administrative burdens associated with

paper records and fragmented information systems. The availability of real-time patient information supports more efficient clinical workflows, reduces time spent locating and transferring information, and enables improved multidisciplinary team working across organisational boundaries. By streamlining information management and supporting more effective communication between services, the programme is intended to enable clinical staff to spend more time on direct patient care.

The programme has also required significant investment in workforce development, training and change management to support implementation across the HSC system. This has contributed to the development of digital capabilities across the workforce and established a foundation for future digital transformation initiatives. The availability of more timely and consistent information is expected to strengthen performance management, workforce planning and service redesign by providing improved insight into activity, demand, capacity and workforce utilisation.

As a clinically and operationally led transformation programme, Encompass extends beyond technology implementation and represents a fundamental change in how health and social care services are delivered. The programme establishes a digital foundation for future innovation, including the expansion of citizen-facing services through the My Care patient portal, greater use of data analytics, population health management and the application of emerging technologies to support service delivery. Through these developments, Encompass is expected to support safer care, improved patient experience, enhanced workforce productivity and the long-term sustainability of health and social care services in Northern Ireland.

### **3.4.3 My Care Patient Portal**

The My Care patient portal forms an important element of the Department's wider digital transformation agenda by providing citizens with secure online access to aspects of their healthcare information and services. Introduced alongside the rollout of Encompass, My Care enables patients and service users to access information contained within their digital health record through a web browser or mobile application.

My Care provides personalised access to a range of healthcare information and services, including appointments, medications, selected test results and other clinical information recorded within the Encompass system. The portal supports improved

communication between patients and health and social care services while providing individuals with greater visibility of, and engagement in, their care. Patients may also choose to grant proxy access to carers or family members where appropriate to support the management of their healthcare needs.

The portal supports a more person-centred approach to care by enabling citizens to play a more active role in managing their health and wellbeing. By providing access to information through digital channels, My Care improves convenience for patients and supports increased transparency regarding appointments, treatment and ongoing care. The platform also provides the foundation for the further development of citizen-facing digital services and functionality over time. The benefits associated with My Care will depend on continued patient adoption, digital inclusion and the ongoing expansion of digital services and functionality as the wider Encompass programme matures.

From an operational perspective, My Care has the potential to reduce reliance on traditional paper-based correspondence and administrative processes. The increased use of digital communications and self-service functionality can help improve efficiency, reduce administrative workload and support more effective use of staff resources. As adoption increases, digital access to healthcare information and services is expected to contribute to improved patient experience while supporting wider productivity and service transformation objectives across Health and Social Care.

The continued development of My Care will support the Department's ambition to expand digitally enabled services, improve accessibility and strengthen patient engagement, ensuring that citizens can increasingly interact with health and social care services through secure and convenient digital channels.

#### **3.4.4 EQUIP Programme**

The EQUIP Programme is a major regional transformation initiative which is replacing Health and Social Care's legacy workforce and corporate service systems with a modern, cloud-based Oracle Fusion platform. The programme will support Finance, Human Resources, Payroll, Procurement and Logistics Services (PaLS), and Systems

Administration functions across all 16 HSC organisations, benefiting over 86,000 staff across the health and social care system.

The programme represents one of the most significant business transformation initiatives undertaken within HSC and is aligned with the wider Digital Operations Strategy. By replacing the current Human Resources, Payroll and Travel System (HRPTS) and Finance, Procurement and Logistics (FPL) systems, EQUIP will provide a single integrated platform designed to standardise, simplify and modernise workforce and corporate support processes.

Implementation is being delivered through a phased approach. The first release will introduce Finance and Procurement and Logistics Service (PaLS) functionality, followed by a second release covering Human Resources and Payroll functions. This phased implementation is intended to support organisational readiness and facilitate effective change management across the HSC system.

A key objective of EQUIP is to improve the quality, consistency and accessibility of workforce and business information. The introduction of integrated systems will provide enhanced reporting, analytics and management information capabilities, supporting workforce planning, resource allocation, financial management and strategic decision-making. Access to more timely and reliable data will improve organisational oversight and support evidence-based decision-making at local, regional and departmental levels.

From a workforce perspective, the programme is expected to deliver significant operational benefits through streamlined processes, increased automation and improved self-service functionality. Staff will be able to undertake activities such as accessing payslips, submitting expenses, managing annual leave requests and completing other routine transactions through a modern and intuitive digital platform. These improvements are expected to reduce administrative burdens, improve user experience and create time efficiencies across a wide range of staff groups.

For staff working within Finance, HR, Payroll and PaLS functions, EQUIP will provide a modern integrated system to support day-to-day operational activities and replace a range of legacy processes and systems. The programme will be supported by significant investment in training, user support and organisational change

management to ensure staff are equipped with the skills and knowledge required to maximise the benefits of the new platform.

The scale and complexity of the EQUIP Programme presents a number of implementation challenges, including change management, workforce adoption, data migration, business continuity and the transition from long-established legacy systems. As with any major business transformation programme, the successful realisation of benefits will depend not only on the deployment of new technology but also on the effective redesign of business processes and the adoption of new ways of working across HSC organisations.

To support successful implementation, readiness structures have been established across HSC organisations to help ensure staff are supported throughout the transition and that organisations are prepared for each phase of implementation. A comprehensive programme of training, user support and organisational change management is being delivered to facilitate adoption of the new system and help embed new ways of working. The phased approach to implementation is intended to manage risk, maintain service continuity and support the achievement of intended outcomes.

A benefits realisation framework has been established to monitor and evaluate the impact of the programme over time. Key areas of expected benefit include improved data quality, increased automation, enhanced user experience, greater consistency of business processes, reduced administrative burden and improved access to management information. The programme will also seek to measure the extent to which the new platform contributes to productivity improvements, more effective workforce planning, improved financial management and the efficient deployment of resources across Health and Social Care.

The full benefits of the programme are expected to be realised over a number of years as implementation is completed, processes are standardised and users become familiar with the new system. Continued monitoring and evaluation will be important to ensure that the anticipated workforce, operational and financial benefits are achieved and sustained.

By providing more accurate and timely information, reducing reliance on manual processes and supporting more efficient ways of working, EQUIP will contribute to

improved productivity, workforce sustainability and the delivery of modern, efficient and effective corporate services. The programme also establishes a digital platform capable of supporting continuous improvement and future transformation across Health and Social Care for many years to come.

### **3.4.5 Digital, Data and Innovation**

Digital technologies, data and innovation continue to play an increasingly important role in the transformation of health and social care services. The Department recognises the importance of using high-quality data and advanced analytical capabilities to support service planning, performance management and policy development.

The establishment of major digital platforms such as Encompass and EQUIP is expected to significantly enhance the volume, quality and timeliness of data available across Health and Social Care. The availability of more consistent and integrated data provides opportunities to develop more sophisticated approaches to service planning, workforce modelling, demand forecasting and performance management.

Data-driven approaches are supporting improved understanding of population health needs, workforce requirements and service demand. The increasing availability of digital information provides opportunities to enhance workforce planning, support performance improvement and inform decisions regarding the allocation of resources. Improved access to data and analytical insights will assist organisations in identifying emerging pressures, targeting interventions and evaluating the impact of service transformation initiatives.

Digital technologies are also supporting the expansion of virtual consultations, remote monitoring and other digitally enabled models of care, helping to improve access to services and support more flexible service delivery. These developments have the potential to improve patient experience, increase service accessibility and support the more effective utilisation of workforce capacity.

Emerging technologies, including artificial intelligence and advanced analytical tools, have the potential to support clinical decision-making, improve operational efficiency and enhance patient outcomes. Alongside the continued development of digital services and data capabilities, these innovations are expected to play an increasingly

important role in supporting workforce productivity, improving service delivery and helping Health and Social Care respond to growing demand within available resources.

#### **3.4.6 Digital Transformation and Workforce Productivity**

Collectively, recent investments in digital transformation are expected to support improvements in workforce productivity through reducing administrative burdens, improving access to information and enabling more efficient management of resources. Programmes such as Encompass, My Care and EQUIP provide the foundations for more streamlined workflows, improved workforce planning and enhanced decision-making across Health and Social Care.

While many of the anticipated benefits will be realised over time, these investments are intended to support workforce sustainability and enable staff to focus a greater proportion of their time on the delivery of patient care.

Further information on workforce productivity is provided in Section 10.3: Productivity.

## **Section Four – General Medical Practitioners**

### **4.1 Introduction**

The Department of Health recognises the valuable role and contribution of GPs and their Practice staff as the first point of contact for the majority of patients in the delivery of treatment, care and support.

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

The Northern Ireland Statistics and Research Agency's 2024 mid-year population estimates for Northern Ireland, published on 11 September 2025<sup>20</sup>, report that the proportion of the population aged 65 and over has increased by 38.2 per cent from mid-1999 to mid-2024. In the year to mid-2024, the number of people aged 65 or more increased by 2.0 per cent from 342,500 to 349,200 people. In mid-2024, just over one in six people in Northern Ireland (18.1%) were aged 65 and over. The population aged 85 and over increased by 24.6 per cent in the decade since mid-2014, a rate over five times higher than the population as a whole.

The prevalence of long-term conditions is increasing and as the population ages, people are living with an increasing number of co-morbidities. First results from the Northern Ireland Health Survey 2024/25<sup>21</sup>, note that the proportion of respondents reporting a physical or mental health condition or illness expected to last 12 months or more has been between 40% and 46% over the last ten years and was 44% in 2024/25. A third (33%) of respondents have a long-standing illness that reduces their ability to carry out day to-day activities. Reporting a long-term condition increased with age from around a quarter of those aged 16-34 (26%), to two-thirds (69%) of those aged 75 and over.

### **4.2 DDRB Recommendations - GMP Pay Uplift 2025/26**

In 2025/26, in response to the recommendations in the 53rd report of the Review Body on Doctors' and Dentists' Remuneration (DDRB) published in May 2025, a 4% uplift to GP earnings was implemented wef 1 April 2025, in line with the DDRB recommendation. In addition, a 4% uplift for staff expenses was also approved,

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<sup>20</sup> Mid Year Population Estimates | Northern Ireland Statistics and Research Agency

<sup>21</sup> Health survey Northern Ireland: first results 2024/25 | Department of Health

together with a 4.1% uplift for other non-staff expenses. This equated to a monetary cost £11.7m.

As self-employed contractors, in order to implement the DDRB recommendation of a net increase in pay for GMP independent practitioners, account is taken of the fact that they are provided with a gross income from which they must also pay expenses, including staffing costs.

The Department draws on previous work by the DDRB to break the existing spend baseline into proportions reflecting the average split between GP pay, staffing costs and other expenses and then applies agreed uplifts against each of these elements.

There is a robust process in place to ensure that the approved uplift is applied to the GMS global sum payments.

GP practices are required to provide assurance that the funding for staff expenses is used for this purpose and that staff receive the full benefit of this uplift for staff expenses.

The Department does not collect information on the salary of GMPs. This may vary across practices and areas. Pay uplifts for salaried GPs are an arrangement between the Contractor and the Salaried GP.

### **4.3 General Practice Demographics**

The Business Services Organisation (BSO) Family Practitioner Services Information Unit produces annual and quarterly statistics for Family Practitioner Services, including General Medical Services. The most recent General Medical Services for Northern Ireland: Annual Statistics 2025/26 was published on 4 June 2026<sup>22</sup>. The report provides summary information in relation to General Practitioners, GP practices and registered patients, including registration activity in Northern Ireland. Key information from the annual statistics report is outlined below.

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<sup>22</sup> [General Medical Services Statistics - Business Services Organisation \(BSO\) Website](#)

### **4.3.1 GP Practices**

The 2025/26 GMS annual statistics report shows that Northern Ireland had 304 active GP practices at 31 March 2026<sup>23</sup>. This is a reduction of 1 practice since 2025 and a reduction of 46 (13.1%) since 2014. The number of GP practices per 100,000 registered patients was 14.6 - a decrease of 1.4% from the previous year (14.8 per 100,000 at March 2025). The number of GP practices per 100,000 registered patients has decreased across all GP Federation areas since 2016 with a reduction of 17.5% at Northern Ireland level during this period.

At Northern Ireland level, 97.7% of the population live within five miles of a GP Practice whilst at least 88.1% of the population live within a three-mile radius of a GP Practice.

### **4.3.2 GP Workforce**

The Business Services Organisation's GP statistics report shows there were 1,505 GPs (headcount), excluding Locums<sup>24</sup> at 31 March 2026. This is a 2.5% increase in the number of GPs since 2025 and a 27.5% increase since 2014. It should be noted that GP figures are headcount and do not reflect different working patterns individual GPs may operate.

As noted in the BSO report, while quality-assured data on GP working patterns are not currently available, unpublished management information from the Northern Ireland Medical and Dental Training Agency (NIMDTA) provides additional context to the published GP headcount figures.

Analysis of GP appraisals up to 2023/24 (the latest report presenting data as Whole Time Equivalent (WTE)), suggests that the sustained increase in headcount has not been fully reflected in WTE GP numbers. WTE levels for GP Partners and salaried GPs remained broadly stable until 2018/19, before falling by over 5% between 2018/19 and 2021/22, and subsequently increasing by around 17% by 2023/24. Overall, while BSO-reported headcount increased by 23.2% between 2014 and 2024, the corresponding increase in NIMDTA-derived WTE for Partners and salaried GPs was more modest at 10.8% between 2014/15 and 2023/24.

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<sup>23</sup> Figures presented are as at 31st March and include only those practices which will be open on 1st April.

<sup>24</sup> Figures presented for GPs are headcount by individual contract and refer to Unrestricted Principals or Equivalents (UPEs), Salaried GPs and Retainers

More recent NIMDTA data, including sessional activity up to 2024/25, provides a further perspective on service capacity, with sessions by GP type used as a measure. Focusing on the period from 2022/23 onwards (as 2021/22 may have been affected by the COVID-19 pandemic), headcount increased by approximately 1.1%, while sessions delivered rose by around 1.2%, indicating that recent changes in workforce numbers and activity have been broadly aligned.

These figures should be interpreted with caution. The NIMDTA data is self-reported and largely unvalidated, methodologies may vary over time, some GPs may not have undergone appraisal, and locum-delivered sessions may not be fully captured. Nonetheless, the comparison highlights that headcount alone may not fully reflect underlying GP workforce capacity or service delivery<sup>25</sup>.

Caution should be exercised when making comparisons, particularly across time, based purely on headcount figures alone.

### **4.3.3 GP Contract Type**

In terms of contract type, the BSO statistics show that of the 1,505 active GPs at March 2026 (excluding Locums), the number of Principal GPs was 1,099 (73.0%). In 2018, there were 1,190 Principal GPs out of a total of 1,323 active GPs excluding Locums (89.9%). Between 2018 and 2026, the number of salaried GPs has increased from 8.8% to 26%<sup>26</sup>.

The statistical data published by BSO shows 571 Locums at March 2026 compared to 575 in 2025. Locum figures are GPs registered on the NI Performers List as Locum only i.e. they do not hold another GP contract type. The Locum count presented does not equate to the number actively working but rather the count of individuals registered to provide Locum cover at the point of data capture.

The table below shows information for the first time a GP has ever held a partner contract (per calendar year).

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<sup>25</sup> General Medical Services for Northern Ireland: Annual Statistics 2025/26

<sup>26</sup> fps\_gms\_annual\_tables\_25-26.xlsx

**Table 3: Number of GPs Entering a Partner Role for the First Time (per calendar year)**

| Year  | First time GP has taken on a Principal/Partner contract |
|-------|---------------------------------------------------------|
| 2018  | 57                                                      |
| 2019  | 48                                                      |
| 2020  | 52                                                      |
| 2021  | 51                                                      |
| 2022  | 44                                                      |
| 2023  | 50                                                      |
| 2024  | 53                                                      |
| 2025  | 28                                                      |
| 2026* | 31                                                      |

*Source: Common Practitioner Model (CPM) updated by BSO*

\*up to June 2026

- Captures the first time a GP has ever held a Principal/Partner contract
- If a subsequent Principal/Partner contract is taken on by an individual GP it is not included in the counts presented
- GPs may have previously held another contract type e.g. Salaried position.

#### 4.3.3.1 GP Age and Gender Profile

In terms of the gender and age profile of GPs, the BSO statistics show that

60.8% are female and 39.2 % 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 8.2% lower than in 2014, while the number of female GPs has increased to almost two thirds more (70.4%) during the same period.

In terms of age profile, the BSO report indicates that over half of GPs in the 60+ age-group are male, while there are significantly more female GPs in the younger age groups.

The 25-39 age band is made up of 32.8% male and 67.2% female GPs. As age increases, so broadly does the percentage of male GPs until the oldest age bracket (60+) where the figures are 65.0% male and 35.0% female.

Around one-third of female GPs (33.6%) are in the 25-39 age band compared to just over a quarter of male GPs (25.5%). Conversely only 4.9% of female GPs are aged 60 and over compared to 14.1% of male GPs.

The average age of Northern Ireland GPs is 46 years, with 18.9% of GPs aged 55 and over.

#### 4.3.3.2 GP Leavers

**Table 4: The table below shows the number of GP leavers since 2016/17**

| Year           | Number of Leavers |      | Total |
|----------------|-------------------|------|-------|
|                | Female            | Male |       |
| <b>2016/17</b> | 55                | 32   | 85    |
| <b>2017/18</b> | 62                | 43   | 105   |
| <b>2018/19</b> | 55                | 50   | 105   |
| <b>2019/20</b> | 52                | 38   | 90    |
| <b>2020/21</b> | 43                | 41   | 84    |
| <b>2021/22</b> | 84                | 64   | 148   |
| <b>2022/23</b> | 104               | 100  | 204   |
| <b>2023/24</b> | 106               | 83   | 189   |
| <b>2024/25</b> | 101               | 60   | 161   |
| <b>2025/26</b> | 105               | 74   | 179   |

*Source: Business Services Organisation.*

- Data presented is counts of GPs who held a contract type Partner, Salaried, Retainer or Locum between April 2016 and March 2026.
- Information on the reason for leaving (including retirement) is not recorded.
- Some GPs have multiple contracts recorded with clear breaks in between. If an individual GP held more than one contract between April 2016 and March 2026 the most recent contract end date is counted as their leaving date.
- While the most recent contract end date is counted as a left date for the purposes of the table above, it is possible they may return to practice in the future.

- The Covid-19 pandemic saw GPs returning as Locums and this will potentially have contributed to the increase in number of leavers since. GPs who returned during Covid may otherwise have had an earlier left date and have otherwise been counted in one of the earlier years presented.

The Department does not hold information on GP vacancies. As independent contractors, GP partners are responsible for identifying and recruiting the GPs and other staff required within their own business to deliver services.

The Department does not hold information on the number of GP practitioners who deliver private primary medical services in addition to services under the General Medical Services (GMS) contract.

#### **4.3.4 Registered Patients**

The BSO annual statistics<sup>27</sup> show there were 2,078,635 individuals on the index of patients registered with a GP practice at 31 March 2026, compared to 2,066,970 at March 2025 – an increase of 0.6%. The number of registered patients has increased by 8.0% since 2014.

During the 2025/26 financial year, GP practices in Northern Ireland registered 87,507 patients. This comprised 44,358 new patients (first time registrations in NI) and 43,149 patients transferring from another Northern Ireland GP practice. This represents a 7.4% decrease in total registration activity on the previous year.

The average number of registered patients per practice has increased by 0.9% over the past year from 6,777 to 6,838. Since 2014, the average number of registered patients per practice has increased by 24.3%.

The BSO report indicates that in Northern Ireland there were 72.4 GPs per 100,000 registered patients at March 2026. This is a 2.0% increase from last year and a 9.0% increase from 2017.

The BSO report also contains some General Medical Services comparisons with other UK nations. Data for GPs reflect what is reported at Northern Ireland level i.e. headcount and includes Unrestricted Principals or Equivalents (UPEs), Salaried

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<sup>27</sup> [General Medical Services Statistics - Business Services Organisation \(BSO\) Website](#)

GPs and Retainers. As noted in the report, GP practices vary in size and number of live GP contracts associated with them. Comparisons using this measure should therefore be treated with a degree of caution.

In terms of GP practices per 100,000 registered patients, Northern Ireland and Scotland (with 14.6) have the most GP practices per 100,000 registered patients followed by Wales (11.1) with England (9.7) having the fewest. GP practices vary in size and number of live GP contracts associated with them.

In terms of GPs per 100,000 registered patients, the report notes that Scotland has the highest headcount number of GPs per 100,000 registered patients (76.5) followed by Northern Ireland (72.4). Wales had 65.5 GPs per 100,000 registered patients while England had the lowest ratio at 61.7.

As noted in the report, figures take no account of any inter-country differences in working patterns and differences in how services are delivered between countries that can impact on the figures. Accordingly, care needs to be taken when interpreting any inter-country differences.

#### **4.3.5 Responding to the challenges facing General Practice**

GP Practices in Northern Ireland are grouped geographically into one of 17 GP Federations. Each Federation is a Community Interest Company (CIC) Limited by Guarantee which means that they exist for the benefit of the communities and any financial surplus generated must be reinvested in line with their members' agreement.

Four Federation Support Units (FSUs), co-terminus with Local Medical Committee areas, support the work of GP Federations. The FSUs work collaboratively to provide a regionally co-ordinated approach but are also sensitive to local issues.

Stabilisation and the sustainability of General Practice remain a key focus for the Department, which continues to engage and work with GP representatives and other stakeholders to support continuity of GMS provision in the face of increasing demand and the ongoing challenging climate.

GP Contract hand backs have declined in recent years, falling from 11 in 2023/24 to 5 in 2024/25 and 1 in 2025/26. Additionally, there has been 1 contract removal.

With the support of GP Federations and Trusts in taking on contracts, the Department has been able to ensure that only one of these contract hand-backs has resulted in practice closure.

There is no existing dataset on reasons for contract hand backs. Based on local knowledge, there are a range of reasons for contracts being handed back which vary from practice to practice. These include a Partner is retiring from the GP practice, instability in partnership agreements, an inability to recruit GPs to work in the practice either as a salaried GP or Partner, increased workload for the GP practice, and work-life balance.

Measures taken to respond to the pressures facing General Practice include increasing the capacity of Primary Care to meet the demand from patients; reinforcing the GP workforce and increasing the range of healthcare professionals working in Primary Care and the implementation of new and innovative ways of working.

To support practices in difficulty and at risk, the General Practice Improvement and Crisis Response Team (GPICRT), facilitated and managed by the Eastern Federation Support Unit, is able to provide advice and support to practices which are at risk. This includes the provision of locum cover to help secure continued service provision and supporting practices to develop and implement effective Practice Recovery Plans to ensure that they can deliver their contractual obligations to their registered patients. This advice also covers practice management issues, such as support for Practice Managers, as well as GP clinical cover both on-site and remotely.

The Department has been working with GP Federations to explore how they can play a role in the longer-term sustainability of GMS, including moving away from the locum-reliant model that has been in place in some Trust-run practices, and implementing a more sustainable salaried GP model.

Other measures in place to support General Practice include the GPNI website which provides a key regional communications platform designed to improve dissemination of, and access to, information for Primary Care practitioners (inclusive of the entire Primary Care Multi-disciplinary Team). Since its inception, the website has evolved to deliver high quality education to all those within GP primary care.

Practice Based Learning is also provided in all GP Federation areas. The aim of the service is to provide Federation-led learning for the GP Practice team, tailored to local needs.

#### **4.3.6 Access to General Practice**

Access to General Practices attracts significant political and public interest. In March 2024, the Northern Ireland Audit Office published a report on 'Access to General Practice'

The report concluded that many factors are impacting on the successful development of General Medical Services, that the issues are complex and will need a sustained long-term response to ensure that General Practice is sustainable and an attractive place to work. The Report made eight recommendations across several areas including activity data, workforce review, stabilisation of General Practice and actions to improve patient access.

The Department has responded to the report and its recommendations and is working to progress on these as appropriate.

Following the NIAO report and recommendations, the NI Public Accounts Committee (PAC) undertook its own inquiry of access to General Practice in Northern Ireland. The report of its findings was published on 4 December 2025 and included ten recommendations, a number of which focussed on improving patient access, the roll out of Primary Care Multi-disciplinary teams and the development of new models of service delivery for primary care.

A number of the recommendations made in the Committee's report will be addressed in work that is already in train and set out in the *Health and Social Care NI Reset Plan* published in July 2025 (see below).

The Department recognises the importance of access to GP services for patients. The Department has overseen the development of guidance for practices relating to the management of patient demand and optimising workflow to maximise efficiency, and consideration of how technology can be best used to improve experience for both patients and practices. This best practice guide, 'Making all Contacts Count', was disseminated to all GP Practices in October 2025.

The Department is also taking forward work to develop a new model of neighbourhood care that will enable providers to work more effectively together, and that delivers more care in primary and community settings in order to enable people to stay healthier for longer, reducing the demand for expensive, hospital-led care. In addition, work is ongoing to develop a new Vision for General Practice. A key focus of these strategic pieces of work will be on improving access to primary care services.

The Department is committed to working with General Practitioners and their representatives to improve access to services and to ensure that arrangements remain responsive to the needs of patients. As part of this, the Department is currently engaged in negotiations with the NI General Practitioners Committee on the General Medical Services contract for 2026/27 and beyond.

#### **4.3.7 GP Vision**

Integral to progress on the Neighbourhood Health Model is the development of a Vision for General Practice in Northern Ireland. The Department's aim is to work with stakeholders to co-create a Vision for a modern, sustainable General Practice at the heart of the Neighbourhood model of care, harnessing clinical excellence, technological advancements and new ways of working in order to provide accessible, high quality and safe services that support continuity of care for patients; and rewarding and fulfilling careers for GPs and wider practice teams.

Key stakeholder organisations including BMA, the Royal College of General Practitioners and GP Federations are represented on a Reference Group to support the co-design and development of the GP Vision. It is anticipated that the GP Vision will be published by summer 2026.

#### **GMS Contract**

The GMS contract for 2025/26 provided an additional £9.5million invested into core GP services to address key priorities and pressures in the service.

The Department regrets that it was not possible to secure agreement with the NI General Practitioners Committee on the 2025/26 General Medical Services contract and their subsequent decision to take collective action.

Formal negotiations with NIGPC on the 2026/27 GMS contract commenced in March 2026. The Department continues to engage with NIGPC with a view to concluding negotiations on the 2026/27 GMS Contract as soon as possible.

The Department is committed to working with GPs to support primary care services with the aim of securing the long-term future of General Practice, reflecting the Minister's ambition for General Practice to be at the heart of the neighbourhood model of care outlined in the Department's Health and Social Care Reset Plan.

#### **4.3.8 GP Workforce and Training**

The Department of Health recognises the importance of a sustainable workforce for General Practice and the need to build and sustain the GP workforce, whilst recognising also that the issues that are impacting General Practice are complex and will require a long-term approach to address.

To help primary care to deliver and grow, it is critical that we train, develop, and retain the GP workforce. The number of annual GP training places has been retained at 121, an increase of 86% since 2015/16.

A Department of Health Task and Finish group has recently completed work to review the number of GP training places required going forward. This is currently under consideration as part of a wider consideration of training needs, in the context of funding pressures.

Other schemes in place to support the GP workforce include the Attract, Recruit, Retain scheme which aims to support practices in attracting and recruiting new GPs, as well as retaining those who join their team. GP practices can apply for a number of packages under the Scheme including a Golden Hello, relocation costs, recruitment costs, management costs, reimbursement Costs for applying to the NI Performers List and funding for international GPs. Since its establishment in January 2023, 116 practices have applied and received approval in principle for funding under the scheme; 76 practices have applied and received final approval for payment in respect of a recruited GP (at June 2026).

The Northern Ireland Induction and Refresher scheme has been updated and is now known as the International Induction Programme (IIP) and the Return to Practice

Programme (RtP). The IIP provides a structured and supportive route for internationally trained GPs to enter General Practice in Northern Ireland.

The RtP Programme supports UK trained GPs who have been out of practice for over two years in refreshing their skills and knowledge, ensuring they can return to independent practice with confidence. The updated programme includes changes to streamline the application process and to reflect current best practice across the UK.

The GP Retainer Scheme was designed to assist the retention of GPs in the primary care workforce in Northern Ireland. This scheme was updated in April 2025 to reflect the changing nature of the GP workforce and recognise the need for the Scheme to be more attractive / flexible.

The GP Mentor Scheme is an independent, supportive and safe mechanism for individual GPs to avail of support and mentorship from experienced, trained peers in a safe and positive environment. It is open to GPs at any stage of their career.

GP Fellowship Schemes are supporting recently qualified GPs to transition from the training environment to independent practice, with opportunities for personal and professional development.

The Department has also taken steps to increase the range of healthcare professionals working in primary care through the roll out of MDTs and the introduction of new roles such as Advanced Nurse Practitioners, additional General Practice Nurses and General Practice Pharmacists. Rollout of Practice based Pharmacists began in 2016 and in 2025/26, £22.4m funding has been allocated to support 303.5 whole time equivalent pharmacist in GP practices across Northern Ireland.

The Department plans to develop a Primary Care Workforce Strategy by the end of 2026. In the interim, we will continue to progress the Department's ongoing initiatives to build and retain the primary care workforce.

#### **4.3.9 GP Recruitment**

The table below shows the number of GP training places and GPs in training 2015/16 to 2026/27.

**Table 5: GP training places and initial fill numbers since 2015/16**

| Year    | Training Places | Initial fill rate of training places | Total number of GPs in training |
|---------|-----------------|--------------------------------------|---------------------------------|
| 2015/16 | 65              | 64                                   | 177                             |
| 2016/17 | 85              | 85                                   | 218                             |
| 2017/18 | 97              | 93                                   | 222                             |
| 2018/19 | 111             | 88                                   | 233                             |
| 2019/20 | 111             | 109                                  | 243                             |
| 2020/21 | 111             | 111                                  | 349                             |
| 2021/22 | 111             | 110                                  | 405                             |
| 2022/23 | 121             | 121*                                 | 379                             |
| 2023/24 | 121             | 121*                                 | 451                             |
| 2024/25 | 121             | 121                                  | 475                             |
| 2025/26 | 121             | 121*                                 | 446                             |
| 2026/27 | 121             | 121*                                 | 508 (as of 12th October 2026)   |

\*1-2 late withdrawals from the programme following initial recruitment

**Table 6: Number of GP Trainees who gained Certificate of Completion of training since 2018**

| CCT Year         | Number gaining CCT |
|------------------|--------------------|
| Aug 18 - July 19 | 65                 |
| Aug 19 - July 20 | 68                 |
| Aug 20 – July 21 | 74                 |
| Aug 21 - July 22 | 77                 |
| Aug 22 - July 23 | 78                 |
| Aug 23 - July 24 | 82                 |
| Aug 24 - July 25 | 98                 |
| Aug 25 – May 26* | 72                 |

\*As of 21/05/2026

Recruitment to the GP Training programme in the Northern Ireland Medical and Dental Training Agency (NIMDTA) is managed through a national UK process. In recent years there have been initiatives to promote the return of doctors to train in General Practice in Northern Ireland and recently all training places have been filled at initial recruitment.

Data shows that since 2019, 326 GP Trainees have required a visa. Of these 132 are current GP Trainees with an active visa.

The Department has worked with key stakeholders to increase the exposure of undergraduates to General Practice; encourage more GP trainees; and ensure that there are sufficient GP training practices to meet demand and support GPs in training.

For example, in 2022, twenty “Integrated Training Posts” (ITPs) were funded at GPST2 level. These posts allow increased training time in a GP setting by removing GP Trainees from a six-month hospital post to a GP setting instead. The posts provide additional training in specific areas with high relevance to General Practice including palliative care, inclusion health, dermatology and gynaecology. A review of the Integrated Training Post initiative found that the programme is highly valued by GP Trainees who benefitted from the additional time aligned to their GP training practice while gaining valuable experience in GP relevant clinical settings.

Research and Leadership opportunities such as the GP Academic Research Program (GPARTS) and the Achieve, Develop, Explore Programme for Trainees (ADEPT) are open to GP Trainees.

The GPARTS programme offers GP Trainees the opportunity to undertake over a two-year period research relevant to primary care while remaining based in a GP practice.

The ADEPT (Achieve | Develop | Explore) Programme, delivered by NIMDTA, offers senior GP Trainees the opportunity to enhance organisational leadership skills through a structured one-year clinical leadership fellowship.

Both the GPARTs and ADEPT programmes provide opportunities for GP Trainees to develop particular skills and professional networks that can facilitate retention in Northern Ireland post-CCT.

In terms of GP registrations, based on GMC information, for 2025/2026 of the 105 GP registration applications granted to doctors with a derived location in NI, 103 had completed their training in Northern Ireland, registering via the CCT pathway. The remaining 2 registered via the Recognised European Qualification pathway, having been awarded their GP qualification by the Medical Council of Ireland and Irish College of General Practitioners (ICGP).

#### 4.3.10 Supporting Retention Post CCT

NIMDTA, in association with the Department's Strategic Planning and Performance Group, continues to deliver a number of schemes and initiatives to promote GP retention post-CCT. These include the GP Retention Scheme, the Return to Practice and International Induction Programmes as well as GP careers advice and support.

NIMDTA has also worked extensively with GP practices and employing organisations to encourage expansion of visa sponsorship opportunities to facilitate retention of specific sub-groups post CCT.

GPs who remain connected to the Department's Strategic Planning and Performance Group as their Designated Body (DB) continue to undertake GMS or GP Out of Hours in Northern Ireland.

An analysis of the DB status of 869 GPs who gained CCT through the NIMDTA training programme between 2012 and 2025 was undertaken in late 2025 and early 2026. The results are below:

**Table 7: Retention rates of GPs providing GMS in Northern Ireland based on location of Primary Medical Qualification**

| Location of Primary Medical Qualification | Number of GPs completing training through NIMDTA | Number of GPs Providing GMS in Northern Ireland |
|-------------------------------------------|--------------------------------------------------|-------------------------------------------------|
| UK                                        | 771                                              | 689 (89%)                                       |
| Non-UK (excl. ROI)                        | 76                                               | 49 (64%)                                        |
| ROI                                       | 22                                               | 18 (82%)                                        |
| <b>Totals</b>                             | <b>869</b>                                       | <b>756 (87%)</b>                                |

#### 4.4 Primary Care Multi-Disciplinary Teams (MDTs)

The increase in demand for Primary Care services cannot be met solely by increasing the number of GPs. In terms of the wider primary care workforce, the Department has continued to boost its capacity by investing £25million per year in the Primary Care MDT Programme.

Additionally, a successful bid for £61m was made to the Transformation Fund, to support the further rollout of the MDT Programme across the five-year span of the Transformation Fund.

The Primary Care Multi-disciplinary Teams (MDTs) Programme has introduced new physiotherapy, social work, and mental health roles into General Practice, working alongside the existing practice team and enhanced levels of nursing.

MDT practitioners are working with patients of all ages to ensure they have access to timely assessment and appropriate support to address their individual needs. There is a strong focus on prevention and early intervention to help patients self-manage a variety of issues.

The MDT Programme has already delivered a range of positive outcomes across a variety of areas. By focusing on wellbeing rather than just sickness and proactively managing patient need in their local GP practice setting through a multi-disciplinary early intervention approach, patient outcomes are being improved, reducing the need for referrals and appointments elsewhere, and ultimately easing pressure on GP and hospital services.

The MDT model remains the key to stabilising and strengthening vital Primary Care services to ensure they can continue to provide high quality care to people, now and into the future.

In July 2025, the Department published the MDT Implementation Plan. The Plan set out how the MDT model will be rolled out in full across all areas of Northern Ireland over the next 8 years. Implementation will proceed in two phases:

- Phase 1, supported by £61m Transformation Funding, will run from 2025/26 – 2028/29 and will see MDT completed in the seven existing Federation areas where implementation has already commenced, and expansion to a further 5 Federation areas.
- Phase 2 will run for a further four years from 2029/30 and will see MDT complete in the remaining 5 GP Federation areas.

As of March 2026, through the rollout of the MDT Programme over 1.1m citizens now have access to physiotherapy, social work or mental health services across 165 GP practices, in 12 GP Federation areas.

There are currently over 412 WTE front line MDT staff supported by the programme.

MDT teams are providing vital additional capacity in general practice settings, often without the need for a patient to first see a GP. During 2025/26 an additional 354k consultations were provided by MDTs.

Patients can see a member of the MDT without first having to be assessed by a GP. With ongoing challenges in relation to GP retention and recruitment across Northern Ireland, MDT practitioners are key in helping to meet rising demand in the Primary Care setting.

It is estimated that once fully rolled out, the programme could provide around a million consultations each year in General Practice. Feedback from senior GPs in existing MDT areas indicates that these practice-based MDT roles have been critical in stabilising GP services in these areas and averting further practice closures to date. Of the GP contracts that have been returned over the past two years, none have been from practices with the full MDT in place.

The introduction of new roles such as Advanced Nurse Practitioners, additional General Practice Nurses and General Practice Pharmacists is also making a difference to the capacity of primary care services and how those services are delivered and is contributing to improved patient outcomes.

While it has been difficult to fully assess the impact on appointments for GP's the MDT programme staff in post have provided treatment to over 73% of their patients within primary care, and therefore with no need for referral to secondary care.

#### **4.4.1 Investment in General Practice in Northern Ireland**

The Department of Health published its most recent 'Investment in General Practice, Northern Ireland 2020/21 to 2024/25' in October 2025<sup>28</sup>

The report provides information on investment in General Practice and the reimbursement for drugs dispensed in General Practices in Northern Ireland.

It draws on information from the financial reporting system of the Strategic Planning and Performance Group within the Department of Health 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

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<sup>28</sup> [Investment in general practice report, Northern Ireland 2020/21 to 2024/25 | Department of Health](#)

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<sup>29</sup>,. 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.

The report shows that in 2024/25, the total investment in General Practice, including the reimbursement of drugs dispensed in general practice, was £412.2m. Compared with 2023/24, this represents an increase in the total investment in General Practices of 6.2% in Northern Ireland (from £388.2m); in real terms, this equates to an increase of 2.0% (from £404.0m). Over a 5-year period (comparing 2024/25 with 2019/20), the total investment has increased by 26.2% in cash terms (2.2% increase in real terms).

The report focuses on the elements of funding that are allocated directly to GP practices and GP Federations. It does not include elements of spend which are allocated to other HSC bodies, including Trusts, but which are investment in primary care. In 2024/25, this amounted to £19m.

#### **4.4.2 Trends in the Earnings and Expenses of GMPs**

The most recent GP Earnings and Expenses Estimates Report for 2023/24 was published by NHS England on 28 August 2025. Based on the most recent estimates report:

- The average gross earnings for Contractor GPs in Northern Ireland in 2023/24 were £274,300 compared to £259,000 in 2022/23, an increase of 5.9%.
- The average total expenses for Contractor GPs in Northern Ireland in 2023/24 were £160,500 compared to £150,700 in 2022/23, an increase of 6.5%.
- The Expenses to Earnings Ratio for Contractor GPs in Northern Ireland in 2023/24, which represents the proportion of gross earnings taken up by

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<sup>29</sup> NHS Digital legally merged with NHS England on 1st February 2023.

expenses, was 58.5%, an increase of 0.3 percentage points since 2022/23 (58.2%).

- The average income before tax for Contractor GPs in Northern Ireland in 2023/24 was £113,800 compared to £108,300 in 2022/23, an increase of 5.1%.

The table below shows the average GMS Gross Earnings, Expenses and Income Before Tax since 2016/17.

**Table 8: Average Gross Earnings, Expenses, Income before Tax and Expenses to Earnings Ratios for GMS Contractor GPs in NI – 2016/17 to 2023/24 (cash terms) – All practice types**

| Year    | Gross Earnings | Expenses | Income Before Tax | Expenses as a % of Gross Earnings |
|---------|----------------|----------|-------------------|-----------------------------------|
| 2016/17 | £195,200       | £104,700 | £90,500           | 53.6%                             |
| 2017/18 | £205,700       | £112,400 | £93,400           | 54.6%                             |
| 2018/19 | £208,400       | £116,200 | £92,300           | 55.7%                             |
| 2019/20 | £228,000       | £128,400 | £99,600           | 56.3%                             |
| 2020/21 | £246,800       | £134,800 | £112,000          | 54.6%                             |
| 2021/22 | £258,300       | £143,200 | £115,000          | 55.5%                             |
| 2022/23 | £259,000       | £150,700 | £108,300          | 58.2%                             |
| 2023/24 | £274,300       | £160,500 | £113,800          | 58.5%                             |

Source: Primary Care, Department of Health

GP earnings and expenses have both increased in cash terms. From 2022/23 to 2023/24, expenses showed a greater percentage increase (6.5%) than earnings (5.9%), which, other than in 2020/21, has been the situation in recent years. In cash terms, Income Before Tax increased by 5.1% from £108,300 in 2022/23 to £113,800 in 2023/24. Over the longer-term, Income Before Tax has increased by 25.7% since 2016/17. The rate of growth in Income before tax in real terms is lower than in cash terms; a decrease of 0.1% since 2016/17.

The average income before tax for Salaried GPs in Northern Ireland in 2023/24 was £69,000 compared to £63,100 in 2022/23, an increase of 9.3%.

#### 4.5 GMP Pension Arrangements

The HSC Pension Scheme forms an important part of the overall GMP reward package. From April 2022 all members of the HSC Pension Scheme (including GMPs)

are now members of the 2015 Scheme. GPs 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%.

The Department introduced legislation in April 2024 providing the legal framework for the introduction of a package of new retirement flexibilities including pensionable re-employment, partial retirement and removal of the 16-hour rule, for the 1995 Section of the HSC Pension Scheme. Flexible Retirement Guidance for members of the HSC Pension Scheme was launched on 1 December 2024 with information sessions being delivered to explain the new features in detail. It is hoped these flexibilities will offer members a greater degree of flexibility around how they take their pension benefits as well as providing an important boost to HSC capacity.

## **Section Five – General Dental Practitioners**

### **5.1 General Dental Service Arrangements in Northern Ireland**

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 be fulfilled in order to be valid.

### **5.2 GDS Pay Uplift for 2025/26**

In November 2025 funding was secured to implement in full the recommendations of the 53rd DDRB report, combined with a 4.1% increase for expenses, matching the CPIH rate for April 2025, resulting in a 4.04% pay increase for dentists. The total uplift was backdated to 1 April 2025.

On 9 April 2026, the Minister for Health, accepted the recommendations of the 54th DDRB report for a 3.75% increase in pay for dentists, with an inflationary component matching March 2026 YoY inflation (CPIH). Funding for this must be secured before implementation can take place.

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

**Table 9 – GDS Pay Uplifts<sup>30</sup>**

|                            | <b>2021/22</b> | <b>2022/23</b> | <b>2023/24</b> | <b>2024/2025</b> | <b>2025/2026</b> |
|----------------------------|----------------|----------------|----------------|------------------|------------------|
| <b>DDRB Recommendation</b> | 3%             | 4.5%           | 6%             | 6%               | 4%               |
| <b>GDS Uplift</b>          | 3%             | 4.5%           | 6%             | 6%               | 4%               |

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<sup>30</sup> Review Body on Doctors' and Dentists' Remuneration on doctors' and dentists' pay in England, Wales, Scotland and Northern Ireland – reports relating to GDP Pay:2020/21 – 2024/25

### **5.2.1 Inflation**

The Department has noted recommendation 6 of the 54th DDRB report for the development of an index of dental costs.

The fees and allowances paid to GDPs cover both pay, operating costs and other expenses. In order to implement any agreed pay award a calculation is undertaken to determine the net uplift applied to the fees. This ensures the increase appropriately reflects both the income and staff costs proportions of the fees.

Inflation is also considered as part of this process to increase the expenses element of the fees. The CPIH rate at the time of the DDRB publication is taken into account in this calculation and has been applied in each of the last 4 years.

A review of this process and consideration of the above recommendation will be included as part of the dental reform process.

### **5.2.2 Investment 2025/26**

£7m was invested in GDS in 2025/26 to continue supporting the industry as reform is progressed. The investment funded;

- The continuation of the Enhanced Child Examination Scheme for newly registered patients aged 0-10,
- The continuation of the 30% enhancement on fees paid to dentists for Health Service fillings, extractions, and root canal treatments,
- A £1.6m activity enhancement allocation to reward practitioners who continue to provide Health Service care,
- The expansion of the Happy Smiles Programme to include Primary 1, 2, and 3 children. Happy Smiles was originally launched in 2016 with the aim of improving the oral health of nursery school children in the 20% most deprived areas in Northern Ireland.

The Dental Access Scheme, which commenced in August 2024, continued to provide additional access for unregistered patients with an urgent or pressing oral health need.

A further £2.5m in recurrent funding was provided to practices to help mitigate the effects of the National Insurance contributions increase.

### **5.2.3 Additional Investment 2026/27**

Access to Health Service dentistry remains a priority for the Department and investment in 2026/27 has been specifically targeted at improving access for priority groups.

£8m of additional investment in GDS is being provided for 2026/27.

This investment will fund;

- The continuation of the Enhanced Child Examination Scheme,
- The continuation of the 30% enhancement to the fees associated with Fillings, Extractions and Root Canal treatment,
- An increase to the activity enhancement allocation to £2m,
- The commissioning of an Emergency Dental Clinic in the Western area, and
- An additional 6 Dental Foundation Training places.

### **5.3 General Dental Practitioners**

As of 18 June 2026(the most recent annual statistics release), there were 1,180 GDPs providing Health Service treatment in 351 practices in Northern Ireland compared with 1,206 GDPs working in 359 practices in 2025. Since 2016, the number of practices has decreased by 29, while the number of dentists has increased by 9% during this time. As of June 2026, there were 61 dentists per 100,000 resident population in Northern Ireland.

Dentistry was previously a male dominated profession but that has changed rapidly in recent years. In particular, the majority of newly qualified dentists are female, with 76% of dentists aged under 35 being female while the reverse is true in the older age groups with 58% 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 2016, the number of female dentists has exceeded males with 62% of the workforce now being female in 2026.

#### **5.3.1 Dental Access & Registration**

The percentage of the population registered with a dentist remained stable at around 64% between 2014 and 2020, increasing to 70% by 2023, however by 2026 this had

fallen markedly, by 21 percentage points, to 49%. Current registration rates are now comparable to 2009 levels.

Children are more likely to be registered with a health service dentist than adults (67% compared to 44%). 94% of the population in Northern Ireland live within five miles of a dental practice.

Once registered with a dentist, a 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. Table 10 below shows the number of patients registered and overall percentage of registration rate to 2026.

**Table 10 – GDS supply & registrations<sup>31</sup>**

|                              | 2020   | 2021   | 2022   | 2023   | 2024   | 2025   | 2026   |
|------------------------------|--------|--------|--------|--------|--------|--------|--------|
| <b>Number of dentists</b>    | 1,147  | 1,142  | 1,146  | 1,163  | 1,210  | 1,206  | 1,180  |
| <b>Number of practices</b>   | 372    | 368    | 365    | 363    | 360    | 359    | 351    |
| <b>Patient Registrations</b> | 1.219m | 1.246m | 1.289m | 1.341m | 1.294m | 1.040m | 0.945m |
| <b>Registration Rate</b>     | 64.1%  | 65%    | 67%    | 70%    | 68%    | 54%    | 49%    |

This data evidences what we have hearing from both the public and the profession. Dentists are reducing their Health Service (HS) commitment and switching to private care and independent insurance plans. As a result, patient's registrations are lapsing and many of those patients have not been able to either re-register with the same dentist or register with another dentist.

The likely scenario is that some dentists have stopped contacting patients for routine checkups every 6-24 months and unless the patient contacted the practice requesting to be seen those patient registrations have lapsed after the standard registration period of 24 months.

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<sup>31</sup> General Dental Services for Northern Ireland: Annual Statistics 2024/25

### 5.3.2 Dental Activity

The number of dental treatment claims submitted and paid by BSO in 2025/26 decreased by 5% from last year. Patients seen decreased by 4% compared to 2024/25, with children remaining relatively similar (+0.3%) compared to last year and adults decreasing by 6%.

The impact for registered patients is longer waiting times and for unregistered patients it is a lack of access to Health Service dental care.

### 5.3.3 General Dental Services funding – 2025/26

The net cost of primary care dental services in Northern Ireland was £111.6 million with an additional £22.2 million in patient contribution for treatments in 2025/26. The net cost increased slightly by 1% compared to 2024/25 (£110.5 million), while the patient contribution decreased by 2% (£22.7 million).

The Rebuilding Support Scheme (RSS), which was initially introduced to support the sustainability of practices through the COVID pandemic, did not continue into 2024/25. Some financial support payments continued into the 2024/25 financial year though, including for Personal Protective Equipment and for the trainee block top-up payment scheme, which have added a small amount to the overall cost (see Table 11).

**Table 11 – General Dental Services – Costs<sup>32</sup>**

| <b>Financial Year</b> | <b>Net Cost of Dental Service</b> | <b>Patient Payments</b> | <b>Support Payments</b> | <b>Total Costs of Dental Services</b> |
|-----------------------|-----------------------------------|-------------------------|-------------------------|---------------------------------------|
| <b>2020-21</b>        | £72,700,000                       | £7,100,000              | £51,900,000             | <b>£131,700,000</b>                   |
| <b>2021-22</b>        | £87,000,000                       | £13,100,000             | £43,700,000             | <b>£143,800,000</b>                   |
| <b>2022-23</b>        | £100,000,000                      | £20,400,000             | £13,000,000             | <b>£133,400,000</b>                   |
| <b>2023-24</b>        | £97,900,000                       | £21,400,000             | £2,300,000              | <b>£121,600,000</b>                   |
| <b>2024-25</b>        | £110,500,000                      | £22,700,000             | £600,000                | <b>£133,700,000</b>                   |
| <b>2025-26</b>        | £111,600,000                      | £22,200,000             | £600,000                | <b>£134,400,000</b>                   |

<sup>32</sup> General Dental Services for Northern Ireland: Annual Statistics 2024/25

### **5.3.4 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.

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.

#### **5.3.4.1 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.

#### 5.3.4.2 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.

#### 5.3.4.3 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.

#### 5.3.5 GDP Earnings & Expenses

The most recent Dental Earnings and Expenses Estimates (2023/24) report<sup>33</sup>, published by NHS Digital, showed that the average taxable NHS and private dentistry income for Principal dentists in Northern Ireland was £121,200 in 2023/24 (a 2.73% decrease on the previous year but a 22.18% increase in the four years since the pandemic commenced in 2019/20), whilst that for Associate dentists was £65,500 (a 2.67 decrease on the previous year and a 14.51% increase in the four years since the pandemic commenced in 2019/20.). Per the report in 2023/24, the earnings of dentists in Northern Ireland were broadly on a par with those in Scotland, England & Wales, however the position has changed in recent years. A new Dental Earnings and Expenses Report is due to be published in July 2026. Table 12 below shows the average Taxable income for a Principal and an Associate in Northern Ireland, per the most recent report from 2023/24.

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<sup>33</sup> Dental Earnings and Expenses Estimates - NHS England Digital

**Table 12 – GDP Taxable Income**

|                  | 2018/19  | 2019/20 | 2020/21  | 2021/22  | 2022/23  | 2023/24  |
|------------------|----------|---------|----------|----------|----------|----------|
| <b>Principal</b> | £104,400 | £99,200 | £122,000 | £138,000 | £124,600 | £121,200 |
| <b>Associate</b> | £58,700  | £57,200 | £59,500  | £60,700  | £67,300  | £65,500  |

Taxable income is calculated as Gross Earnings minus Expenses. The table below shows that, in 2023/24, the total expenses of Principal dentists had increased by 12.84% since 2018/19 and by 4.05% over the previous year. Expenses had also decreased for Associates since 2018/19 by 10.15% and by 8.05% over the previous year, although this has changed since and will be reflected in the new Earnings and Expenses Report in July 2026.

**Table 13 – GDP Expenses**

|                  | 2018/19  | 2019/20  | 2020/21  | 2021/22  | 2022/23  | 2023/24  |
|------------------|----------|----------|----------|----------|----------|----------|
| <b>Principal</b> | £229,700 | £213,700 | £197,900 | £245,000 | £248,700 | £259,200 |
| <b>Associate</b> | £39,400  | £39,000  | £31,300  | £36,800  | £38,500  | £35,400  |

### 5.3.6 Future Developments

#### 5.3.6.1 Contract reform

The need for reform of General Dental Services has been recognised for some time and the challenges faced today reinforce the urgency of that reform. The Department's Health and Social Care NI Three-year plan includes a commitment to develop an Action Plan and programme of work for the reform of General Dental Services by the end of this financial year. A critical first step on this path is to establish a robust understanding of the real cost of providing dental services, so that realistic options for reform of the service can be developed.

To achieve this, a Cost of Service Review was commissioned in December 2024. The Department has received a draft of the Review and is currently undertaking a final analysis of its findings. A GDS Reform Advisory Group has also been established, bringing together representatives from the Department, Commissioners (SPPG), the British Dental Association and the Association of Dental Groups, as well as dental practitioners. The Cost of Service Review and the work of the GDS Reform Advisory group will play a central role in informing the future direction, scope and pace of reform.

The long-term vision for reform is a sustainable, resilient Health Service dental system that provides access for those who need it most, supports a motivated and retained workforce and delivers value for public money.

#### 5.3.6.2 Cost of Service Review

The Cost of Service Review was commissioned in December 2024. In parallel, a GDS Reform Advisory Group has been established. The Cost of Service review and the work of the Advisory Group will play a key role in informing the future direction, scope and pace of reform. The Cost of Service Review was published<sup>34</sup> by the Department of Health on 16 September 2026, following consultation with stakeholders and the British Dental Association. Early analysis of the review suggests that estimating the cost per hour of delivering dental care is not straightforward in theory or practice, and there is significant variation across the region.

#### 5.3.6.3 Dental Amalgam

In July 2023, the European Commission published a proposal to amend Regulation (EU) 2017/852 of the European Parliament and of the Council on Mercury (the EU Mercury Regulation). The main impact of the amendment would be to prohibit the use of, and sale of, dental amalgam from January 2025, save on grounds of medical need.

The previous regulatory changes restricting the use of amalgam in children under 15 years and pregnant and breastfeeding women outlined above had cost implications of approximately £340k per year, in 2018 prices. The new requirements would have placed further and more significant pressure on health service budgets (a much larger patient group is affected), as alternative materials would have to be used and paid for in all adult dental care.

The estimated cost per annum of the new laws was £3.6m per year (4% of the overall GDS budget), based on 2022/23 activity levels, which are around 25% less than pre-covid years. There would also have been additional costs for dental services delivered within HSC Trusts through the Community Dental Service in particular.

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<sup>34</sup> [General Dental Services in Northern Ireland Cost of Service Review | Department of Health](#)

#### 5.3.6.4 Derogation

Following discussions and negotiations between NI, Cabinet Office and the EU, the EU published a notice setting out an arrangement that would allow Northern Ireland dentists to use dental amalgam until 31 December 2034, or until the date agreed by the global Minamata Convention, to which the UK is a signatory, whichever is earlier. There are a number of conditions attached, mainly around reporting and showing continued progress, to reduce the use of amalgam.

The key and most meaningful benefit from the Derogation is that the deferral to phase out by 2035, rather than 2025, is much more in line with the current trajectory within the UK in terms of the longer term reduced usage of dental amalgam.

National Plan to Phase Down the Use of Dental Amalgam (published in 2019) has been amended to reflect the move to a phase out approach.

In January 2025, per the derogation conditions, a ban on non-UK residents receiving dental amalgam fillings was introduced in Northern Ireland. This was communicated to the profession via MDS 761<sup>35</sup>, alongside a letter from the Chief Dental Officer for Northern Ireland which was issued to all General Dental Practitioners.

In addition, the Department of Health contributed to a Cabinet Office led 'Dental Amalgam Annual Report' which was presented to the EU per the conditions set out in Commission Notice C/2024/4675<sup>36</sup> as regards dental amalgam and other mercury-added products subject to export, import and manufacturing restrictions to and in the United Kingdom in respect of Northern Ireland.

#### 5.3.6.5 GDP Motivation

According to the most recently published Dentists Working Patterns, Motivation and Morale Survey from April 2024 (pertaining to 2022/2023), motivation and morale levels have dropped since the last survey for most dental cohorts in England, Scotland and Wales. However, in Northern Ireland, there has been an increase in the percentage of dentists answering positively to the motivation questions.

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<sup>35</sup> [MDS 754](#)

<sup>36</sup> [EUR-Lex - 52024XC04675 - EN - EUR-Lex](#)

The most common contributory factor to low morale for Providing-Performer/Principal dentists is increasing expenses and/or declining income. Recruitment and retention issues have become increasingly prevalent for dentists in England, Northern Ireland and Scotland since the last survey. Around two-thirds of dentists across the UK often think of leaving dentistry (63.4% of Principals and 66.0% for Associates in NI).

#### 5.3.6.6 Systematic data on salaried GDPs

According to the most recently published Dentists Working Patterns, Motivation and Morale Survey from April 2024 (pertaining to 2022/2023), overall, dentists of all ages spent more than three quarters of their time on clinical work, with female associate dentists aged 35-44 spending the greatest average percentage of time (87.9%) on clinical work. Females of all ages spent more time than males on Health Service work, with those aged 35-44 spending over 70% of their time on Health Service work.

Males in all age groups worked greater average weekly hours than females, although this was not always the case when Health Service weekly hours were considered, with females aged less than 35 and more than 45 having higher average weekly working hours than their male counterparts.

For 62.1% of dentists, less than 30% of their time was spent on Health Service orthodontic activity. A majority of dentists (82.6%) reported that they spent less than 30% of their time on clinical orthodontic activity.

For dentists overall and associate dentists, those with a greater than 75% Health Service work commitment spent more time on clinical work than those who had lower health service work commitments. For principal dentists, those with a Health Service commitment less than 25% spent most time on clinical work.

All dentists (principals and associates) with 75% or more Health Service work commitments reported greater average clinical weekly hours than those dentists with lower Health Service work commitments.

### 5.3.6.7 Earnings by FTE (as well as headcount)

According to the most recently published Dental Earning's and Expenses Report from July 2026 (pertaining to 2024/2025), the following table shows the earnings by FTE for Northern Ireland, as well as headcounts.

**Table 13 – Earnings by FTE**

|                          | Estimated Population | Mean Gross Earnings | Mean Total Expenses | Mean Income Before Tax |
|--------------------------|----------------------|---------------------|---------------------|------------------------|
| <b>Principal Dentist</b> | 200                  | £455,500            | £321,900            | £133,500               |
| <b>Associate Dentist</b> | 900                  | £199,000            | £42,500             | £76,500                |
| <b>Whole of NI</b>       | 1100                 | £184,700            | £97,100             | £87,600                |

### 5.3.6.8 Demographic information and working hours of GDPs

According to the most recently published Dental Earning's and Expenses Report from July 2026 (pertaining to 2024/2025), the following tables show the demographic information for both Principal, and Associate Dentists in Northern Ireland, as well as headcounts.

**Table 14: Demographic information for Principal Dentists in Northern Ireland**

|               | Estimated population | Mean gross earnings | Mean total expenses | Mean income before tax |
|---------------|----------------------|---------------------|---------------------|------------------------|
| <b>Male</b>   | 150                  | £484,200            | £342,400            | £141,900               |
| <b>Female</b> | 100                  | £408,800            | £288,800            | £120,000               |

**Table 15: Demographic information for Associate Dentists in Northern Ireland**

|               | Estimated population | Mean gross earnings | Mean total expenses | Mean income before tax |
|---------------|----------------------|---------------------|---------------------|------------------------|
| <b>Male</b>   | 300                  | £157,300            | £60,500             | £96,800                |
| <b>Female</b> | 600                  | £100,700            | £33,900             | £66,800                |

Analysis shown in the Dental Earning's and Expenses Report from July 2026 for some previous years includes breakdowns by weekly working hours bandings using information from the Dental Working Patterns Survey, however the Dental Working Patterns Survey was not run for 2020/21 and 2021/22 due to the COVID-19 pandemic,

or in 2023/24 and 2024/25, and these data are not available for 2020/21, 2021/22, 2023/24, and 2024/25.

Per 2022/23 data, dentists reported working an average of 35.6 hours per week in dentistry in 2022/23, with Associates working an average of 33.6 hours per week and Principals working an average of 41.4 hours per week.

**Number of consultations carried out** - For 2025/26, approximately 795,200 patients were seen.

**Timeseries of the value of dental clawback** - The Department of Health doesn't currently hold the information required to provide an answer for this heading.

**NHS and private earnings split** - The Department of Health doesn't currently hold the information required to provide an answer for this.

**Data on joiners and leavers from the dental workforce and evidence on job vacancies, in addition to the concerns around earnings data** - The Department of Health doesn't currently hold the information required to provide an answer for this.

**Evidence to provide a better understanding on how DDRB recommendations can contribute to incentivising NHS dentistry** - The Department of Health doesn't currently hold the information required to provide an answer for this.

## **Section Six - Hospital Medical and Dental Staff**

### **6.1 Introduction**

The Hospital Medical and Dental workforce plays a central role in the delivery of Health and Social Care (HSC) services across Northern Ireland. This workforce includes consultants, doctors and dentists in training, specialty and specialist (SAS) doctors and dentists, locally employed doctors, community dentists and other medical and dental staff working across a wide range of hospital and community settings.

Hospital Medical and Dental staff are employed across the five Health and Social Care Trusts in Northern Ireland and a range of regional services like the Single Lead Employer. Medical education and postgraduate medical and dental training are supported through the Northern Ireland Medical and Dental Training Agency (NIMDTA), which plays a key role in developing the future medical and dental workforce.

Hospital Medical and Dental staff provide emergency, elective, diagnostic and specialist services and are critical to the delivery of safe, effective and high-quality care. They also play an important role in supporting service transformation, reducing waiting times, improving patient outcomes and delivering many of the strategic priorities outlined in Section 3 of this report.

As the HSC continues to respond to increasing demand, demographic change and service reform, ensuring a sustainable and appropriately skilled Medical and Dental workforce remains fundamental to the delivery of services across Northern Ireland. The Hospital Medical and Dental workforce continues to operate in a challenging environment characterised by increasing demand, service reform and ongoing workforce pressures. The following sections provide a detailed assessment of workforce composition, recruitment and retention, vacancies and shortages, workforce mobility, international recruitment and wider workforce sustainability issues affecting Hospital Medical and Dental services.

## **6.2    Medical and Dental Workforce**

The Medical & Dental workforce stood 6,082 (5,554.7 WTE) at 31<sup>st</sup> March 2026, with consultants accounting for 39% (2,302 staff or 2,147.1 WTE) of WTE in this Staff Group. Further detail by HSC organisation is provided in the **Section 11 at, Table 33.**

## **6.3    Reward Strategies**

The total reward offer available to medical and dental staff extends beyond pay and includes pension provision, occupational sick pay, annual leave, flexible working, health and wellbeing support, career development opportunities, learning and development, staff benefits and wider terms and conditions. Trusts consistently reported that staff attraction and retention are influenced by the overall employment offer rather than pay alone. Consequently, actions to improve staff experience, wellbeing, career development and workforce flexibility form an important component of workforce sustainability strategies

## **Section Seven – Workforce Context**

### **7.1 Workforce Overview and Demand Pressures**

Health and Social Care (HSC) services across Northern Ireland continue to operate in an increasingly challenging environment characterised by rising demand, workforce shortages, increasing patient complexity and significant financial pressures. Trusts across the region report sustained growth in demand for services, with activity levels continuing to exceed available workforce capacity across a range of acute, community, mental health and social care settings.

Increasing demand is being driven by an ageing population, rising clinical complexity, higher levels of co-morbidity and chronic disease, growing social need and continued expectations to improve access to services, reduce waiting times and maintain safe and effective care. Demand for Health and Social Care services remained consistently high throughout 2025/26 and continues to exceed available capacity across many service areas.

Trusts consistently report that demand growth is outpacing workforce supply in a number of specialties and service settings. Ongoing recruitment and retention challenges, hard-to-fill posts, trainee workforce shortages and persistent vacancies continue to affect workforce capacity. In some specialties, trainee numbers remain below required levels, creating additional pressure on existing staff and raising concerns regarding future workforce sustainability. By way of illustration, one Trust reported approximately 85 medical vacancies across services and trainee workforce gaps of 10-15% in some specialties.

There are sustained pressures across both unscheduled and elective care pathways. Emergency Departments continue to experience high levels of attendance, while elective and outpatient services face increasing referral volumes and persistent waiting list pressures despite focused recovery initiatives. Diagnostic services, particularly imaging and endoscopy, continue to experience significant demand, with capacity often prioritised to support urgent and cancer pathways. Community and social care services are also managing increasing levels of complexity, alongside the ongoing implementation of service transformation and reform programmes. These pressures are having a particular impact on consultants and SAS doctors, who

continue to provide additional programmed activity, vacancy cover, supervision, on-call commitments and support for elective recovery initiatives in order to sustain service delivery. Medical and dental staff are increasingly required to work more intensively to maintain services, support rota resilience and respond to workforce gaps. At the same time, there is increasing demand for flexible working arrangements, reduced working hours, family-friendly working patterns and flexible retirement options. While these developments are important in supporting workforce wellbeing and retention, they also present additional workforce planning challenges.

To maintain service resilience, organisations continue to utilise a range of measures including workforce modernisation initiatives, service redesign, productivity improvements, increased programmed activity and the use of temporary staffing arrangements. Despite these measures, Trusts report continued reliance on workforce flexibility and additional activity to sustain service delivery and maintain patient access to care.

Workload pressures are also affecting the capacity available for non-clinical activities, including education and training, supervision, quality improvement, research and service development. Wider system constraints, including limited bed capacity, delayed discharges, community capacity pressures and challenges within domiciliary care services, continue to affect patient flow and operational efficiency across the region.

Trusts reported that service improvement and transformation initiatives, including enhanced triage arrangements, Patient Initiated Follow-Up (PIFU), pathway redesign and service validation exercises, are helping to improve efficiency and maximise available capacity. The phased implementation of Encompass has also delivered significant digital transformation benefits across HSC services. However, Trusts reported that implementation required substantial staff engagement, training and adaptation, creating temporary workload pressures and, in some areas, affecting the interpretation of performance trends during the transition period.

Overall, Trusts consistently report that demand for medical and dental services continues to grow faster than workforce supply in a number of specialties and care settings. Rising patient complexity, workforce shortages, vacancy pressures and increasing service expectations continue to place significant pressure on workforce

capacity and service resilience. While organisations are implementing a range of recruitment, productivity and service transformation initiatives, sustained workforce investment and effective retention measures will be required to support safe, sustainable and resilient services in the years ahead.

### **7.1.1 Population Change and Complexity of Care**

Trusts reported that demand and workload pressures are being driven by a number of interrelated demographic, workforce and service factors, including:

- An ageing population and increasing levels of multi-morbidity;
- Rising prevalence of chronic disease, frailty and social need;
- Growing safeguarding requirements across health and social care services;
- Increasing demand for acute, emergency and unscheduled care;
- Higher patient acuity requiring more complex and resource-intensive interventions;
- Workforce shortages across key professional groups;
- Increased administrative and documentation requirements;
- Sustained growth in diagnostic and laboratory demand;
- Rising demand for social work, mental health and children's services;
- Structural challenges associated with rurality, deprivation and access to services; and
- The emotional impact on staff of managing trauma, serious illness and distressed families.

Trusts consistently reported that increasing patient complexity is affecting both service demand and workforce workload. Patients are increasingly presenting with multiple long-term conditions, complex health and social care needs and greater requirements for multidisciplinary intervention and support. These trends are increasing pressure across hospital, community and social care services and require greater workforce capacity to maintain safe, effective and timely care.

### **7.1.2 Community and Social Care Pressures**

The continued implementation of the strategic shift towards community-based models of care has resulted in more patients being supported outside traditional hospital settings. However, workforce growth within community services has not always kept

pace with increasing demand. As a result, discharge planning has become increasingly complex, with greater reliance on community services, social care provision and coordinated multi-agency support, particularly for vulnerable individuals with complex needs.

Trusts reported ongoing pressures associated with delayed discharges, limited community capacity, placement shortages and challenges in domiciliary care provision. One Trust reported that, at the end of the 2025/26 reporting period, 3,905 adults and children were awaiting assessment or allocation to a keyworker, with the largest proportion within Older People's Services. These pressures continue to affect patient flow and wider system performance.

Wider system constraints, including limited bed availability, delayed discharges and community capacity pressures, continue to affect operational efficiency across the region and place additional demands on both frontline services and support functions.

### **7.1.3 Impact on Workforce and Service Delivery**

Trusts reported that increasing service user expectations, the need to maintain 24/7 service provision and the continued impact of waiting lists are creating workload pressures and prioritisation challenges. Workforce shortages, increasing demand and growing complexity are contributing to increased workload intensity, reduced workforce resilience and ongoing challenges in meeting service standards and performance targets.

The combined impact of rising demand and workforce shortages is creating sustained operational pressure across all parts of the HSC system. Trusts reported increasing difficulties in reducing waiting times, maintaining workforce capacity and delivering timely care. Workforce constraints are also affecting staff wellbeing, with increased levels of stress, burnout, sickness absence and retention concerns reported across a range of services.

Trusts continue to implement productivity initiatives, workforce modernisation programmes, digital transformation projects and service redesign measures to improve efficiency and service resilience. However, organisations consistently reported that future improvements in service performance will depend upon sustained

investment in workforce capacity, recruitment, retention, service transformation and measures to improve patient flow.

Trusts further emphasised that the ability to deliver elective recovery, reduce waiting lists, support service transformation and maintain safe staffing levels is fundamentally dependent upon the recruitment and retention of sufficient medical and dental staff. Workforce availability therefore remains a key determinant of organisational performance, service resilience and patient access to care.

These workforce pressures also have important affordability implications. Workforce shortages can increase expenditure on temporary staffing, delay service improvements and reduce organisational flexibility. Consequently, addressing workforce supply challenges remains important from both a workforce sustainability and affordability perspective.

Overall, Trusts indicate sustained growth in demand and workload across Health and Social Care services, with workforce supply unable to fully meet demand in a number of areas. While organisations continue to implement workforce, productivity and service transformation initiatives, workforce shortages, increasing service demand and growing complexity continue to place significant pressure on workforce capacity, staff wellbeing and service resilience across the region.

## **7.2 Workforce Composition, Demographics and Equality, Diversity and Inclusion**

### **7.2.1 Workforce demographic data**

The Medical and Dental workforce is increasingly diverse, with women now accounting for 54% of the workforce. Working patterns vary between grades, with part-time working more prevalent amongst female staff. The age profile also highlights workforce sustainability challenges, with a significant proportion of staff approaching retirement age in some professional groups.

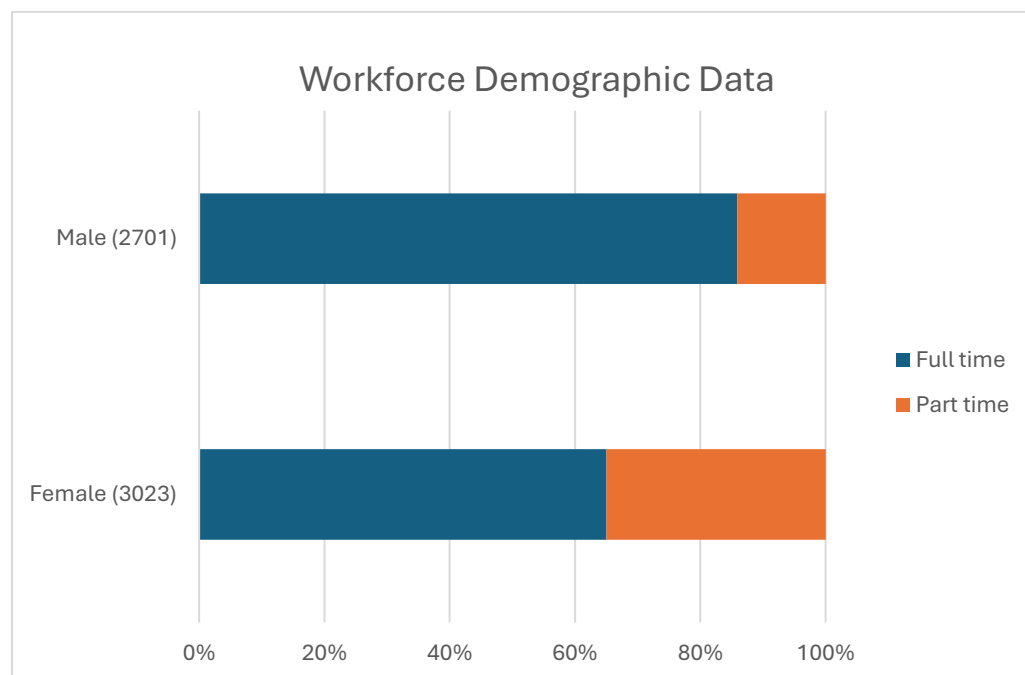
These workforce characteristics have important implications for workforce planning, workforce supply and future service delivery, particularly when considering the impact of flexible working patterns, retirement profiles and increasing service demand.

The demographic profile of the HSC workforce provides important context for workforce planning, recruitment and retention. Changes in workforce composition, age

profile and working patterns influence workforce supply, future service delivery and the sustainability of the workforce. The latest workforce census demonstrates a workforce that is increasingly diverse, with significant variation in working patterns and age profile across staff groups.

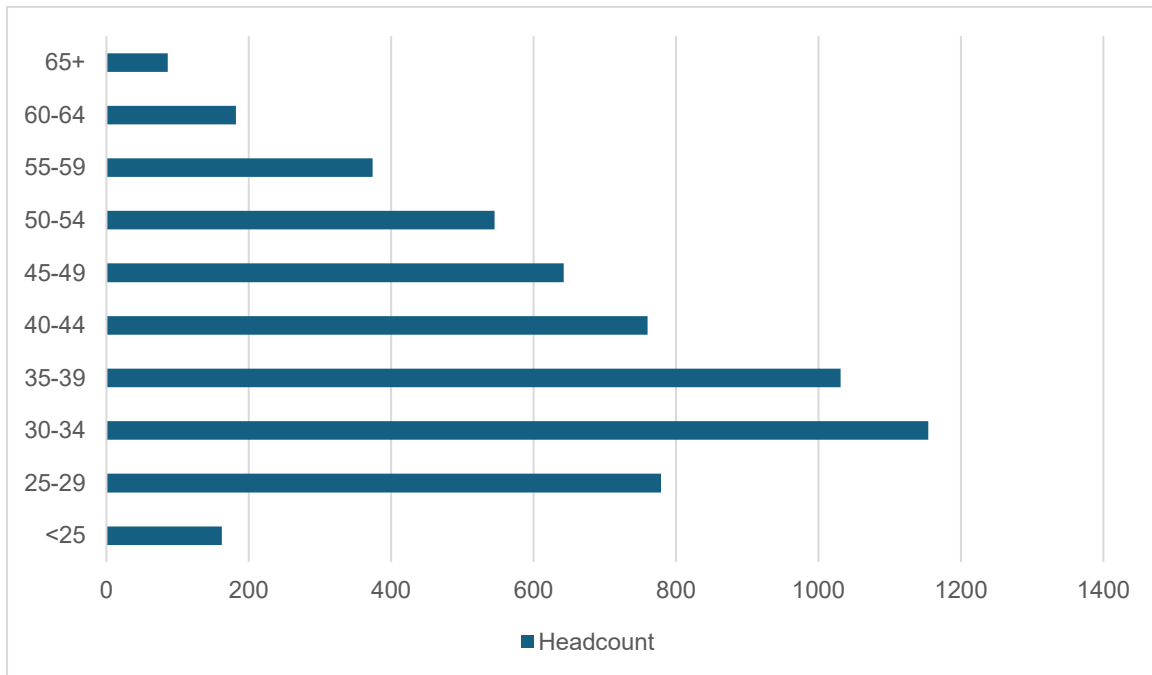
The latest statistics on the demographics of the HSC medical and dental workforce can be found below with additional information available at Section 11: Workforce Data.

**Chart 1 – Demographics of the HSC Medical and Dental Workforce**



The gender profile of the Medical and Dental workforce reflects longer-term workforce trends and demonstrates the increasing importance of ensuring workforce planning assumptions take account of flexible working patterns and less-than-full-time working.

**Chart 2: NI Health and Social Care Medical and Denal Staff by Age Group (Headcount) at 31 March 2026**



Additional age profile data for the HSC workforce is provided in Section 11: Workforce Data.

Within the Medical and Dental workforce, females now account for approximately 54% of staff. This reflects longer-term workforce trends and has implications for workforce planning, particularly in relation to flexible working patterns, less-than-full-time working and future workforce supply assumptions.

Medical and dental staff have an older age profile than the overall HSC workforce, with a greater proportion of staff aged 45 years and over. This has implications for succession planning, training pipelines and future workforce supply.

### **7.2.2 Nationality of workforce**

While comprehensive nationality data is not currently available through centrally held datasets, internationally trained doctors continue to make an important contribution to workforce supply. Further information is provided in Section 5.10 International Recruitment.

### **7.2.3 Equality, Diversity and Inclusion**

The Department recognises that a diverse and inclusive workforce is important in supporting workforce sustainability, staff experience, recruitment and retention. Equality, diversity and inclusion considerations form an important component of workforce planning and organisational development across Health and Social Care organisations.

A workforce that reflects the population it serves can support staff experience, organisational culture, recruitment and retention. HSC organisations continue to promote equality, diversity and inclusion through local and regional initiatives aimed at creating supportive and inclusive workplaces. The Department recognises that workforce diversity data currently remains underdeveloped in some areas. While workforce information relating to gender is available, the availability and completeness of ethnicity, disability and nationality data remain more limited. The introduction of EQUIP is expected to improve future workforce equality monitoring and reporting capability.

### **7.2.4 Gender Pay Gap**

The Department does not currently hold a comprehensive regional dataset that would allow a formal gender pay gap analysis for the secondary care medical and dental workforce to be undertaken. However, workforce demographic and working pattern data can provide insight into factors that may influence pay differentials across the workforce.

Medical and Dental roles are remunerated using nationally agreed pay structures based on national terms and conditions within Northern Ireland. HSC organisations do not have discretion to set local pay rates for medical and dental staff on these terms and conditions. Consequently, any differences in average earnings are more likely to reflect workforce composition, grade distribution and working patterns including the prevalence of part-time working, flexible working arrangements and career breaks, rather than differences in pay rates for equivalent roles. For example, one Trust highlighted wider HSC evidence suggesting that women may be underrepresented in some senior management roles despite forming the majority of the workforce.

Whilst the HSC Medical and Dental workforce now comprises a higher proportion of females (54%) than males, workforce profile data indicates that whole-time equivalent (WTE) to headcount ratios are generally lower for female staff across all medical and dental grades. This reflects a greater prevalence of part-time and flexible working arrangements, particularly within the SAS workforce, where the WTE-to-headcount ratio is 0.85 for females compared with 0.98 for males. In addition, males continue to represent the majority of staff at Consultant grade, accounting for approximately 58% of consultants.

These workforce characteristics do not indicate differences in pay rates between males and females in equivalent roles. However, they may contribute to differences in average earnings and are important considerations when examining workforce demographics, career progression patterns and workforce supply. The increasing prevalence of flexible and less-than-full-time working also has implications for workforce planning, as proportionately larger headcount growth may be required to deliver the workforce capacity needed to meet future service demand.

Detailed Medical and Dental workforce profile data is provided at Section 11: Workforce Data.

In the absence of formal reporting arrangements, the extent of any gender pay gap cannot currently be quantified.

Overall, it is not currently possible to quantify a regional gender pay gap across HSC Northern Ireland. However, some Trusts have identified gender pay gap monitoring as a potential future reporting requirement through the development of the new Human Resources, Payroll, Travel and Procurement system (EQUIP), should legislation be introduced. The implementation of EQUIP may also provide opportunities to strengthen workforce equality reporting and support future analysis of workforce demographics and pay-related trends.

### **7.2.5 Ethnicity Pay Gap**

The Department does not currently hold sufficiently robust centrally available ethnicity workforce data to undertake a formal ethnicity pay gap analysis across the medical and dental workforce. Unlike other parts of the UK, mandatory reporting of ethnicity

pay gaps is not currently in place for employers in Northern Ireland. As a result, HSC organisations do not currently publish regional ethnicity pay gap reports.

Medical and Dental roles are remunerated using nationally agreed pay structures based on national terms and conditions within Northern Ireland. HSC organisations do not have discretion to set local pay rates for medical and dental staff on these terms and conditions. These frameworks are designed to support equal pay for work of equal value regardless of ethnicity or other protected characteristics.

In the absence of comprehensive ethnicity workforce data and formal reporting arrangements, it is not currently possible to quantify a regional ethnicity pay gap across the medical and dental workforce. Trusts have noted that the absence of formal pay gap reporting limits the ability to assess whether workforce representation across grades and roles results in differential earnings outcomes for particular groups. In addition, ethnicity information is provided on a voluntary basis and available workforce equality data may not fully reflect the composition of the workforce.

Improving the quality, consistency and availability of workforce equality data remains an important priority in supporting workforce planning, workforce sustainability and understanding the changing composition of the workforce.

#### **7.2.6 Conclusion**

The Medical and Dental workforce in Northern Ireland continues to evolve, with increasing workforce diversity, changing working patterns and an age profile that presents both workforce planning opportunities and challenges. The growing proportion of female staff, increasing prevalence of flexible and less-than-full-time working, and the number of staff approaching retirement age in some professional groups have important implications for future workforce supply, succession planning and service delivery.

The Department recognises the importance of equality, diversity and inclusion in supporting workforce sustainability, recruitment, retention and staff experience. Whilst nationally agreed pay structures support equal pay for equivalent roles, limitations in the availability and completeness of workforce equality data mean that regional gender and ethnicity pay gap analyses cannot currently be undertaken.

Improving the quality, consistency and completeness of workforce demographic and equality data will remain important in supporting future workforce planning and understanding workforce trends. The implementation of EQUIP is expected to strengthen workforce reporting and analytical capability, supporting a more comprehensive understanding of workforce composition, workforce supply and equality-related issues across the Health and Social Care system.

Overall, workforce demographics, working patterns, equality considerations and workforce data capability will continue to inform workforce planning assumptions and influence the long-term sustainability of the Medical and Dental workforce in Northern Ireland.

### **7.3 Vacancies and Shortages**

Health and Social Care (HSC) services across Northern Ireland and indeed the wider UK continue to grapple with persistent and complex challenges in recruiting and retaining clinical staff, particularly within the Medical and Dental workforce. Despite sustained and proactive recruitment efforts, vacancy rates remain high, creating significant operational pressures across the system.

Trusts continue to report vacancy pressures and recruitment difficulties across a range of specialties, with particular challenges evident in a number of hard-to-fill specialties. These workforce pressures contribute to increased workload, reduced workforce resilience and ongoing service delivery challenges.

#### **7.3.1 Vacancy Methodology**

The HSC definition of vacancies is a measure of recruitment - ***‘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’.***

The HSC vacancy measure therefore provides an indication of active recruitment activity and workforce demand rather than a measure of all funded but unfilled posts. The current HSC vacancy methodology measures active recruitment activity but does not capture vacancy duration. Consequently, it is not currently possible to distinguish

between vacancies that are short-term and those that have remained difficult to fill over a prolonged period. The Department recognises this limitation and continues to consider opportunities to enhance workforce intelligence through future workforce systems developments.

The latest regional statistics on active vacancies are presented in the table below, with additional information available at Section 11: Workforce Data.

**Table 16: HSC Vacancies Actively Being Recruited by Profession & HSC Organisation, at 31 March 2026**

| Profession                                  | Total |
|---------------------------------------------|-------|
| Consultant                                  | 142   |
| Locum Consultant                            | 30    |
| SAS Doctor (Specialist or Specialty Doctor) | 66    |
| Resident Doctor*                            | 1     |
| Other Doctor                                | 122   |
| Dental Officer                              | 3     |
| Total Medical & Dental                      | 3     |

*Source: HSC Active Recruitment Statistics March 2026<sup>37</sup>*

\*Data relates to Trust local recruitment only and not training programme enrolment.

As at 31 March 2026, there were 364 Medical and Dental vacancies being actively recruited to across HSC organisations, including 142 Consultant vacancies and 66 SAS vacancies. Further information on the impact of vacancies, turnover and workforce shortages on service delivery is provided at Section 7.3.4.

#### 7.3.1.1 Consultant Vacancies by Specialty

Consultant vacancies continue to be concentrated within a relatively small number of specialties. As at 31 March 2026, the largest numbers of actively recruited consultant vacancies were in Psychiatry (28 vacancies), Acute/General Medicine (13), Radiology (11), Anaesthetics, Intensive Care and Critical Care Medicine (9) and Paediatrics (7). Vacancy levels in these specialties highlight ongoing recruitment pressures within areas that are critical to service delivery, waiting list reduction and the sustainability of specialist services.

<sup>37</sup> <https://www.health-ni.gov.uk/articles/staff-vacancies>

Persistent consultant vacancies can have a disproportionate impact on service resilience, particularly within smaller specialties where vacancies may increase reliance on locum cover, place additional pressure on existing staff and limit opportunities for service development and transformation.

Detailed consultant vacancy data by specialty is provided at Section 11: Workforce Data.

#### **7.3.1.2 SAS Doctor Vacancies by Specialty**

Vacancies within the SAS workforce also remain concentrated within a number of key specialties. As at 31 March 2026, Emergency Medicine accounted for the largest number of SAS vacancies (22 vacancies), followed by Care of the Elderly (5), Acute Medicine (4) and a range of other specialties including Neurology, Surgery and Obstetrics and Gynaecology.

These vacancies are particularly significant given the important role SAS doctors play in supporting service continuity, rota resilience and patient flow across services. Persistent shortages within the SAS workforce can increase workload pressures on both SAS and consultant staff and contribute to an increased reliance on temporary staffing arrangements.

Detailed SAS vacancy data by specialty is provided at Section 11: Workforce Data.

### **7.3.2 Long-term and short-term vacancies**

DoH do not collect HSC workforce vacancies by long-term and short-term definitions. As a result, it is not possible to distinguish between short-term and long-term vacancies within the centrally reported vacancy dataset.

### **7.3.3 High vacancy rates in some areas of medicine**

Persistent vacancy challenges were reported across a number of medical and dental specialties, with particular difficulties identified across Psychiatry, Radiology, Anaesthetics, Emergency Medicine, Neurology, Geriatric Medicine, Oral and Maxillofacial Surgery (OMFS), ENT and Hospital at Home services.

The most frequently cited barrier to filling vacant roles was the constrained supply of suitably qualified clinicians, with insufficient numbers entering and completing training programmes to meet service demand. In some specialties, workforce demand

continues to exceed the available supply of trained clinicians. Concerns were raised regarding limited trainee pipelines in specialties such as Radiology, while OMFS faces additional recruitment challenges because of lengthy and highly specialised training requirements.

Trusts also reported that prolonged vacancies can increase workload and rota pressures, reduce team resilience and affect the attractiveness of posts, particularly in smaller specialist services. Geographical recruitment challenges were also highlighted in some specialties and locations.

These challenges highlight the importance of sufficient training capacity and ongoing measures to support recruitment and retention within hard-to-fill specialties. Further information on wider recruitment, retention and labour market pressures is provided in Sections 7.4 to 7.8.

#### **7.3.4 Impact on service of vacancies, turnover and shortages**

Vacancies, turnover and workforce shortages continue to have a significant impact on the delivery of medical and dental services across Northern Ireland. Trusts reported ongoing staffing challenges across a number of specialties and grades, affecting service capacity, workforce resilience and the ability to maintain timely access to care.

Across the Trusts, workforce shortages were reported as increasing pressure on rota resilience and placing greater demands on existing staff. Trusts highlighted increased workload intensity, reduced workforce flexibility and growing reliance on locum and temporary staffing arrangements to maintain service delivery. While temporary staffing supports service continuity, concerns were raised regarding increased costs, reduced continuity of care and reduced service stability.

Western Trust reported difficulties securing sufficient staff to fill vacant roles and provide locum cover, resulting in delays to patient care and reduced flexibility to respond to service demand. The Trust also highlighted the impact of resident doctor allocation shortfalls and increasing levels of less than full-time working, which have placed additional pressure on substantive staff and reduced workforce resilience. Belfast Trust similarly noted challenges within smaller specialties providing regional services, where limited staffing levels can increase reliance on agency locum cover and create vulnerabilities in service provision.

Trusts reported that workforce shortages are affecting their ability to reduce waiting lists, progress service recovery initiatives, deliver service transformation and support service development and quality improvement activities. In some specialties, collaborative arrangements between Trusts have been required to maintain service provision and manage workforce gaps. This demonstrates the direct relationship between workforce capacity and the ability of organisations to deliver service recovery, reduce waiting times and progress wider transformation programmes.

Broader concerns were also raised regarding the long-term sustainability of services where vacancies persist over extended periods, particularly within smaller specialties and regional services. One Trust reported a permanent vacancy rate of approximately 11.7% and a turnover rate of 5.88% for medical and dental staff during 2025/26, illustrating the ongoing workforce pressures experienced within the system. This demonstrates that workforce pressures are not confined to recruitment alone, but also require effective retention strategies to maintain workforce stability.. In some instances, persistent workforce shortages have contributed to service reconfiguration decisions which have attracted significant public, clinical and political interest.

Overall, the evidence indicates that vacancies, turnover and workforce shortages continue to place considerable pressure on medical and dental services across the region, affecting workforce resilience, service capacity and the sustainability of service delivery across HSC Northern Ireland.

Collectively, these findings demonstrate that vacancies are not solely a recruitment issue but a wider workforce sustainability challenge. Persistent workforce shortages affect staff wellbeing, service resilience, waiting time performance and the ability of organisations to deliver long-term service transformation.

### **7.3.5 Conclusion**

Vacancy pressures continue to present a significant challenge across the medical and dental workforce in Northern Ireland, particularly within a number of hard-to-fill specialties including Psychiatry, Radiology, Anaesthetics and Emergency Medicine. The evidence demonstrates that workforce demand in some specialties continues to exceed the available supply of suitably qualified clinicians, creating persistent recruitment challenges across the Health and Social Care system.

These pressures have implications beyond recruitment alone. Trusts reported that workforce shortages affect rota resilience, increase reliance on temporary staffing, place additional pressure on existing staff and limit the ability of organisations to support service recovery, reduce waiting lists and progress service transformation initiatives. Persistent vacancies within key specialties also create risks for service sustainability and continuity of care.

While organisations continue to invest in recruitment, workforce planning and training capacity, the evidence suggests that addressing workforce shortages will require a sustained focus on workforce supply, training pipelines, recruitment and retention. Overall, vacancy pressures should be viewed as a broader workforce sustainability challenge that will continue to influence workforce resilience, service capacity and the long-term delivery of health and social care services in Northern Ireland.

## **7.4 Workforce Mobility and Labour Market Competition**

### **7.4.1 Competition for Medical and Dental Staff Across the UK**

Workforce mobility is an important consideration for Northern Ireland given the increasingly competitive labour market for medical and dental staff across the UK. While the movement of staff between jurisdictions cannot always be directly measured, understanding the factors influencing recruitment, retention and workforce mobility is important in maintaining a sustainable workforce and ensuring Northern Ireland remains an attractive place to work.

Trusts do not hold direct or quantified data on the extent to which medical and dental staff move in response to higher rates of pay in other parts of the UK. As a result, the specific impact of pay differentials on workforce movement cannot be directly measured.

Across the region, Trusts reported that workforce movement is influenced by a combination of factors including workload, rota intensity, career progression opportunities, access to training, flexibility, working conditions and wider contractual arrangements. Within this context, pay forms an important component of the overall employment offer and was identified as one factor influencing recruitment and retention decisions.

Moreover, there is variation in pay and contractual arrangements across the four UK nations. Consultant, SAS and resident doctor pay rates are no longer fully aligned, with resident doctors being employed under different contractual frameworks in England and Wales compared with Northern Ireland, and Scotland. Pay parity with NHS England is not an established Executive policy for medical and dental staff, as separate contractual arrangements and pay structures operate across the UK nations. While departmental policy has generally sought to maintain alignment with Doctors' and Dentists' Review Body (DDRB) recommendations, Trusts noted that even where workforce movement cannot be attributed to pay alone, differences in reward packages and contractual arrangements can contribute to a competitive disadvantage for Northern Ireland, particularly in hard-to-fill specialties.

The Department has committed to exploring the reform of the Northern Ireland resident doctor contract as part of wider efforts to support recruitment, retention and workforce sustainability. However, this work is currently paused due to ongoing industrial action by the BMA Resident Doctors Committee.

Trusts also highlighted the importance of both the level and timeliness of pay awards. Delays in implementing pay settlements, alongside perceived pay disparities compared to other UK regions, may affect staff perceptions of fairness and reduce the attractiveness of posts in Northern Ireland. While pay is rarely viewed as the sole reason for workforce movement, Trusts consider it to be an important element within a broader range of factors influencing recruitment and retention decisions.

Trusts highlighted ongoing recruitment and retention challenges within a competitive labour market, alongside wider concerns relating to workload pressures, career development opportunities and workforce sustainability. There is limited formal information available regarding movement of medical and dental staff from Northern Ireland to Great Britain, as current workforce systems do not routinely capture the reasons why doctors leave employment or whether they subsequently take up posts elsewhere in the UK. However, anecdotal evidence suggests that some workforce mobility exists, particularly among early-career doctors and specialist staff. Factors identified as potentially influencing movement include career development opportunities, pay competitiveness and wider employment conditions. For more data on leavers, please refer to section 7.8.1 on reasons for leaving.

Overall, pay competitiveness remains an important consideration in recruitment and retention, particularly within hard-to-fill specialties. However, workforce mobility is influenced by a broader combination of factors including workload, flexibility, contractual arrangements, career development opportunities and working conditions. Maintaining Northern Ireland's competitiveness will therefore require a balanced approach encompassing pay, workforce wellbeing, training opportunities and career progression.

#### **7.4.2 International Workforce Supply**

Trusts reported limited local data on the flow of medical and dental staff to and from other countries. Consequently, direct information on international workforce mobility remains limited and assumptions must largely be drawn from recruitment activity and wider workforce trends. However, the available information highlights the growing importance of international recruitment as a key component of workforce supply and workforce sustainability across Health and Social Care (HSC) services in Northern Ireland. In the context of ongoing recruitment challenges, hard-to-fill specialties and constrained domestic labour markets, international recruitment has become an increasingly important mechanism for attracting doctors and dentists and supporting service delivery.

Trusts reported that internationally recruited doctors make an important contribution to workforce supply across a range of specialties. International recruitment initiatives have been used to fill vacancies, reduce workforce gaps and improve service resilience in areas where local and UK recruitment has not been sufficient to meet workforce demand. In a number of specialties, international recruitment has become an important mechanism for maintaining workforce capacity where domestic recruitment alone has been insufficient to meet service requirements. This contribution is particularly important in specialties experiencing persistent vacancies and workforce shortages.

Trusts reported continued reliance on international recruitment pathways to support staffing levels across a range of specialties. Western Trust reported that 44 international doctors were appointed during 2025/26 through standard recruitment processes and its International Medical Recruitment (IMR) programme. In addition,

one Trust reported applying for 24 Certificates of Sponsorship for medical and dental staff during 2025/26, including both new appointments and visa extensions.

Available Trust information demonstrates recruitment from a wide range of countries, including India, Egypt, Sudan, Pakistan, Malaysia, Nigeria, Jordan, Kenya, Romania, Nepal, Canada and the United States. In addition, doctors have been recruited from a variety of healthcare systems, such as the Republic of Ireland, Saudi Arabia, Kuwait, the United Arab Emirates and other international locations. This highlights the increasingly global nature of the medical workforce and the importance of international labour markets in supporting healthcare services in Northern Ireland.

Despite limited information from Trusts, national workforce trends suggest increasing competition for internationally trained healthcare professionals. Responses referenced wider workforce data indicating that internationally qualified doctors form a substantial proportion of the UK medical workforce and that international recruitment remains an important component to maintaining workforce supply. However, rising numbers of internationally trained doctors leaving the UK, together with reported recruitment pipeline challenges, may reflect increasing competition for internationally trained healthcare professionals within the global labour market. These trends suggest that while international inflows remain important, retention of internationally trained staff is also an increasingly significant workforce consideration.

Trust reports also drew attention to the potential future risks to workforce supply. Changes to training pathways, increasing international competition for healthcare workers and a slowing growth rate in international recruitment may reduce the availability of overseas candidates in future years. In this context, international recruitment alone is unlikely to provide a complete solution to workforce pressures, reinforcing the need to maintain attractive employment conditions, career development opportunities and effective retention strategies.

In conclusion, the available evidence shows that international recruitment remains an essential element of workforce planning across Northern Ireland. While robust data on the flow of staff to and from other countries is not consistently available at Trust level, the available evidence suggests that HSC continues to benefit from international inflows of medical staff through overseas recruitment. Wider workforce data also indicate increasing competition for internationally trained healthcare professionals and

potential challenges in retaining this workforce. Overall, internationally trained doctors make an important contribution to service delivery and workforce sustainability across the region.

### **7.4.3 Conclusion**

Workforce mobility remains an important consideration for recruitment and retention across the medical and dental workforce in Northern Ireland. While limited data is available to directly quantify workforce movement, the evidence suggests that pay competitiveness, career development opportunities, workload, flexibility, working conditions and contractual arrangements all influence employment decisions. International recruitment continues to make an important contribution to workforce supply and service delivery; however, increasing competition for skilled clinicians means that maintaining an attractive overall employment offer remains critical to workforce sustainability. Ensuring that Northern Ireland remains competitive within both the UK and international labour markets will require continued focus on pay, workforce planning, career progression, staff wellbeing and service sustainability.

## **7.5 Contractual Differences and Reward Structures Across Jurisdictions**

### **7.5.1 Consultant Contractual and Pay Comparisons**

Consultant contractual arrangements have diverged across the UK over time, reflecting separate national negotiations and pay settlements. Whilst consultant Terms and Conditions are broadly similar this cannot be said for the terms and conditions offered by the HSE in the Republic of Ireland. Differences exist in relation to pay scales, job planning arrangements, private practice provisions and reward mechanisms. These differences may influence the relative attractiveness of consultant posts and contribute to recruitment and retention challenges in some specialties. Trusts operating close to the border, are the most likely to feel the effects of the implementation of Slaintecare in the Republic of Ireland.

Consultant pay in Northern Ireland remains broadly competitive when compared with the other UK nations. Subject to implementation of the 2026/27 DDRB recommendation, Northern Ireland would offer one of the highest consultant starting salaries across the UK. However, Trusts reported that recruitment and retention

decisions are influenced by a wider range of factors than basic salary alone, including reward arrangements, contractual flexibility and career opportunities.

**Table 17: Comparison Consultant Salaries Across the UK Nations**

| Nation                                     | Entry Salary | Top Salary |
|--------------------------------------------|--------------|------------|
| <b>Wales</b>                               | £114,099     | £166,585   |
| <b>England</b>                             | £113,565     | £150,569   |
| <b>Scotland</b>                            | £111,430     | £148,064   |
| <b>Northern Ireland</b> (with 3.5% uplift) | £114,555     | £150,611   |

In addition to differences in basic salary and contractual arrangements, Trusts also highlighted differences in reward mechanisms across jurisdictions. In particular, differences in recognition and reward arrangements, including Clinical Excellence Award schemes, may influence perceptions of competitiveness when comparing employment opportunities across jurisdictions. While Trusts were unable to quantify the direct impact of these arrangements on recruitment or retention outcomes, they were identified as one element of the overall employment offer considered by consultants.

While consultant pay remains broadly competitive across the UK, differences in contractual arrangements, reward mechanisms and employment models may influence recruitment and retention decisions in highly competitive specialties.

### **7.5.2 SAS Contractual and Pay Comparisons**

SAS contractual arrangements remain broadly comparable across the UK, although there are a number of differences reflecting separate national negotiations and the implementation of contractual reforms. In Northern Ireland, the 2021 SAS contract reforms introduced a reformed Specialty Doctor contract and a new Specialist grade, providing additional opportunities for career progression and recognition within the SAS workforce.

Subject to implementation of the 2026/27 pay recommendations, Northern Ireland would offer one of the most competitive basic salary ranges for SAS doctors and dentists across the UK. However, as with consultants, recruitment and retention decisions are influenced by a broader range of factors than salary alone, including

career development opportunities, contractual flexibility, workload, working conditions and access to progression routes.

**Table 18: Specialty Doctor (SAS) Pay Comparison**

| Nation                                         | Entry Salary | Top Salary |
|------------------------------------------------|--------------|------------|
| <b>Wales</b>                                   | £64,292      | £102,689   |
| <b>Scotland</b>                                | £64,158      | £99,975    |
| <b>England</b>                                 | £63,696      | £102,689   |
| <b>Northern Ireland</b> (+3.5% assumed uplift) | £63,696      | £102,689   |

**Table 19: Specialist Grade (Senior SAS) Comparison**

| Nation                                         | Entry Salary | Top Salary |
|------------------------------------------------|--------------|------------|
| <b>Wales</b>                                   | £104,401     | £115,343   |
| <b>England</b>                                 | £104,401     | £115,341   |
| <b>Scotland</b> (Associate Specialist)         | £100,870     | £111,441   |
| <b>Northern Ireland</b> (+3.5% assumed uplift) | £104,401     | £115,343   |

These pay comparisons demonstrate that, while remuneration remains an important component of the overall employment offer, Northern Ireland's ability to attract and retain SAS doctors and dentists will also depend upon providing attractive career pathways, flexible working opportunities and positive workplace experiences.

### **7.5.3 Resident Doctor Contractual Arrangements**

Resident Doctor contractual arrangements have increasingly diverged across the UK. England introduced a new contract in 2016, Wales agreed a new Resident Doctor contract for implementation from August 2026, while Scotland continue to progress contractual reform discussions. In addition, Scotland did not seek recommendations from the independent review body instead choosing to negotiate a 3 year pay deal, which resulted in resident doctors receiving 3.75%. Discussions on a reformed contract for Resident Doctors and Dentists in Northern Ireland are currently paused due to ongoing industrial action by the BMA.

Resident Doctors/Dentists in Northern Ireland are continuing to be paid under the 2002 New Deal contract with a lower basic salary and variable pay banding depending on the number of hours worked and the frequency of night and weekend work. Direct comparison of pay scales alone is unlikely to reflect the differences in contractual terms, pay progression arrangements and other conditions of service across

jurisdictions. These differences have the potential to influence perceptions of attractiveness and competitiveness when doctors are considering training and employment opportunities across the UK.

#### **7.5.4 Impact of Contractual Differences on Recruitment and Retention**

Trusts reported limited quantitative evidence directly linking divergent contract and reward structures to recruitment and retention outcomes. However, there was broad agreement that differences in pay, contractual arrangements, reward mechanisms and the timing of pay awards can influence workforce mobility and the attractiveness of posts across the UK.

Trusts reported that differences in contractual and reward arrangements across the UK have the potential to influence recruitment and retention, although the extent of these differences varies between staff groups. For Consultants and SAS doctors, terms and conditions remain broadly comparable across the four UK nations, with Trust responses focusing more on differences in reward mechanisms, career opportunities and the implementation of pay awards than on fundamental contractual differences. In contrast, Trusts identified greater divergence in Resident Doctor contracts, with England operating under a different contractual framework to that currently used in Northern Ireland. Such differences may influence perceptions of attractiveness, flexibility and career progression when doctors are considering employment opportunities across the UK.

Pay and reward arrangements were widely reported as important factors affecting the competitiveness of posts in Northern Ireland. While pay parity is not an established policy for medical and dental staff, Departmental policy has generally sought to maintain alignment with DDRB recommendations across the UK. Trusts highlighted that delays in implementing pay awards, alongside differences in reward mechanisms such as Clinical Excellence Awards, may affect perceptions of fairness, competitiveness and the overall attractiveness of consultant posts. While Trusts could not provide direct evidence linking these factors to recruitment outcomes, they considered that they may influence workforce mobility and employment decisions, particularly in highly competitive specialties.

Across the board, recruitment and retention are influenced by a combination of pay, reward and career development opportunities. Factors highlighted included pension

arrangements, professional development opportunities, availability of Specialist grade roles, recognition and reward mechanisms, flexible working arrangements and wider employment benefits. Some Trusts suggested that differences in these areas may contribute to perceptions of relative attractiveness between UK jurisdictions, although no Trust provided quantitative evidence demonstrating a direct impact on recruitment or retention outcomes.

Overall, Trusts reported limited evidence directly linking contractual differences to recruitment and retention outcomes. However, competitive pay, reward arrangements, career development opportunities and wider employment conditions were consistently identified as factors influencing workforce mobility and perceptions of attractiveness. Trusts highlighted greater contractual divergence for Resident Doctors, while Consultant and SAS arrangements remain broadly comparable across the UK. As contractual arrangements continue to evolve across the UK, maintaining a competitive and attractive overall employment offer will remain important in supporting workforce sustainability across Northern Ireland.

### **7.5.5 Conclusion**

Contractual and reward arrangements have increasingly diverged across the UK and the Republic of Ireland, creating a more complex and competitive labour market for medical and dental staff. While there is limited evidence directly linking contractual differences to workforce movement, Trusts consistently reported that pay, reward mechanisms, contractual flexibility, career progression opportunities and wider employment conditions contribute to the attractiveness of posts. Differences are most evident within Resident Doctor contractual arrangements, while Consultant and SAS contracts remain broadly comparable across much of the UK. Maintaining a competitive and attractive overall employment offer will therefore remain an important component of workforce sustainability, recruitment and retention across Northern Ireland.

## **7.6 Cross-Border Recruitment and Retention Challenges**

### **7.6.1 Competition from the Republic of Ireland**

Northern Ireland operates within a unique labour market environment due to the open land border with the Republic of Ireland. Medical and dental staff can readily compare

employment opportunities across both jurisdictions and, in some cases, commute across the border without relocating. As a result, recruitment and retention challenges in Northern Ireland cannot be considered in isolation from wider labour market developments within the Republic of Ireland.

This shared labour market creates additional recruitment and retention challenges across the medical and dental workforce. These pressures can be particularly acute in border areas where staff can readily compare employment opportunities across Northern Ireland, the Republic of Ireland and other parts of the UK. Although there is limited formal data quantifying workforce movement between jurisdictions, the available evidence indicates that cross-border competition is an important factor affecting the attractiveness of posts, particularly within hard-to-fill specialties. Factors influencing staff decisions include pay, contractual arrangements, working patterns, career progression opportunities, access to training, workload, flexibility and travel requirements.

Competition from the Republic of Ireland was highlighted as a particular consideration, especially for organisations operating close to the border. Northern Ireland and the Republic of Ireland operate under different healthcare systems, employment models, contractual arrangements, pay structures, employment and pension legislation as well as differing tax law. For consultant staff in particular, differences in salary levels and contractual arrangements between Northern Ireland and the Republic of Ireland may be a relevant consideration in recruitment and retention decisions, especially in hard to fill specialties or where commuting between the North and South of Ireland is acceptable. Despite this there is very little evidence that large numbers of consultants choosing to work for the HSE in the Republic of Ireland.

### **7.6.2 Impact of Sláintecare**

Trusts do not hold comprehensive datasets quantifying the impact of Sláintecare on recruitment and retention or measuring the movement of doctors and dentists between Northern Ireland and the Republic of Ireland. Consequently, its direct impact on workforce movement, recruitment and retention cannot be quantified. However, reports consistently identify Sláintecare and wider healthcare reforms in the Republic of Ireland as important contextual factors influencing recruitment and retention across the regional medical and dental labour market.

This issue is particularly relevant for Trusts operating in border areas. Due to their location, both the Southern and Western Trusts reported that the Republic of Ireland has become an increasingly significant competitor for medical and dental staff. The implementation of Sláintecare was introduced in the Republic of Ireland to support workforce expansion, consultant contract reform and increased investment in the Irish health service, this has contributed to a more competitive labour market across Ireland. Trusts highlighted that differences in pay, working hours, contractual arrangements and employment conditions have the potential to influence workforce decisions, particularly for staff with transferable skills and the flexibility to work across geographical borders.

Several Trusts highlighted the particular significance of the Republic of Ireland's public-only consultant contract. Compared with HSC consultant arrangements, the Irish contract offers a different employment model, including a 37-hour working week and substantially higher salary scales. Trusts noted that these differences may increase the attractiveness of roles within the Republic of Ireland, particularly in hard-to-fill specialties and in border areas where cross-border commuting is more feasible. These developments have the potential to increase competition for experienced consultants and specialist staff, particularly within border areas and in specialties where workforce supply is already constrained.

While formal workforce mobility data is limited, some Trusts reported examples of doctors and dentists leaving HSC employment to take up positions in the Republic of Ireland, including consultant doctors, both substantive and locum, leaving HSC posts to take up employment in Ireland and community dental staff reducing their hours in Northern Ireland to undertake work within the HSE. In addition, Western Trust referenced published commentary from medical representative bodies which has raised concerns regarding the potential impact of pay and conditions differentials on workforce mobility across Ireland. However, these examples are anecdotal and do not provide a basis for quantifying the scale of movement or attributing it directly to Sláintecare.

Despite pay being identified as a key contributing factor, the impact of Sláintecare is not viewed as solely a pay issue. Trusts highlighted that recruitment and retention decisions continue to be influenced by a combination of factors including workload,

service pressures, career opportunities, working conditions, contract design and overall quality of working life. Trust responses indicate that Sláintecare is regarded as one of a number of factors that may influence recruitment and retention pressures for some HSC organisations.

### **7.6.3 Conclusion**

The evidence indicates that cross-border labour market dynamics continue to influence recruitment and retention across the medical and dental workforce in Northern Ireland. While the scale of workforce movement between Northern Ireland and the Republic of Ireland cannot be quantified with certainty, Trusts consistently identified the Republic of Ireland as an increasingly significant competitor for skilled medical and dental professionals, particularly in border areas and hard-to-fill specialties.

Differences in pay, contractual arrangements, working hours, career opportunities and wider employment conditions have the potential to influence workforce decisions, alongside broader factors such as workload, service pressures, workforce wellbeing and quality of working life. The implementation of Sláintecare and wider health service reforms in the Republic of Ireland have further increased competition within the all-island healthcare labour market.

Although there is limited evidence of large-scale movement of staff from Northern Ireland to the Republic of Ireland, the available evidence suggests that cross-border competition remains an important consideration for workforce planning, recruitment and retention. This is particularly relevant for consultant, specialist and community dental roles, where workforce supply is already constrained.

Overall, recruitment and retention challenges in Northern Ireland cannot be viewed solely through a regional or UK-wide lens. The unique labour market created by the open land border means that workforce decisions are influenced by employment opportunities across both jurisdictions. Maintaining an attractive overall employment offer, alongside continued focus on workforce development, career progression, pay competitiveness and workforce wellbeing, will remain important in supporting workforce sustainability and service resilience across Health and Social Care services in Northern Ireland.

## **7.7 Recruitment and Workforce Attraction**

### **7.7.1 Recruitment and Attraction Initiatives**

HSC organisations continue to utilise a range of local, regional, national and international recruitment initiatives to attract medical and dental staff. In the context of increasing service demand, workforce shortages and competition for skilled clinicians, recruitment remains a key component of workforce sustainability strategies across Northern Ireland.

In response, HSC organisations have taken steps to enhance their recruitment strategies. Selection and recruitment materials have been updated to reflect the HSC's core Values and Behaviours, reinforcing a culture of compassion, professionalism, and excellence. Additionally, work is ongoing to develop a cohesive HSC employer brand—one that positions the organisation as an attractive and rewarding place to work.

To broaden their reach and appeal, employing organisations have adopted a multi-faceted approach to candidate attraction. This includes targeted advertising on social media platforms, participation in career fairs, the production of promotional videos, and engagement with international recruitment initiatives. These efforts aim to not only fill immediate vacancies but also build a sustainable pipeline of talent for the future.

The primary recruitment mechanism remains the regional HSC recruitment platform, supplemented by specialty-specific advertising, targeted recruitment campaigns, attendance at recruitment events, and international recruitment initiatives. These initiatives aim to increase the visibility of vacancies and broaden access to potential candidates, although their effectiveness has varied across specialties and staff groups.

Western Trust's International Medical Recruitment project has become an established part of its wider workforce strategy for hard-to-fill posts. It combines targeted overseas campaigns with structured follow-up, candidate engagement and support through appointment and pre-employment processes. This has helped the Trust widen its recruitment reach beyond the local and UK market, secure appointments in a number of specialties and build a stronger pipeline of candidates for future vacancies where domestic supply remains limited.

Trusts have also undertaken targeted recruitment activity, including attendance at national and international recruitment events, development of talent pools and use of digital recruitment platforms to widen their recruitment reach.

A number of Trusts have implemented alternative workforce models, including Clinical Fellow programmes, rotational doctor pathways and specialist grade roles, to support recruitment and service resilience. Additional initiatives include joint appointments and 'grow your own' workforce approaches aimed at improving longer-term workforce sustainability and addressing recruitment challenges. NIMDTA also reported that the expansion of the Northern Ireland Foundation Programme has enabled a greater number of trainees to rotate through less popular specialties, which may help increase awareness of and future interest in careers within these areas.

These initiatives are intended not only to support immediate recruitment requirements but also to strengthen the longer-term attractiveness of HSC Northern Ireland as an employer in an increasingly competitive labour market.

### **7.7.2 Impact of Recruitment Approaches**

HSC organisations utilise a combination of national, regional, local and international recruitment approaches to support workforce supply across the medical and dental workforce. The effectiveness of these approaches varies by specialty and workforce group. While national recruitment can provide access to a wider applicant pool and improve fill rates in some specialties, local recruitment offers greater flexibility to respond to Northern Ireland workforce needs.

For medical and dental training posts, NIMDTA delivers a mix of national and local recruitment arrangements. Dental training is predominantly recruited through national schemes, while approximately 30 medical training programmes are recruited locally where this is considered beneficial to appointment rates. NIMDTA reported that while national recruitment arrangements provide access to a wider applicant pool, they do not always align fully with Northern Ireland workforce requirements. In some specialties, applicants appointed through national recruitment subsequently choose not to take up posts in Northern Ireland, impacting appointment and fill rates.

Across the region, recruitment activity has had greater success in attracting applicants to junior and training-level posts than to consultant, SAS and other hard-to-fill specialist positions. Trusts reported that workforce demand continues to exceed

available supply in a number of specialties, resulting in repeated recruitment campaigns, unfilled vacancies and ongoing reliance on locum staffing. For a more detailed insight into RRP and the impact of vacancies and the impact of vacancies and workforce shortages on service delivery, see Sections 9.4.6 and 7.3.4.

Several Trusts have expanded their recruitment reach through international recruitment, targeted attraction campaigns and engagement with wider labour markets. These initiatives have helped create candidate pipelines and increase interest in some specialties. However, challenges remain due to global workforce shortages, competition from other UK regions, the Republic of Ireland and the independent sector, as well as practical barriers such as visa processing, registration requirements and relocation timescales. As a result, international recruitment is viewed as an important component of workforce planning but is not considered a short-term solution to vacancy pressures.

Despite these efforts, recruitment difficulties continue to impact service resilience, workforce sustainability and service delivery across the region.

Trusts reported strong competition for candidates from other UK regions, the Republic of Ireland and the independent sector, with factors such as pay, workload and flexible working opportunities influencing recruitment outcomes. Persistent vacancies can contribute to increased workload pressures, rota gaps and continued reliance on temporary staffing arrangements. NIMDTA reported increasing numbers of Inter-Deanery Transfer requests to other UK regions, reflecting the mobility of the medical workforce and the competitive environment for medical training across the UK.

Overall, evidence from Trusts and NIMDTA indicates that both national and local recruitment approaches have benefits depending on the specialty and workforce context. Consequently, organisations continue to utilise a combination of national, local and international recruitment approaches alongside workforce development initiatives to maximise recruitment opportunities and support longer-term workforce sustainability. NIMDTA also highlighted growing operational challenges in delivering local recruitment processes due to increasing application volumes and limited recruitment resources, resulting in some specialties reverting from local to national recruitment arrangements for the 2026 intake.

### **7.7.3 Changing Recruitment Behaviour and Workforce Expectations**

Employing organisations reported changes in recruitment behaviour in recent years, reflecting the higher female component of the workforce and the subsequent demands for more flexibility in working hours, with applicants becoming increasingly selective about the roles they pursue. Factors influencing recruitment decisions include location, pay, workload, rota intensity, flexibility, career progression opportunities, training availability and overall working conditions.

Workforce shortages, growing competition for medical and dental staff, and a more complex and mobile labour market has also contributed to the changes in how the workforce seek employment and how employers recruit to vacant posts. Across the region, organisations described a smaller available candidate pool for some specialties, greater reliance on repeated recruitment campaigns, increased use of alternative workforce models, and increasing reliance on international recruitment to address persistent vacancies.

International recruitment continues to influence recruitment behaviour across the region and has contributed to changes in workforce composition and recruitment requirements, including increased visa sponsorship and more complex recruitment processes. While Trusts reported that international recruitment has expanded the available candidate pool, organisations also highlighted lengthy recruitment timelines, visa and registration requirements, and challenges maintaining candidate engagement throughout the recruitment process. Government policy and recruitment systems have also influenced workforce availability and recruitment patterns, with Trusts noting that changes to immigration policy have expanded access to international candidates and contributed to increased competition for training opportunities.

In some specialties, vacancies require multiple recruitment rounds, repeated advertising exercises, or alternative workforce solutions before appointments can be secured. Several Trusts also highlighted increasing competition from other UK regions, the Republic of Ireland and international employers, with one Trust reporting particular competition from Australia as an attractive destination for medical staff particularly during their early training.

### 7.7.3.1 Resident Doctor and dentist recruitment

Northern Ireland does not train sufficient doctors for its healthcare needs and is reliant on attraction of doctors who have qualified outside Northern Ireland to fill training programmes and provide healthcare service. This applies both to the supply of general practitioners and specialists. Potential recruitment sources include the use of international medical graduates (IMGs) who may or may not have previous experience working within the NHS or HSC.

NIMDTA is reliant on recruitment of non-Northern Ireland graduates in order to fill its training posts. Aside from the implications of having insufficient trained general practitioners and specialists, incomplete training programmes result in rota gaps and service pressures and make the training experience less attractive and fulfilling for those doctors who have committed to postgraduate training.

There has been an increase over the past few years in the number of trainees requiring a visa to commence in a training programme in Northern Ireland. In August 2021 there were 61 new trainees requiring visa sponsorship to commence training (total 181 trainees requiring visa sponsorship) this increased to 369 in August 2024 which included 188 new trainees. In the 2025/26 academic year there are 382 trainees requiring visa sponsorship. This reflects the growing importance of international graduates in supporting workforce supply across a number of training programmes and specialties.

Change in recruitment processes since 2020 has become more resource dependent for both administrative and educator (admin staff and consultants) producing challenges in its delivery. There have been record numbers of applicants to specialty training programmes for 2026 and the resource to deliver recruitment is not sufficient with the continual increases. Applicant behaviour is changing with applicants making more applications in a bid to secure a training programme. In addition, as applicants can apply from anywhere in the world, it is impossible to predict the number of applicants who will apply. Although fill rates have increased, we need to ensure we are identifying appointments to the HSC ensuring Northern Ireland, UK and international graduates who are a key part of the workforce.

International recruitment may look different for HSC organisations following the Medical Training (Prioritisation) Act, which came into effect on 5<sup>th</sup> March 2026. This

Act requires graduates with a primary medical qualification from the UK or the Republic of Ireland to be prioritised over international graduates when recruiting for medical training programmes. This will affect recruitment into specialty training and the foundation programme across the UK and will impact on the number of doctors requiring sponsorship, potentially the overall demographic of the cohort recruited.

At the same time, training allocation processes, the availability of training places and growth in less-than-full-time training are influencing workforce capacity by affecting rota coverage, workforce continuity and the speed at which vacancies can be filled.

Collectively, the evidence suggests that recruitment behaviour has become more competitive and increasingly influenced by the changing demographic of the entire medical and dental workforce. While government policies and recruitment systems have supported broader access to candidates and improved consistency in recruitment practices, organisations continue to report challenges associated with workforce supply constraints, competition for skilled staff and the need for more agile recruitment approaches to support long-term workforce sustainability. The introduction of regional employment arrangements and the wider use of online recruitment systems have improved consistency, accessibility and reach; however, organisations reported that recruitment processes can still be lengthy, resource-intensive and insufficiently flexible to meet the needs of some hard-to-fill specialties.

#### **7.7.4 Recruitment Challenges**

Recruitment difficulties in Northern Ireland are driven by a combination of structural, geographic and labour market factors. While factors vary across Trusts, there are several recurring issues that can be identified.

Regional evidence indicates that recruitment difficulties are occurring within a context of increasing service demand, population ageing and workforce supply constraints. Respondents consistently identified a growing imbalance between workforce supply and demand, resulting in sustained staffing pressures across a range of professional groups. See chapters 7.1 on Workforce Overview and Demand Pressures and 7.3.4 on the Impact of Vacancies, Turnover and Shortages for further information on staff shortages.

Age demographic change was also identified as contributing factors. Trusts highlighted both an ageing population, which is increasing service demand and

complexity, and an aging workforce, with increasing retirements contributing to the loss of experienced staff across a range of professional groups. Some Trusts also noted changing workforce expectations among newer entrants, particularly in relation to flexibility, career development and work-life balance.

Labour market competition continues to compound existing workforce shortages. Trusts reported recruitment and retention pressures arising from opportunities within the Republic of Ireland, private sector, agency employment and other public sector organisations. Pay, flexibility, career progression opportunities and wider employment conditions were cited as factors influencing workforce mobility across a range of professions. Cross-border workforce mobility was identified as a particular challenge in some staff groups, reflecting Northern Ireland's proximity to the Republic of Ireland and competition from employers operating within a shared labour market.

Geographical factors present further challenges for Trusts. Issues relating to travel requirements, multi-site working, relocation costs and accessibility can make some locations less attractive to potential applicants, limiting recruitment pools and increasing retention pressures. The Western Trust in particular highlighted challenges associated with its large, predominantly rural catchment area, while other Trusts identified local recruitment difficulties in more remote, rural and coastal locations.

#### **7.7.5 Conclusion**

Recruitment to the medical and dental workforce continues to be influenced by increasing demand, workforce shortages, labour market competition and changing workforce expectations. While HSC organisations continue to invest in recruitment initiatives, targeted attraction campaigns and workforce development programmes, workforce demand continues to exceed available supply in a number of specialties. Maintaining a sustainable pipeline of applicants will require continued focus on recruitment innovation, education and training supply, workforce planning and the attractiveness of the overall employment offer. In the absence of sufficient workforce supply, recruitment challenges will continue to affect workforce sustainability, service resilience and the ability to meet increasing patient demand.

## **7.8 Retention, Turnover and Workforce Stability**

### **7.8.1 Reasons for Leaving**

On a regional level, resignation is the most commonly reported reason for leaving among medical and dental staff and represents the largest area of workforce movement across HSCNI. Where data was available, voluntary resignations consistently exceeded other forms of workforce exits, including retirement and the end of fixed-term contracts. Comparative data provided by some Trusts indicates that resignation continues to account for a significant proportion of workforce exits. This may reflect challenges relating to workforce retention, workforce sustainability and labour market competition, including competition from other regions and employers perceived to offer more attractive pay and conditions. These findings suggest that retaining existing staff may be as important as attracting new recruits in addressing workforce supply challenges across the medical and dental workforce. However, the availability and level of detail of exit data varies across Trusts and, in some cases, limits the extent to which regional conclusions can be drawn regarding the underlying reasons for leaving.

Several Trusts reported that workforce turnover can affect workforce stability, contribute to rota gaps and increase reliance on locum staffing. Trusts also highlighted the impact of workforce shortages and service pressures on existing teams, with potential implications for workforce resilience and service delivery.

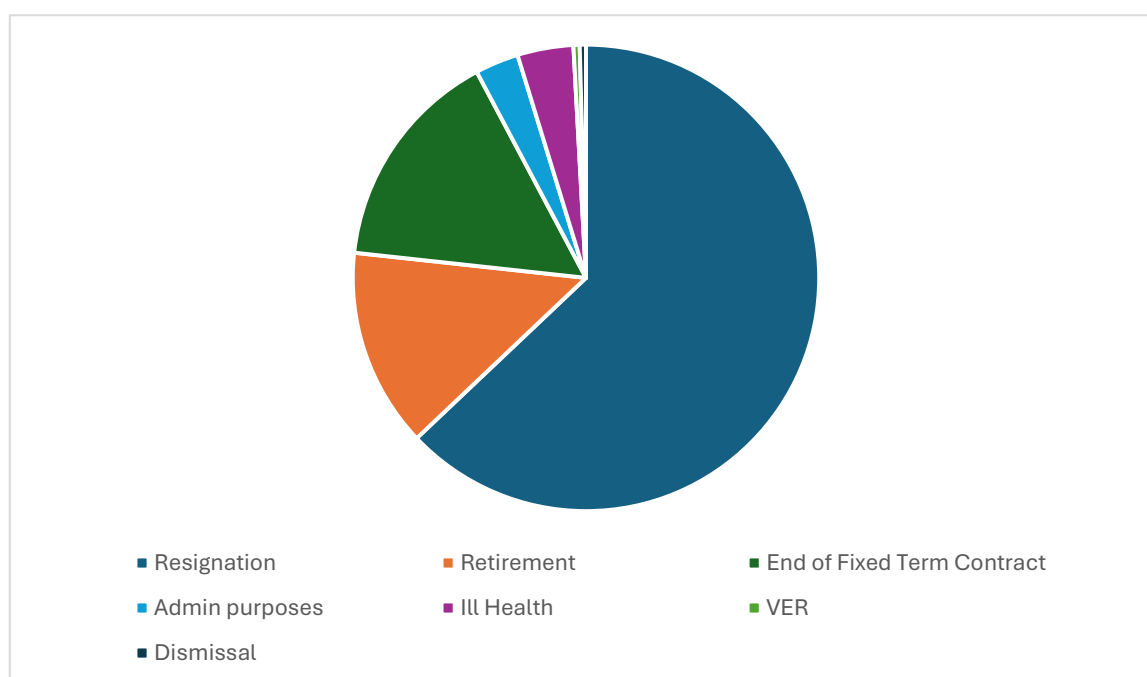
In addition to the figures above, Belfast Trust highlighted that there were 71 leavers from their Medical and Dental Locum Bank from April 2025 – March 2026.

As depicted in the table, retirement remains an important, but secondary, reason for leaving. Trusts reported a smaller proportion of leavers retiring compared with those resigning. Some organisations noted increases in retirement activity and suggested that factors such as workforce demographics, workload pressures and pension considerations may influence retirement decisions.

The latest regional statistics on HSC leavers, including headcount and leaving rates by staff group for 2024/25, are provided in Section 11: Workforce Data.

Across HSC Northern Ireland, resignation accounted for the largest proportion of medical and dental workforce exits during 2025/26, significantly exceeding retirements and other forms of workforce turnover.

**Chart 3: Reasons for Leaving 2025/26**



*Source: HSC Trust Returns*

The comparative data indicates differing trends across Trusts, with reductions in some categories of leavers and increases in others.

Analysis of available Trust data indicates that resignation remains the most common reason for leaving the medical and dental workforce, accounting for the majority of recorded exits during 2025/26. Retirement represents the second largest reason for leaving, while other categories such as ill-health retirement and fixed-term contract expiry account for a relatively small proportion of exits. This suggests that workforce retention remains a more significant challenge than workforce retirement in maintaining workforce stability and workforce supply.

In summary, resignation was the most commonly reported reason for leaving across the medical and dental workforce during 2025/26, with retirement representing the second largest category of exits. While some Trusts highlighted factors such as workload pressures, increasing service demand, recruitment difficulties, labour market competition, career progression considerations and pay competitiveness as potential

contributors to turnover, detailed reasons for leaving are not routinely captured across the region. Improving the quality and consistency of exit data, alongside measures to address workload pressures, workforce capacity and wider retention challenges, will be important in informing workforce planning and supporting long-term workforce sustainability.

### **7.8.2 Turnover**

The medical and dental leaving rate of 5.7% remains lower than a number of other HSC staff groups. However, even relatively modest levels of turnover can have a significant impact in specialties where workforce supply is constrained and vacancies remain difficult to fill.

### **7.8.3 Workforce Stability and Retention Challenges**

Recruitment and retention difficulties for medical and dental staff in Northern Ireland are driven by a combination of workforce supply constraints, increasing service demand, geographical factors and competition within wider labour markets (see Sections 7.7.3 *Changing Recruitment Behaviour and Workforce Expectations*, 7.7.4 *Recruitment Challenges*).

The available supply of trained medical and dental professionals remains insufficient to fully meet service requirements across a number of specialties. Evidence submitted by HSC employers highlights ongoing recruitment and retention challenges within a range of hard-to-fill specialties, including psychiatry, radiology, anaesthetics and ENT. This is occurring against a backdrop of increasing demand for health and social care services, an ageing population, growing clinical complexity and sustained workforce pressures. Recruitment challenges are particularly evident in specialties where workforce shortages are experienced across Northern Ireland, the wider UK and internationally.

Competition for medical and dental staff exists across Northern Ireland, the wider UK, the Republic of Ireland and the independent sector. HSC employers report that competition from these sectors can affect recruitment outcomes, particularly in specialties where workforce supply is limited. Evidence provided by Trusts indicates that factors such as pay competitiveness, workload, flexible working arrangements and career development opportunities can influence recruitment and retention outcomes.

Persistent vacancies may increase workloads, reduce rota resilience and place additional demands on existing staff (see Sections 7.3.4 *Impact of Vacancies, Turnover and Shortages*). These factors can be particularly significant in smaller specialties and services where workforce numbers are limited and where vacancies may be more difficult to fill.

Recruitment and retention outcomes are further influenced by workforce supply and training capacity. The limited size of the local labour market and reliance on finite training pipelines can constrain workforce supply, particularly in shortage specialties. Difficulties in recruiting to training and substantive posts can increase reliance on temporary staffing arrangements and create additional workforce pressures.

Overall, the Department considers that retention challenges within the medical and dental workforce arise from a combination of constrained workforce supply, growing demand for services, competitive external labour markets and workload pressures. Regional evidence indicates that resignation is the most commonly reported reason for leaving among medical and dental staff, exceeding retirements and other forms of workforce exit.

Evidence provided by HSC organisations indicates that retention outcomes are influenced by a combination of organisational, professional and personal factors. Factors reported as supporting retention include opportunities for career progression, access to flexible working arrangements, wellbeing support, positive workplace culture and supportive leadership. Trusts identified these factors as increasingly important in maintaining workforce stability and responding to evolving workforce expectations.

Conversely, evidence submitted by Trusts suggests that workload intensity, persistent vacancies, increasing service demand and reduced workforce resilience can negatively impact retention. Trusts reported that vacancies and workforce shortages in some specialties place additional pressure on existing staff through increased workloads, rota gaps, vacancy cover requirements and service delivery pressures. Competition from employers elsewhere within the UK, the Republic of Ireland and the independent sector was also identified as influencing retention outcomes, particularly where alternative employment opportunities may offer different remuneration, working patterns or career opportunities.

These factors are often interconnected and may affect specialties differently depending on workforce supply, service pressures and local labour market conditions. While detailed reasons for leaving are not consistently captured across all HSC organisations, the evidence provided by Trusts suggests that both employment conditions and wider workforce pressures influence workforce stability and retention outcomes.

Further evidence relating to these factors is set out in Sections 7.7.3 *Changing Recruitment Behaviour and Workforce Expectations*, 7.7.4 *Recruitment Challenges*, and 7.8.1 *Reasons for Leaving*.

#### **7.8.4 Conclusion**

Resignation continues to be the most commonly reported reason for leaving the medical and dental workforce, while workload pressures, labour market competition, career opportunities, pay and workforce wellbeing all influence retention. Workforce stability remains essential to service resilience, reducing reliance on temporary staffing and supporting long-term workforce sustainability. Effective retention strategies will therefore remain a critical component of workforce planning and workforce sustainability across Northern Ireland.

### **7.9 Agency and Locum Use**

#### **7.9.1 Agency/ Locum Utilisation**

Health and Social Care (HSC) organisations continue to utilise agency and locum doctors to support service delivery, maintain rota resilience and address workforce shortages across a range of specialties. The recruitment of locum doctors presents particular challenges in Northern Ireland due to its geographical separation from the rest of the UK, which can limit the available pool of candidates and increase competition for temporary medical staff. As a result, securing appropriate locum cover often requires the recruitment of doctors working outside their substantive contracts, highlighting the importance of efficient recruitment processes and workforce planning arrangements in maintaining safe and sustainable services.

Continued reliance on agency and locum staffing reflects underlying workforce supply challenges and persistent vacancy pressures within a number of specialties. To mitigate these workforce gaps, HSC Trusts have increasingly relied on locum doctors

at both training and specialty grade levels, as well as agency staff. While these temporary solutions provide short-term relief, they come with notable drawbacks. Trusts consistently report that locum arrangements lack the continuity, stability, and integration offered by substantive staff. Moreover, locum and agency services are significantly more costly, placing additional strain on already stretched budgets.

While temporary staffing arrangements support service continuity and service resilience, they are generally more costly than substantive staffing and may affect workforce stability, continuity of care and long-term workforce sustainability. As such, levels of agency and locum utilisation provide an important indicator of wider workforce pressures and workforce supply challenges across the medical and dental workforce.

Detailed information on Medical and Dental agency and locum utilisation is provided within the Annex 2. This includes regional and Trust-level information by specialty and grade, together with agency framework usage and workforce deployment data. The information represents a point-in-time position and reflects the dynamic nature of temporary staffing utilisation, which can fluctuate in response to vacancies, rota gaps and service pressures. Agency utilisation figures are reported as shifts or individual engagements rather than whole-time equivalent (WTE) posts and should therefore be interpreted as an indicator of temporary workforce activity rather than workforce establishment.

### **7.9.2 Agency and Locum Activity**

In addition to agency staffing arrangements, HSC organisations make use of internal locum arrangements through the e-Locum system and other locally managed medical staff banks. These arrangements are primarily used to address ad hoc staffing gaps and short-term rota pressures rather than long-term vacancies.

The use of internal locum arrangements enables organisations to utilise existing workforce capacity before seeking external agency support and forms an important component of wider efforts to manage workforce shortages and maintain service continuity.

The Western Health and Social Care Trust does not routinely utilise the regional e-Locum system and instead operates its own internal medical staffing bank to support temporary workforce requirements.

The new Medical and Dental Agency Framework was implemented on 2 March 2026. Regional reporting arrangements for agency medical and dental activity continue to develop; however, Trust-level information indicates a significant ongoing reliance on temporary staffing arrangements to support service delivery and maintain rota resilience.

During 2025/26, four trusts collectively recorded more than 1.1 million agency hours across the medical and dental workforce. This level of temporary staffing activity highlights the scale of workforce pressures affecting a number of specialties and demonstrates the continued importance of agency staffing in maintaining service continuity. In addition, one trust reported engaging approximately 100 WTE locum doctors in longer-term bookings, comprising 45 consultants, 24 registrar-level doctors and 36 ST1/SHO-level doctors.

The scale of agency and locum utilisation demonstrates the extent to which workforce shortages and recruitment difficulties continue to affect a number of specialties and services. Temporary staffing arrangements remain an important mechanism for maintaining service continuity; however, they also highlight the ongoing challenge of aligning workforce supply with service demand.

### **Internal Locum Activity**

Internal locum arrangements continue to play an important role in maintaining service delivery across Health and Social Care services in Northern Ireland. During 2025/26, HSC organisations utilised internal locum arrangements for more than 13,800 shifts, equating to approximately 140,000 hours of clinical activity and expenditure of £8.5 million.

The scale of internal locum utilisation demonstrates the extent to which organisations continue to rely on workforce flexibility to maintain medical staffing levels, support rota resilience and address staffing shortages. Internal locum arrangements provide an important alternative to agency staffing and are generally viewed as a more cost-effective means of addressing short-term workforce gaps while retaining continuity and organisational knowledge.

There is, however, significant variation in utilisation across organisations, reflecting local workforce pressures, service configuration and the availability of alternative

medical staffing arrangements. For example, the Western Health and Social Care Trust operates a separate internal medical staffing bank rather than routinely using the regional e-Locum system.

Detailed agency and internal locum activity data, including shifts, hours worked, expenditure information and Trust-level activity, is provided within the Annex 2.

### **7.9.3 Agency and Locum Rates**

#### **7.9.3.1 NI Medical & Dental Agency Framework Rates**

A new Medical and Dental Agency Framework was implemented on 2 March 2026, establishing a regional approach to the engagement of agency medical staff across HSC Northern Ireland. The framework includes agencies supplying staff across a range of grades and specialties, with rates varying according to grade, shift type and working arrangements.

Detailed Medical and Dental Agency Framework rates are provided at Annex 2. These include hourly rates applicable to standard shifts, on-call duties and bank holiday working. The framework currently includes 58 participating agencies and provides a defined range of rates across the medical workforce.

The introduction of a regional framework provides greater consistency in agency engagement arrangements and supports efforts to improve workforce governance, control costs and reduce reliance on off-framework agency staffing.

#### **7.9.3.2 E-Locum Rates**

Internal locum arrangements are also supported through Department of Health e-Locum rates. A departmental circular establishing these rates was issued in 2015 and the approved hourly rates remain in place. However, the medical and dental labour market has changed significantly since the publication of the original circular and, in practice, locally negotiated arrangements are often required to secure sufficient internal locum cover.

Trusts reported that the age of the current e-Locum rates can make it difficult to attract doctors to undertake additional internal locum shifts, particularly in specialties experiencing workforce shortages. This may contribute to greater reliance on agency staffing where gaps cannot be filled internally.

A review of the e-Locum rates is currently underway. The objective of this work is to ensure that internal locum arrangements remain an attractive and cost-effective alternative to agency staffing while supporting wider efforts to reduce dependency on temporary staffing arrangements.

Detailed e-Locum rates are provided at Annex 2.

#### **7.9.4 Addressing Dependency on Temporary Staffing**

Reducing reliance on agency and locum staffing remains a key workforce priority for HSC Northern Ireland. While temporary staffing arrangements are often necessary to maintain service delivery and patient safety, sustained dependence on locum staffing is neither financially sustainable nor conducive to long-term workforce stability. A range of regional initiatives has therefore been established to address the underlying workforce issues that drive agency and locum utilisation, including workforce shortages, recruitment difficulties and service fragility within vulnerable specialties.

The Regional Agency Reduction Implementation Group (ARIG) was established by the then Minister for Health, Robin Swann in March 2020 to co-ordinate the improvement of staff utilisation, with the aim of reducing unsustainable agency spend across HSC NI.

The ARIG has developed a regional programme of work encompassing short, medium and long-term actions designed to reduce unsustainable agency expenditure and strengthen workforce sustainability. Further detail on the Medical and Dental Agency Reduction Programme Structure is provided at Annex 2.

A regional Medical and Dental Locum Reduction Action Plan has been developed with the full engagement of all HSC Trusts, NIMDTA, DoH, SPPG, and BSO PaLS. This extensive programme is designed to address many of the underlying causes of instability in the medical and dental workforce. A small project team has been appointed to support delivery of this work programme.

The action plan recognises that reducing agency dependency requires action across the wider workforce system, including improvements in workforce planning, recruitment, retention, training capacity and rota resilience. Consequently, many of the programme's workstreams focus on addressing the root causes of workforce shortages rather than simply reducing agency utilisation in isolation.

Each Trust has appointed an operational senior responsible officer (SRO) who acts as the key liaison and lead for the actions for their Trust. In addition to this each organisation has an agreed governance structure to oversee delivery of the programme. SROs are responsible for ensuring any key organisational risks associated with the programme are identified and highlighted to ARIG where relevant actions and mitigations can be considered.

Implementation of the medical and dental workstreams outlined in the Programme Structure will continue during the next 12 months. A number of priority work areas are detailed below.

#### 7.9.4.1 E-Locum rates

A review of internal e-Locum rates is currently underway. Trusts reported that existing rates, originally established in 2015, are no longer fully reflective of current labour market conditions. This has made it more difficult to secure internal locum cover and, in some circumstances, has contributed to greater reliance on agency staffing. The review aims to ensure that internal locum arrangements remain a viable and cost-effective alternative to agency provision.

#### 7.9.4.2 Vulnerable Specialities Group

A group reviewing vulnerable specialties are considering short to medium term actions to support specialties and locations that have been identified as at risk or vulnerable. Specialties being considered in the first instance include chemical pathology, microbiology, haematology and radiology. As well as completing a scoping exercise, this group is considering steps to support stabilisation of these services and giving consideration to telemedicine, digital innovation to support regional working and the development of regional cover for particular advisory specialties. This work is intended to improve service resilience and reduce reliance on temporary staffing within specialties experiencing persistent workforce shortages.

#### 7.9.4.3 Medical Workforce Planning

The nature of the workforce challenges within the medical workforce mean that a range of other actions will be required to address the factors which have allowed the current reliance on locum doctors to develop. It is recognised that workforce planning workstreams are critical. A dedicated workforce planning workstream has been

established. This group is considering how the NI Health and Social Care (HSCNI) Consultant and SAS Doctor Workforce by Specialty Report (May 2023) can be utilised to inform future requirements, key areas of risk and the numbers of doctors required in each of the specialist training programmes. The workstream recognises that reducing agency dependence is ultimately dependent on improving substantive workforce supply through workforce planning, training capacity and recruitment.

In addition, a further workstream is in place to review how doctors in training are allocated across the Region. This group is also considering what further steps can be taken to reduce the reliance on resident doctor locums across Trusts.

Collectively, these initiatives are intended to reduce reliance on temporary staffing arrangements and improve workforce sustainability across the medical and dental workforce. While agency and locum staffing will continue to play an important role in maintaining service delivery, the long-term objective remains the growth and retention of a sustainable substantive workforce supported by effective workforce planning, recruitment and retention strategies.

#### **7.9.5 Reducing Agency Expenditure**

The reduction of agency expenditure remains a key objective of the Regional Agency Reduction Implementation Group (ARIG). As part of this work, the new Northern Ireland Medical and Dental Agency Framework was implemented on 2 March 2026. In preparation for its introduction, Trusts completed risk assessments and transition plans to support the phased removal of off-framework agency providers, with transition arrangements operating until June 2026.

The implementation of the new framework is expected to significantly reduce the number of doctors supplied through off-framework agencies and limit the use of off-framework rates. This should support improved value for money, strengthen workforce governance arrangements and contribute to a reduction in overall locum expenditure. As with previous workforce framework initiatives, it is also anticipated that some locum doctors may transition into substantive posts, supporting greater workforce stability and continuity of care.

#### 7.9.5.1 Progress to date

As at 2 March 2026, approximately 48% of agency engagements were being supplied at off-contract rates. By 26 May 2026, this had reduced to approximately 10%, with further work ongoing to eliminate the remaining off-contract engagements during the agreed transition period.

In addition, a "price cap" has been introduced for the first time within the Medical and Dental Agency Framework. Similar to arrangements already operating within the Nursing and Midwifery Framework, this measure is intended to support greater cost control and reduce upward pressure on agency expenditure. Under these arrangements, annual medical and dental pay award uplifts will not automatically be applied to framework agency rates during the life of the contract.

Actions taken through the Medical and Dental Agency Reduction Programme have contributed to a reduction in agency expenditure during 2025/26. Total Medical and Dental agency framework expenditure reduced by approximately 10% compared with 2024/25, while expenditure on off-framework agency staffing reduced by approximately 19% over the same period. Expenditure on directly employed locums also reduced by approximately 20% compared with 2024/25.

These reductions reflect the combined impact of regional agency reduction initiatives, implementation of the Medical and Dental Agency Framework and wider efforts to improve workforce planning and reduce reliance on temporary staffing arrangements. While the reductions do not necessarily represent direct cash-releasing savings, they demonstrate progress in reducing reliance on higher-cost temporary staffing arrangements and support wider objectives relating to workforce sustainability, workforce stability and financial efficiency.

Detailed Medical and Dental agency expenditure information is provided a Annex 2.

#### **7.9.6 Temporary Staffing Expenditure and Paybill Impact**

The Medical & Dental 2025/26 pay bill was approximately £840 million (£968m including agency) meaning that the cost of agency/locum for Medical & Dental in 2025/26 was 13.2% (£128.2m) of the HSC Medical & Dental pay costs.

### **7.9.7 Conclusion**

Agency and locum staffing continues to play an important role in maintaining service delivery across medical and dental services in Northern Ireland. However, sustained reliance on temporary staffing reflects underlying workforce supply challenges, recruitment difficulties and service pressures within a number of specialties. While significant progress has been made through implementation of the Medical and Dental Agency Framework, the Medical and Dental Locum Reduction Action Plan and wider agency reduction initiatives, reducing dependency on temporary staffing will ultimately require continued improvements in workforce planning, recruitment, retention and substantive workforce supply. The long-term objective remains the development of a stable and sustainable workforce that reduces reliance on agency and locum arrangements while maintaining safe and effective patient care.

### **7.10 International Medical Recruitment**

#### **7.10.1 Current International Recruitment Position**

International recruitment continues to make an important contribution to workforce supply across a number of medical specialties in Northern Ireland. Based on information provided by the Western Health and Social Care Trust, 44 internationally recruited doctors commenced employment during 2025/26 across a range of grades and specialties. In addition, the Southern Health and Social Care Trust recruited a further 30 internationally recruited doctors between April 2025 and March 2026 across a range of medical specialties

International recruits were appointed across consultant, specialty doctor, resident doctor and foundation grades, demonstrating the importance of international recruitment throughout the medical workforce pipeline. Appointments were made in a range of specialties including General Medicine, Psychiatry, Surgery, Radiology, Oncology, Anaesthetics, Urology, Acute Medicine, Emergency Medicine, Geriatric Medicine, Paediatrics and Obstetrics & Gynaecology.

The largest concentration of appointments was within General Medicine, accounting for 11 appointments during the year. A further five doctors were progressing through pre-employment checks at the time of reporting, indicating continued recruitment activity.

The breadth of specialties represented within the recruitment data illustrates the growing role of international recruitment in addressing workforce shortages and supporting service delivery in hard-to-fill specialties.

Detailed International Medical Recruitment appointments by specialty and grade are provided within Annex 3.

### **7.10.2 Trends in International Recruitment**

Analysis of recruitment activity indicates that international recruitment is supported by a combination of direct overseas recruitment and the movement of internationally trained doctors already working within the UK and other international healthcare systems. Among doctors recruited during 2025/26, a substantial proportion were working in Great Britain immediately prior to appointment, while others were recruited from a diverse range of international labour markets including India, Saudi Arabia, Egypt and the Republic of Ireland.

These patterns demonstrate the increasingly global nature of the medical workforce and highlight the importance of maintaining an attractive employment offer within an increasingly competitive international labour market. They also indicate that international recruitment is not solely dependent on direct overseas recruitment but is increasingly supported by attracting internationally trained doctors already practising elsewhere.

Recruitment data suggest three broad trends:

- International recruitment continues to be concentrated within a relatively small number of source countries, particularly India and Egypt.
- A significant proportion of recruits are already working within the UK labour market prior to appointment, demonstrating the importance of UK-wide workforce mobility.
- Multi-step migration patterns are increasingly evident, with some recruits moving to Northern Ireland after previously working in other international healthcare systems, including the Gulf states.

Detailed information on the nationality and previous employment locations of internationally recruited doctors is provided within Annex 3.

### 7.10.3 International Recruitment Initiatives

Western Trust IMR Project is a structured end-to-end process that supports international recruitment and onboarding, including pre-employment checks, accommodation support, induction planning and HR set-up. The core elements of this operational model as follows:

- **Pre-employment checks tracking:** capture of key steps such as alert list checks, references, occupational health/medical assessment, Access NI, declarations, certificate of good standing, nationality verification and COS processing.
- **Onboarding logistics:** accommodation confirmation where required, induction scheduling, welcome emails, welcome tours and taxi arrangements.
- **Workforce systems readiness:** set-up activities such as SAP/HRPTS set-up, contracts, iFile/COS file creation, staff number creation in addition to HR tracking
- **Relocation support:** accommodation requirements and confirmation details and providing ongoing practical support for relocating doctors where needed.

While this is Western Trust specific information rather than a region-wide (NI) programme register, it demonstrates the types of ongoing international recruitment activity being delivered in practice: maintaining an international recruitment pipeline and putting in place the checks and onboarding support required to safely and efficiently bring doctors into post.

This support can be used to support bespoke recruitment campaigns that are targeted at specific hard to fill specialties. Although there have been a considerable number of international medical staff who have over the years, there were still a number of posts that we were unable to source applicants for using the current model. **A bespoke recruitment campaign was undertaken in Mumbai** which sourced a total of 28 doctors in September 2024.

There has been continued progress on a Western Trust Targeted Attraction Strategy. The trust has attended medical Job Fairs in Dublin and London, **as well as the Royal College of Psychiatrists National Congress in Wales and the World Psychiatry Congress in Prague**. The trust has also sought to attract Medical and Dental staff

returning to Northern Ireland for the Christmas period with a 'coming Home for Christmas' campaign, promoting opportunities in the Western Trust on a range of media platforms.

These activities help develop a talent pipeline, capturing interest and keeping in contact with potential applicants, and as means of building sustainable recruitment outcomes while enhancing the Trust's profile as an employer of choice.

These initiatives not only support immediate recruitment requirements but also contribute to the development of longer-term talent pipelines and strengthen the attractiveness of HSC Northern Ireland as an employer.

#### **7.10.4 Future Outlook**

Western Trust data for FY 2025/26 indicates that the Trust is continuing to attract doctors from outside the UK. This suggests that, in the near term, the UK (and NI) remains able to attract overseas doctors into a range of grades and specialties.

However, the same data also indicates that attracting candidates is only one part of the challenge: the process requires completion of multiple checks and logistical steps (e.g., references, certificates of good standing, nationality verification, COS where applicable, occupational health, and induction planning). The presence of detailed milestone tracking within Western Trust recruitment and onboarding processes implies that sustaining overseas recruitment at scale depends on maintaining capacity for these checks and for onboarding support.

On the basis of this FY 2025/26 evidence alone, it is reasonable to conclude that the UK is currently continuing to attract overseas doctors; longer-term certainty will depend on external factors not captured in the IMR starter's dataset (e.g. International competition, immigration policy, and candidate preferences).

Within the Trust's control, continued investment in streamlined CV Sourcing, interview support, pre-employment processing, relocation support and timely induction arrangements will help to protect the UK/NI offer and support conversion from appointment to start.

Changes to UK Home Office immigration rules may have an impact on healthcare recruitment from abroad for doctor's i.e. Increased visa and sponsorship costs, new prioritisation rules favouring UK-trained doctors for training posts. Attracting doctors

from abroad may become more expensive, slower, and more competitive internationally.

Trusts also highlighted the increasingly competitive global market for medical professionals. International recruitment remains an important source of workforce supply for Northern Ireland; however, healthcare systems across the world are actively competing for many of the same groups of clinicians. In this context, maintaining an attractive overall employment offer, including competitive pay, career development opportunities, professional support and positive working environments, will remain important in attracting internationally trained doctors.

In addition, changes to immigration and recruitment policies have the potential to influence future international workforce supply. While international recruitment continues to make an important contribution to workforce capacity, reliance on overseas recruitment alone is unlikely to provide a sustainable long-term solution to workforce shortages. Continued investment in domestic workforce supply, education, training and retention will therefore remain essential.

The Department considers that Northern Ireland should continue to be able to attract internationally trained doctors in the foreseeable future. However, increasing international competition for healthcare professionals, global workforce shortages and changing migration patterns may affect the availability of future recruits and reinforce the importance of maintaining a competitive and attractive employment offer.

While international recruitment is expected to remain an important workforce supply mechanism, growing global competition for healthcare professionals means that it cannot be relied upon as the sole solution to workforce shortages.

#### **7.10.5 Conclusion**

International recruitment remains an important component of workforce supply across Northern Ireland and continues to support service delivery in a number of hard-to-fill specialties. Evidence indicates that internationally trained doctors make a significant contribution to workforce resilience and workforce sustainability across the region.

However, increasing global competition for healthcare professionals, evolving immigration policies and continuing workforce shortages mean that international recruitment alone cannot provide a complete solution to workforce pressures. While

international recruitment will continue to play an important role in supporting workforce supply, long-term sustainability will also depend upon effective workforce planning, domestic training capacity, recruitment, retention and workforce development initiatives.

International recruitment remains an essential component of workforce supply across Northern Ireland but should be viewed as complementing rather than replacing investment in domestic education, training and workforce planning arrangements.

## **Section Eight - Industrial Relations**

### **8.1 Industrial Relations and Industrial Action**

#### **8.1.1 Industrial Relations Context**

Industrial relations remain an important workforce consideration across the medical and dental workforce in Northern Ireland. During 2026, disputes relating to pay, contractual issues and workforce sustainability resulted in industrial action by a number of medical workforce groups. While service continuity arrangements were put in place, these disputes highlight ongoing concerns relating to pay, workforce morale and the attractiveness of medical careers within Northern Ireland.

The BMANI is in dispute with the Department regarding the DDRB's 2026/27 recommendation of a 3.5% pay uplift, which it considers insufficient to address ongoing pay erosion and recruitment and retention challenges. The Department's 2026/27 budget contains no provision for pay awards above the level recommended by the DDRB.

On 10 April 2026, the Department of Health received joint correspondence from the Chairs of the Resident Doctors, SAS and Consultants Branches of Practice notifying the Department that they were in a formal dispute with the Department in relation to the DDRB 2026/27 recommendation of 3.5%.

Pay restoration to 2008/09 levels, as previously advocated by the BMANI, in real terms, is not current government policy. Any decisions on public sector pay must be considered in the broader context of affordability and fairness across all public sector professions. The Department recognises the strength of feeling that exists within parts of the medical workforce regarding pay and reward. However, decisions on medical and dental pay must be considered alongside affordability considerations, wider public sector pay policy and the need to maintain the sustainability of public services within available funding.

#### **8.1.2 Industrial Action During 2026**

A ballot on industrial action for consultant, SAS and resident members of the BMA opened on 11 May 2026 and ran for four weeks, closing on 8 June 2026.

The consultants and SAS strike took place over a 24-hour period, commencing at 7am on Thursday 25 June and concluding 7am Friday 26 June. The BMA confirmed that Christmas cover would be in place on the day of the strike, ensuring that emergency care could still be provided.

Resident doctors held a full walk-out for 24 hours, starting at 7am on Monday 29 June and ending at 7am on Tuesday 30 June 2026.

Trusts implemented extensive contingency planning arrangements to maintain patient safety and ensure the continuation of urgent and emergency services. Despite these measures, industrial action resulted in disruption to planned activity across a number of services. Approximately 2250 elective patient interactions were cancelled in total across the 2 days.

While emergency and urgent care services were maintained through extensive contingency planning arrangements, industrial action placed additional operational pressures on organisations and resulted in disruption to planned activity. The action highlighted the potential impact that workforce disputes can have on service delivery, patient access, workforce morale and organisational resilience, and reinforced the importance of maintaining constructive engagement with workforce representatives through established industrial relations mechanisms.

The BMA have announced that they will be taking further strike action in November in respect of the dispute over pay, with resident doctors undertaking a 24-hour strike from 20 to 21 November, and consultants and SAS doctors providing Christmas Day cover from 23 to 24 November.

### **8.1.3 Response to the DDRB Recommendation**

A Ministerial Direction was issued to implement the DDRB pay recommendations. As the matter is considered cross-cutting and has potential implications for the wider Executive budget, due to affordability approval by the Northern Ireland Executive is required before the Direction can be actioned. Following correspondence between the Permanent Secretaries of the Departments of Health and Finance, a paper seeking Executive approval of the Direction was issued by the Department of Health on 6 August 2026. At the time of writing, no decision has been taken. Minister Butler continues to press for an urgent decision.

#### **8.1.4 Conclusion**

The industrial action undertaken during 2026 reflects wider workforce concerns relating to pay, reward and workforce sustainability. While the Department continues to engage with trade union representatives and professional bodies, the resolution of these issues remains important in supporting workforce morale, recruitment, retention and service resilience. Constructive industrial relations will remain an important component of maintaining a sustainable medical and dental workforce in Northern Ireland.

## **Section Nine - Medical and Dental Staff Groups**

This section sets out the key issues affecting individual medical and dental workforce groups across Northern Ireland. While a number of workforce challenges are common across the medical and dental workforce, including recruitment difficulties, workforce shortages and increasing service demand, the nature and scale of these challenges vary between workforce groups. The following sections consider workforce supply, recruitment, retention, career development, reward and workforce sustainability issues affecting each group.

### **9.1 Doctors and Dentists in Training (DDiT)**

#### **9.1.1 Overview of the DDiT Workforce**

Doctors and dentists in training play a critical role within Health and Social Care (HSC) services in Northern Ireland, delivering frontline patient care while undertaking the education and training necessary to progress to senior clinical roles. They contribute significantly to service delivery across a wide range of specialties and settings and represent the future consultant, SAS, general practice and dental workforce. Ensuring access to high-quality training, supervision and development opportunities is essential to maintaining a skilled, sustainable and resilient workforce capable of meeting future service needs. As such, their recruitment, retention, progression and overall training experience remain key workforce priorities for Health and Social Care services in Northern Ireland.

#### **9.1.2 Resident Doctor Contract Reform**

As part of the 2023/24 NI pay dispute settlement agreed on 27 January 2025, the Department committed to beginning meaningful discussions on contract reform for resident doctors. The intention is to update and modernise the Northern Ireland training contract in line with best practice and ensure it remains fit for purpose.

Preparatory engagement commenced in June 2025 and involved the Department, the BMA NI Resident Doctors Committee, HSC employers and the Single Lead Employer. These discussions focused on evidence gathering, the identification of shared priorities and the exploration of potential areas for reform.

Formal negotiations have not yet commenced, as preparatory work, including evidence gathering, option development and initial costing exercises, remains ongoing. The pace of progress will also depend on the wider financial context.

Terms of Reference for contract reform have been agreed and a timetable established. However, progress has been paused due to industrial action. Following formal dispute notification and subsequent industrial action ballots by the BMA NI Resident Doctors Committee, discussions unrelated to pay have been suspended pending resolution of the dispute.

Despite this, all parties remain committed to maintaining a constructive relationship throughout the process, recognising that any future contractual arrangements must support safe patient care, sustainable training pathways and improved recruitment and retention across the resident doctor workforce.

Alongside contractual reform, a range of additional initiatives are being progressed to improve trainee experience and strengthen Northern Ireland's attractiveness as a location for postgraduate medical training.

#### 9.1.2.1 Improving Trainees' Lives

The Department is progressing a number of recommendations arising from the Strategic Group for the Enhancement of the Quality of Medical Education in Northern Ireland (SGEQMENI). These measures are intended to improve the attractiveness of Northern Ireland as a location for postgraduate medical training and support the retention of resident doctors.

The following areas are currently being progressed:

- Mandating protected educational time.
- Better, more sensitive and more timely organisation of work schedules and rotas.
- Over-recruitment to training programmes.
- Promotion of Less Than Full-Time (LTFT) training opportunities.
- Development of a transparent methodology for the distribution of medical training posts across Northern Ireland.
- Supporting SAS careers as an attractive and rewarding career option, alongside alternative routes to consultant practice.

- Providing high-quality induction and mentoring arrangements for doctors joining medical training programmes from outside Northern Ireland.

Collectively, these initiatives are intended to improve trainee experience, strengthen workforce wellbeing and enhance Northern Ireland's attractiveness as a location for postgraduate medical training. They also support wider efforts to improve recruitment, retention and long-term workforce sustainability within the resident doctor workforce.

### 9.1.3 Training Capacity and Workforce Supply

Training Capacity and Workforce Supply are critical components of long-term workforce sustainability. Given the length of medical and dental training pathways, decisions regarding training capacity have a direct impact on the future supply of clinicians available to meet service demand. The Department continues to work with NIMDTA, HSC organisations and education providers to align training capacity with workforce planning priorities and future service requirements.

#### 9.1.3.1 Dental Training

| Training Programme                | Number of places available                                                                                                                                                                   |
|-----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Dental Foundation Training</b> | <b>36</b> this number is ordinarily 30 however an increase of 6 places has been accommodated reflecting a one-year surge in UK university graduate output                                    |
| <b>Dental Core Training</b>       | <b>22</b> posts are available and this will remain the same for next year                                                                                                                    |
| <b>Specialty Training</b>         | <b>10</b> in total however programmes are 3 to 5 years long so some years no posts are available. Each year the number of post vacancies varies never exceeding 3 as people exit programmes. |

The relatively small number of dental specialty training places highlights the importance of maintaining training capacity and ensuring that available places are aligned with future workforce requirements within dental services.

#### 9.1.3.2 Medical Training

Any increase in specialty training posts is subject to available funding from the Department of Health and in line with Workforce Planning, where applicable. There

remains a list of training posts required to meet workforce review requirements with approximately 30 identified as a priority following the expansion of 11 training places across medical specialty training programmes for August 2025.

The Department of Health has supported a significant expansion of postgraduate medical training capacity to strengthen future workforce supply and support future service requirements. Foundation Programme places in the Northern Ireland Foundation School increased from 252 to 294 in 2023, with a further expansion to 363 places from August 2025 to accommodate the graduate output from Ulster University Medical School. NIMDTA worked collaboratively with the Department of Health, HSC Trusts and local medical schools to establish the distribution of additional training posts to support workforce and service requirements. Further detail is provided in Section 9.1.3, Training Capacity and Workforce Supply. The Elective Care Framework (ECF) published in June 2021 set out the strategic approach to address backlog of patients waiting for assessment and treatment. The ECF Implementation and Funding Plan committed £6.5m to increase HSC training places and support additional training posts in vulnerable specialties. This is in addition to any expansion identified via the Department of Health's Workforce Policy Directorate. This approach demonstrates how workforce investment and service recovery initiatives are increasingly being considered together in order to support both immediate service pressures and longer-term workforce sustainability.

A collaborative approach across the Department of Health's Workforce Policy Directorate, SPPG and NIMDTA has resulted in the expansion of the training programme places aligned with training capacity, workforce planning priorities and units with existing consultant vacancies (where possible). In August 2025, there was an expansion of the anaesthetic training programme by an additional 7 places with a further 25 training places across a number of training programmes identified for August 2026, with recruitment currently taking place.

Annual intake into GP training expanded from 65 (2015/16) to 121 (2022/23) and has remained at that level since then. This sustained expansion reflects the importance of general practice in supporting population health, managing demand and strengthening primary care services across Northern Ireland.

Overall, training capacity has expanded in a number of key areas in recent years, reflecting efforts to strengthen future workforce supply and address identified workforce planning priorities. However, further expansion remains dependent upon available funding and training capacity, and workforce planning evidence continues to identify additional areas where increased training numbers would support future service delivery.

#### **9.1.4 Training Uptake and Fill Rates**

##### **9.1.4.1 Medical Training**

There were 414 specialty recruitment posts advertised to commence in August 2025, with an overall recruitment fill rate of 96%. This demonstrates that recruitment into medical training programmes remains strong overall and highlights the continued attractiveness of postgraduate training opportunities in Northern Ireland. Recruitment for August 2026 has recently concluded; however, fill-rate data is not yet available and will be provided to the Department of Health's Workforce Policy Directorate following August changeover.

Fill rates remained highest in Foundation Training (97.3%), Core Surgical Training (96.1%) and Public Health (100%), while lower fill rates were observed in Group 1 Medical Specialties, Psychiatric Specialties and Histopathology. These differences highlight the importance of maintaining sufficient training capacity in specialties experiencing workforce pressures while ensuring training numbers remain aligned with future workforce requirements.

Detailed training fill rate and vacancy data by HSC Trust and specialty is provided within Annex 4.

##### **9.1.4.2 Dental Foundation Training**

Northern Ireland usually fills its dental foundation training places however Northern Ireland cannot always fill its training scheme exclusively from List A (UK graduates). This reflects the fluid nature of the national recruitment process and the fact that trainees select their region on preference. Northern Ireland is geographically challenged in this regard for a one-year programme. NIMDTA may need to rely on List B (international graduates) to ensure all places are filled. The list B intake varies from year to year and depends on a number of factors. One aspect is due to Scotland

operating a separate recruitment process for foundation training. Inevitably, some candidates hold offers in both regions and may release their Northern Ireland place if they secure their preferred practice in Scotland. Efforts have been made in the past year Nationally to align the recruitment process' further to reduce this impact. This reliance on List B is difficult to predict in advance.

In the current dental training year one post remains vacant due to personal circumstances changing for a dentist immediately prior to scheme commencement.

The remaining reliance on dental practices to accept risk and directly employ Foundation Dentists is a deterrent to practices applying to training. Foundation dentists are under SLE in all other regions. Intake into training not only relies on new graduates choosing Northern Ireland but also on sufficient training placements (practices) participating

The table below shows 2025-2026 Foundation Dentist Scheme intake by university.

**Table 20: 2025/26 Foundation Dentist Scheme Intake by University**

| University                 | Intake Number |
|----------------------------|---------------|
| Queen's University Belfast | 26            |
| Glasgow                    | 1             |
| Plymouth                   | 1             |
| Dublin                     | 1             |
| Total                      | 29            |

Despite generally strong uptake into Dental Foundation Training, recruitment remains sensitive to wider UK recruitment processes, trainee preferences and the availability of participating training practices. The continued reliance on non-UK graduates to fully populate some training cohorts, together with the challenges associated with maintaining sufficient training placements, highlights the importance of sustaining the attractiveness of Northern Ireland as a training location and ensuring sufficient training capacity is available.

#### 9.1.4.3 Dental Core Training

Dental Core Training (DCT) fill rates remain unpredictable. Northern Ireland currently lags behind other nations in the variety of posts available, primarily because we do not have the flexibility to offer blended DCT/ DFT posts that span both primary and secondary care. This limitation arises from the fact that Foundation Dentists are not

currently included under the SLE (Single Lead Employer) model. The ability to compete with other regions is impacted. Northern Ireland is an outlier in this regard. These factors may contribute to recruitment challenges and reduce the attractiveness of Dental Core Training posts in Northern Ireland when compared with other UK regions, potentially affecting future workforce supply within specialty training pathways.

#### 9.1.4.4 Dental Specialty Training

The small number of available posts (n=10) makes it challenging to offer flexible training opportunities or to respond proactively to emerging opportunities that could support local trainees in progressing within Northern Ireland. There is always a higher demand for posts than there are placements. Northern Ireland trainees are usually forced to leave Northern Ireland to complete specialty training. The small number of posts mean it is also not possible to offer the full range of training programmes on an annual basis with an impact on workforce pipeline.

While demand for specialty training remains high, the limited number of available training posts restricts progression opportunities within Northern Ireland and may contribute to trainee migration to other jurisdictions. This has implications for the long-term sustainability of the local dental workforce and the availability of future specialists.

#### 9.1.4.5 Training Programme Fill Rates

Postgraduate training fill rates for the training year 2025-26

- Dental Foundation Training - 100% fill rate however there was one withdrawal prior to commencement.
- Dental Core Training - 73% fill rate.
- Dental Specialty Training - All posts recruited into for 2025 September start have filled this year, including one inter deanery transfer from another region. New STRs commenced in Restorative and Oral Surgery.
- Currently 7 of 10 STRs filled.
- Projected Recruitment of Special Care x 2 ongoing.

Overall, medical recruitment into training programmes remains strong. However, recruitment challenges persist within a number of specialties, particularly where workforce shortages, service pressures and labour market competition continue to affect training programme attractiveness and fill rates.

Overall, uptake into medical and dental training programmes remains strong in many areas, reflecting the continuing attractiveness of healthcare careers and postgraduate training opportunities in Northern Ireland. However, recruitment challenges persist within some specialties and training pathways, particularly where geographical factors, limited training opportunities and workforce shortages affect attractiveness. These issues have implications for future workforce supply, succession planning and the long-term sustainability of medical and dental services across Northern Ireland.

### **9.1.5 Training Quality, Progression and Outcomes**

#### **9.1.5.1 Dental Training Programme Structure**

Dental Foundation and Dental Core Training programmes are one year in duration, running from 1 September to 31 August. Dental Specialty Training programmes vary in length from two to five years, depending on the specialty and curriculum requirements

#### **9.1.5.2 Progression and Training Extensions**

The majority of dental trainees progress through training without the need for additional training time. The table below outlines the number of trainee extensions awarded through the Final Review of Competence Progression (FRCP) process.

**Table 21: Dental Training Extensions**

|                   | <b>2022-23</b> | <b>2023-24</b> | <b>2025-25</b> |
|-------------------|----------------|----------------|----------------|
| <b>Foundation</b> | 1              | 2              | 0              |
| <b>Core</b>       | 0              | 0              | 0              |
| <b>Specialty</b>  | 0              | 2              | 0              |

The relatively small number of formal training extensions indicates generally positive progression through dental training pathways. However, additional supervision and educational support is often required to help trainees meet curriculum requirements and avoid the need for formal extension.

#### **9.1.5.3 Retention and Employment Outcomes**

Retention following dental training remains strong. In August 2025, 90% of trainees completing Dental Foundation Training progressed to a subsequent post within Northern Ireland.

For Dental Core Training, 93% of trainees secured employment following completion of training, with 67% remaining within Northern Ireland.

These data indicate that dental training programmes continue to achieve strong progression into employment. However, the proportion of trainees remaining within Northern Ireland highlights the ongoing challenge of retaining trained professionals within the local workforce and supporting long-term workforce sustainability.

#### 9.1.5.4 Training Quality

##### 9.1.5.4.1 Dental Foundation Training

Graduates are increasingly entering Foundation Training with reduced practical experience in some clinical disciplines, particularly oral surgery, endodontics and fixed prosthodontics. This trend has been evidenced through joint work involving the Dental Schools Council and COPDEND and has required educational supervisors to provide increased levels of supervision and support.

To address these pressures, NIMDTA has enhanced educational programmes and developed additional teaching modules to support both trainees and educational supervisors, helping to maintain patient safety and training standards.

Variation in undergraduate curricula among non-UK graduates can also result in the need for enhanced induction, additional training and, in some cases, remediation support. Delays associated with visa processing can further affect timely commencement of training and may create additional pressures for training practices.

##### 9.1.5.4.2 Dental Core Training

The quality of specialty training remains high; however, training pathways are increasingly influenced by Less Than Full Time (LTFT) working, Out of Programme (OOP) activity and other personal or professional circumstances which can affect progression through training.

##### 9.1.5.4.3 Progression into Specialty Training

Opportunities for progression into Dental Specialty Training remain constrained by the limited number of available training posts. The number of specialty training posts in Northern Ireland has remained unchanged since 2009 and many trainees continue to seek specialty training opportunities elsewhere in the UK.

Progression from Dental Core Training into Specialty Training within Northern Ireland has remained limited, as seen below.

**Table 22: Number of Dental Core Trainees Progressing to Specialty Training, 2022/23 to 2025/26**

| Training Year | Number Progressing to Specialty Training |
|---------------|------------------------------------------|
| 2022/23       | 1                                        |
| 2023/24       | 2                                        |
| 2024/25       | 1                                        |
| 2025/26       | 2 (current position)                     |

The limited availability of specialty training opportunities has implications for future workforce supply, as trainees who leave Northern Ireland for specialty training may not subsequently return to practice locally.

#### 9.1.5.5 Medical Training Quality, Progression and Outcomes

For doctors in training, workforce governance and performance management are supported through the Annual Review of Competency Progression (ARCP) process, which is administered by NIMDTA.

During the 2024/25 academic year, ARCP outcomes were recorded for 2,393 trainees, comprising 1,790 specialty trainees and 603 foundation trainees.

The majority of trainees achieved satisfactory outcomes, with 1,911 satisfactory outcomes recorded, including 593 trainees who successfully completed a core or specialty training programme. A further 83 trainees received an Outcome 2 (development required without additional training time), 96 received an Outcome 3 (development and additional training time required), and 9 trainees received an Outcome 4 (released from training).

These data indicate that the majority of trainees progressed satisfactorily through their training programmes during 2024/25.

Revalidation is the process through which licensed doctors demonstrate that they remain fit to practise and continue to provide a high standard of care. As the Designated Body for postgraduate medical trainees in Northern Ireland, NIMDTA makes recommendations to the GMC regarding trainee revalidation based on

evidence reviewed through ARCP processes and local educational provider governance arrangements.

During 2024/25, positive recommendations were made for 482 (93.4%) doctors in training. There were 34 deferrals (6.6%) where insufficient evidence was available due to recent connection with NIMDTA as the designated body. No doctors in training required notification to the GMC due to non-engagement with the revalidation process.

Overall, the majority of doctors and dentists in training continue to progress successfully through training programmes, demonstrating the overall strength of postgraduate medical and dental education arrangements in Northern Ireland. However, retention of trained professionals within Northern Ireland, limited specialty training opportunities and increasing workforce pressures continue to present challenges for future workforce supply. Supporting progression, training quality and retention will remain critical to ensuring a sustainable future workforce.

### **9.1.6 Trainee Experience and Working Lives**

#### **9.1.6.1 Learning and development Support**

Doctors in training have access to funded study leave to support education and training requirements associated with their training programme. Specialty trainees may access up to 30 days of funded study leave and a study leave budget of up to £1,250 to support mandatory educational and professional development activities.

Training courses and activities required by the relevant Royal College are generally supported through these arrangements. In addition, access to mandatory online learning modules is provided through both NIMDTA and HSC Trust host organisations.

Access to study leave, education funding and development opportunities forms an important component of the overall trainee experience and supports the development of a skilled and sustainable future medical workforce.

#### **9.1.6.2 Dental Trainee Experience**

NIMDTA introduced a revised allocation procedure for Dental Foundation Training in 2024 to support a more proportionate geographical distribution of Foundation Dentists across Northern Ireland. This approach aims to better align training placements with service need while ensuring equitable access to training opportunities

The revised allocation model distributes Dental Foundation Training places across three geographical schemes (corresponding chart can be seen within the Annex 4) to support a more balanced placement of trainees and ensure training opportunities are available across Northern Ireland.

A comprehensive range of initiatives has been implemented to support and enhance the experience of dental trainees across all levels of training. These include:

- Welcome and induction events for new trainees.
- Enhanced induction arrangements for international graduates.
- Teamworking and professional development activities.
- Study leave and career development support.
- Regular trainee surveys and engagement mechanisms.
- Ongoing engagement with Directors of Medical Education.
- Quality visits and follow-up processes.
- Professional support and wellbeing services.
- Leadership, research and fellowship opportunities.
- Continued collaboration with counterparts across other UK regions to share best practice.

These initiatives aim to strengthen trainee experience, support wellbeing and ensure that training programmes continue to meet educational and professional development requirements.

#### 9.1.6.3 Medical Trainee Experience

Following endorsement by HSC Chief Executives and the Postgraduate Training and Education Board, a series of recommendations arising from the Strategic Group for the Enhancement of the Quality of Medical Education in Northern Ireland (SGEQMENI) are being implemented.

Key areas of work include:

- Protected Self Development Time (SDT) for trainees.
- Improved rota design and rota notification arrangements.
- Enhanced rest and on-call facilities.
- Pilots of over-recruitment in selected specialties.

- Support for Less Than Full Time (LTFT) training.
- Improved methodologies for the distribution of training posts.
- Development opportunities for SAS doctors and dentists.
- Enhanced support for doctors joining Northern Ireland training programmes from outside the region.

Progress to date includes the introduction of protected educational time, improvements to rota management processes, expansion of trainee support initiatives, improvements in trainee facilities and the continuation of pilots designed to improve both trainee experience and workforce sustainability.

#### 9.1.6.4 Supporting Doctors New to Northern Ireland

NIMDTA continues to develop the New to Northern Ireland (N2NI) programme, which supports doctors relocating to Northern Ireland for training.

The programme focuses on:

- Relocation support.
- Enhanced induction arrangements.
- Educational and professional support.
- Simulation-based training and induction.
- Mentoring and buddy schemes.
- Improved access to information and resources.
- Cultural integration and wellbeing initiatives.

These arrangements are intended to improve trainee experience, support retention and encourage doctors joining Northern Ireland training programmes to develop longer-term careers within the HSC.

#### 9.1.6.5 Single Lead Employer Support

The Single Lead Employer (SLE) continues to support doctors and dentists in training through a range of workforce and employment initiatives, including:

- Improved payroll accuracy and reduction in off-cycle payments.
- Regional induction and engagement events.
- Guidance on monitoring of hours and LTFT arrangements.

- Improved communication and information resources.
- Standardisation of employment processes.
- Support associated with the implementation of Encompass.

Together, these measures help provide a more consistent employment experience for trainees across Northern Ireland.

Collectively, these initiatives are intended to improve trainee experience, strengthen workforce wellbeing and enhance Northern Ireland's attractiveness as a location for postgraduate medical and dental training. Improving working lives, educational quality, professional development opportunities and employment support arrangements is recognised as an important component of recruitment, retention and the long-term sustainability of the future medical and dental workforce.

### **9.1.7 Working Patterns and Workforce Sustainability**

#### **9.1.7.1 Dental Training**

A small proportion of dental trainees currently work Less Than Full Time (LTFT), with 3.5% (2 trainees) across the three dental training programmes undertaking LTFT training.

#### **9.1.7.2 Medical Training**

Working patterns within the resident doctor workforce continue to change, with increasing numbers of trainees choosing Less Than Full Time (LTFT) training arrangements. Currently, 77% (1,837) of trainees work full-time, while 23% (426) work LTFT.

While LTFT training provides important flexibility and supports work-life balance, workforce wellbeing and retention, it also has implications for workforce planning. The 426 trainees currently undertaking LTFT training equate to approximately 316 whole-time equivalent (WTE) posts, resulting in a reduction in available workforce capacity of approximately 90 doctors across the HSC.

These trends highlight the importance of ensuring workforce planning assumptions adequately reflect changing working patterns. As the proportion of trainees working LTFT continues to increase, proportionately larger trainee cohorts may be required to deliver the workforce capacity needed to support future service delivery.

Detailed information on average contracted hours for doctors and dentists in training is provided at Annex 4.

Changing working patterns, including increasing uptake of LTFT training, are reflecting broader workforce expectations relating to flexibility and work-life balance. While these arrangements contribute positively to trainee experience and retention, they also create additional workforce planning challenges and reinforce the importance of maintaining sufficient training capacity to meet future workforce requirements.

### **9.1.8 Recruitment and Retention Challenges**

Recruitment and retention challenges affecting doctors and dentists in training vary across specialties, training pathways and geographic locations. While many training programmes continue to attract strong interest from applicants, workforce supply constraints, changing trainee expectations, competition from other jurisdictions and limited training capacity continue to affect recruitment and retention in some areas.

#### **9.1.8.1 Dental Core Training**

Historically, the distribution of Dental Core Training (DCT) posts in Northern Ireland has been concentrated in busy Oral and Maxillofacial Surgery (OMFS) units, where trainees have provided rota cover and supported service delivery. However, shifts in trainee demand, evolving interests across a broader range of specialties, and changing criteria for specialty training suggest that we may now have a disproportionately high number of DCT posts in OMFS settings. This imbalance may be contributing to current fill rate challenges. This has been addressed in some other regions by allowing posts to be blended across primary and secondary care. The infrastructure to pay for supervision of DCT in primary care is not in place and therefore this approach is not possible in Northern Ireland. This impacts on experience gained in post and makes Northern Ireland DCT post arguably less attractive to some potential applicants.

In addition, DCTs may leave the programme for higher-paid locum opportunities locally or in the Republic of Ireland or to take up roles in community dental services. In the interim, HSC Trusts often rely on locums to fill vacant posts and maintain service delivery. However, sustaining training quality under these conditions is increasingly difficult. In the current year HSC Trusts reported they were unable to secure locum

cover to fill vacancies and by exception filled the posts with international medical doctors. These challenges demonstrate how workforce supply, service requirements and training design can interact to affect both recruitment and retention within Dental Core Training pathways.

#### 9.1.8.2 Dental Specialty Training

There are no shortages of applicants for specialty training posts. Despite strong demand for specialty training, limited specialty training capacity continues to constrain progression opportunities within Northern Ireland and may contribute to trainee migration to other jurisdictions.

#### 9.1.8.3 Medical Training

Northern Ireland does not train sufficient doctors for its healthcare needs and is reliant on attraction of doctors who have qualified outside Northern Ireland to fill training programmes and provide healthcare service. This applies both to the supply of general practitioners and specialists. Potential recruitment sources include the use of international medical graduates (IMGs) who may or may not have previous experience working within the NHS or HSC.

NIMDTA is reliant on recruitment of non-Northern Ireland graduates in order to fill its training posts. Aside from the implications of having insufficient trained general practitioners and specialists, incomplete training programmes result in rota gaps and service pressures and make the training experience less attractive and fulfilling for those doctors who have committed to postgraduate training.

There has been an increase over the past few years in the number of trainees requiring a visa to commence in a training programme in Northern Ireland. In August 2021 there were 61 new trainees requiring visa sponsorship to commence training (total 181 trainees requiring visa sponsorship) this increased to 369 in August 2024 which included 188 new trainees.

In the 2025/26 academic year there are 382 trainees requiring visa sponsorship.

Change in recruitment processes since 2020 has become more resource dependent for both administrative and educator (admin staff and consultants) producing challenges in its delivery. There have been record numbers of applicants to specialty

training programmes for 2026 and the resource to deliver recruitment is not sufficient with the continual increases. Applicant behaviour is changing with applicants making more applications in a bid to secure a training programme. In addition, as applicants can apply from anywhere in the world, it is impossible to predict the number of applicants who will apply. Although fill rates have increased we need to ensure we are identifying appointments to the HSC ensuring Northern Ireland, UK and international graduates who are a key part of the workforce.

The Medical Training (Prioritisation) Act 2026 which came into effect on 5th March will affect recruitment into specialty training and the foundation programme across the UK and will impact on the number of doctors requiring sponsorship, and potentially the overall demographic of the cohort recruited.

Collectively, these factors demonstrate that while recruitment into medical training programmes remains strong overall, workforce supply continues to depend on attracting trainees from outside Northern Ireland and supporting international graduates through the training system.

#### 9.1.8.3 Cross-Border and Contractual Recruitment Challenges

##### 9.1.8.3.1 Dental Training

Increasingly, the Republic of Ireland is becoming a more attractive option for dental professionals, offering competitive remuneration, different contractual arrangements, and perceived improvements in work-life balance.

These factors contribute to cross-border workforce movement, making it more difficult to retain talent within Northern Ireland and to attract new recruits, particularly in border regions. The divergence in terms and conditions of service further complicates long-term workforce planning and stability.

A number of specialists trained in Northern Ireland have ultimately gone to ROI to work however this was also impacted by a lack of availability of local Northern Ireland posts.

Northern Ireland is the only region in the UK where Foundation Training is not delivered under a Single Lead Employer (SLE) model. This limits the ability to offer longitudinal training opportunities comparable to those in other UK regions, which can affect both recruitment and retention.

Wales has significantly increased the salary paid to Foundation dentists and introduced strong rural incentivisation schemes. This may make Wales more attractive to Northern Ireland graduates or to those domiciles in Northern Ireland but graduating from Cardiff university.

The limited number of specialist training posts in dentistry in Northern Ireland (currently 10) also presents a significant challenge. Strong candidates who perform well in national recruitment often secure posts in other UK regions even though their preference is to train in Northern Ireland. Once they relocate, there is a risk they will continue their career progression elsewhere and not return to Northern Ireland.

#### 9.1.8.3.2 Medical Training

Although comprehensive workforce mobility data is not available, the available evidence suggests that opportunities within the Republic of Ireland continue to influence training and career decisions for some doctors and dentists in training. 45% (22 of 46) of withdrawals from applicants due to commence F1 in August 2025 were from RoI graduates to take up an intern place in RoI. Similar trends have been noted in previous years.

#### 9.1.8.4 Single Lead Employer (SLE)

No data available via SLE re recruitment and retention challenges.

19 Northern Ireland Residents have left SLE employment to take up inter-deanery transfers. However, there is no evidence to support that this has been because of pay and conditions/contractual differences.

Recruitment and retention challenges affecting doctors and dentists in training reflect wider workforce supply constraints, increasing service demand and a competitive labour market. While training programmes continue to attract large numbers of applicants in many areas, persistent challenges remain in relation to workforce supply, specialty training capacity, geographical factors and cross-border competition. Addressing these issues will be essential to supporting future workforce supply, maintaining training capacity and ensuring the long-term sustainability of the medical and dental workforce in Northern Ireland.

## **9.1.9 Single Lead Employer (SLE)**

### **9.1.9.1 Benefits of SLE model**

The Single Lead Employer (SLE) model received praise from Trusts for delivering a range of benefits for Hospital based Doctors and Dentists in Training (DDiT), principally through providing a more consistent and standardised employment experience across Northern Ireland. The introduction of a single employer throughout the duration of training has improved continuity of employment, Trusts reported that this has reduced duplication of administrative processes and simplified matters relating to pay, taxation, pension arrangements and service history.

Trusts highlighted how the SLE model removed the need for hospital-based trainees to repeatedly transfer between employers as they rotate through different organisations as a key benefit. Instead, under the model, hospital based trainees employed under the 2002 new Deal TCS have a single contract for the duration of their training programme and a single point of contact for payroll and pension administration. The SLE identified greater pay accuracy as a further benefit of the model, alongside improved consistency in the interpretation and application of terms and conditions. Improved continuity of service also assists in the administration of employment benefits, including maternity entitlements and recognition of continuous service.

Trusts also highlighted the benefits of greater standardisation. The SLE model has enabled a more consistent interpretation and application of 2002 New Deal hospital terms and conditions of service across the region, alongside more standardised employment processes and HR arrangements. This includes improved consistency in areas such as contractual documentation, employment entitlements and access to support services. Trusts considered that these arrangements contribute positively to trainee experience and satisfaction.

One Trust also reported that the SLE model can provide clearer accountability for employment matters, including wellbeing and pastoral support, through the identification of a single employing organisation.

Trusts generally viewed the SLE model as having improved continuity of employment, reduced administrative burden and provided a more consistent employment experience for doctors and dentists in training across Northern Ireland.

Under the model, the SLE acts as the formal employer with responsibility for employment matters, while Host Organisations retain responsibility for supervision, training delivery, rota management and local workforce oversight. Evidence also indicated that, where partnership working is effective, the model can provide a more structured approach to managing trainee employment issues.

#### 9.1.9.2 Operational Challenges and Areas for Improvement

Despite the benefits of the model, many Trusts also highlighted ongoing challenges relating to the interface between the SLE and host organisations. A recurring theme was uncertainty regarding roles, responsibilities and escalation routes, particularly where local workforce management responsibilities remain with host organisations while employment responsibilities sit with the SLE. According to reports, this can create confusion for trainees and administrative teams, particularly in relation to local processes such as grievance, disciplinary and banding appeals etc.

Overall, the effectiveness of the SLE model is dependent on strong alignment between the lead employer and host organisations, clear communication and consistent application of policies. This is not always the case, however, as administrative duplication still occurs in certain circumstances and host Trusts continue to undertake workforce-related functions despite not being the formal employer.

However, evidence provided by Trusts and the SLE also identified a number of challenges relating to the operation of the relationship between the SLE and Host Organisations. A recurring theme across the evidence was the need for greater clarity regarding roles, responsibilities and decision-making authority. The evidence highlighted that the separation between employer and workplace can create complexity, particularly where employment decisions have operational implications for service delivery.

A number of Trusts raised ongoing concerns that significant workforce management responsibilities continue to sit with Host Organisations despite employment responsibility transferring to the SLE. Workforce planning, rota management,

onboarding processes, monitoring of RD working hours and subsequent banding application, less-than-full-time working arrangements, relocation processes and day-to-day workforce administration were among the areas identified. Trusts noted that this can result in duplication of effort and additional administrative burdens. The evidence also highlighted operational challenges arising from differences in the interpretation and application of policies and processes between organisations. Areas such as leave management, study leave, sickness absence, flexible working requests and the escalation of concerns were identified as examples where responsibilities may not always be clearly understood, creating additional complexity and requiring greater coordination between organisations. The SLE similarly highlighted challenges arising from differing expectations regarding respective responsibilities, noting that resource limitations and the need to rely on local knowledge, processes and decision-making within Host Organisations can affect the operation of the model in practice.

Communication and information sharing were also identified as areas requiring further development. Challenges associated with differing organisational structures were highlighted, uncertainty regarding appropriate points of contact and the need for greater alignment between the SLE, Host Organisations and NIMDTA Education and Training, particularly in relation to trainee rotations, workforce planning and the dissemination of information.

In response to these issues, regional concerns have been raised by Trusts with the SLE who have requested a review of the current Roles and Responsibilities Framework to provide greater clarity regarding respective responsibilities and decision-making authority. Evidence indicates that further work is required to strengthen operational alignment and governance arrangements. Work on this review is due to commence in 2027.

Ongoing staffing and capacity challenges within the SLE itself have also presented challenges, with staff shortages and turnover affecting responsiveness and support. In addition, some Trusts highlighted the absence of formal mechanisms for managing certain issues arising within Host Organisations where local engagement structures differ from those operating within the SLE.

### 9.1.9.3 Future Development

Overall, the evidence suggests that the SLE model has delivered significant benefits, particularly in relation to continuity of employment, consistency of employment processes and governance arrangements for Doctors and Dentists in Training employed under the 2002 New Deal TCS and contract. However, the evidence also highlighted ongoing challenges relating to roles and responsibilities, operational interfaces, communication and organisational capacity. Both Trusts and the SLE emphasised the importance of clear accountability, effective collaboration and a shared understanding of responsibilities between the SLE, Host Organisations and NIMDTA Education and Training to maximise the effectiveness of the model.

### 9.1.9.4 Conclusion

Trusts reported that the Single Lead Employer (SLE) model has strengthened the employment relationship with doctors and dentists in training by improving continuity of employment, reducing administrative burden and promoting greater consistency in employment arrangements across Northern Ireland. However, evidence also highlighted ongoing challenges relating to roles and responsibilities, communication, operational interfaces and local workforce management arrangements. Continued refinement of the model, alongside stronger alignment between the SLE, Host Organisations and NIMDTA, will remain important in supporting trainee experience, workforce stability and the effective delivery of postgraduate medical and dental training.

## 9.1.10 Widening Participation and Future Workforce Characteristics

### 9.1.10.1 Entry to Medical and Dental Education

**Queen's University Belfast QUB** - The average tariff score for students commencing Year 1 undergraduate degrees in Medicine and Dentistry during 2025/26 can be seen below:

**Table 23 - Average Tariff Score of Students Commencing Year 1 Undergraduate Medicine and Dentistry Degrees, 2025/26**

| UG Degree | Average Tariff |
|-----------|----------------|
| Medicine  | 185.7          |
| Dentistry | 176.8          |

*Source: 2025-26 Provisional HESA Student return (1 July 2026)*

**Ulster University UU** - Entry to the Graduate Entry Medical Programme requires applicants to hold a minimum 2:1 Honours degree in any discipline or a Master's qualification with an overall mark of at least 60%. As graduate entry pathways are based on prior degree attainment, UCAS tariff scores are not used within the admissions process.

**Widening Participation and Future Workforce Diversity** - The Department recognises the importance of ensuring that access to medical and dental education remains open to individuals from a broad range of backgrounds. Expanding training opportunities and supporting a wider range of entry pathways can contribute to a more diverse and representative future workforce.

#### 9.1.10.2 Dental Training

In the past year, two of the ten dental specialty trainees accepted posts in the Republic of Ireland. In both cases, the decision was not primarily related to the terms and conditions associated with Sláintecare. One trainee accepted a post due to limited opportunities within Northern Ireland, while the other had always intended to return to practice within the Republic of Ireland following completion of a specific element of training.

There has not yet been any significant expansion of dental specialty training places within Northern Ireland. However, increasing training capacity has been identified as an important consideration given widening oral health inequalities affecting vulnerable groups, including older people, children and disadvantaged communities.

Expansion of specialty training opportunities could help support a more representative workforce and improve access to career progression opportunities. The current limited number of specialty posts means that individuals with greater flexibility to relocate or undertake Out of Programme (OOP) opportunities may have an advantage in

progressing through training pathways. This has the potential to create barriers for some trainees from less advantaged backgrounds.

Increased specialty training capacity may also create opportunities to support alternative training and progression routes, including specialist list entry through equivalence pathways.

#### 9.1.10.3 Medical Training

Expansion of medical training capacity has primarily focused on increasing training numbers, improving geographical distribution of training posts and increasing exposure to community-based and vulnerable specialties. These measures are intended to support future workforce supply while ensuring that training opportunities remain aligned with workforce planning priorities and future service requirements.

Access to medical and dental education, training capacity and progression opportunities all play an important role in shaping the future workforce. While expansion has taken place in a number of medical training programmes, opportunities remain to further strengthen workforce diversity, widen participation and support future workforce supply through continued investment in education and training pathways.

#### **9.1.11 Conclusion**

Doctors and Dentists in Training remain central to the future sustainability of the medical and dental workforce in Northern Ireland. Recruitment into training programmes remains strong overall and significant progress has been made in improving trainee experience, expanding training capacity and supporting workforce development. However, challenges remain in relation to recruitment and retention in some specialties, training capacity constraints, increasing reliance on internationally recruited trainees and competition from other jurisdictions. Continued investment in training, workforce development and trainee experience will be essential to supporting future workforce supply and ensuring a sustainable pipeline of medical and dental professionals for Northern Ireland.

### **9.2 SAS Doctors and Dentists**

#### **9.2.1 Overview of the SAS Workforce**

Specialty and Associate Specialist (SAS) doctors and dentists form an important and growing component of the medical workforce in Northern Ireland. Working across

acute, community and specialist services, they provide senior clinical expertise, support multidisciplinary teams, contribute to education and service development, and help maintain continuity of care. Their contribution is increasingly important in supporting workforce sustainability, service resilience and the delivery of high-quality patient care across the HSC.

As at June 2026, departmental workforce returns identified 838 SAS doctors and dentists employed across Northern Ireland, including 727 Specialty Doctors and 50 Specialists demonstrating the increasingly important role of the SAS workforce in supporting service delivery across a wide range of specialties.

The SAS workforce continues to evolve following the introduction of the 2021 SAS contract and the creation of the Specialist grade. A range of workforce initiatives have also been introduced to support career development, recruitment, retention and workforce wellbeing. The following sections outline the current position of the SAS workforce, uptake of the 2021 contract, development of the Specialist grade and wider workforce support initiatives.

### **9.2.2 Uptake of the 2021 SAS Contract**

The 2021 SAS contract introduced significant reforms to career progression, pay progression and the wider employment framework for SAS doctors and dentists. As part of the 2024/25 SAS pay settlement, agreement was reached to extend the transfer window for eligible doctors wishing to move from legacy contractual arrangements to the 2021 contract.

Following agreement between the Department of Health, HSC employers and the British Medical Association (BMA), the transfer window was extended until 31 March 2027 through Circular HSC (TC8) 04/2025. This extension was intended to provide additional flexibility and support SAS doctors and dentists in considering transfer to the revised contractual arrangements.

Departmental workforce returns indicate that 524 were employed on the 2021 SAS contract as at June 2026. The majority of doctors employed on the 2021 contract were appointed directly following its introduction, rather than transferring from legacy contractual arrangements.

Workforce data demonstrates that uptake of the 2021 contract has increased steadily since implementation, although the pace of adoption has varied between organisations. While 87 doctors have transferred from legacy contractual arrangements since the introduction of the contract, growth has been driven primarily by recruitment of new staff directly onto the revised contractual terms and conditions.

Trust returns indicate that some organisations have seen substantial growth in the proportion of SAS doctors employed on the 2021 contract, supported by both recruitment and contractual transfers. However, uptake amongst doctors employed on previous contractual arrangements has remained more limited.

The reasons underpinning individual decisions to transfer are not routinely collected. However, experience during implementation of the 2021 SAS contract suggests that some doctors may have considered factors such as pay progression arrangements, progression gateway requirements and the balance between short-term and longer-term financial benefits when deciding whether to transfer from legacy contracts.

Overall, the available evidence indicates a continuing transition towards the 2021 SAS contract across Northern Ireland. While uptake among legacy contract holders has been variable, the 2021 contract has become the predominant contractual framework for new SAS appointments and is playing an increasingly important role in the development of the SAS workforce.

Detailed information on contract uptake, transfers and contractual distribution across HSC organisations is provided at Annex 5.

### **9.2.3 Development of the Specialist Grade**

The Specialist grade was introduced as part of the 2021 SAS contract reforms and provides a structured career progression pathway for experienced SAS doctors and dentists. The development of the Specialist grade has also supported workforce transformation and service delivery. Guidance has been developed to support HSC organisations in identifying where Specialist roles can be created and how they can be integrated into local workforce structures and service models.

Workforce returns indicate that, as at June 2026, there were 838 SAS posts across Northern Ireland, comprising 727 Specialty Doctors, 50 Specialists and 61 Associate Specialists and Staff Grade. While the Specialist grade is now established across the

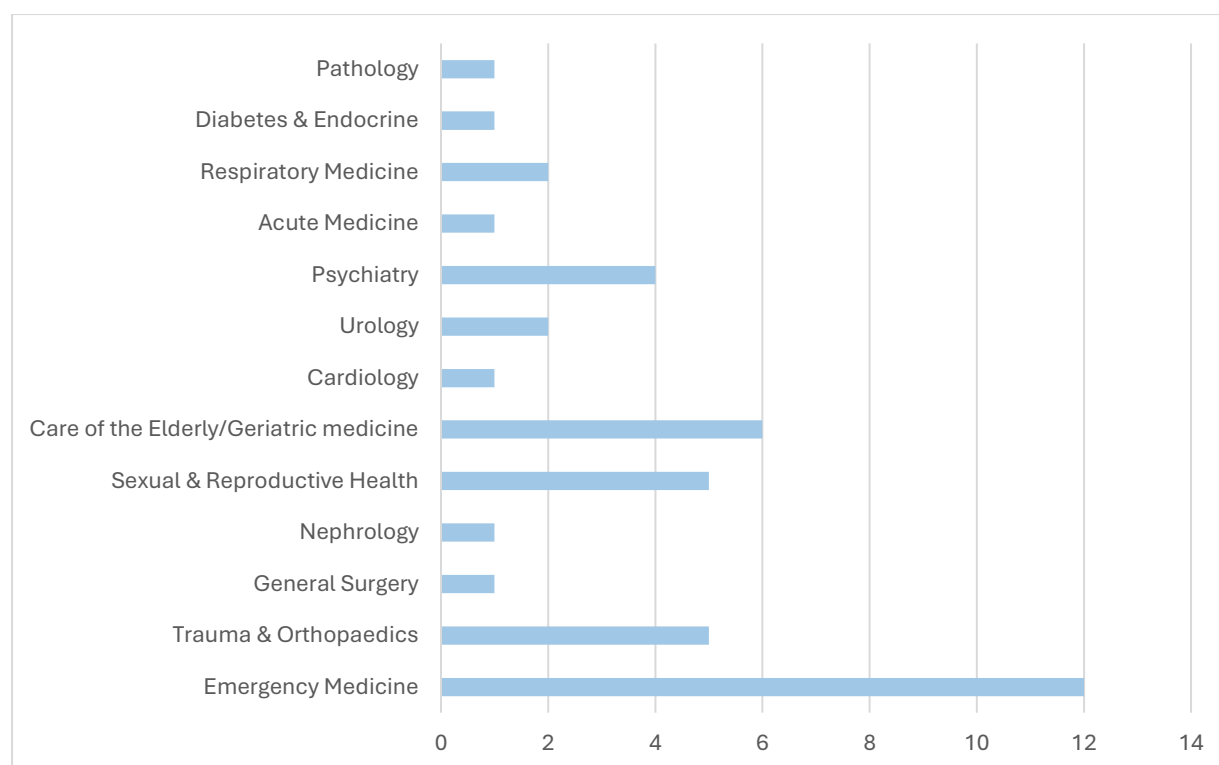
HSC, uptake remains relatively modest, with Specialists accounting for approximately 6% of the overall SAS workforce. Uptake of the Specialist grade has been slower than anticipated despite the availability of suitably experienced Specialty Doctors who may be eligible to apply.

#### 9.2.3.1 Contribution of Specialist Roles to Service Delivery

Since the introduction of the 2021 SAS contract, Specialist roles have been established across a wide range of specialties and service settings, including both acute and community services. Trusts reported that these posts have generally been created in areas experiencing workforce shortages, recruitment difficulties, increasing demand or a need for enhanced senior clinical capacity.

Workforce data provided by the Associate SAS Dean indicates that Specialist doctors are currently working across services including Emergency Medicine, Care of the Elderly, Sexual and Reproductive Health, Trauma and Orthopaedics, Psychiatry, Urology, Respiratory Medicine and a range of additional acute and community specialties. There are currently 42 Specialists which accounts for approximately 5% of the SAS workforce.

**Chart 4: Specialists by headcount**



*Source: NIMDTA – SAS Associate Dean*

Specialist doctors provide autonomous clinical care within defined areas of competence and contribute significantly to senior clinical decision-making within multidisciplinary teams. Trusts reported that these roles support more effective deployment of consultant time, improve continuity of care and enhance senior clinical capacity within services.

In addition to direct clinical responsibilities, Specialist doctors contribute to teaching, training, leadership, quality improvement, research and service development activities. Trusts highlighted their role in mentoring colleagues, supporting workforce development and helping to implement new models of care and service redesign.

Evidence from Trusts and the Associate SAS Dean suggests that the Specialist grade is delivering benefits for both workforce sustainability and service delivery. The role provides an important career progression pathway for experienced SAS doctors and dentists while supporting the development of a substantive senior workforce. Organisations also reported benefits including improved patient flow, increased service capacity, greater service stability and reduced reliance on temporary staffing arrangements.

Overall, the Specialist grade is making an increasingly important contribution to the medical workforce across Northern Ireland. While uptake remains relatively modest, these roles are enhancing senior clinical capacity, supporting recruitment and retention, improving workforce resilience and contributing to the delivery of sustainable services across a broad range of specialties and care settings.

#### **9.2.4 Workforce Support and Professional Development**

The SAS workforce continues to play an increasingly important role in service delivery across Northern Ireland. However, Trusts identified a number of ongoing challenges affecting this workforce group, including career progression opportunities, workforce visibility, access to professional development, recruitment to Specialist grade posts and retention of experienced clinicians. A range of workforce support and professional development initiatives have therefore been established to strengthen engagement, progression and workforce sustainability across the SAS workforce.

#### 9.2.4.1 Supporting Professional Activities (SPAs)

Supporting Professional Activities (SPAs) form an important component of the SAS role and provide protected time for activities that support professional development, education, quality improvement, leadership, research and service development. Appropriate access to SPA time helps ensure that SAS doctors and dentists can maintain and develop their skills while contributing to wider organisational objectives.

As part of the resolution of the 2023/24 SAS pay dispute, the Department issued Circular HSC (TC8) 04/2025 reminding HSC Employers of the entitlement of SAS doctors and dentists to a minimum of one Supporting Professional Activity (SPA).

Used effectively, SPAs benefit the individual, the organisation and the wider HSC by creating dedicated time for continuing professional development, quality improvement initiatives, research, teaching, leadership and service development activities. Access to appropriate SPA time and study leave also supports career progression, job satisfaction and workforce wellbeing, while contributing to improved patient care and service quality.

#### 9.2.4.2 Associate SAS Dean

The Associate SAS Dean role has become an important component of SAS workforce development across Northern Ireland. The role provides regional leadership for the SAS workforce and supports education, career development, workforce planning and professional progression. While not a Trust-based post, the Associate SAS Dean contributes to workforce sustainability by improving access to development opportunities, supporting progression and promoting SAS careers across the HSC.

A key responsibility of the role is leadership of the regional SAS Career Development Programme, supported by the Deputy Associate Dean and Career Development Team. Through an annual programme of educational events, webinars, workshops and e-learning opportunities, the programme supports appraisal, revalidation, continuing professional development and career progression. Trusts reported that these arrangements have improved access to development pathways and increased awareness of progression routes, including progression to Specialist posts and consultant roles through the Portfolio Pathway.

The Associate SAS Dean also oversees access to the SAS Career Development Fund, which enables SAS doctors and dentists to undertake development projects, enhance clinical skills and contribute to service improvement activities. Trusts reported that these opportunities have strengthened workforce capability and supported greater engagement with quality improvement, leadership and service development initiatives.

Evidence provided by Trusts also highlighted the role's contribution to mentoring and workforce support. The Associate SAS Dean and Deputy Associate Dean provide career guidance, professional advice and one-to-one support for SAS doctors and dentists considering progression to more senior roles or seeking greater autonomy within their current posts. These activities have helped strengthen workforce engagement and support longer-term career development.

The role also contributes to regional collaboration and workforce coordination through engagement with SAS networks, development initiatives and workforce representation structures. Trusts reported that the Associate SAS Dean has supported greater consistency in SAS workforce development across Northern Ireland, promoted the sharing of good practice and helped ensure that SAS workforce issues are represented within wider professional, educational and workforce discussions.

Overall, Trusts and information provided by the Associate SAS Dean indicate that the role has made a positive contribution to workforce capability, career progression, professional development and workforce sustainability. Through regional leadership, mentoring, education and workforce development initiatives, the Associate SAS Dean plays an important role in supporting a skilled, engaged and sustainable SAS workforce across HSC Northern Ireland.

Figures illustrating the strategic framework underpinning the SAS Career Development Programme and examples of educational, developmental and support initiatives available to SAS doctors and dentists across Northern Ireland can be seen within Annex 5.

#### 9.2.4.3 SAS Leads

Trusts and the Associate SAS Dean reported that SAS Leads have made an important contribution to workforce engagement, representation and professional development across the SAS workforce. The role provides a clear link between SAS doctors and

dentists and organisational leadership structures, helping to ensure that SAS workforce perspectives are reflected within workforce planning, operational decision-making and service development.

A key function of SAS Leads is to support career development and workforce progression. Trusts reported that SAS Leads facilitate access to professional development opportunities, mentoring, appraisal support and career guidance, while encouraging participation in leadership, educational and service improvement activities. These initiatives have helped improve awareness of progression opportunities, including Specialist grade posts and consultant progression through the Portfolio Pathway, while also supporting workforce engagement and retention.

Trusts and the Associate SAS Dean also highlighted the important role SAS Leads have played in supporting implementation of workforce and contractual initiatives. This has included promoting understanding of the 2021 SAS contract, supporting Specialist grade development, facilitating job planning discussions and increasing awareness of available career pathways. SAS Leads have also contributed to local educational programmes, networking events, workforce engagement initiatives and implementation of regional workforce development strategies.

In addition to workforce development activities, SAS Leads provide an important communication and advocacy function. Trusts reported that SAS Leads facilitate engagement between frontline clinicians, senior managers and workforce teams, helping to identify issues, resolve barriers and improve organisational understanding of SAS workforce needs. This has supported greater visibility of the SAS workforce and strengthened engagement within local organisations.

Trusts also reported benefits for service delivery and workforce stability. By supporting the effective utilisation of experienced SAS clinicians, promoting appropriate levels of autonomy and encouraging workforce development, SAS Leads contribute to service resilience, continuity of care and reduced reliance on temporary staffing arrangements.

Overall, Trusts and the Associate SAS Dean considered that SAS Leads have made a positive contribution to workforce engagement, professional development, communication and workforce sustainability. Through mentoring, advocacy,

educational activity and workforce leadership, the role has strengthened the visibility, development and effective utilisation of the SAS workforce across HSC organisations.

With the recruitment of SAS Advocates across the region, some elements of the current SAS Lead role will transfer to the Advocate function. This is expected to allow SAS Leads to place a greater focus on education, learning, career development and progression opportunities, further strengthening support for the SAS workforce across Northern Ireland.

Examples of SAS Lead activity across HSC organisations can be viewed in Annex 5.

#### 9.2.4.4 SAS Advocate Role

The SAS Advocate role was introduced to strengthen support, representation and wellbeing for SAS doctors and dentists across Northern Ireland. The role is intended to complement, rather than replace, existing SAS support arrangements, including the SAS Lead role, and provides an additional mechanism for workforce engagement and advocacy.

While implementation of the role was initially delayed by funding constraints, the provision of recurrent departmental funding equivalent to one Supporting Professional Activity (SPA) per acute HSC Trust has enabled organisations to establish the role across the region. As at 2026, all Trusts have either appointed a SAS Advocate or are in the final stages of recruitment.

Trusts reported that the SAS Advocate role is intended to provide visible leadership and representation for the SAS workforce, strengthen engagement with senior management and improve communication between SAS doctors and organisational leadership structures. The role also promotes workforce wellbeing, supports professional development and helps raise awareness of SAS workforce issues within organisations.

Evidence from Trusts suggests that the SAS Advocate role is already helping to strengthen workforce engagement and representation by providing a clear point of contact for SAS doctors and dentists and supporting the resolution of workforce concerns. Trusts also highlighted the potential contribution of the role to staff wellbeing, workforce morale and retention, particularly as SAS doctors and dentists continue to take on increasingly important service delivery responsibilities.

Overall, implementation of the SAS Advocate role is well advanced across Northern Ireland and is being delivered alongside wider SAS workforce initiatives. While the role remains relatively new, Trusts reported broad recognition of its potential to improve communication, engagement, representation and wellbeing, while contributing to the longer-term sustainability of the SAS workforce.

SAS doctors and dentists represent an increasingly important component of the medical workforce in Northern Ireland and play a significant role in maintaining service delivery, workforce resilience and continuity of care. The introduction of the 2021 SAS contract, the development of the Specialist grade and the establishment of workforce support initiatives have strengthened career development opportunities and supported workforce engagement. However, challenges remain in relation to recruitment, retention, uptake of the Specialist grade and long-term workforce sustainability. Continued investment in career development, workforce support and progression pathways will be important in maximising the contribution of the SAS workforce and supporting future service delivery across Northern Ireland.

### **9.2.5 Working Patterns and Workforce Sustainability**

Trust data demonstrates considerable variation in working patterns across specialties, with workload intensity influenced by service demand, workforce availability and clinical requirements.

One Trust reported marked differences in programmed activity (PA) levels between specialties. While the overall average for SAS doctors was 10.7 programmed activities per whole-time equivalent (WTE), activity levels were substantially higher in some services. SAS doctors working in Surgery, Emergency Medicine, Paediatrics, Child and Adolescent Mental Health Services (CAMHS), and Obstetrics and Gynaecology were reported to be undertaking between 12 and 14.5 programmed activities. This demonstrates the extent to which workforce shortages and increasing service demand continue to place additional pressure on certain specialties and highlights the important contribution SAS doctors make in maintaining service delivery. By comparison, services such as Acute Care at Home and Geriatric Medicine were reported to be operating closer to standard contractual levels.

One Trust reported that SAS doctors worked an average of 33.4 hours per week in March 2026. The Trust also reported increases in SAS doctor headcount and whole-

time equivalent (WTE) numbers over the same period, indicating growth in workforce capacity.

Regional workforce data also demonstrates differences in working patterns by gender. As at 31 March 2026, female SAS doctors had a lower WTE-to-headcount ratio than male SAS doctors, indicating a greater prevalence of less-than-full-time and part-time working arrangements. This reflects wider workforce trends and has implications for workforce planning, as additional headcount may be required to deliver equivalent workforce capacity. Detailed workforce profile data is provided in the table below.

**Table 24: SAS Workforce Profile**

|                             | Female SAS Doctors | Male SAS Doctors |
|-----------------------------|--------------------|------------------|
| <b>Headcount</b>            | 515                | 306              |
| <b>WTE</b>                  | 438.2              | 300.2            |
| <b>WTE: Headcount Ratio</b> | 0.85               | 0.98             |

*Source: Department of Health, Information and Analysis Branch*

Trusts also reported that workforce planning is increasingly influenced by work-life balance considerations, with growing numbers of SAS doctors choosing to work less than full-time. At the same time, workload pressures, rota gaps and increasing service demand mean that some SAS doctors continue to work above their contracted hours on a regular basis. Trusts highlighted that sustained periods of high workload intensity can affect workforce wellbeing, increase the risk of fatigue and contribute to challenges in maintaining workforce resilience.

Overall, the evidence suggests that working patterns within the SAS workforce are increasingly influenced by service demand, workforce availability and changing workforce expectations. While flexible and less-than-full-time working arrangements can support wellbeing, recruitment and retention, they also create additional workforce planning challenges and have implications for workforce capacity. Trusts reported particular workload pressures within acute specialties, reinforcing the growing importance of the SAS workforce in supporting service resilience, continuity of care and workforce sustainability across Northern Ireland.

Trusts also highlighted that maintaining workforce wellbeing is increasingly important in supporting retention, job satisfaction and long-term workforce sustainability. Persistent service pressures, workforce shortages and high workload intensity can increase the risk of burnout and may affect morale, engagement and workforce

stability. Supporting wellbeing, ensuring appropriate job planning arrangements and maintaining sustainable workloads will therefore remain important considerations in retaining experienced SAS doctors and dentists and maximising their contribution to service delivery.

## **9.2.6 Recruitment and Retention**

SAS doctors and dentists represent an increasingly important component of the medical workforce in Northern Ireland and play a significant role in maintaining service delivery across a wide range of specialties. As at June 2026, departmental workforce returns identified 878 SAS doctors and dentists employed across Northern Ireland, including 738 Specialty Doctors. Their contribution is increasingly important in supporting workforce resilience, service sustainability and continuity of care.

### **9.2.6.1 Recruitment and Workforce Supply**

Evidence from Trusts indicates continued recruitment into SAS roles, driven by increasing service demand, workforce shortages and the need to maintain service delivery across a range of specialties. Recruitment activity has been particularly evident in services experiencing sustained workforce pressures, with some Trusts reporting growth in SAS numbers in areas such as Emergency Medicine and other hard-to-fill specialties.

SAS doctors are recruited through a variety of local, regional, UK-wide and international recruitment pathways. These include internationally trained doctors, doctors progressing from training programmes, locally employed doctors moving into substantive SAS posts and experienced clinicians seeking alternative career pathways within the medical workforce. Trusts reported that international recruitment has become increasingly important in supporting workforce supply where local recruitment has been insufficient to meet service need.

Trusts also highlighted the importance of developing sustainable recruitment pipelines. Movement from locally employed doctor and fixed-term roles into substantive SAS appointments provides an important route into the permanent SAS workforce. In addition, the SAS Career Development Team continues to provide career guidance and support to doctors considering SAS careers, helping to raise awareness of progression opportunities and career pathways within the SAS workforce.

#### 9.2.6.2 Retention Challenges

While recruitment activity remains positive in many areas, Trusts reported a number of ongoing retention challenges. Workload intensity, rota gaps, increasing service demand and workforce shortages continue to place pressure on SAS doctors and dentists and may affect the long-term attractiveness of SAS careers.

Trusts also identified career progression opportunities, access to professional development and recognition of the contribution made by SAS doctors and dentists as important retention factors. Concerns were raised that limited progression opportunities or perceptions of restricted career development could affect retention, particularly where alternative opportunities are available elsewhere.

Workforce turnover remains an important consideration. Trust evidence demonstrates continued movement into and out of SAS roles, highlighting the need for ongoing workforce support, professional development opportunities and clear progression pathways to support workforce stability.

#### 9.2.6.3 Workforce Development and Retention Initiatives

A range of regional initiatives has been implemented to support recruitment, retention and workforce sustainability within the SAS workforce. These include:

- Introduction and expansion of the 2021 SAS Contract.
- Development of the Specialist grade.
- Appointment of SAS Leads and SAS Advocates.
- Establishment of the Associate SAS Dean role.
- Delivery of the Regional SAS Career Development Programme.
- Access to a recurrent SAS Development Fund.
- Improved engagement with appraisal and job planning processes.
- Implementation of the SAS Charter.

Collectively, these initiatives are intended to strengthen workforce engagement, improve career development opportunities, enhance job satisfaction and support longer-term workforce sustainability.

#### 9.2.6.4 Specialist Grade Recruitment Challenges

Despite the introduction of the Specialist grade, Trusts reported ongoing challenges in recruiting to some Specialist posts. Limited applicant availability, workforce shortages and a lack of familiarity with the Specialist grade were identified as factors influencing recruitment. Trusts also emphasised that the creation of Specialist posts must be driven by service need and workforce requirements rather than the existence of the grade itself. The Specialist grade is intended to support service delivery models where there is a clear requirement for additional senior clinical capacity and an appropriate level of autonomous practice. Consequently, the number of Specialist posts that can be created will vary depending on local service priorities, workforce planning considerations and organisational need. To support implementation, regional guidance has been developed to assist organisations in identifying circumstances where Specialist roles may add value and strengthen workforce resilience.

SAS doctors and dentists continue to play an increasingly important role in supporting service delivery, workforce resilience and continuity of care across Northern Ireland. Recruitment activity remains positive in many specialties and the introduction of the 2021 SAS contract, Specialist grade and wider workforce development initiatives has strengthened career progression opportunities and workforce support arrangements. However, workforce pressures, recruitment difficulties in some specialties, workload intensity and the need to strengthen progression pathways continue to present challenges. Continued investment in career development, workforce support, recruitment and retention initiatives will be essential to ensuring the long-term sustainability of the SAS workforce and maximising its contribution to service delivery across HSC Northern Ireland.

#### **9.2.7 Retirement Trends**

Trust information suggests that the average age of retirement for SAS doctors generally ranges between 59 and 65 years, although variation exists between organisations and reporting periods. Trusts also advised that the relatively small number of retirements limits the ability to draw firm conclusions regarding long-term retirement trends.

Trusts have advised that retirement accounts for only a proportion of overall SAS doctor workforce turnover. One Trust reported that retirements represent

approximately 15% of SAS doctor leavers annually, while other Trusts indicated that resignations and other forms of workforce movement account for a larger share of departures. This suggests that workforce turnover within the SAS workforce is influenced by a range of factors beyond retirement alone. This indicates that, while retirement remains an important workforce planning consideration, recruitment, retention and wider workforce mobility are likely to have a greater influence on overall SAS workforce sustainability.

Overall, the retirement data supplied by Trusts indicates a broadly consistent pattern, with average retirement ages generally reported around the early 60s, although some variation exists between organisations and reporting periods. Trusts also highlighted that retirement decisions may be influenced by a range of factors, including pension arrangements, workload considerations, personal circumstances and work-life balance preferences. Given the relatively small number of retirements reported, individual cases can have a significant impact on annual averages.

From a regional perspective, the information available does not indicate any significant trend towards either earlier or later retirement among SAS doctors. Overall, the evidence suggests a broadly stable pattern of retirement occurring in the early 60s, although caution should be exercised when interpreting trends given the relatively small number of retirements recorded.

From a regional perspective, the available evidence does not indicate any significant trend towards either earlier or later retirement among SAS doctors. Retirement patterns appear broadly stable, with most retirements occurring in the early 60s. While retirement remains an important workforce planning consideration, the evidence suggests that future workforce sustainability will depend equally on effective recruitment, retention and career development strategies to maintain SAS workforce capacity and resilience.

### **9.2.8 Conclusion**

SAS doctors and dentists continue to play an increasingly important role in supporting service delivery, workforce resilience and continuity of care across Northern Ireland. The evidence presented within this chapter demonstrates that the SAS workforce is a growing and increasingly important component of the medical workforce, providing senior clinical expertise across a wide range of specialties and care settings.

The introduction of the 2021 SAS contract, development of the Specialist grade and implementation of workforce support initiatives have strengthened career development opportunities and enhanced the attractiveness of SAS careers. Regional initiatives, including the work of the Associate SAS Dean, SAS Leads and SAS Advocates, have also improved workforce engagement, professional development and support for the SAS workforce.

However, challenges remain in relation to recruitment, retention, workload pressures, uptake of the Specialist grade and long-term workforce sustainability. Continued investment in workforce development, career progression pathways and workforce support arrangements will therefore remain important in ensuring that the SAS workforce is able to maximise its contribution to service delivery and meet future workforce requirements across Health and Social Care services in Northern Ireland.

### **9.3 Consultant Workforce**

#### **9.3.1 Overview of the Consultant Workforce**

Consultants play a pivotal role within the HSC system in Northern Ireland, providing expert clinical leadership, delivering specialist care and contributing to service development, education and research. As senior medical professionals, they are responsible for complex clinical decision-making, mentoring junior staff and ensuring high standards of patient care across a wide range of specialties. Their leadership is essential in shaping clinical pathways, driving innovation and supporting multidisciplinary teams in delivering safe and effective healthcare.

As at March 2026, the consultant workforce comprised approximately 2,147 WTE consultants, representing an increase of almost 27% since 2018. This growth reflects sustained investment in workforce supply and training and has contributed to increasing consultant capacity across a number of specialties.

Despite this growth, consultant workforce pressures remain evident in a number of areas. Increasing demand, population ageing, growing service complexity and continuing recruitment challenges mean that consultant capacity remains under pressure in some specialties. Consultants therefore continue to play a critical role in supporting service delivery, workforce development, clinical leadership and the long-term sustainability of health and social care services across Northern Ireland.

### **9.3.2 Reward and Recognition**

#### **9.3.2.1 Clinical Excellence Awards (CEA)**

The Northern Ireland Clinical Excellence Awards (CEA) scheme has been paused for a number of years, with no new awards being made since its suspension, although existing legacy awards continue to be paid. The absence of an active awards scheme has been a recurring concern raised by consultant representatives and the British Medical Association (BMA), particularly given the continuation of reformed consultant reward schemes in other UK jurisdictions.

In response, the Department developed proposals for a reformed Clinical Excellence Awards scheme in partnership with the BMA and HSC employers. The proposed reforms were intended to modernise the scheme, improve transparency and fairness, and ensure stronger alignment with contemporary service priorities. A formal public consultation on the proposals has been completed.

Progress in finalising a reformed scheme was delayed due to significant workforce and industrial relations pressures within the Workforce Policy Directorate. However, dedicated resource has now been secured, and work has recommenced on analysing consultation responses and developing recommendations on the future direction of consultant reward arrangements.

In its 54th Report, the DDRB noted that Northern Ireland is currently the only UK nation without an active clinical impact or excellence awards scheme and suggested that developments elsewhere in the UK should inform future consideration of reward arrangements in Northern Ireland. In developing proposals for reform, the Department considered approaches adopted in other UK jurisdictions.

The Department recognises that reward and recognition schemes can play a positive role in supporting excellence, encouraging leadership and innovation, improving patient outcomes, and strengthening consultant recruitment and retention. However, affordability remains a significant constraint. Any future reward scheme will require both initial and recurring financial investment and must be considered alongside wider workforce priorities and the challenging financial position facing Health and Social Care services.

### 9.3.2.2 Wider Reward and Recognition

Beyond formal reward schemes, Trusts highlighted the importance of recognition, professional development opportunities, leadership roles and involvement in service improvement activity in supporting consultant engagement and job satisfaction. Opportunities to lead services, contribute to education and training, undertake research and drive quality improvement initiatives were all identified as important aspects of the overall consultant employment offer.

These wider forms of recognition can contribute positively to workforce morale, professional fulfilment and retention, particularly within specialties experiencing sustained workforce pressures.

Reward and recognition continue to be important components of the overall consultant employment offer. The Department acknowledges the potential contribution of reward schemes in supporting excellence, leadership, innovation and workforce retention. However, any future arrangements must be affordable, transparent, equitable and aligned with wider workforce strategy and service priorities. Alongside any future CEA scheme, broader opportunities for professional development, leadership and service improvement will remain important in supporting consultant engagement, recruitment and long-term workforce sustainability across Northern Ireland.

## 9.3.3 **Working Patterns and Job Planning**

### 9.3.3.1 Programmed Activities and Job Planning

The information provided by Trusts indicates that the average number of Programmed Activities (PAs) and Supporting Professional Activities (SPAs) undertaken by consultants has remained broadly stable over the reporting period. While some variation exists between organisations and specialties, the available evidence shows little indication of significant year-on-year change.

Supporting Professional Activities (SPAs) continue to form an important component of consultant job plans. Where detailed information was available, Trusts reported average SPA allocations of between 1.5 and 2.0 programmed activities within core consultant job plans. SPA time supports a range of essential non-clinical activities, including education and training, appraisal, clinical governance, quality improvement, leadership, research and service development.

Information on Additional Programmed Activities (APAs) was more limited. Where reported, average APA allocations ranged between approximately 1.9 and 2.7 programmed activities. APAs are generally agreed to support additional service requirements such as increased clinical demand, waiting list initiatives, additional clinic capacity and theatre activity. Although detailed APA data is not available across all organisations, Trusts reported that a proportion of consultants continue to undertake activity beyond their core contractual commitments to support service delivery.

Variation in programmed activity levels was also observed across specialties. Higher levels of programmed activity were generally associated with specialties such as Emergency Medicine, Cardiology, General Medicine and Surgery, reflecting differences in clinical workload, service models and on-call commitments.

Overall, the evidence suggests a broadly consistent pattern in consultant job planning. SPAs remain a key component of consultant job plans, supporting education, training, clinical governance, leadership and service improvement activities. At the same time, APAs provide additional flexibility and capacity to support service delivery and workforce resilience.

### 9.3.3.2 Appraisal and Workforce Governance

Medical appraisal and revalidation remain important components of workforce governance and professional regulation within the consultant workforce. Trusts reported continued engagement with appraisal processes and highlighted the role of appraisal in supporting professional development, clinical governance, revalidation and workforce wellbeing.

The rates for staff appraisal across Trusts are as follows:

**Table 25: Appraisals**

| Year           | Compliance Rate | Yet to Complete |
|----------------|-----------------|-----------------|
| <b>2023*</b>   | 97.8%           | 2.2%            |
| <b>2024**</b>  | 94.5%           | 5.5%            |
| <b>2025***</b> | 23.3%           | 76.7%           |

\* Based on available Trust returns (Based on available data submitted by four of five HSC Trusts)

\*\* Based on available Trust returns (Based on available data submitted by three of five HSC Trusts)

\*\*\* In-year position and therefore not directly comparable with completed annual returns.

Trusts also reported continued improvement in consultant job planning arrangements, supported by strengthened governance processes, improved partnership working and

increasing use of electronic job planning systems. Trusts advised that electronic job planning systems have improved transparency, consistency and oversight of consultant activity, while helping to align consultant job plans with service delivery requirements and organisational priorities. Internal audit reports indicate that a number of Trusts have introduced, enhanced or are implementing electronic job planning systems and associated tracking arrangements for consultant job plans. Trust returns indicate that job planning completion rates have improved across a number of organisations over the reporting period.

The rates for job planning across Trusts are as follows:

**Table 26: Job Planning**

| <b>Year</b>   | <b>Consultant Completion Rate</b> | <b>SAS Completion Rate</b> |
|---------------|-----------------------------------|----------------------------|
| <b>2023</b>   | 68.7%                             | 55.7%                      |
| <b>2024*</b>  | 81.9%                             | 78.4%                      |
| <b>2025**</b> | 74.5%                             | 74.0%                      |

\* Based on available Trust returns (Based on available data submitted by four of the five HSC Trusts)

\*\*\* In-year position and therefore not directly comparable with completed annual returns.

Despite these improvements, workforce pressures continue to affect the quality and sustainability of job planning processes. High vacancy levels, increasing service demand and reliance on temporary staffing can limit opportunities for meaningful job planning discussions and increase reliance on additional programmed activity to support service delivery.

### 9.3.3.3 Working Patterns

Regional workforce data indicates that consultant working patterns vary between individuals, with evidence of increasing levels of less-than-full-time working across the consultant workforce.

As at 31 March 2026, female consultants had a WTE-to-headcount ratio of 0.91 compared with 0.95 for male consultants, indicating a slightly higher prevalence of less-than-full-time and flexible working arrangements. This reflects wider workforce trends across the HSC and changing workforce expectations relating to flexibility and work-life balance.

Detailed workforce profile data is provided within section 11.

**Table 27: Consultant Workforce Headcount and Whole-Time Equivalent (WTE) Ratios at 31 March 2026**

|                             | Female Consultants | Male Consultants |
|-----------------------------|--------------------|------------------|
| <b>Headcount</b>            | 976                | 1,326            |
| <b>WTE</b>                  | 891.0              | 1,256.2          |
| <b>WTE: Headcount Ratio</b> | 0.91               | 0.95             |

*Source: Department of Health, Information Analysis Directorate*

The increasing prevalence of less-than-full-time working has important implications for workforce planning and workforce supply. As working patterns continue to evolve, proportionately larger headcount growth may be required to achieve planned workforce capacity and support future service delivery requirements.

Trusts also reported that sustained workforce pressures and consultant vacancies can increase reliance on additional programmed activity within some specialties. While this flexibility supports service continuity, maintaining sustainable workloads remains important in supporting consultant wellbeing, retention and workforce sustainability.

Overall, consultant working patterns are increasingly influenced by service demand, workforce availability and changing workforce expectations. While flexible working arrangements can support wellbeing and retention, they also create additional workforce planning challenges and reinforce the importance of maintaining sufficient consultant workforce capacity to meet future service needs.

Trusts highlighted that sustained periods of high workload intensity can affect workforce wellbeing, increase the risk of fatigue and contribute to challenges in maintaining workforce resilience. Maintaining sustainable workloads, effective job planning arrangements and access to appropriate SPA time will therefore remain important in supporting consultant wellbeing, engagement and long-term workforce sustainability.

### **9.3.4 Retirement Trends and Workforce Sustainability**

Information provided by Trusts indicates that consultant retirements occur in relatively small numbers each year, limiting the scope for robust trend analysis. While the available evidence suggests that consultants generally retire in their early 60s, annual averages can be significantly influenced by individual retirements due to the relatively low volume of cases reported.

Rather than indicating a significant change in retirement behaviour, the available evidence highlights the growing importance of workforce demographic considerations. Trusts reported that a notable proportion of the consultant workforce is approaching retirement age, with one organisation advising that approximately 14% of consultants were aged 58 years or over as at March 2026. This suggests that a sizeable cohort of experienced consultants may become eligible for retirement within the coming years, creating potential challenges for workforce supply, succession planning and service continuity.

Trusts also highlighted the workforce implications of consultant retirements. The departure of experienced consultants can affect service delivery, leadership capacity, training environments and workforce resilience, particularly within specialties where recruitment remains difficult. Consequently, succession planning, retention measures and flexible working arrangements remain important considerations in workforce planning.

Definitive regional data on early retirement trends among consultants is not available due to the complexity of HSC pension arrangements. Nevertheless, available evidence suggests that retirement patterns have remained broadly stable, with most retirements occurring in the early 60s, and does not indicate any significant shift towards either earlier or later retirement among consultants. Ongoing monitoring of retirement patterns remains important given the age profile of the consultant workforce and the potential implications for future workforce supply.

While retirement remains an important workforce planning consideration, the evidence suggests that future workforce sustainability will depend equally on effective recruitment, retention and succession planning strategies to maintain consultant workforce capacity and resilience. Supporting experienced consultants to remain in practice where appropriate, while continuing to develop future consultant workforce supply, will be important in maintaining service delivery, clinical leadership and workforce resilience across Northern Ireland.

### **9.3.5 Consultant Recruitment and Retention**

Consultant recruitment and retention continue to present challenges across HSC Northern Ireland, reflecting a constrained supply of suitably qualified candidates and increasing competition for experienced clinicians. Trusts reported ongoing difficulties

filling vacancies in a number of specialties, with some recruitment campaigns attracting few or no appointable applicants despite repeated advertising. Particular challenges were identified in specialties including Radiology, Anaesthetics, Emergency Medicine, Psychiatry, Microbiology, Care of the Elderly and Hospital at Home services.

Workforce shortages within these specialties continue to place pressure on service delivery and workforce resilience. Difficulties recruiting substantive consultants can increase reliance on locum staffing arrangements, affect continuity of care and place additional workload pressures on existing staff. These challenges also have implications for service development, waiting list management and workforce sustainability.

Consultants are recruited through a range of pathways, including locally trained doctors progressing through postgraduate training programmes, applicants from elsewhere in the UK and international recruitment initiatives. Trusts highlighted the importance of international recruitment in widening the available candidate pool where local workforce supply is insufficient. Organisations also continue to utilise national advertising platforms, targeted recruitment campaigns and recruitment events to support consultant recruitment activity. Further information on regional international recruitment activity is provided in Section 7.10.

While recruitment challenges persist, some Trusts reported positive outcomes from targeted recruitment activity. One organisation reported an increase in consultant and locum consultant starters from 19 in 2024/25 to 27 in 2025/26, demonstrating the potential benefits of sustained recruitment efforts and targeted attraction initiatives. However, leaver data also indicated continued turnover, with resignations accounting for the majority of departures in that organisation during the same period.

Retention pressures were also identified across the region. Workload intensity, service pressures, workforce sustainability concerns, career development opportunities, flexible working arrangements, pay and wider employment conditions were all reported as factors influencing decisions to remain in post or seek opportunities elsewhere. Competition from alternative employment opportunities, including posts within the Republic of Ireland and elsewhere in the UK, continues to influence consultant mobility and workforce retention.

Although comprehensive consultant mobility data is not routinely available, Trusts reported that the increasingly competitive labour market for senior medical staff continues to affect recruitment and retention. The portability of specialist skills, combined with opportunities elsewhere in the UK and Republic of Ireland, means that consultant retention cannot be considered solely within a local labour market context. Maintaining an attractive overall employment offer therefore remains an important component of consultant workforce sustainability.

Available information indicates that resignations account for a significant proportion of consultant turnover in some organisations, exceeding retirements in recent reporting periods. Trusts also highlighted that ongoing consultant turnover contributes to service pressures and, in specialties experiencing recruitment difficulties, can increase reliance on locum staffing and affect continuity of care.

Although Recruitment and Retention Premia (RRP) are available in a small number of hard-to-fill specialties, Trusts advised that consultant recruitment and retention are influenced by a much broader range of factors than financial incentives alone. Workforce planning, career development opportunities, working conditions, workforce wellbeing and service sustainability all remain important considerations.

Overall, the evidence indicates that consultant recruitment and retention continue to be affected by workforce supply constraints and competition for experienced clinicians. While organisations continue to utilise local, national and international recruitment routes, challenges in attracting and retaining consultants remain across a number of specialties. Ensuring a sustainable consultant workforce will require continued focus on recruitment, retention, workforce planning and the overall attractiveness of consultant careers within Northern Ireland.

### **9.3.6 Recruitment and Retention Premia (RRP)**

Recruitment and Retention Premia (RRP) are targeted financial supplements available for consultant posts where workforce shortages or labour market pressures create sustained recruitment and retention difficulties. RRP's are intended to support recruitment to hard-to-fill posts and are used on a limited and exceptional basis across HSC Northern Ireland.

Applications for RRP require Departmental approval and must demonstrate evidence of recruitment difficulties, previous recruitment efforts and the need for additional intervention. Trusts are also required to demonstrate that alternative recruitment approaches have been explored and that the proposed use of RRP is supported by relevant clinical and workforce stakeholders.

#### 9.3.6.1 Current Use of RRP

Recruitment and Retention Premia are currently used on a limited and targeted basis across HSC Northern Ireland. A regional approach is maintained to avoid destabilising neighbouring services through local variations in reward arrangements.

Most Trusts reported either no use of RRP or only limited application within hard-to-fill specialties. Where utilised, RRP are generally linked to service-critical consultant vacancies that have proven difficult to fill through conventional recruitment processes.

Current approved applications are concentrated within Psychiatry and Haematology services. At present, RRP are being applied in four areas within the Southern Trust and two areas within the Western Trust.

Recruitment and Retention Premia (RRP) continue to be used only on a limited and targeted basis across Northern Ireland. Current applications are concentrated within a small number of hard-to-fill specialties, particularly Psychiatry. Evidence from Trusts indicates that, while RRP can support recruitment efforts, some services continue to experience significant recruitment difficulties despite the availability of these incentives. In a number of cases, higher levels of RRP have been required following unsuccessful recruitment campaigns at lower premium levels. Detailed information on approved RRP arrangements is provided within Annex 6.

#### 9.3.6.2 Impact of RRP

Evidence from Trusts suggests that RRP can support recruitment and retention efforts in certain circumstances, particularly within specialties experiencing longstanding recruitment difficulties. However, RRP are generally most effective when implemented alongside wider workforce measures, including recruitment campaigns, workforce planning initiatives, international recruitment and service redesign.

The Department also recognised the severe workforce pressures affecting Psychiatry services and introduced additional temporary RRP flexibility to support recruitment within this specialty. Trusts are able to apply a higher premium where previous recruitment attempts at lower levels have proven unsuccessful.

Despite the availability of RRPs, recruitment challenges continue to persist within a number of specialties. Trusts reported that workforce shortages, limited applicant supply and wider labour market competition remain significant barriers to recruitment.

#### 9.3.6.3 Limitations of RRP

Trusts consistently advised that RRPs should be viewed as one component of a broader workforce strategy rather than a standalone solution to workforce shortages. Consultant recruitment and retention are influenced by a range of factors including workload, career development opportunities, flexible working arrangements, workforce sustainability and wider employment conditions.

Trusts also noted that widespread use of RRPs may risk destabilising neighbouring organisations or specialties by encouraging workforce movement between services.

One Trust additionally highlighted the absence of comparable arrangements for medical and dental staff working within prison healthcare services, despite equivalent Agenda for Change staff receiving a recruitment and retention allowance.

The Department recognises that the current RRP arrangements were developed in a different workforce context and that labour market conditions have changed significantly in recent years. Consideration is therefore being given to reviewing existing arrangements to ensure they remain fit for purpose, support recruitment to hard-to-fill specialties and appropriately reflect developments across other UK healthcare systems. Any future review would consider workforce evidence, affordability, workforce sustainability and the experience of other UK jurisdictions.

Overall, Recruitment and Retention Premia provide a useful, targeted intervention within a small number of hard-to-fill consultant specialties. While available evidence suggests that RRPs can support recruitment and retention in some circumstances, they do not in themselves resolve underlying workforce shortages. The evidence indicates that RRPs are most effective when used alongside wider workforce planning,

recruitment and retention initiatives designed to improve long-term workforce sustainability and service resilience.

### **9.3.7 Consultant Contract Reform**

The Department would be interested in exploring the possibility of wider consultant contract reform when resources and capacity allow. Any future reform would need to support workforce sustainability, service delivery and the recruitment and retention of consultants across Northern Ireland.

Evidence provided by Trusts indicates broad agreement that there is scope to modernise consultant contractual arrangements so that they better reflect contemporary service models, workforce expectations and patient demand. Trusts noted that consultant contractual arrangements have remained largely unchanged for over two decades, despite significant developments in healthcare delivery, including service transformation, elective recovery programmes, digital innovation, workforce pressures and increasing cross-site working.

A recurring theme across Trust responses was the potential for contract reform to improve workforce flexibility and support more effective deployment of consultant time. Trusts highlighted opportunities to align consultant working patterns more closely with service demand, including supporting evening and weekend activity, improving responsiveness to patient need and facilitating more flexible approaches to job planning. These changes were viewed as having the potential to improve access to care, reduce service pressures and support the delivery of more sustainable services.

Trusts also identified opportunities to improve the operation of consultant job planning arrangements. Greater flexibility in the allocation of consultant time across Direct Clinical Care (DCC), Supporting Professional Activities (SPA) and service development activity was viewed as a potential means of improving service efficiency. At the same time, organisations stressed the continued importance of maintaining sufficient SPA time to support education and training, clinical governance, quality improvement, leadership, research and service development.

Several Trusts highlighted the potential recruitment and retention benefits of contract reform. Improved flexibility, greater transparency in contractual arrangements and a more contemporary employment offer were all identified as factors that could enhance

the attractiveness of consultant roles. Greater recognition of workload, career development opportunities and flexible working arrangements were also considered important in supporting workforce morale, recruitment and retention.

Trusts further noted that contract reform could help support wider service transformation and workforce sustainability by improving alignment between consultant availability and service demand, supporting new models of care and enabling more flexible approaches to service delivery. Some organisations also highlighted the potential to better support less-than-full-time consultants and retain experienced consultants later in their careers.

However, Trusts were clear that contract reform alone would not resolve the wider workforce challenges affecting consultant services. Any reform would need to be accompanied by wider action addressing workforce supply, recruitment difficulties, pay competitiveness, workload pressures, workforce wellbeing and service sustainability. Trusts also emphasised the importance of meaningful engagement with consultants and consistent implementation arrangements across organisations.

Overall, Trusts considered that consultant contract reform has the potential to modernise working arrangements, improve workforce flexibility and better align consultant activity with contemporary service requirements. Potential benefits include enhanced workforce sustainability, improved recruitment and retention, greater responsiveness to service need and more effective deployment of consultant capacity. However, any future reform would need to be considered as part of a broader programme of workforce and service reform and balanced against affordability, workforce wellbeing and wider service priorities.

### **9.3.8 Conclusion**

Consultants remain central to the delivery of safe, effective and high-quality healthcare across Northern Ireland, providing clinical leadership, specialist expertise, education, research and service development across a wide range of specialties. The consultant workforce has grown in recent years and continues to make a critical contribution to service delivery, workforce development and the wider sustainability of Health and Social Care services.

The evidence presented within this chapter demonstrates both the strengths and challenges of the consultant workforce. While initiatives such as targeted recruitment activity, international recruitment, selective use of Recruitment and Retention Premia and ongoing workforce development initiatives continue to support workforce stability, recruitment and retention challenges remain evident across a number of specialties. Workload pressures, workforce shortages, retirement risks and increasing competition for experienced clinicians continue to affect workforce resilience and service delivery.

Trusts also highlighted the importance of pay, reward and recognition in maintaining an attractive consultant employment offer. The continued absence of an active Clinical Excellence Awards scheme in Northern Ireland has remained a concern for consultants and their representative bodies, while wider discussions regarding consultant contract reform have highlighted opportunities to modernise working arrangements and better align consultant activity with contemporary service requirements. However, affordability remains a significant consideration. Any future developments in relation to consultant reward arrangements, Clinical Excellence Awards or contractual reform would require both initial and recurring financial investment and would need to be considered alongside wider public sector pay policy, competing workforce priorities and the overall financial position of Health and Social Care services. The Department therefore considers that any future reforms must balance workforce sustainability and service delivery objectives with affordability and value-for-money considerations.

Alongside pay and contractual arrangements, career development opportunities, flexible working arrangements, workforce wellbeing and succession planning will remain important factors in supporting consultant recruitment and retention. As a significant proportion of the consultant workforce approaches retirement age, ensuring adequate workforce supply and supporting the retention of experienced consultants will remain key workforce planning priorities.

Overall, consultants will continue to play a pivotal role in meeting increasing service demand and supporting future healthcare transformation across Northern Ireland. Ensuring that consultant careers remain attractive, sustainable and aligned with modern service requirements will be critical to maintaining workforce resilience,

supporting patient care and delivering long-term service sustainability across Health and Social Care services in Northern Ireland.

## **9.4 Community Dental Service (CDS)**

### **9.4.1 Overview of the Community Dental Service Workforce**

The Community Dental Service (CDS) provides dental care for patients who are unable to access treatment through General Dental Services due to age, disability, medical complexity or additional support needs. The service plays an important role in supporting some of the most vulnerable patient groups in Northern Ireland, including people with learning disabilities, complex medical conditions, severe mental health conditions and those requiring specialist or community-based dental care.

Community Dentists are employed under the Community Dental Services (Northern Ireland) Terms and Conditions of Service (2015), which introduced a revised contractual framework incorporating job planning, appraisal, competency-based pay progression and training and development arrangements.

Detailed Community Dental Service (CDS) workforce data, including whole-time equivalent (WTE) trends, is provided in Section 11: Workforce Data.

Trusts reported that the CDS workforce remains relatively small and that maintaining workforce capacity can be challenging, particularly given the high proportion of less-than-full-time working and the difficulties associated with securing temporary or locum cover.

### **9.4.2 Recruitment and Retention Challenges**

Recruitment and retention were consistently identified as the most significant workforce challenges affecting Community Dental Services across Northern Ireland.

Trusts reported ongoing difficulties attracting and retaining Community Dentists, citing competition from General Dental Services, private dental practice and opportunities outside Northern Ireland. Pay competitiveness, flexible working opportunities, career progression and wider employment conditions were all identified as factors influencing recruitment and retention decisions.

A recurring concern was the limited availability of senior and specialist posts within Community Dental Services. Trusts reported that experienced dentists can face limited

opportunities for progression once they reach the top of the Dental Officer scale, contributing to difficulties retaining experienced staff.

Competition from private dentistry and alternative employment opportunities continues to affect workforce supply. Trusts reported that some staff have reduced their HSC commitments or left the service entirely in favour of other opportunities.

The workforce profile also presents challenges. The CDS workforce contains a high proportion of less-than-full-time staff and maternity leave can create significant workforce pressures where temporary cover cannot be secured.

There were 4 leavers during 2025/26, which equated to a 4.7% leaver rate. Note that there were also 6 joiners during 2025/26.

As at 31<sup>st</sup> March 2026 there were 3 vacancies in active recruitment.

#### **9.4.3 Workload, Demand and Service Pressures**

Trusts reported increasing demand for Community Dental Services and growing complexity among the patient groups receiving care.

A substantial increase in referrals from General Dental Services has been reported across the region, reflecting wider pressures within Health Service dentistry. Trusts advised that Community Dental Services are increasingly acting as a safety-net service for vulnerable patients who are unable to access treatment elsewhere.

Workforce pressures have been compounded by:

- Increasing patient complexity.
- Rising waiting lists.
- Reduced access to theatre sessions.
- Limited specialist support.
- Growing demand from vulnerable patient groups.

Trusts also reported that oral health inequalities continue to affect vulnerable populations, including older people, children and individuals with complex health needs.

Many organisations highlighted concerns regarding service sustainability, noting that workforce growth has not kept pace with increasing demand.

#### **9.4.4 Workforce Profile, Activity and Vacancies**

Available workforce data indicate variation in workforce size and staffing patterns across Community Dental Services.

Trusts reported a workforce characterised by:

- Relatively small clinical teams.
- Significant levels of part-time working.
- Difficulties recruiting to vacant posts.
- Challenges securing temporary cover.
- Limited availability of locum staff.

Regional vacancy data indicates that vacancies continue to exist within Community Dental Services despite ongoing recruitment activity.

The available evidence also suggests that long recruitment processes can contribute to extended periods of vacancy, creating additional pressure on existing staff and reducing clinical capacity.

#### **9.4.5 Reward, Career Progression and Workforce Development**

Trust evidence suggests that while the current reward framework provides a consistent structure for pay progression and employment conditions, it does not always fully support career development and progression within Community Dental Services.

Trusts highlighted concerns regarding:

- Pay competitiveness.
- Limited progression opportunities.
- Restricted access to specialist posts.
- Limited specialist career pathways.
- The absence of some specialist roles available in other UK jurisdictions.

Through engagement between the Department of Health, Trusts and staff representatives, workforce planning, recruitment, retention, specialist career pathways and workforce development have all been identified as priority areas for future action.

The current limited number of specialist training and progression opportunities may affect workforce retention and the attractiveness of Community Dental Services as a long-term career option.

#### **9.4.6 Workforce Wellbeing and Morale**

Workforce wellbeing and morale emerged as significant themes throughout Trust evidence.

Trusts reported that increasing workloads, workforce shortages, waiting list pressures and growing patient complexity are affecting morale across Community Dental Services. A number of organisations highlighted concerns regarding stress, burnout and workforce fatigue.

Staff also reported concerns regarding:

- Limited opportunities for progression.
- Increasing service demand.
- Workforce capacity pressures.
- Reduced time for preventive and developmental work.
- Challenges associated with managing increasingly complex patients.

Trusts advised that these factors may affect job satisfaction, retention and the long-term sustainability of the CDS workforce.

Maintaining workforce wellbeing was therefore identified as an important component of future workforce sustainability.

#### **9.4.7 Conclusion**

Community Dental Services provide essential care for some of the most vulnerable patient groups in Northern Ireland and remain an important component of the wider dental system. While workforce stability has generally been maintained, Trust evidence indicates continuing recruitment and retention challenges, increasing patient complexity, workforce pressures and limited progression opportunities.

Rising demand, increasing referrals from General Dental Services and workforce capacity constraints continue to place pressure on services and contribute to concerns regarding workforce wellbeing and service sustainability.

Ensuring that Community Dental Service careers remain attractive, professionally rewarding and supported by clear development and progression pathways will be important in strengthening workforce supply, improving retention and maintaining access to dental services for vulnerable populations across Northern Ireland.

## 9.5 Locally Employed Doctors (LEDs)

### 9.5.1 Overview of the Locally Employed Doctor Workforce

Locally Employed Doctors (LEDs) are doctors working in non-training roles, often on fixed-term or service contracts, outside formal specialty training pathways. While definitions vary slightly across organisations, LEDs are generally employed to provide workforce flexibility, support service delivery and address gaps that cannot be filled through substantive recruitment or postgraduate training pathways.

Trust evidence indicates that LEDs form an increasingly important component of the medical workforce across Northern Ireland and are employed across a wide range of specialties and grades. These roles support service delivery, rota resilience and continuity of care, particularly in areas experiencing workforce shortages and recruitment difficulties.

**Table 28 – Number of LEDs being paid at Resident Doctor and Dentist pay scales**

| Trust         | WTE    |
|---------------|--------|
| Belfast       | 101.65 |
| Northern      | 11.00  |
| South Eastern | 30.30  |
| Southern      | 76.15  |
| Western       | 104.15 |
| Total         | 323.25 |

*Source: HRPTS at 31<sup>st</sup> March 2026*

Overall, LEDs have become an important source of workforce capacity within Health and Social Care services and increasingly support frontline service delivery across a number of specialties.

### 9.5.2 Contribution to Service Delivery and Workforce Capacity

Trust evidence indicates that LEDs make a significant contribution to workforce capacity across Northern Ireland. These doctors support service continuity, maintain safe staffing levels and provide resilience in the context of workforce shortages, rota gaps and service pressures.

LEDs are employed across a broad range of specialties including General Medicine, Emergency Medicine, Paediatrics, Orthopaedics, General Surgery, Psychiatry and

Oral and Maxillofacial Surgery. Evidence suggests that LEDs are increasingly supporting core service provision rather than simply providing short-term cover.

Trusts reported that LED roles are commonly used where:

- training numbers are insufficient to meet service demand;
- substantive recruitment has proven difficult;
- workforce shortages have created service pressures;
- additional rota capacity is required.

Information on direct employment locum consultant vacancies actively being recruited across HSC Trusts by specialty is provided in Section 11: Workforce Data Evidence from Trusts suggests that increasing reliance upon LED roles reflects wider workforce supply challenges affecting the medical workforce.

Overall, LEDs play a significant role in maintaining service delivery and supporting workforce resilience across Northern Ireland.

### **9.5.3 Workforce Profile and Employment Arrangements**

Trusts reported significant variation in the size and composition of their LED workforce, reflecting differences in service pressures, workforce requirements and organisational models.

LEDs are typically employed across a variety of grades and roles including:

- Clinical Fellows;
- Locum Appointment for Service (LAS) doctors;
- Locum Consultants;
- Locum Specialty Doctors;
- Hospital Practitioners;
- Salaried GPs.

Most LED appointments are fixed-term or temporary in nature and are commonly used to support service delivery where national recruitment or training pathways have been unable to provide sufficient workforce supply.

Trust evidence indicates that locally employed contracts generally mirror nationally agreed medical and dental terms and conditions applicable to the grade concerned. However, some local variation was reported in areas such as:

- contractual arrangements;
- leave entitlements;
- access to training and development opportunities;
- probationary arrangements.

Where working-hours data was available, LEDs were predominantly employed on full-time contracts and frequently participated in resident doctor rotas, on-call arrangements and out-of-hours services.

#### **9.5.4 Recruitment, Retention and Career Progression**

Trust evidence highlighted a number of challenges relating to recruitment, retention and career progression within the LED workforce.

While LEDs provide valuable workforce flexibility and support service delivery, many organisations reported that these roles often sit outside established career progression structures. Trusts noted that access to professional development opportunities, structured career pathways and formal progression routes can vary considerably.

A recurring theme within the evidence was that LEDs often serve as a transitional workforce group, with many individuals progressing into:

- specialty training programmes;
- substantive SAS posts;
- consultant posts.

While this demonstrates the value of LED roles as part of the wider workforce pipeline, it can also contribute to workforce turnover and reduced continuity.

Trusts also identified opportunities to better integrate LED experience within wider medical workforce structures. Some organisations highlighted potential benefits from recognising relevant LED service experience within formal training and career progression frameworks.

The Department recognises that LEDs represent a distinct workforce group whose roles, responsibilities and career pathways differ from those of doctors in formal training programmes.

Overall, Trusts considered that strengthening career development opportunities, improving workforce support arrangements and enhancing progression pathways could help improve retention and workforce stability.

#### **9.5.5 Workforce Planning, Data and Future Development**

Trusts reported that current workforce systems do not always allow LEDs to be identified consistently. A number of organisations highlighted the need for:

- a regionally agreed definition of LEDs;
- improved workforce coding arrangements;
- standardised workforce reporting;
- improved visibility of LED workforce data.

Improved workforce information would support more robust workforce planning by providing greater insight into:

- workforce numbers;
- specialty distribution;
- recruitment and retention patterns;
- workforce progression pathways;
- workforce supply risks.

Trusts also highlighted the potential value of a more standardised regional approach to LED contracts and terms and conditions.

The Department recognises that LEDs may require a distinct workforce strategy and is supportive of further work, including collaboration across the four UK nations, to consider the future development of more consistent contractual and workforce arrangements for this staff group.

#### **9.5.6 Opportunities and Risks**

Trusts identified both benefits and risks associated with increasing reliance on the LED workforce.

##### **9.5.6.1 Opportunities**

LEDs provide:

- workforce flexibility;

- rapid deployment into vacant roles;
- improved rota resilience;
- support for service continuity;
- reduced reliance on agency staffing.
- Trusts also highlighted the important contribution LEDs make in maintaining services where substantive recruitment remains challenging.

#### 9.5.6.2 Risks

Trusts reported that continued reliance on LEDs may create workforce challenges including:

- reduced continuity of care;
- increased induction and supervision requirements;
- higher workforce turnover;
- variation in contractual arrangements;
- limited career progression opportunities;
- workforce planning complexity.

Several Trusts noted that frequent turnover can reduce workforce stability and create additional recruitment, training and onboarding costs.

Evidence also suggested that extensive use of LEDs may mask underlying workforce shortages and delay implementation of longer-term workforce solutions.

Overall, Trusts considered that LEDs provide an important workforce resource. However, maximising the benefits of this workforce group will require improved workforce planning, clearer development pathways, greater standardisation and enhanced workforce data.

#### **9.5.7 Conclusion**

Locally Employed Doctors have become an increasingly important component of the medical workforce across Northern Ireland and provide essential workforce flexibility, service capacity and rota resilience. Trust evidence indicates that LEDs play a significant role in maintaining service continuity and addressing workforce shortages across a range of specialties.

However, the evidence also highlights that LEDs represent a distinct workforce group whose career pathways, contractual arrangements and workforce needs do not always align with those of doctors in training or substantive medical staff. Continued reliance on LED roles reflects wider workforce supply challenges and underlines the need for improved workforce planning, better workforce data and clearer development pathways.

The Department therefore considers that further work to strengthen understanding of the LED workforce, improve workforce information and explore more consistent contractual and workforce arrangements will be important in ensuring that LEDs continue to contribute effectively to service delivery and long-term workforce sustainability across Northern Ireland.

## **9.6 Salaried General Practitioners Working in Secondary Care**

Salaried General Practitioners (GPs) working in secondary care within HSC are employed directly by HSC Trusts to provide medical services across a range of hospital and community settings. These roles are typically focused on delivering generalist medical care within secondary care and integrated care services, including intermediate care, ambulatory care, specialist clinics and community-based services. Their responsibilities commonly include providing care to patients who do not require consultant-led specialist intervention, supporting discharge planning, and contributing to multidisciplinary teams. They play an important role in supporting patient pathways across the interface between primary and secondary care.

These doctors are distinct from salaried GPs employed within general practice. While primary care salaried GPs provide ongoing care to registered practice populations, salaried GPs in secondary care work within Trust-managed services and are integrated into hospital and community care pathways. Their contribution has become increasingly important in supporting service continuity, addressing medical workforce gaps and improving patient flow across the health and social care system.

There is currently no regionally agreed contractual framework for salaried GPs employed by HSC Trusts. As a result, Trusts have developed local arrangements over time based on a range of existing medical and dental contracts and pay models. These arrangements are not applied consistently across organisations and may be based on

salaried GP pay scales, Specialty Doctor terms and conditions, Consultant arrangements, locally agreed rates, or other recruitment and retention mechanisms.

An initial review of current arrangements identified that one Trust applies the salaried GP pay scale contained within the Medical and Dental Pay Circular, while other Trusts utilise alternative arrangements, including alignment with Specialty Doctor or Consultant roles, GP Out of Hours arrangements, GPwSI arrangements, or locally determined sessional rates. Pay and contractual arrangements therefore vary considerably between organisations despite the broadly similar nature of the work undertaken.

The absence of a standardised framework creates challenges for workforce planning, recruitment and retention. It can also result in differences in remuneration and employment conditions for doctors undertaking comparable roles in different organisations. As the use of salaried GPs within secondary care services continues to develop, consideration may need to be given to whether existing arrangements remain appropriate and whether a more consistent regional approach would support workforce sustainability, service delivery and organisational mobility.

The Department intends to undertake further work to better understand the size, composition and employment arrangements of this workforce group and, subject to available resources, consider the development of more consistent regional terms and conditions.

## **Section 10 - Staff Experience**

### **10.1 Pensions**

Pension arrangements remain an important component of the overall employment offer for medical and dental staff. Pension-related issues can influence recruitment, retention, retirement decisions and workforce sustainability. The HSC Pension Scheme forms an important part of the overall reward package available to staff and recent pension reforms, greater retirement flexibility and changes to pension taxation may influence the extent to which experienced staff remain in employment beyond traditional retirement points. This section outlines recent pension developments and their potential implications for workforce sustainability across Health and Social Care in Northern Ireland.

#### **10.1.1 Consideration of Additional Pension Flexibilities**

The Department of Health has not undertaken any formal consideration of additional pension flexibilities that would allow staff to reduce their pension contributions whilst retaining the value of active scheme membership. The HSC Pension Service has confirmed that it has no comments or evidence to provide in relation to this matter.

Consequently, no analysis, modelling or policy development work has been undertaken regarding additional pension flexibilities, and no evidence is available to support further comment.

The Department has, however, implemented and supported existing pension flexibilities available through the HSC Pension Scheme, including partial retirement and retire-and-return arrangements. These are discussed in the following sections.

#### **10.1.2 Retirement Trends and Workforce Re-entry**

Due to the structure of HSCNI pension arrangements, it is not possible to provide definitive data on early retirement trends. However, Trusts do hold some data on the number of full and partial retirees, as well as those who choose to return to work after retirement. It is important to note that staff may hold benefits across multiple schemes, each with different retirement ages and rules, which makes consistent classification of early retirement unfeasible at Trust level.

Table 15 provides the total number of retirees reported by Trusts during 2025/26.

**Table 29: Retirees per Trust in 2025/26 for all HSC Staff**

| <b>Trust</b>               | <b>Total no. of retirees</b> | <b>No. of employees at retirement age (Aged Under 66*)</b> | <b>No. of employees below retirement age (Aged Before 66*)</b> |
|----------------------------|------------------------------|------------------------------------------------------------|----------------------------------------------------------------|
| <b>Southern Trust</b>      | 179                          | 74                                                         | 105                                                            |
| <b>Western Trust</b>       | 215                          | N/A                                                        | N/A                                                            |
| <b>Belfast Trust</b>       | 351                          | 264                                                        | 21                                                             |
| <b>South Eastern Trust</b> | 178                          | 61                                                         | 117                                                            |
| <b>Northern Trust</b>      | 138                          | N/A                                                        | N/A                                                            |

*Source: HSC Trusts*

\*Age 66 has been used as a reporting threshold based on the UK State Pension Age and should not be interpreted as a definitive classification of normal or early retirement.

Note - Data was not available from all Trusts for the breakdown of retirees by age, therefore totals may not equal the sum of the age categories presented.

While caution should be exercised when interpreting retirement data due to differences in pension scheme arrangements and retirement ages, the evidence indicates that a significant number of staff continue to leave the workforce each year through retirement. Retirement therefore remains an important workforce planning consideration, particularly given the demographic profile of many professional groups the loss of experienced staff and the corresponding need for succession planning, knowledge transfer and workforce renewal.

Trusts reported ongoing use of both partial retirement and retire-and-return arrangements during 2025/26. Partial retirement enables staff to access a proportion of their pension while remaining in employment, whereas retire-and-return arrangements allow staff to return to work following retirement. The level of uptake reported by Trusts varied considerably, as shown in Table 30. As Trusts record these arrangements differently, the figures are not directly comparable.

**Table 30: Staff continuing in employment following retirement-related arrangements**

| Trust                      | Number of staff                              | Details                                                                                                                                               |
|----------------------------|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Southern Trust</b>      | 167 Partial Retirement                       | Of the 167 staff; 144 (86%) were aged under 66 and 23 (14%) over 66.                                                                                  |
| <b>Western Trust</b>       | 40 Partial Retirement; 2 Retire and Return   | Enquiry level remains consistent regarding partial retirement. Partial retirement is underutilised.                                                   |
| <b>Belfast Trust</b>       | 291 Partial Retirement; 6 Retire and Return  | The majority of retirement-related workforce participation was through partial retirement rather than Retire and Return arrangements.                 |
| <b>South Eastern Trust</b> | 70 Retire and Return                         | 70 of 117 staff retiring aged under 66 returned to work, including 61 (52%) on Bank contracts and 9 (8%) on temporary Retire and Return arrangements. |
| <b>Northern Trust</b>      | 187 Partial Retirement; 49 Retire and Return | Of the 49 staff specified; 46 were in Bank roles and 3 in part-time substantive roles following retirement.                                           |

*Source: HSC Trusts*

The growing use of partial retirement and retire-and-return arrangements suggests that pension flexibility is increasingly supporting workforce retention. These arrangements enable experienced staff to remain economically active while accessing pension benefits and may help retain valuable skills, experience and organisational knowledge within the HSC workforce.

While the available evidence suggests that these flexibilities support retention, no quantitative assessment of their impact on workforce capacity or service delivery has been provided.

Overall, while the structure of HSC pension arrangements means that early retirement cannot be consistently identified across Trusts, available evidence indicates that a number of staff continue in, or return to, the workforce through partial retirement and retire-and-return arrangements. However, approaches to recording these arrangements vary across Trusts and do not currently support a comprehensive regional assessment of retirement behaviour, workforce re-entry trends or the overall impact of these arrangements on workforce sustainability.

The total number of GP's and Dental Practitioners who retired on Voluntary Early Retirement (VER) for period 01/04/2025 to 31/03/2026 is 40 (18 Dentists, 22 GP's) with 9 Dentists and 12 GP's indicating a return to work after retirement.

Information on VER has only been provided for GPs and Dental Practitioners. Equivalent information for other HSC staff groups is not available and therefore the data presented below should not be interpreted as representing retirement trends across the wider HSC workforce.

**Table 31 – Number of members who took VER for years 2022/23 to 2025/26**

| Year                    | GP's and Dental Practitioners |
|-------------------------|-------------------------------|
| 01/04/2022 – 31/03/2023 | 18                            |
| 01/04/2023 – 31/03/2024 | 16                            |
| 01/04/2024 – 31/03/2025 | 26                            |
| 01/04/2025 – 31/03/2026 | 40                            |

The increase in voluntary early retirement activity during 2025/26, combined with the number of retirees subsequently returning to work, suggests that pension flexibility continues to play an important role in enabling experienced clinicians to remain within the workforce while accessing retirement benefits.

### **10.1.3 Pension Scheme Opt-Outs**

Information on pension scheme opt-outs has only been provided for GPs and Dental Practitioners. Equivalent information for other HSC staff groups is not available at the time of submission of this report and therefore the data presented below should not be interpreted as representing opt-out trends across the wider HSC workforce.

**Table 32 - Pay levels for the opt outs for GPs and Dental Practitioners for 2025/2026**

| <b>Pay Level</b>     | <b>Opt Outs</b> |
|----------------------|-----------------|
| £0 to £50,000        | 24              |
| £50,000 to £70,000   | 6               |
| £70,000 to £100,000  | 6               |
| £100,000 to £150,000 | 26              |
| £150,000 +           | 1               |
| <b>Total</b>         | <b>63</b>       |

The overall number of Out Outs for GP's and Dental Practitioners in the year 2025/26 increased by 21 on the year 2024/25. For those who opted out the main reasons given were personal/financial reasons.

While the reasons provided are primarily personal and financial, opt-out behaviour remains an important workforce consideration as pension participation forms a key component of the overall employment offer for medical and dental staff.

#### **10.1.4 Impact of Pension Tax Changes**

The HSC Pension Scheme view is that the long-term value of scheme membership remains significant and that, despite the continued application of pension tax charges in some circumstances, the vast majority of members continue to benefit from participation in the scheme.

The changes to the Annual Allowance and the abolition of the Lifetime Allowance announced in the Spring 2023 Budget remain broadly welcomed by HSC Pension Scheme members and their representatives. It is anticipated that these changes may reduce the pension taxation concerns previously experienced by some higher earners and support continued participation in both the HSC workforce and the HSC Pension Scheme.

The introduction of flexible retirement arrangements for 1995 Scheme members in December 2024 was also welcomed. These arrangements provide members with greater flexibility in managing their pension benefits and may enable some individuals

to use partial retirement as a means of mitigating future Annual Allowance growth while remaining in employment.

Collectively, these changes may reduce some of the pension-related factors that have previously influenced retirement decisions and workforce participation among experienced staff. Greater flexibility, alongside changes to pension taxation arrangements, may support the retention of experienced employees by enabling them to remain in employment while making informed decisions about retirement and pension planning.

#### **10.1.5 Retention Measures Related to Pensions**

No specific actions were taken to address the impact of pension taxation changes on workforce retention. Pension taxation policy is determined by the UK Government and HM Treasury and is therefore outside the direct control of the Department of Health. The Department considers pension-related matters as part of its wider approach to workforce sustainability, recruitment and retention.

While pension taxation policy remains outside the Department's control, recent pension reforms and retirement flexibilities may support workforce retention by providing staff with greater choice regarding retirement planning and workforce participation. Measures such as partial retirement, retire-and-return arrangements and other pension flexibilities enable experienced staff to remain in employment while accessing pension benefits.

Although pension arrangements represent only one component of the overall employment offer, they remain an important consideration for some staff when making decisions regarding retirement, continued workforce participation and long-term career planning. Consequently, pension-related developments continue to be considered within the wider context of workforce sustainability and retention.

#### **10.1.6 Pension Taxation and Additional Programmed Activities for Consultants**

Based on recent feedback from members and HR staff within the trusts, HSC Pension Service believe that the below points have improved the pension taxation situation for clinicians and will encourage them to take on additional PA's

- the changes in methodology in how AA is calculated

- the increase in the allowance to £60,000
- the ability to offset negative growth in one scheme against growth in the other  
e.g. 1995/2015

Collectively, these changes have reduced some of the pension taxation disincentives previously associated with undertaking additional programmed activities.

Trusts reported that pension taxation considerations have contributed to consultants declining additional programmed activities, reducing both contracted and additional programmed activities, and opting not to undertake management responsibilities or other roles that attract additional remuneration. Trusts also reported increased requests for flexible working arrangements, alongside applications for retirement and flexible retirement, which were attributed, at least in part, to pension taxation concerns.

#### **10.1.7 Pension Scheme Membership in Core Training**

The Department notes the findings highlighted by the DDRB regarding pension scheme membership among doctors in core training. Several factors may influence an individual's decision to opt out of scheme membership, including contribution costs and personal financial circumstances. Membership of the scheme remains a matter for individual choice.

#### **10.1.8 Impact of the McCloud Remedy**

Immediate Choice has commenced for those members who retired before the implementation of McCloud. Pension taxation and Annual Allowance will be recalculated based on the member's decision.

We have not processed individual revisions as yet so have no specific data however, it is broadly expected that those that choose to have the remedy period put back into the legacy Scheme as opposed to the CARE scheme will have a lower tax liability. Refunds and revisions to Scheme pays will be processed by HSC PS and HMRC for later years.

At present, the implications for workforce behaviour and retirement decisions remain uncertain. The Department will continue to monitor implementation of the McCloud remedy and any implications for pension taxation, retirement decisions and workforce participation as additional data becomes available.

### **8.2.6 Pension Recycling**

Some staff may be concerned about potential pension tax charges and feel the need to take steps to manage their pension growth. Actions they might consider include:

- Reducing their working hours
- Declining additional paid responsibilities
- Temporarily or permanently opting out of the HSC Pension Scheme
- Accessing their pension and leaving HSC employment
- Retiring and returning to work, often on reduced hours

While these decisions may help individuals manage their pension tax liabilities, they can also result in reduced clinical capacity and impact service delivery. To help retain experienced senior clinicians within the HSC, the Department of Health introduced a model Pension Recycling policy for HSCNI employers, which was implemented at the end of 2024.

Pension recycling was introduced to help mitigate the risk that experienced staff may reduce their hours, decline additional duties or leave employment due to pension taxation considerations. The policy therefore supports wider workforce sustainability objectives by encouraging the retention of experienced staff and helping maintain workforce capacity.

### **10.1.9 The impact of changes to the pension regime on the retention**

The Department introduced legislation in April 2024 providing the legal framework for the introduction of a package of new retirement flexibilities including pensionable re-employment, partial retirement and removal of the 16-hour rule, for the 1995 Section of the HSC Pension Scheme.

These flexibilities have been designed to offer staff increased options at the end of their careers. This has been welcomed by members and encourages retention of senior doctors and dentists as they can partially retire or return to work seamlessly and continue building pension after retirement if they wish to do so.

These retirement flexibilities provide additional options for senior clinicians and may support retention by enabling experienced doctors and dentists to continue contributing to service delivery while managing retirement transition in a more flexible manner.

### **10.1.10 Conclusion**

Pension arrangements continue to form an important component of the overall employment offer for medical and dental staff and remain an important factor in workforce sustainability, retirement decisions and continued workforce participation. While pension policy and taxation arrangements are largely determined at a UK level, recent changes to pension taxation, the introduction of additional retirement flexibilities and wider pension reforms have generally been welcomed by scheme members and their representatives.

Available evidence indicates that a significant number of staff continue to retire each year, highlighting the importance of workforce planning, succession planning and the retention of experienced employees. The increasing use of partial retirement and retire-and-return arrangements suggests that pension flexibility is supporting workforce participation by enabling experienced staff to remain in or return to employment while accessing pension benefits.

Although the full impact of recent pension reforms is still emerging, measures such as pensionable re-employment, partial retirement, pension recycling and changes to pension taxation arrangements may help reduce some of the pension-related factors that have previously influenced retirement decisions and workforce participation. These measures provide staff with greater flexibility and choice regarding retirement planning and may support the retention of valuable skills, experience and knowledge within the Health and Social Care workforce.

While pensions represent only one element of the overall employment offer, confidence in pension arrangements and access to appropriate retirement flexibilities remain important considerations in supporting workforce retention, maintaining workforce capacity and ensuring the long-term sustainability of Health and Social Care services in Northern Ireland.

## **10.2 Staff Wellbeing, Engagement and Workforce Experience**

### **10.2.1 Introduction**

Staff wellbeing, engagement and workforce experience remain key priorities across Health and Social Care (HSC) in Northern Ireland. Trusts continue to invest in a range of initiatives designed to support physical, psychological and emotional wellbeing,

recognising the important relationship between staff experience, workforce sustainability and the delivery of safe, high-quality patient care.

Across the region, there is increasing emphasis on preventative approaches to wellbeing, staff engagement, flexible working and organisational culture. Trusts recognise that supporting staff wellbeing is not only important for individual employees but also contributes positively to recruitment, retention, attendance, workforce resilience and organisational performance.

### **10.2.2 Staff Engagement and Organisational Culture**

Across the region, Trusts continue to employ a range of local and regional staff engagement approaches aimed at improving workforce experience, supporting wellbeing and strengthening organisational culture. Staff engagement is recognised as an important contributor to workforce sustainability, patient safety and the delivery of high-quality care. Staff engagement activity includes staff experience surveys, pulse surveys, organisational culture assessments, leadership engagement events, coaching and mentoring programmes, staff networks and organisational development initiatives. These mechanisms provide opportunities for staff to share feedback, influence decision-making and contribute to service improvement.

Trusts reported increasing use of structured feedback mechanisms to better understand workforce experience, identify areas for improvement and inform local action planning. Engagement data provides valuable insight into staff perceptions of organisational culture, involvement in decision-making, psychological safety and wellbeing, all of which are recognised indicators of quality and safety within healthcare organisations.

Trusts also highlighted ongoing work to create positive, open and inclusive workplace cultures through initiatives such as Open, Just and Learning Culture programmes, psychological safety training, leadership development activities and staff networks promoting equality, diversity and inclusion. A recurring theme across responses was the importance of visible leadership, effective communication and ensuring staff can clearly see how feedback has informed organisational decisions and service improvement activity. Trusts reported that staff engagement is most effective when individuals feel listened to, valued and involved in decision-making processes.

Overall, Trusts reported that staff engagement contributes positively to workforce wellbeing, morale, workforce stability and service improvement. Evidence suggests that staff who feel valued and engaged are more likely to contribute positively to team performance, patient experience and organisational improvement.

### **10.2.3 Health and Wellbeing Policies and Regional Framework**

Trusts implement a range of staff wellbeing initiatives in line with the Department of Health's *Strengthening Our Core Regional Framework*. Introduced in 2024<sup>38</sup>, the Framework recognises that staff wellbeing is integral to workforce sustainability, staff experience and the delivery of safe, high-quality care. It promotes a shift from reactive interventions towards a preventative, whole-system approach focused on culture, leadership and the working environment. Implementation of the Framework is supported by regional governance arrangements, including the establishment of a Regional Operational Group, a regional self-assessment process and the development of shared wellbeing resources, training programmes, communications materials and approaches to wellbeing measurement and evaluation. Trusts reported increasing collaboration in the development and delivery of wellbeing initiatives across the region.

In keeping with the Framework, Trusts reported increasing emphasis on prevention and early intervention. This includes investment in:

- Occupational Health services.
- Psychological wellbeing support.
- Counselling and stress management programmes;
- Critical incident support arrangements.
- Coaching and mentoring programmes.
- Leadership development.
- Wellbeing champions and peer support networks.
- Health promotion initiatives.
- Financial wellbeing support.
- Flexible working arrangements.

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<sup>38</sup> [Strengthening Our Core: A Regional Framework for HSC Staff Health and Wellbeing in the Workplace](#) | Department of Health

- Menopause support initiatives;
- Support for carers and staff with additional needs; and
- Domestic and sexual violence support programmes.

Trusts reported that wellbeing initiatives are increasingly informed by staff feedback, organisational culture assessments and workforce engagement activity, wellbeing forums and listening exercises.. These mechanisms help identify emerging workforce needs and support continuous improvement of wellbeing programmes and support arrangements. Trusts also highlighted the importance of organisational culture and compassionate leadership in supporting workforce wellbeing. Manager wellbeing training, leadership development initiatives, reflective practice opportunities and team-based wellbeing approaches have all been introduced to strengthen workplace support arrangements and promote psychological safety.

Evidence provided by Trusts indicates that wellbeing initiatives contribute positively to workforce resilience, staff engagement, attendance and staff experience. Trusts highlighted that supporting staff wellbeing can help mitigate the impact of stress and burnout, improve workforce resilience and strengthen continuity of care. The evidence also suggests a positive relationship between workforce wellbeing, service quality and patient experience.

Early evidence suggests that the Strengthening Our Core Framework is helping to provide greater consistency and structure to staff wellbeing approaches across Health and Social Care organisations. Trusts reported positive outcomes in relation to wellbeing awareness, workplace

Overall, Trusts reported that wellbeing initiatives are contributing positively to workforce resilience, wellbeing awareness, workplace culture and access to support. However, organisations also noted that the effectiveness of wellbeing initiatives remains closely linked to wider workforce pressures, including staffing shortages, workload intensity and increasing service demand. While wellbeing initiatives are making a positive contribution, sustained improvements in workforce experience and wellbeing will require continued investment in both workforce support arrangements and wider workforce capacity.

#### **10.2.4 Flexible Working and Flexible Retirement**

Flexible working continues to be an important component of workforce policy across Health and Social Care organisations. Trusts reported increasing demand for flexible working arrangements as staff seek to balance work with health conditions, caring responsibilities, education, work-life balance and other personal commitments.

Trusts recognise that flexible working can support recruitment, improve staff retention and contribute positively to workforce wellbeing. Flexible working arrangements are also viewed as an important mechanism for supporting workforce diversity and retaining experienced staff.

Flexible retirement has also become an increasingly important workforce consideration. Traditional models of retirement are evolving, with many staff seeking opportunities to reduce their working commitments gradually while continuing to contribute to service delivery.

The Department introduced a range of retirement flexibilities, including partial retirement arrangements, to support staff approaching retirement age. These measures are intended to help retain experienced staff, reduce the sudden loss of expertise and support workforce continuity. Trusts reported considerable interest in these arrangements and noted that retaining experienced clinicians for longer can provide important benefits for patient care, workforce development and succession planning. Information on the uptake of partial retirement and retire-and-return arrangements is provided at Section 10.1.2 Retirement Trends and Workforce Re-entry.

Overall, Trusts reported that flexible working and retirement arrangements contribute positively to workforce wellbeing, workforce retention and workforce sustainability.

#### **10.2.5 Pension Recycling**

Some staff may be concerned about potential pension tax liabilities and may take action to manage pension growth. These actions may include reducing working hours, declining additional paid responsibilities, opting out of the HSC Pension Scheme, retiring earlier or retiring and subsequently returning to work. While these decisions may assist individual staff members in managing pension taxation, they can also reduce workforce capacity and create challenges for service delivery.

To support retention of experienced staff, the Department introduced a model Pension Recycling Policy for HSC employers at the end of 2024. The policy is intended to provide additional flexibility and encourage experienced staff to remain in employment where appropriate. Trusts reported that pension flexibility measures have the potential to support workforce retention and help maintain workforce capacity, particularly amongst senior clinical staff and those approaching retirement age.

### **10.2.6 Medical and Dental Staff Wellbeing**

In addition to Trust-wide wellbeing initiatives, a number of programmes are in place to support doctors and dentists at different stages of their careers.

#### **10.2.6.1 Medical and Dental Workforce Wellbeing Challenges**

While a wide range of workforce wellbeing initiatives and support mechanisms are in place, Trusts and medical workforce groups continue to report challenges associated with increasing service demand, workforce shortages, workload intensity, rota pressures and growing patient complexity. These pressures can affect morale, increase the risk of fatigue and burnout, and create challenges for recruitment, retention and workforce sustainability.

The evidence presented throughout this report indicates that workforce wellbeing is closely linked to staffing levels, workload management, career development opportunities and access to appropriate professional support. As a result, wellbeing initiatives are increasingly being integrated into broader workforce planning and workforce sustainability arrangements across the HSC.

#### **10.2.6.2 Medical Training**

NIMDTA's Professional Support and Wellbeing Team provides confidential support to trainees, including career counselling, mentoring, coaching, educational assessments, Occupational Health referrals, counselling services and educator training.

#### **10.2.6.3 Single Lead Employer (SLE)**

Doctors employed through the Single Lead Employer model have access to wellbeing support through both host organisations and regional services. Support includes access to Occupational Health services, NIMDTA wellbeing services, counselling support and wider wellbeing resources.

#### 10.2.6.4 SAS Doctors and Dentists

The SAS Career Development Programme supports wellbeing through promotion of professional identity, workforce recognition, career development opportunities and support for career progression. During 2025/26, activities included dedicated wellbeing events, development opportunities and access to one-to-one support through the Associate SAS Dean and Deputy Associate Dean.

Overall, targeted wellbeing arrangements continue to support doctors and dentists across a range of career stages and contribute positively to workforce wellbeing, engagement and professional development.

#### 10.2.6.5 Consultants and Senior Medical Staff

Trust evidence also highlighted the importance of flexible working arrangements, flexible retirement options and effective job planning processes in supporting the wellbeing of consultants and senior medical staff. Consultants continue to report workforce pressures associated with persistent vacancies, increasing service demand and additional programmed activity requirements in some specialties.

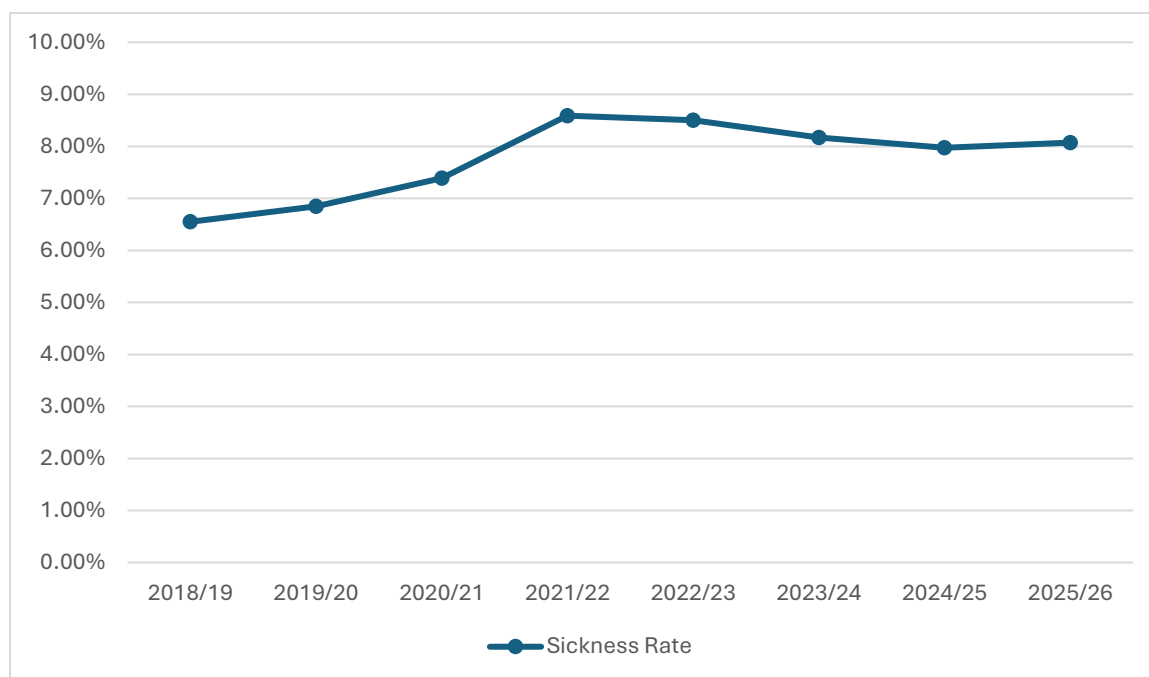
Trusts reported that initiatives such as flexible working, partial retirement, improved job planning arrangements and support for work-life balance can contribute positively to workforce wellbeing, retention and workforce sustainability. These measures are particularly important in supporting the retention of experienced clinicians and helping to maintain workforce capacity within specialties experiencing recruitment difficulties.

Across all medical and dental workforce groups, wellbeing is increasingly recognised as a key component of workforce sustainability. Initiatives such as Protected Self Development Time for Resident Doctors, improved rota management, enhanced rest facilities, New to Northern Ireland (N2NI) support arrangements, SAS career development initiatives, flexible working arrangements and retirement flexibility measures all seek to improve workforce experience, strengthen retention and support long-term workforce resilience. Collectively, these measures demonstrate an increasing focus on creating supportive working environments that enable staff to develop, remain engaged and continue delivering high-quality patient care.

### 10.2.7 Mental Health and Stress-Related Absence

Sickness absence data indicates that workforce wellbeing remains an important consideration across Health and Social Care services.

**Chart 5 - HSC Sickness Rates (% of hours lost)**



During 2025/26, mental health reasons accounted for 39.5% of all HSC absence hours lost due to sickness absence or industrial injury.

Further information on HSC sickness rates, including the percentage of hours lost due to sickness absence or industrial injury, is provided in Section 11: Workforce Data.

While overall sickness absence rates have stabilised in recent years, the proportion attributable to mental health highlights the continuing importance of workforce wellbeing, psychological support and preventative interventions. Trusts reported that high workload intensity, workforce shortages, increasing service demand and organisational change can all contribute to stress-related absence and affect workforce resilience.

The significant contribution of mental health-related absence to overall sickness absence demonstrates the importance of sustaining investment in wellbeing initiatives, psychological support services and workplace cultures that promote resilience, openness and early intervention.

### **10.2.8 Conclusion**

Staff wellbeing, engagement and workforce experience remain important components of workforce sustainability across Health and Social Care in Northern Ireland. Trusts continue to invest in staff wellbeing, engagement, flexible working and workforce support initiatives, recognising the relationship between staff experience, workforce retention and patient care.

The implementation of the Strengthening Our Core framework, increasing emphasis on preventative wellbeing approaches and continued investment in psychological support, occupational health services and workforce engagement initiatives demonstrate a regional commitment to improving staff experience and workforce resilience.

However, Trusts consistently highlighted that wellbeing initiatives alone cannot fully offset wider workforce pressures. Staffing shortages, increasing demand, workload intensity and service pressures continue to affect staff wellbeing, engagement and workforce sustainability.

Overall, the evidence suggests that proactive approaches to wellbeing, engagement, flexible working and workforce support are contributing positively to workforce resilience, organisational culture and staff experience. Continued investment in both workforce wellbeing and workforce capacity will be essential to supporting retention, reducing sickness absence and ensuring the delivery of safe, effective and sustainable health and social care services across Northern Ireland.

## **10.3 Productivity**

### **10.3.1 Productivity and Service Delivery**

Productivity within Health and Social Care (HSC) is complex and cannot be assessed through activity levels alone. Instead, productivity must be considered within the context of increasing patient complexity, rising service demand, patient safety requirements, workforce capacity and workforce wellbeing. As a result, productivity within HSC is assessed using a range of clinical, operational, workforce and quality indicators rather than through a single standardised measure.

Across the region, Trusts reported evidence of increased activity, throughput and service delivery improvements across a number of clinical pathways, particularly within elective care and outpatient services. Examples included increased outpatient attendances, higher levels of elective activity and improvements in measures such as patient non-attendance rates, theatre utilisation and waiting list validation.

A common theme across Trust responses was that productivity is closely linked to workforce capacity. Workforce shortages, vacancies, staff turnover, retirements, recruitment and retention difficulties, and increasing uptake of flexible working and retirement flexibilities continue to influence service capacity and operational performance.

Productivity improvements have been supported through service redesign, increased utilisation of existing capacity, improved patient flow and scheduling, enhanced triage processes, waiting list validation, targeted waiting list initiatives and expanded use of digital transformation initiatives. Trusts reported a range of initiatives designed to maximise available capacity and improve service delivery, including:

- Outpatient pathway redesign;
- Elective care centres;
- Pathway standardisation
- Enhanced triage models;
- Waiting list validation;
- Improvements in theatre utilisation and scheduling;
- Reduction in delayed discharges; and
- Digital transformation initiatives.

Trusts further emphasised that productivity should be considered alongside quality and patient outcomes, as increases in activity alone do not necessarily indicate improved productivity. Several organisations highlighted that productivity gains are frequently offset by increasing patient complexity, rising emergency care demand and ongoing workforce pressures, therefore they must be balanced against workforce sustainability, staff wellbeing and the delivery of safe and effective care.

Evidence provided by Trusts demonstrates ongoing efforts to maximise service capacity despite significant operational challenges. For example, one Trust reported

a 3.9% increase in unscheduled emergency care attendances, a 1.1% increase in inpatient and day case activity, a 10% increase in consultant-led outpatient attendances and a 26.7% increase in nurse-led outpatient attendances during 2025/26. The Trust also reported reductions in inpatient and day case waiting lists (10.5%) and new outpatient waits (3.1%), alongside increased activity across a range of social care services.

Trusts consistently reported that increased activity levels have been supported by significant workforce effort. Additional programmed activity, service flexibility and medical and dental staff working beyond their core contractual commitments were all identified as factors contributing to increased throughput and service delivery. While these measures have supported operational performance and waiting list recovery, Trusts expressed concern regarding the long-term sustainability of relying on additional workforce effort to deliver productivity gains.

Overall, Trusts reported evidence of productivity improvement across a range of services. However, these improvements continue to be delivered within a challenging operating environment characterised by increasing demand, workforce shortages, financial constraints and wider system pressures like substantial waiting list backlogs. The need to deliver productivity gains alongside the Department's Reset and Recovery Plan reinforces the importance of continued service transformation, workforce development, digital innovation and sustainable productivity improvement across Health and Social Care services.

### **10.3.2 Workforce Capacity and Working Patterns**

Average working hours vary considerably across medical and dental staff groups and are influenced by contractual arrangements, rota design, on-call commitments, less-than-full-time working, vacancies and service demand. The available evidence suggests that the most significant trend is not necessarily a change in contractual hours, but rather changes in workforce capacity and how available hours are deployed to maintain services.

For Consultants, evidence indicates that average job plans remain around or above the standard contractual commitment of 10 Programmed Activities (PAs), equivalent to 40 hours per week. Trusts reported average consultant job plans ranging from approximately 9.5 PAs (38 hours per week) to 11.37 PAs (45.5 hours per week), with

an overall reported average of approximately 10.64 PAs (42.6 hours per week). Some consultants continue to undertake substantially higher levels of programmed activity to support service delivery.

For SAS doctors, average job plans remain broadly aligned with established contractual commitments, although variation exists between specialties and organisations. Trusts reported average SAS job plans ranging from approximately 8.87 PAs (35.5 hours per week) to 10.73 PAs (42.9 hours per week), with an overall average of around 9.51 PAs (38.0 hours per week).

For Resident Doctors, available evidence suggests that working patterns are influenced primarily by rota design, training numbers and increasing uptake of less-than-full-time working. Single Lead Employer data indicated average working hours of approximately 38.22 hours per week during 2026.

Community Dentists generally work within established contractual arrangements with average reported working hours ranging from approximately 19 to 30 hours per week, although variation exists between grades and organisations.

Across all medical and dental workforce groups, Trusts consistently identified increasing patient demand, workforce shortages, vacancies, service recovery pressures and rota gaps as key factors influencing working patterns. While changing workforce preferences and flexible working arrangements support wellbeing and retention, they can also reduce available workforce capacity unless accompanied by corresponding workforce growth.

Overall, the evidence does not indicate a consistent regional trend towards either increasing or decreasing contractual working hours. Rather, workforce capacity is increasingly affected by workforce shortages and changing working patterns, resulting in additional pressure on existing staff in some services.

### **10.3.3 Productivity Growth and Efficiency Targets**

Trusts reported continued efforts to improve productivity and operational efficiency through service redesign, workforce initiatives and digital transformation programmes. Measures implemented included reductions in agency utilisation, expansion of bank staffing arrangements, length of stay initiatives, enhanced workforce deployment

processes, improved rostering arrangements and the application of quality improvement methodologies.

While evidence of increased activity and improved patient throughput was reported across a range of services, Trusts indicated that progress towards productivity and efficiency objectives continues to be constrained by wider system pressures. These include sustained growth in demand, increasing patient complexity, workforce shortages, high bed occupancy levels, delayed discharges and ongoing financial constraints.

Trusts also reported challenges associated with establishing consistent productivity baselines following the implementation of new digital systems and changes to performance reporting arrangements. These factors have, in some cases, limited the ability to compare productivity performance over time and assess progress against efficiency objectives.

Several Trusts reported that current efficiency expectations require productivity gains that are increasingly challenging to achieve within existing operational constraints. Productivity improvement programmes comprise a combination of recurrent and non-recurrent measures and, while efficiency savings continue to be delivered, organisations noted that opportunities for further efficiencies are becoming increasingly limited. Trusts expressed concern regarding the diminishing availability of non-recurrent savings and highlighted that future productivity improvement is likely to require more fundamental service transformation and wider system reform.

Overall, Trusts continue to pursue productivity and efficiency improvements across services. However, achieving sustained productivity growth will depend upon continued transformation, digital innovation, workforce sustainability and wider system reform to address the capacity pressures facing Health and Social Care services.

#### **10.3.4 Productivity and Workforce Sustainability**

Trusts consistently reported that recent productivity gains and workforce sustainability are closely linked and are dependent in part upon workforce flexibility, additional programmed activity, overtime working and the continued commitment of staff to maintaining service delivery in the face of workforce pressures.

A common theme across Trust responses was that workforce capacity remains a significant determinant of productivity. Vacancies, staff turnover, recruitment and retention difficulties, retirements and workforce shortages continue to affect service delivery and limit organisational flexibility. While retirement flexibilities and retire-and-return arrangements have supported workforce participation in some areas, workforce supply constraints continue to affect the pace and scale of productivity improvement.

While these approaches have supported increased activity, throughput and service resilience, concerns were raised regarding the long-term sustainability of relying on additional workforce effort to maintain productivity improvements. Organisations emphasised that sustained reliance on workforce goodwill and additional effort may have implications for workforce wellbeing, retention, morale and burnout.

Trusts noted that productivity is routinely affected by the need to prioritise urgent and time-critical services. Delayed discharges, patient flow challenges, increasing patient complexity and ongoing workforce pressures can limit elective throughput and reduce opportunities for further productivity gains.

Trusts highlighted that future productivity gains are most likely to be achieved through service redesign, workforce development, digital transformation, improved patient pathways and investment in workforce capacity rather than through continued increases in workload intensity. Several organisations noted that opportunities to secure further productivity gains solely through additional workforce effort are becoming increasingly limited and that longer-term improvement will require broader system transformation.

Maintaining workforce wellbeing and workforce sustainability was identified as an important consideration when assessing future productivity performance. Trusts reported that sustainable productivity improvement depends on ensuring that workforce capacity keeps pace with service demand and that staff remain supported, engaged and able to work effectively.

Overall, productivity and workforce sustainability are closely linked. Long-term improvements in productivity will require continued investment in workforce supply, workforce development, service transformation and digital innovation alongside wider efforts to improve efficiency and patient flow.

### **10.3.5 Conclusion**

Overall, Trusts reported evidence of productivity improvement across a range of services, including increased activity levels, higher patient throughput and improved utilisation of available capacity. These gains have been supported through service redesign, workforce flexibility, digital transformation and operational improvement initiatives.

However, significant challenges remain. Increasing demand, workforce shortages, financial pressures and substantial waiting list backlogs continue to limit progress in some services. Trusts also highlighted concerns regarding the long-term sustainability of productivity gains that rely heavily on additional workforce effort and flexibilities.

Continued progress will therefore depend on a combination of workforce investment, service transformation, digital innovation and productivity improvement initiatives that support both service delivery and long-term workforce sustainability. Trusts consistently emphasised that productivity and workforce sustainability are closely linked, and that sustainable productivity improvement depends upon maintaining workforce wellbeing, supporting retention and ensuring workforce capacity keeps pace with service demand.

Achieving future efficiencies alongside the Department's broader transformation and financial recovery objectives will require sustained focus on workforce capacity, service redesign and the efficient use of available resources across Health and Social Care services in Northern Ireland.

## **10.4 Learning and Development Opportunities for the Medical and Dental Workforce**

### **10.4.1 Overview**

Learning and development opportunities form an important component of the overall employment offer for medical and dental staff across Health and Social Care in Northern Ireland. Access to education, training, leadership development and professional learning supports workforce capability, career progression, recruitment, retention and workforce sustainability. Trusts, the Northern Ireland Medical and Dental Training Agency (NIMDTA) and the HSC Leadership Centre continue to provide a

range of local, regional and national development opportunities for medical and dental staff throughout their careers.

#### **10.4.2 Professional Development Opportunities**

Trusts reported that a wide range of learning and development opportunities are available to medical and dental staff across the HSC. These include:

- Corporate induction and welcome programmes.
- Coaching and mentoring opportunities.
- Leadership and management development programmes.
- Training in communication and interpersonal skills.
- Health and wellbeing learning initiatives.
- Appraisal and revalidation support.
- Quality improvement and service improvement programmes.
- Equality, diversity and inclusion training.
- Digital skills and transformation programmes.

Trusts highlighted that access to professional development opportunities helps support workforce engagement, career progression and workforce retention, while also contributing to service improvement and patient care.

#### **10.4.3 Regional Leadership and Workforce Development Programmes**

Regional learning and development opportunities continue to be delivered through NIMDTA and the HSC Leadership Centre.

Examples include:

- Interview skills programmes.
- Confident communication training.
- Human Factors and Patient Safety education.
- Coaching and mentoring programmes.
- Clinical leadership development.
- Quality improvement training.
- Workforce and service transformation learning programmes.

These initiatives support the development of future clinical leaders while helping staff build the skills required to contribute to service redesign, workforce development and organisational improvement.

#### **10.4.4 Medical and Dental Workforce Development**

Additional learning and development opportunities are available for specific medical and dental workforce groups.

For Doctors and Dentists in Training, learning and development opportunities are supported through study leave arrangements, protected educational time, education programmes and professional support services coordinated through NIMDTA.

For SAS doctors and dentists, the SAS Career Development Programme, Associate SAS Dean, SAS Leads and SAS Development Fund provide access to targeted development opportunities, leadership programmes, mentoring and career progression support.

For Consultants, Supporting Professional Activities (SPAs) provide dedicated time for education, training, appraisal, research, quality improvement, leadership and service development activities.

Trusts reported that these arrangements support professional growth, workforce capability and longer-term workforce sustainability across medical and dental staff groups.

#### **10.4.5 Conclusion**

Learning and development remain important contributors to workforce capability, staff engagement and workforce sustainability across Health and Social Care services in Northern Ireland. Access to education, leadership development, mentoring, coaching and professional development opportunities supports career progression, workforce retention and service improvement. Continued investment in learning and development will remain important in maintaining a skilled, adaptable and sustainable medical and dental workforce capable of meeting future service demands.

## **10.5 Staff Experience, Motivation and Morale**

### **10.5.1 Staff Survey Arrangements**

HSC employers have developed a specification to commence procurement of a provider to undertake the next Regional HSC Staff Survey. However, Human Resources and Organisational Development teams across the HSC are currently heavily engaged in the final stages of development and implementation of the Equip system, the new regional HR, Finance and Procurement system scheduled for introduction in late 2026. Given the scale and importance of the Equip programme, HSC employers have taken the decision to postpone the next Regional HSC Staff Survey during 2026/27 due to limited staff capacity to support both programmes simultaneously. Planning for the next Regional HSC Staff Survey will recommence following successful implementation of Equip.

In the absence of a current Regional Staff Survey, Trusts continue to utilise a range of alternative mechanisms to understand workforce experience, motivation and morale. These include staff engagement and pulse surveys, organisational culture assessments, Investors in People assessments, staff feedback forums, trade union engagement, workforce indicators and wider employee voice mechanisms.

### **10.5.2 Staff Engagement, Motivation and Morale**

Regionally, there is limited formal data available regarding motivation and morale within the medical and dental workforce. Trusts therefore rely on a combination of workforce indicators, engagement mechanisms, organisational culture assessments and staff feedback to inform understanding of workforce experience.

Trusts reported positive findings relating to staff pride, professional commitment, teamwork and workforce engagement. Staff engagement activity across organisations includes staff surveys, pulse surveys, leadership engagement activities, coaching and mentoring programmes, staff networks, wellbeing initiatives and organisational development interventions. These mechanisms provide opportunities for staff to share feedback, influence decision-making and contribute to service improvement.

Survey responses and engagement data provide insight into staff perceptions of organisational culture, involvement in decision-making, psychological safety and

wellbeing, all of which are recognised indicators of quality and safety within healthcare organisations.

#### 10.5.2.1 GMC National Training Survey

Additional insight into workforce experience is available through the General Medical Council (GMC) National Training Survey, which assesses trainee experience across a range of indicators including overall satisfaction, workload, supervision, teamwork, patient safety and workplace culture.

The 2025 survey findings for Northern Ireland were generally positive and compared favourably with UK averages in a number of areas. Overall, 84.3% of doctors in training rated the quality of their training experience as good or very good, compared with 83.6% across the UK. Similarly, 74.2% rated the quality of their induction as good or very good compared with 73.8% across the UK.

The survey also highlighted positive findings in relation to teamwork and workplace culture, with 90.1% of trainees agreeing that their organisation encouraged a culture of teamwork between healthcare professionals, compared with 89.0% across the UK. In addition, 88.8% reported that their training environment was supportive and inclusive, matching the UK average.

A number of indicators also compared favourably with UK benchmarks in relation to workforce wellbeing and patient safety. 62.5% of trainees reported often or always feeling worn out at the end of the working day, slightly lower than the UK average of 63.6%. Similarly, 8.9% reported concerns relating to patient safety compared with 12.3% across the UK, while 5.5% reported experiencing or witnessing bullying or harassment compared with 7.9% across the UK.

These findings suggest that, despite ongoing workforce pressures, doctors in training in Northern Ireland report generally positive experiences in relation to training quality, teamwork, workplace support and patient safety when compared with UK benchmarks.

Further information on trainee experience and selected findings from the 2025 GMC National Training Survey are provided at Annex 7, including Figure 7: Summary of Selected Findings from the 2025 GMC National Training Survey.

The full 2025 GMC NTS findings are published on the GMC's website<sup>39</sup>

Available evidence indicates that medical and dental staff continue to demonstrate a strong commitment to patient care and service delivery despite significant operational pressures. However, Trusts consistently reported that workforce shortages, vacancies, rota gaps, financial pressures, increasing service demand and workload intensity continue to affect morale and workforce experience.

A Trust Culture Survey reported positive levels of workforce engagement and motivation, with scores exceeding comparable NHS staff survey benchmarks. Areas identified for improvement included psychological safety, confidence in speaking up, involvement in decision-making, workload support, wellbeing and career development opportunities. Similar themes were highlighted through organisational culture and Investors in People assessments.

The Single Lead Employer also reported generally positive feedback regarding continuity of employment and support provided through the model. However, some concerns were raised regarding communication and employment transitions between training stages. In addition, a significant volume of employee relations casework relating to pay and rota issues was reported during the year, indicating ongoing workforce concerns.

Pay and reward also remain important influences on morale. Industrial relations activity during 2026 demonstrated continuing dissatisfaction amongst parts of the medical and dental workforce regarding pay and wider employment matters. Trusts advised that industrial action and ongoing disputes can have a broader impact on morale, workforce stability and organisational culture.

Overall, available evidence suggests that morale across the medical and dental workforce reflects a balance between strong professional commitment and continuing operational pressures. While staff remain highly committed to patient care, workforce shortages, workload pressures, service demand and concerns regarding reward and recognition continue to affect workforce experience and morale.

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<sup>39</sup> General Medical Council

### **10.5.3 Workforce Views on Pay and Reward**

In the absence of a formal regional staff survey specifically examining pay satisfaction, Trusts draw on a range of proxy indicators to understand workforce views on pay and reward. These include organisational culture surveys, Investors in People assessments, workforce indicators, employee voice mechanisms, recruitment performance and industrial relations activity.

Available evidence suggests that pay remains an important component of workforce morale, recruitment and retention. However, workforce experience is influenced by a much broader range of factors, including workload, working conditions, leadership, recognition, flexibility, wellbeing and career development and progression opportunities.

Investors in People assessments provided useful insight into staff perceptions of reward and recognition. Two Trusts reported holding Silver Investors in People accreditation. Findings from one Trust's 2025-26 assessment indicated that while pay, terms and conditions form an important part of the overall reward offer, only 41.6% of staff felt that existing reward arrangements aligned with their personal motivations, while 56.8% reported feeling appropriately valued and appreciated in their role. Although these findings extend beyond pay alone, they provide useful evidence regarding how staff perceive reward, recognition and value within the workplace.

Trusts also reported that wider workforce indicators can provide indirect insight into staff satisfaction with pay. Recruitment difficulties, retention challenges, vacancy levels and reliance on temporary staffing may reflect, in part, perceptions regarding pay competitiveness when compared with alternative employment opportunities that offer different pay, conditions or flexibility.

Employee voice mechanisms, including trade union engagement, focus groups, staff networks, pay-related queries and grievance processes, were identified as valuable sources of workforce intelligence. Feedback received through these mechanisms highlighted ongoing concerns regarding pay competitiveness and reward.

Industrial relations activity provides a further indicator of workforce sentiment regarding pay and conditions. While participation in industrial action cannot be regarded as a direct measure of pay satisfaction, support for industrial action across

different branches of medical practice demonstrates that pay and related employment issues remain significant concerns for sections of the medical and dental workforce.

Recruitment performance and applicant behaviour provide a further indicator of workforce perceptions of pay and reward. Trusts reported reduced applicant numbers and recruitment difficulties in some occupations where pay may be perceived as less competitive than alternative employment opportunities especially the private sector or in Republic of Ireland, particularly when considered alongside workload pressures, role complexity and wider employment conditions.

Overall, workforce indicators, organisational assessments, employee voice mechanisms, industrial relations activity and trade union engagement suggest that pay continues to influence workforce morale, recruitment and retention. However, these factors operate alongside wider considerations including workload, wellbeing, flexible working opportunities, career development and organisational culture. In the absence of a current regional staff survey, a definitive assessment of pay satisfaction cannot be made, although the available evidence provides important insight into workforce perceptions of the overall employment offer.

#### **10.5.4 Conclusion**

Available evidence suggests that medical and dental staff remain highly committed to delivering services despite continuing operational pressures across the HSC. In the absence of a current Regional HSC Staff Survey, Trusts have relied on a range of alternative sources, including engagement activity, organisational assessments, workforce indicators, employee voice mechanisms and trade union feedback, to understand staff experience, motivation and morale.

These sources indicate that staff continue to demonstrate strong professional commitment, teamwork and dedication to patient care. However, they also highlight ongoing challenges relating to workload pressures, workforce shortages, wellbeing, recognition and perceptions of pay competitiveness, particularly amongst lower-paid staff groups.

While pay remains an important factor influencing morale, recruitment and retention, workforce experience is shaped by a broader range of factors including leadership, organisational culture, flexibility, career development opportunities and staff wellbeing.

The Department and HSC employers will continue to work in partnership with staff and trade unions to strengthen the overall employment offer, support workforce wellbeing and ensure that HSC employment remains attractive, sustainable and rewarding.

## Section Eleven – Workforce Data

**Table 33 – Medical & Dental Staff by HSC Trust as at 31 March 2026**

|                            | Total Headcount | Total WTE |
|----------------------------|-----------------|-----------|
| <b>Belfast Trust</b>       | 1,266           | 1,164.8   |
| <b>Northern Trust</b>      | 493             | 446.9     |
| <b>South Eastern Trust</b> | 605             | 531.9     |
| <b>Southern Trust</b>      | 651             | 583.2     |
| <b>Western Trust</b>       | 574             | 544.0     |
| <b>Regional Services*</b>  | 2,518           | 2,283.8   |
| <b>Total</b>               | 6,082           | 5,554.7   |

*Source: Department of Health, Information and Analysis Branch*

\*The majority of Medical & Dental staff in this category are Resident doctors in training programmes with NI Medical & Dental Training Agency, who are the single lead employer for Resident Doctors in training programmes.

**Table 34 - Medical and Dental vacancies being actively recruited to across HSC organisations**

| Profession                                         | Belfast Trust | Northern Trust | South Eastern Trust | Southern Trust | Western Trust | Public Health Agency | Total |
|----------------------------------------------------|---------------|----------------|---------------------|----------------|---------------|----------------------|-------|
| <b>Consultant</b>                                  | 35            | 21             | 6                   | 34             | 44            | 2                    | 142   |
| <b>Locum Consultant</b>                            | 12            | 0              | 2                   | 0              | 14            | 2                    | 30    |
| <b>SAS Doctor</b> (Specialist or Specialty Doctor) | 9             | 13             | 1                   | 22             | 21            | 0                    | 66    |
| <b>Resident Doctor*</b>                            | 0             | 0              | 1                   | 0              | 0             | 0                    | 1     |
| <b>Other Doctor</b>                                | 69            | 1              | 0                   | 29             | 23            | 0                    | 122   |
| <b>Dental Officer</b>                              | 0             | 0              | 0                   | 1              | 2             | 0                    | 3     |
| <b>Total Medical &amp; Dental</b>                  | 125           | 35             | 10                  | 86             | 104           | 4                    | 364   |

*Source: HSC Active Recruitment Statistics March 2026*

\*Data relates to Trust local recruitment only and not training programme enrolment.

**Table 35 - Consultant Vacancies Actively Being Recruited in HSC Trusts by Specialty, 31 March 2026\***

| Specialty                                                      | 31 March 2026 |
|----------------------------------------------------------------|---------------|
| Acute/General Medicine                                         | 13            |
| Anaesthetics, ICU, Critical Care Medicine & Retrieval Medicine | 9             |
| Cardiology                                                     | 4             |
| Cellular Pathology                                             | 6             |
| Chemical Pathology                                             | 2             |
| Child and Adolescent Psychiatry                                | 1             |
| Dermatology                                                    | 4             |
| Ear, Nose and Throat                                           | 3             |
| Elderly Care with Stroke Interest                              | 2             |
| Emergency Medicine                                             | 3             |
| Endocrinology/Diabetes                                         | 2             |
| Gastroenterology                                               | 6             |
| Genito-Urinary Medicine                                        | 1             |
| Geriatric Medicine                                             | 2             |
| Haematology                                                    | 3             |
| Haemato-Oncology                                               | 1             |
| Hepatology                                                     | 1             |
| Maternity                                                      | 1             |
| Medical Microbiology                                           | 1             |
| Microbiology                                                   | 2             |
| Neurology                                                      | 3             |
| Neurosurgery                                                   | 1             |
| Obstetrics & Gynaecology                                       | 5             |
| Oncology                                                       | 3             |
| Ophthalmology                                                  | 2             |
| Paediatrics                                                    | 7             |
| Palliative Medicine                                            | 1             |
| Psychiatry                                                     | 28            |
| Radiology                                                      | 11            |
| Rehabilitation Medicine                                        | 1             |
| Respiratory Medicine                                           | 5             |
| Rheumatology                                                   | 1             |
| Stroke Medicine                                                | 1             |
| Surgery                                                        | 1             |
| Trauma & Orthopaedics                                          | 1             |
| Urology                                                        | 2             |
| <b>Total</b>                                                   | <b>140</b>    |

Source: HSC Active Recruitment Statistics March 2026<sup>40</sup>

\*Excludes vacancies in Regional Services.

<sup>40</sup> [Staff vacancies | Department of Health](#)

**Table 36 - Direct Employment Locum Consultant Vacancies Actively Being Recruited in HSC Trusts by Specialty, 31 March 2026\***

| Specialty                      | 31 Mar 2026 |
|--------------------------------|-------------|
| Dentistry                      | 1           |
| Ear, Nose and Throat           | 1           |
| Emergency Medicine             | 2           |
| Haemopathology                 | 1           |
| Hepato Pancreato Biliary (HPB) | 1           |
| Microbiology                   | 1           |
| Neurology                      | 2           |
| Neurosurgery                   | 1           |
| Obstetrics & Gynaecology       | 2           |
| Oncology                       | 1           |
| Ophthalmology                  | 1           |
| Paediatrics                    | 6           |
| Palliative Medicine            | 1           |
| Psychiatry                     | 2           |
| Radiology                      | 1           |
| Stroke                         | 1           |
| Surgery                        | 1           |
| Trauma & Orthopaedics          | 2           |
| <b>Total</b>                   | <b>28</b>   |

*Source: HSC Active Recruitment Statistics March 2026*

\*Excludes vacancies in Regional Services.

**Table 37 - NI Health and Social Care Staff by Gender & Full-Time / Part-Time at 31 March 2025**

|                                                 | Female        | Male          | Full-Time       | Part-Time       |
|-------------------------------------------------|---------------|---------------|-----------------|-----------------|
|                                                 | Headcount*    | Headcount*    | WTE             | WTE             |
| <b>Administration &amp; Clerical</b>            | 11,312        | 3,426         | 10,118.0        | 3,117.0         |
| <b>Ambulance</b>                                | 463           | 817           | 1,175.0         | 79.0            |
| <b>Estates Services</b>                         | 70            | 768           | 812.0           | 14.7            |
| <b>Medical &amp; Dental</b>                     | 3,017         | 2,698         | 4,291.0         | 926.9           |
| <b>Nursing &amp; Midwifery Support</b>          | 4,114         | 742           | 2,584.0         | 1,635.1         |
| <b>Professional &amp; Technical</b>             | 9,173         | 2,236         | 7,305.0         | 2,858.0         |
| <b>Registered Nursing &amp; Midwifery</b>       | 18,582        | 1,450         | 12,786.0        | 5,264.2         |
| <b>Social Services</b> (excl. domiciliary care) | 8,265         | 1,464         | 6,571.0         | 2,277.5         |
| <b>Support Services</b>                         | 3,439         | 3,096         | 2,350.0         | 2,700.6         |
| <b>Total</b>                                    | <b>58,354</b> | <b>16,674</b> | <b>47,992.0</b> | <b>18,873.1</b> |

\*Where individuals hold more than one active post, they are counted once in each category they hold an active post but counted only once in overall totals. Therefore, row and column totals may not sum.

**Table 38 - NI Health and Social Care Staff by Gender & Full-Time / Part-Time at  
31 March 2025**

| Headcount*                                      | Full-Time     |               | Part-Time     |              |
|-------------------------------------------------|---------------|---------------|---------------|--------------|
|                                                 | Female        | Male          | Female        | Male         |
| <b>Administration &amp; Clerical</b>            | 6,940         | 3,170         | 4,404         | 259          |
| <b>Ambulance</b>                                | 390           | 785           | 73            | 32           |
| <b>Estates Services</b>                         | 59            | 753           | 11            | 15           |
| <b>Medical &amp; Dental</b>                     | 1,965         | 2,321         | 1,058         | 380          |
| <b>Nursing &amp; Midwifery Support</b>          | 1,982         | 602           | 2,132         | 141          |
| <b>Professional &amp; Technical</b>             | 5,345         | 1,948         | 3,842         | 293          |
| <b>Registered Nursing &amp; Midwifery</b>       | 11,485        | 1,294         | 7,108         | 157          |
| <b>Social Services (excl. domiciliary care)</b> | 5,326         | 1,235         | 2,949         | 230          |
| <b>Support Services</b>                         | 578           | 1,768         | 2,866         | 1,338        |
| <b>Total</b>                                    | <b>34,059</b> | <b>13,875</b> | <b>24,395</b> | <b>2,835</b> |

\* Where individuals hold more than one active post, they are counted once in each category they hold an active post but counted only once in overall totals. Therefore, row and column totals may not sum.

**Table 39 - HSC Medical & Dental staff, Whole-time Equivalent to Headcount  
ratios by grade at 31<sup>st</sup> March 2026**

| Grade              | Female    |         |       | Male      |         |       |
|--------------------|-----------|---------|-------|-----------|---------|-------|
|                    | Headcount | WTE     | Ratio | Headcount | WTE     | Ratio |
| <b>Consultant</b>  | 976       | 891.0   | 0.91  | 1,326     | 1,256.2 | 0.95  |
| <b>SAS Doctors</b> | 515       | 438.2   | 0.85  | 306       | 300.2   | 0.98  |
| <b>Residents</b>   | 1,512     | 1,401.1 | 0.93  | 997       | 971.1   | 0.97  |
| <b>Other</b>       | 286       | 179.7   | 0.63  | 175       | 117.2   | 0.67  |

**Table 40 - SAS Doctor Vacancies Actively Being Recruited in HSC Trusts by Specialty, 31 March 2026\***

| <b>Specialty</b>                      | <b>31 Mar 2026</b> |
|---------------------------------------|--------------------|
| Acute Medicine                        | 4                  |
| Acute & Ambulatory Paediatrics        | 1                  |
| Ambulatory Medicine                   | 2                  |
| Ambulatory & Geriatric Medicine       | 1                  |
| Anaesthetics                          | 2                  |
| Cardiology                            | 1                  |
| Care Of Elderly                       | 5                  |
| Child and Adolescent Mental Health    | 1                  |
| Ear, Nose and Throat                  | 1                  |
| Emergency Medicine                    | 22                 |
| General Medicine                      | 1                  |
| Haematology                           | 1                  |
| Hospital at Home                      | 1                  |
| Neurology                             | 3                  |
| Obstetrics & Gynaecology              | 3                  |
| Oncology                              | 1                  |
| Ophthalmology                         | 1                  |
| Paediatrics                           | 1                  |
| Psychiatry                            | 2                  |
| Radiology                             | 1                  |
| Respiratory Medicine                  | 2                  |
| Rheumatology                          | 1                  |
| Sexual Assault Referral Centre (SARC) | 2                  |
| Sexual & Reproductive Healthcare      | 2                  |
| Stroke Medicine                       | 1                  |
| Surgery                               | 3                  |
| <b>Total</b>                          | <b>66</b>          |

*Source: HSC Active Recruitment Statistics March 2026*

\*Excludes vacancies in Regional Services.

**Table 41 - 2024/25 HSC Leavers (Headcount) & Leaving Rate, by Staff Group**

| Staff Group                                    | Staff in Post<br>(Headcount)<br># | Leavers      | Leaving<br>Rate (%) |
|------------------------------------------------|-----------------------------------|--------------|---------------------|
| Administration & Clerical                      | 14,656                            | 925          | 6.3%                |
| Ambulance                                      | 1,251                             | 65           | 5.2%                |
| Estates Services                               | 824                               | 48           | 5.8%                |
| Medical & Dental (excl. Resident Doctors)<br>~ | 3,150                             | 179          | 5.7%                |
| Nursing & Midwifery Support                    | 5,078                             | 448          | 8.8%                |
| Professional & Technical                       | 11,143                            | 665          | 6.0%                |
| Registered Nursing & Midwifery                 | 19,711                            | 1,205        | 6.1%                |
| Social Services (excl. domiciliary care)       | 9,481                             | 624          | 6.6%                |
| Support Services                               | 6,547                             | 556          | 8.5%                |
| <b>Total (excl. doctors in training)</b>       | <b>74,039</b>                     | <b>5,202</b> | <b>7.0%</b>         |

Source: HSC Workforce Census March 2025

# Relates to the staff in post position at the end of the previous financial year e.g. for 2024/25, staff in post headcount relates to the position at 31 March 2024.

~ Resident Doctors are excluded from Medical & Dental analysis due to the planned rotation of posts during their training.

**Table 42 - HSC Community Dentists Employed (Whole-Time Equivalent) at 31st March, 2016-2026**

| Position at 31st<br>March: | Whole-time<br>Equivalent |
|----------------------------|--------------------------|
| 2026                       | 64.6                     |
| 2025                       | 65.4                     |
| 2024                       | 66.1                     |
| 2023                       | 67.1                     |
| 2022                       | 66.4                     |
| 2021                       | 67.9                     |
| 2020                       | 67.9                     |
| 2019                       | 64.2                     |
| 2018                       | 65.1                     |
| 2017                       | 63.1                     |
| 2016                       | 63.0                     |

Source: Information and Analysis Directorate, Department of Health

**Table 43 - Consultant Workforce by Age Band (%)**

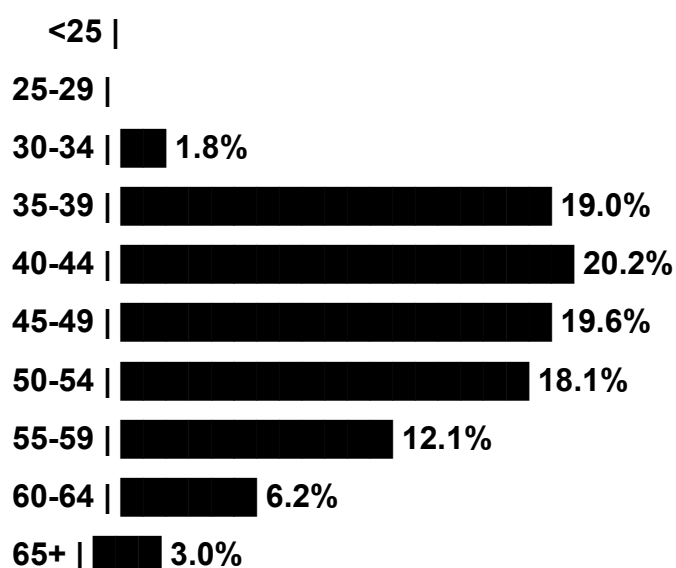


**Table 44 - Medical & Dental staff (headcount) by age group at 31st March 2025**

|                                    | < 25 | 25-29 | 30-34 | 35-39 | 40-44 | 45-49 | 50-54 | 55-59 | 60-64 | 65+ | Total |
|------------------------------------|------|-------|-------|-------|-------|-------|-------|-------|-------|-----|-------|
| <b>Consultants</b>                 |      |       | 40    | 420   | 448   | 433   | 401   | 269   | 137   | 66  | 2214  |
| <b>SAS doctors</b>                 |      | 20    | 100   | 144   | 129   | 121   | 93    | 64    | 29    | 11  | 711   |
| <b>Other Medical &amp; Dental*</b> | 162  | 759   | 1014  | 467   | 183   | 88    | 51    | 41    | 16    | 9   | 2790  |

\*Residents, Dental, GP educators

**Table 45 - Medical & Dental staff (% of total) by age group at 31st March 2025**

|                                    | < 25 | 25-29 | 30-34 | 35-39 | 40-44 | 45-49 | 50-54 | 55-59 | 60-64 | 65+  |
|------------------------------------|------|-------|-------|-------|-------|-------|-------|-------|-------|------|
| <b>Consultants</b>                 | 0.0% | 0.0%  | 1.8%  | 19.0% | 20.2% | 19.6% | 18.1% | 12.1% | 6.2%  | 3.0% |
| <b>SAS doctors</b>                 | 0.0% | 2.8%  | 14.1% | 20.3% | 18.1% | 17.0% | 13.1% | 9.0%  | 4.1%  | 1.5% |
| <b>Other Medical &amp; Dental*</b> | 5.8% | 27.2% | 36.3% | 16.7% | 6.6%  | 3.2%  | 1.8%  | 1.5%  | 0.6%  | 0.3% |

\*Residents, Dental, GP educators

**Table 46 - Average Retirement Age (based on leaver actions data 2025/26 excluding outliers)**

|                    | Range | Average Age |
|--------------------|-------|-------------|
| <b>Consultant</b>  | 55-66 | 60.2        |
| <b>SAS doctors</b> | 58-63 | 60.2        |

Note: excludes ill-health retirement but may include early retirement.

**Table 47 - Direct Employment Locum Consultant Vacancies Actively Being Recruited in HSC Trusts by Specialty, 31 March 2026\***

| Specialty                      | 31 Mar 2026 |
|--------------------------------|-------------|
| Dentistry                      | 1           |
| Ear, Nose and Throat           | 1           |
| Emergency Medicine             | 2           |
| Haemopathology                 | 1           |
| Hepato Pancreato Biliary (HPB) | 1           |
| Microbiology                   | 1           |
| Neurology                      | 2           |
| Neurosurgery                   | 1           |
| Obstetrics & Gynaecology       | 2           |
| Oncology                       | 1           |
| Ophthalmology                  | 1           |
| Paediatrics                    | 6           |
| Palliative Medicine            | 1           |
| Psychiatry                     | 2           |
| Radiology                      | 1           |
| Stroke                         | 1           |
| Surgery                        | 1           |
| Trauma & Orthopaedics          | 2           |
| Total                          | 28          |

Source: HSC Active Recruitment Statistics March 2026

\*Excludes vacancies in Regional Services

**Table 48 - HSC Sickness Rates (percentage of hours lost due to sickness absence or industrial injury)**

|                          | 2018/19 | 2019/20 | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 | 2025/26 |
|--------------------------|---------|---------|---------|---------|---------|---------|---------|---------|
| <b>HSC Sickness Rate</b> | 6.55%   | 6.85%   | 7.39%   | 8.59%   | 8.50%   | 8.17%   | 7.97%   | 8.07%   |

\* Note that the peak of the self-isolation absences occurred during the 'shielding' period at the beginning of the pandemic in 2020. This was not recorded as sickness absence, hence the lower rate in 20/21 compared to the other pandemic years.

## **Annex**

### **Annex Contents**

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## Annex 1 - Strategic Workforce Reviews from the introduction of the Regional HSC Workforce Planning Framework

**Table 49 - Strategic Workforce Reviews from the introduction of the Regional  
HSC Workforce Planning Framework in March 2015: Position at 21 May 2026**

| Profession/Medical Specialty/Programme of Care                                                                                                      | Date completed |
|-----------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| Pathology Services                                                                                                                                  | February 2025  |
| * Psychiatric Specialties                                                                                                                           | July 2024      |
| Mental Health Services                                                                                                                              | July 2023      |
| Dental Services                                                                                                                                     | July 2023      |
| Therapeutic Radiography                                                                                                                             | May 2022       |
| Orthoptics                                                                                                                                          | May 2022       |
| Occupational Therapy                                                                                                                                | May 2022       |
| Music, Art and Drama Therapies                                                                                                                      | May 2022       |
| Dietetics                                                                                                                                           | May 2022       |
| Diagnostic Radiography                                                                                                                              | May 2022       |
| Social Work                                                                                                                                         | March 2022     |
| Pharmacy                                                                                                                                            | September 2020 |
| Speech and Language Therapy                                                                                                                         | August 2020    |
| Prosthetics                                                                                                                                         | August 2020    |
| Podiatry                                                                                                                                            | August 2020    |
| Physiotherapy                                                                                                                                       | August 2020    |
| Clinical Psychology<br>Needs assessment                                                                                                             | February 2020  |
| * Acute Medical Specialties: Acute Internal Medicine; Endocrinology;<br>Gastroenterology; Geriatric Medicine; Respiratory Medicine;<br>Rheumatology | April 2018     |
| * Dermatology                                                                                                                                       | January 2018   |
| * Urology                                                                                                                                           | May 2017       |
| * Neurology                                                                                                                                         | May 2017       |
| * Occupational Medicine                                                                                                                             | May 2017       |
| * Intensive Care Medicine                                                                                                                           | November 2016  |
| * Anaesthetics                                                                                                                                      | November 2016  |
| General Medicine<br>Superseded by the Northern Ireland Medical School Places Review                                                                 | June 2016      |
| * Paediatrics                                                                                                                                       | January 2016   |
| Domiciliary Care                                                                                                                                    | December 2015  |
| Imaging (Radiology)                                                                                                                                 | December 2015  |
| * Emergency Medicine                                                                                                                                | September 2015 |
| * Trauma and Orthopaedics                                                                                                                           | September 2015 |
| * General Practice                                                                                                                                  | June 2015      |
| Nursing and Midwifery                                                                                                                               | May 2015       |
| <b>Profession/Medical Specialty/Programme of Care - Strategic Workforce Review ongoing</b>                                                          |                |
| * Acute Internal Medicine                                                                                                                           |                |
| Cancer Services – Programme of Care (Paused)                                                                                                        |                |
| * Cardiology                                                                                                                                        |                |

|                                                                               |
|-------------------------------------------------------------------------------|
| * Cardiothoracic surgery                                                      |
| Diabetes Services (Specialist) – Programme of Care                            |
| * Emergency Medicine                                                          |
| * Endocrinology and Diabetes                                                  |
| * ENT surgery                                                                 |
| * Gastroenterology                                                            |
| * General surgery (including transplant, breast and gastrointestinal surgery) |
| * Geriatric Medicine                                                          |
| * Haematology                                                                 |
| Learning Disability                                                           |
| * Microbiology, Virology and Infectious Disease                               |
| * Neonatology                                                                 |
| * Neurosurgery                                                                |
| * Obstetrics and Gynaecology                                                  |
| * Ophthalmology                                                               |
| Orthotics                                                                     |
| * Paediatric Intensive Care                                                   |
| * Paediatric surgery                                                          |
| Palliative Care (Specialist) – Programme of Care                              |
| Paramedics                                                                    |
| * Plastic surgery                                                             |
| * Public Health                                                               |
| * Respiratory Medicine                                                        |
| * Rheumatology                                                                |
| Stroke Services – Programme of Care                                           |
| * Vascular surgery                                                            |
| <b>Strategic Workforce Review planned to take place</b>                       |
| * Genitourinary Medicine                                                      |

*Source: Department of Health Workforce Policy*

\* Indicates a Strategic Workforce Review of a medical specialty carried out for the Department of Health by the Public Health Agency

## Annex 2 - Agency and Locum Activity

**Table 50 – Agency hours by HSC Trust**

| HSC Trust           | Agency hours                                                                                                                            |
|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
| Belfast Trust       | 333,742.5                                                                                                                               |
| Northern Trust      | 313,049                                                                                                                                 |
| South Eastern Trust | 228,439                                                                                                                                 |
| Southern Trust      | The Trust engages approximately 100wte locum doctors in longer term bookings (45 consultants, 24 registrar level and 36 ST1/SHO level). |
| Western Trust       | 291,000                                                                                                                                 |

**Table 51 - Internal Medical Locum Activity by HSC Organisation, 2025/26**

| Trust         | Total Number of Shifts | Total Number of Hours Resident and On Call | Total Cost    | Rates Range      |
|---------------|------------------------|--------------------------------------------|---------------|------------------|
| Belfast       | 3920                   | 47449.25                                   | £2,643,993.70 | £12.44 - £125.00 |
| Northern      | 1727                   | 15045.75                                   | £780,289.34   | £12.44 - £125.00 |
| South Eastern | 894                    | 8183.75                                    | £429,417.60   | £12.44 - £90.00  |
| Southern      | 7334                   | 692,49.00                                  | £4,672,050.44 | £10.42 - £165.00 |
| Western*      | 8                      | 126.25                                     | £8,316.64     | £53.06 - £80.00  |
| Regional      | 13883                  | 140,054.00                                 | £8,534,067.72 | £10.42 - £165.00 |

*Source: Business Support Unit, Department of Health*

(NB Western Trust do not routinely utilise Elocums as they have a Trust internal bank system for medical staff)

**Table 52 – NI Agency Framework Hourly Rate\***

| GRADE                                        | Rate Type**  | Mon-Sun (24Hrs)* | On-Call (Availability) * | Public/Bank Holiday* |
|----------------------------------------------|--------------|------------------|--------------------------|----------------------|
| FY1                                          | Lowest rate  | £32.33           | £19.40                   | £48.50               |
|                                              | Highest rate | £39.75           | £23.85                   | £59.63               |
| FY2, CT1, CT2, ST1, ST2                      | Lowest rate  | £47.25           | £28.35                   | £70.88               |
|                                              | Highest rate | £58.00           | £34.80                   | £87.00               |
| ST3, ST4, ST5, ST6, Specialty Doctor         | Lowest rate  | £59.21           | £35.53                   | £88.82               |
|                                              | Highest rate | £72.00           | £43.20                   | £108.00              |
| Consultant, Specialist, Associate Specialist | Lowest rate  | £96.17           | £57.70                   | £144.26              |
|                                              | Highest rate | £118.00          | £70.80                   | £177.00              |

\* Rates including employer contributions but excludes agency fees

\*\* Rate type relates to agency lowest bid rate and the highest agency bid rate across the 58 Agencies on the framework

**Table 53 - Agency Expenditure Reduction**

|                                                              |                    | 2022/23 | 2023/24 | 2024/25 | 2025/26 | 25/26<br>Movement<br>£000's on<br>22/23 | 25/26<br>Movement<br>£000's on<br>24/25 | 25/26<br>Movement<br>% on<br>24/25 |
|--------------------------------------------------------------|--------------------|---------|---------|---------|---------|-----------------------------------------|-----------------------------------------|------------------------------------|
| Medical & Dental                                             |                    | Total   | Total   | Total   | Total   | Total                                   | Total                                   | Total                              |
| Excludes<br>Directly<br>Employed<br>Locums<br>(see<br>below) | Framework<br>spend | 75,455  | 91,957  | 93,046  | 88,832  | 13,377                                  | -4,214                                  | -5%                                |
|                                                              | Off<br>Framework   | 39,447  | 44,136  | 48,904  | 39,377  | -70                                     | -9,527                                  | -19%                               |
|                                                              | Total              | 114,902 | 136,093 | 141,950 | 128,209 | 13,307                                  | -13,741                                 | -10%                               |
| Directly<br>Employed<br>Locums                               | Employed           | 29,386  | 28,673  | 26,766  | 21,528  | -7,858                                  | -5,238                                  | -20%                               |
| Overall total                                                |                    | 144,288 | 164,766 | 168,716 | 149,737 | 5,449                                   | -18,979                                 | -11%                               |

### Annex 3 - International Recruitment

**Table 54 - Westen Trust Internation Medical Recruitment starters by Appointments by Specialty and Grade (01/04/2025 to 31/03/2026)**

| Area               | Consultant | SD        | ST3+     | ST1/2     | FY2      | Total     |
|--------------------|------------|-----------|----------|-----------|----------|-----------|
| Anaesthetics       |            | 3         |          |           |          | 3         |
| COE                |            | 2         |          |           |          | 2         |
| Emergency Medicine |            | 1         |          |           |          | 1         |
| ENT                | 1          | 1         |          |           |          | 2         |
| General Medicine   | 3          | 1         |          | 4         | 3        | 11        |
| Obs & Gynae        |            | 2         |          |           |          | 2         |
| Oncology           |            | 2         | 1        |           |          | 3         |
| Paeds              |            | 2         |          |           |          | 2         |
| Psychiatry         |            | 1         |          | 2         |          | 3         |
| Radiology          | 2          |           |          |           |          | 2         |
| Respiratory        |            | 2         |          |           |          | 2         |
| Sexual Health      |            | 1         |          |           |          | 1         |
| Surgery            | 1          | 1         |          | 2         |          | 4         |
| T&O                |            |           |          | 2         |          | 2         |
| Urology            | 3          |           | 1        |           |          | 4         |
| <b>Total</b>       | <b>10</b>  | <b>19</b> | <b>2</b> | <b>10</b> | <b>3</b> | <b>44</b> |

**Table 55 - Southern Trust IMR Drs Recruited between April 25 – March 26**

| Speciality                          |           |
|-------------------------------------|-----------|
| Medical Education                   | 1         |
| Psychiatry of Old Age               | 1         |
| Paediatrics                         | 2         |
| Medical Ambulatory                  | 1         |
| Trauma & Orthopaedics               | 4         |
| Urology                             | 3         |
| Acute Medicine                      | 2         |
| Salaried Medical Practitioner (OOH) | 4         |
| General Medicine                    | 4         |
| Emergency Medicine                  | 4         |
| Geriatric Medicine                  | 2         |
| Obstetrics & Gynaecology            | 1         |
| Community Paediatrics               | 1         |
| <b>TOTAL</b>                        | <b>30</b> |

**Table 56 – Western Trust: Country Previously Based In**

| Country previously based | Count     |
|--------------------------|-----------|
| GBR                      | 16        |
| IND                      | 6         |
| KSA                      | 5         |
| ROI                      | 4         |
| EGY                      | 3         |
| KWT                      | 2         |
| LKA                      | 2         |
| UAE                      | 2         |
| MYS                      | 1         |
| NGA                      | 1         |
| USA                      | 1         |
| SDN                      | 1         |
| <b>Total</b>             | <b>44</b> |

**Table 57 – Nationality of Western Trust International Recruitment Starters (FY 2025/26)**

| Nationality  | Count     |
|--------------|-----------|
| IND          | 12        |
| EGY          | 10        |
| SDN          | 4         |
| PAK          | 4         |
| LKA          | 3         |
| MYS          | 3         |
| NGA          | 2         |
| JOR          | 1         |
| KEN          | 1         |
| CAN          | 1         |
| ROU          | 1         |
| NPL          | 1         |
| USA          | 1         |
| <b>Total</b> | <b>44</b> |

**Table 58 - Current recruitment pipeline in Western Trust**

| Grade      | Specialty        | Site        |
|------------|------------------|-------------|
| Consultant | Psychiatry       | SWAH        |
| Consultant | Radiology        | SWAH        |
| SD         | Hospital at Home | Altnagelvin |
| ST1/2      | General Medicine | Altnagelvin |
| ST1/2      | General Medicine | Altnagelvin |

## Annex 4 – Doctors and Dentists in Training Data

**Table 59 - Medical Training Uptake and Fill Rates Breakdown by HSC Trust  
and Specialty/Programme (for hospital-based posts)**

| HSC Trust               | Overall Posts | Overall Fill | Overall %Vacant |
|-------------------------|---------------|--------------|-----------------|
| Belfast HSC Trust       | 833           | 89%          | 11%             |
| South Eastern HSC Trust | 281           | 91%          | 7%              |
| Southern HSC Trust      | 252           | 94%          | 6%              |
| Northern HSC Trust      | 272           | 75%          | 25%             |
| Western HSC Trust       | 250           | 89%          | 11%             |
| <b>Total</b>            | <b>1888</b>   | <b>88%</b>   | <b>12%</b>      |

Source: NIMDTA, Single Lead Employer

**Table 60 - Medical Training Uptake and Fill Rates Breakdown by HSC Trust  
and Specialty/Programme (for hospital-based posts)**

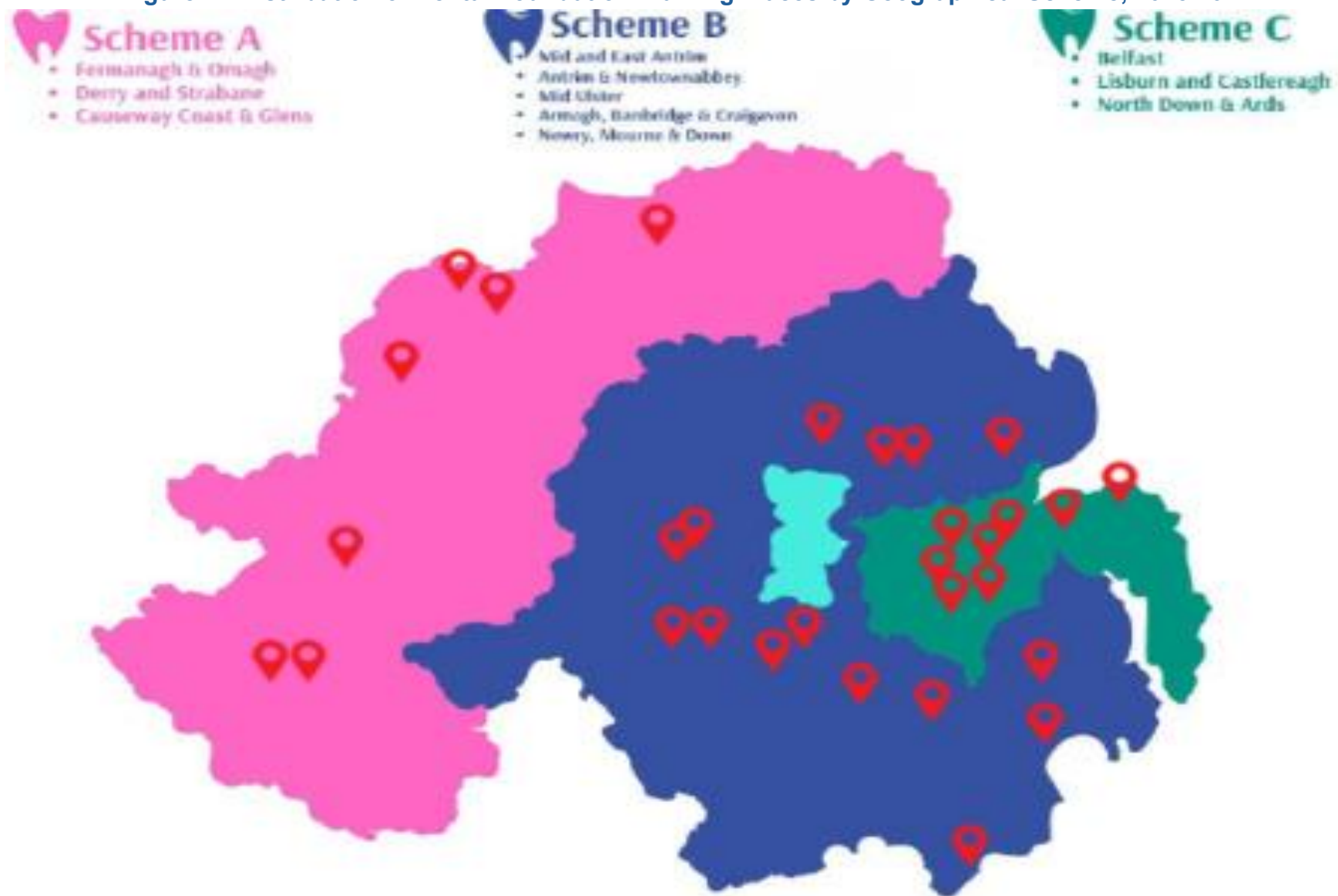
| Specialties                 | Overall Posts | Overall Fill | Overall %Vacant |
|-----------------------------|---------------|--------------|-----------------|
| Foundation                  | 669           | 97.3%        | 2.7%            |
| GP Training                 | 161           | 91.3%        | 8.7%            |
| Anaesthetics                | 134           | 93.3%        | 6.7%            |
| Emergency Medicine          | 71            | 80.3%        | 19.7%           |
| O&G                         | 73            | 90.4%        | 9.6%            |
| Paediatrics                 | 117           | 84.6%        | 15.4%           |
| Radiology                   | 55            | 81.8%        | 18.2%           |
| Histopathology              | 20            | 80.0%        | 20.0%           |
| Internal Medicine Training  | 159           | 84.3%        | 15.7%           |
| Group 1 Medical Specialties | 158           | 64.6%        | 51.9%           |
| Group 2 Medical Specialties | 74            | 71.6%        | 27.0%           |
| Public Health               | 14            | 100.0%       | 0.0%            |
| Core Psychiatry Training    | 40            | 72.5%        | 27.5%           |
| Psychiatric Specialties     | 13            | 61.5%        | 38.5%           |
| Core Surgical Training      | 76            | 96.1%        | 3.9%            |
| Surgical Specialties        | 150           | 89.3%        | 10.7%           |

Source: NIMDTA, Single Lead Employer

**Table 61 - Single Lead Employer (SLE) – Average Contracted Hours**

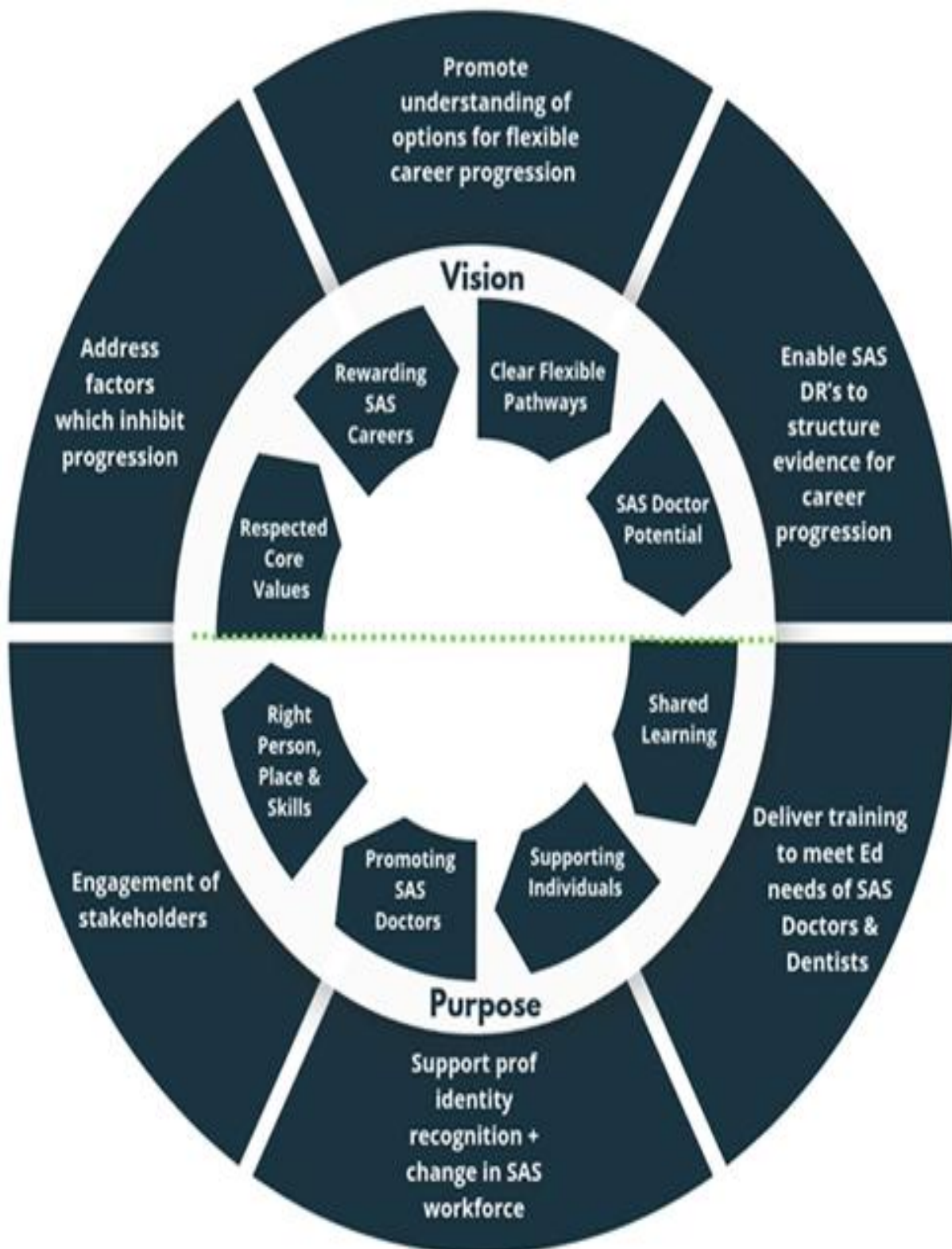
|                    | Average Contracted Hours<br>March 2023 |                |              | Average Contracted Hours<br>March 2024 |                |              | Average Contracted Hours<br>March 2025 |                |              | Average Contracted Hours<br>March 2026 |                |              |
|--------------------|----------------------------------------|----------------|--------------|----------------------------------------|----------------|--------------|----------------------------------------|----------------|--------------|----------------------------------------|----------------|--------------|
|                    | All Data                               | Female<br>Data | Male<br>Data | All Data                               | Female<br>Data | Male<br>Data | All Data                               | Female<br>Data | Male<br>Data | All Data                               | Female<br>Data | Male<br>Data |
|                    | Average                                | Average        | Average      | Average                                | Average        | Average      | Average                                | Average        | Average      | Average                                | Average        | Average      |
| F1                 | 39.75                                  | 39.66          | 39.91        | 39.72                                  | 39.58          | 40.00        | 39.60                                  | 39.40          | 39.87        | 39.69                                  | 39.57          | 39.93        |
| F2                 | 39.63                                  | 39.39          | 40.00        | 39.54                                  | 39.37          | 39.91        | 39.43                                  | 39.27          | 39.75        | 39.33                                  | 39.07          | 39.73        |
| Core               | 38.93                                  | 38.34          | 39.67        | 38.77                                  | 38.07          | 39.56        | 38.71                                  | 37.56          | 39.73        | 38.69                                  | 37.71          | 39.70        |
| Specialty          | 37.86                                  | 36.99          | 39.03        | 37.31                                  | 36.13          | 39.00        | 37.47                                  | 36.47          | 38.90        | 37.17                                  | 36.15          | 38.73        |
| Overall<br>Average | 38.57                                  | 38.00          | 39.39        | 38.24                                  | 37.50          | 39.35        | 38.32                                  | 37.56          | 39.34        | 38.22                                  | 37.51          | 39.27        |
| Number<br>of RDDiT | 1763                                   |                |              | 1820                                   |                |              | 1952                                   |                |              | 2100                                   |                |              |

Figure 1 - Distribution of Dental Foundation Training Places by Geographical Scheme, 2025/26



## Annex 5 – SAS Data

Figure 2 – SAS Career Development Long Term Goals



## Figure 3 SAS Programme Portfolio – SAS Representation and Communications

### SAS Representation



- Appointing an Associate Dean & Deputy Associate Dean within NIMDTA for the SAS Career Development Programme
- Faculty Development Group - Representing SAS Career Development & the NIMDTA programme among colleagues and organisational faculty - 23.10.2025
- Meeting with the DOH to discuss the SAS Career Development Programme within NIMDTA - 12.03.2025
- Carried out the 2025 Training Needs Survey to represent SAS by granting them a platform and providing an insight into the current NI SAS workforce
- Regular SAS presentations to the Board of NIMDTA
- Participation in the Regional Locum Reduction workshop representing SAS
- Twice presenting on SAS Career Development and SEiD Awards proposal to the Medical Leaders Forum at Stormont
- Participating in the national GMC/AoMRC Knowledge, skills and experience framework short-life working group
- Participating in the Regional EMSAS event - 06.11.2025
- The NIMDTA SAS team engaged with the BMA whilst conducting a departmental meeting in February 2025
- Hosted a stall at the NIMDTA Culture Night 2025 - not only representing the diverse SAS body in NI but also encouraging SAS and colleagues to network in a different context
- Highlighting SAS as a career path for the next generation by participating in the QUB Careers event (2025 & 2026)
- Organising the SEiD Stakeholder Workshop to introduce SAS Excellence in Development Awards to N.I.

### Communications & Media



- Developing the SAS website whilst creating a strong online presence
- Releasing 'SAS Socials' - an update, distributed via email, which outlines all relevant content for SAS doctors & dentists, which have been posted on social media (particularly in reference to SAS events)
- Creating a SAS Course Calendar - This acts as an information platform whereby SAS doctors and dentists can book courses, view educational programme features & plan for upcoming events
- Distribution of regular email communications - recognising monthly highlights, upcoming events to be aware of and developing programme features
- Creating a SAS Guide - Highlighting SAS points of contact, outlining the successful steps already implemented within the programme whilst promoting key features of the programme

**Figure 4 SAS Programme Portfolio – SAS Development and Curriculum Creation**

## SAS Development



- SAS Career Development Fund, with regular fund panels . SAS can apply for funding to support bespoke training, service development or skill enhancement
- SAS Leads Day - Considering a SAS strategy to best aid the vision / goals of SAS across all five Trusts
- We collect feedback regularly from SAS, providing them with a voice to highlight their queries, concerns & goals
- Aiding the professional development of SAS by creating a 'Specialist Portfolio Builder' & 'Portfolio Pathway Tool'
- One to one appointments for SAS with the Associate Dean or Deputy Associate Dean

## Teaching & Workshops



- New2NI Webinar
- Portfolio Pathway - Training & Online Forum
- SAS Trust Roadshows \* Miad Training Workshops
- Collaborative training events & courses, hosted in conjunction with Miad, Doctors Training & RCP
- Partaking in SAS Week - Hosting a Regional SAS Day, which highlighted SAS roles within Leadership, Research & Education
- Hosted the SAS Awards (2024 / 2026)
- Flagship events aimed at supporting SAS both professionally & personally i.e. SAS Sustainable Wellness Day: Recognising Burnout & Achieving Balance (12.02.2026)
- SAS Quality Improvement Programme
- Chrysalis Leadership Programme
- Creation of a SAS educational curriculum delivered by specialist facilitators

Figure 5 – SAS Career Development – Local Implementation by SAS Leads



**Figure 6 – SAS Career Development – Local Implementation by SAS Leads**

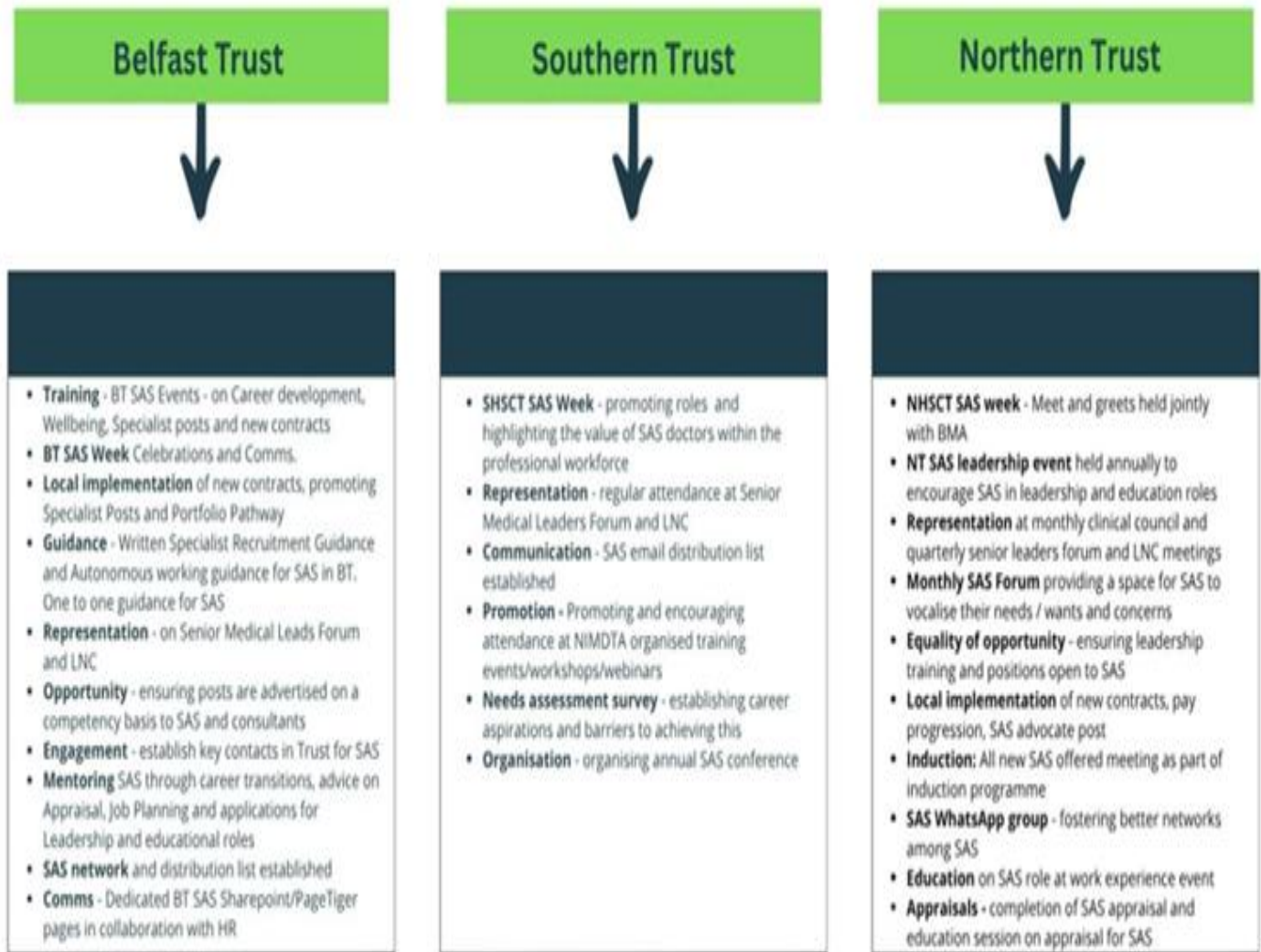
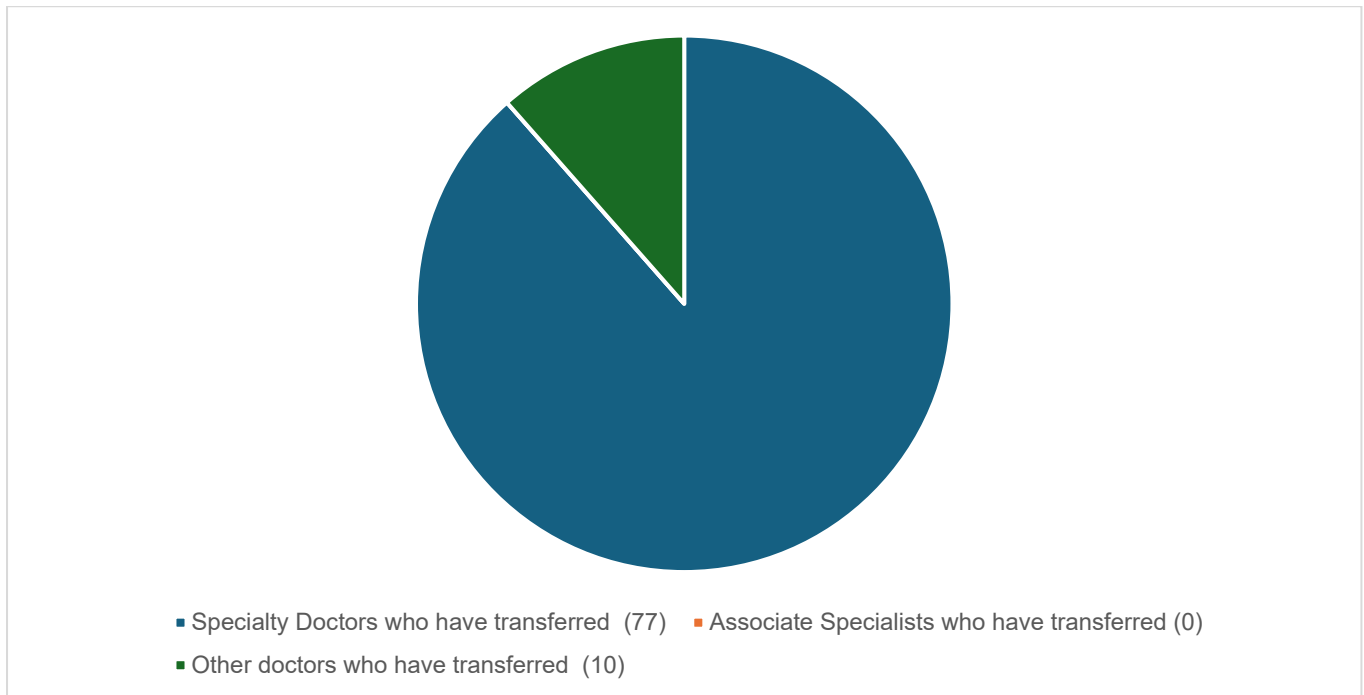
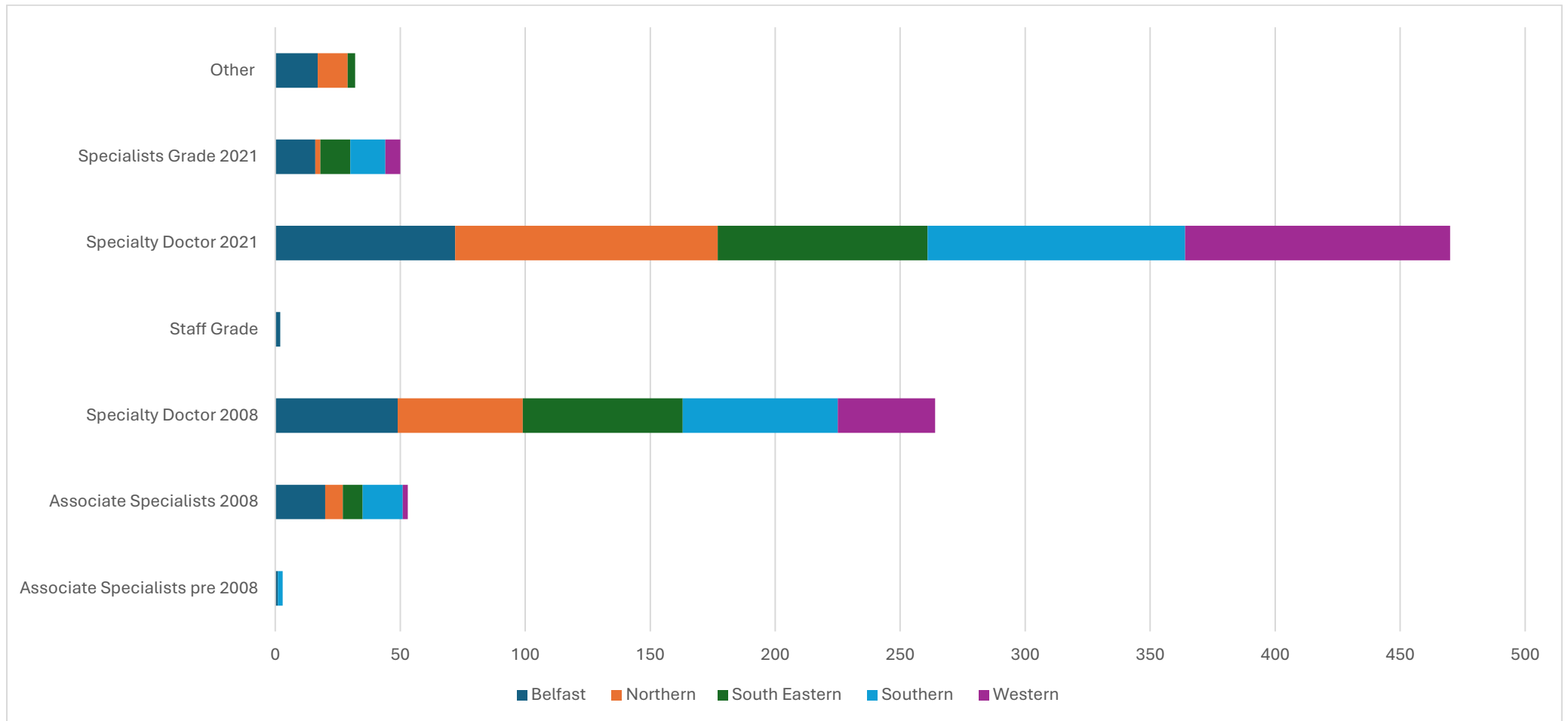


**Chart 6 - Breakdown of Transfer to the 2021 SAS Contract**



*Source: Department of Health, Pay and Employment Unit workforce data returns*

**Chart 7: Breakdown of contracts/grades**



*Source: Department of Health, Pay and Employment Unit workforce data returns*

*\*Other - clinical medical officer, hospital practitioner, clinical assistants*

## Annex 6 - Recruitment and Retention Premia (RRP)

**Table 62 Current approved Recruitment and Retention Premia (RRP)**

| Trust          | Role                                  | RRP | Approved       | Status                 |
|----------------|---------------------------------------|-----|----------------|------------------------|
| Western Trust  | Psychiatry Mental Health Liaison Team | 10% | August 2024    | Unsuccessful           |
|                |                                       | 20% | June 2025      | In progress            |
|                | Psychiatry Crisis Mental Health       | 10% | August 2024    | Unsuccessful           |
|                |                                       | 20% | June 2025      | In progress            |
|                | Psychiatry Lakeview                   | 10% | August 2024    | Unsuccessful           |
|                |                                       | 20% | June 2025      | In progress            |
|                | Psychiatry Recovery                   | 10% | August 2024    | Unsuccessful           |
|                |                                       | 20% | June 2024      | In Progress            |
|                | Old Age Psyciatry                     | 10% | September 2025 | In progress            |
|                | Community Mental Health               | 10% | July 2026      | In progress            |
| Southern Trust | Community Mental Health Team          | 10% | October 2024   | Unsuccessful to date   |
|                | Haematology                           | 10% | August 2025    | Successful appointment |
|                | Gastroenterology                      | 10% | September 2026 | In progress            |

Source: Workforce Policy, Department of Health

## Annex 7 – Staff Experience, Motivation and Morale

**Figure 7: Summary of Selected Findings from the 2025 GMC National Training Survey**

|              |                                                                                                                                                                                                                                                                      |
|--------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>84.3%</b> | of the doctors in training in Northern Ireland rated the quality of the experience in their post as good or very good - a higher figure than that for all doctors in training across the UK (83.6%)                                                                  |
| <b>74.2%</b> | rated the quality of the induction they received as good or very good - a higher figure than that for all doctors in training across the UK (73.8%)                                                                                                                  |
| <b>90.1%</b> | agreed or strongly agreed that the organisation where they were training encouraged a culture of teamwork between healthcare professionals from different disciplines - a higher figure than for all doctors in training across the UK (89%)                         |
| <b>62.5%</b> | said they often or always felt worn out at the end of the working day - a lower figure to that for all doctors in training across the UK (63.6%)                                                                                                                     |
| <b>8.9%</b>  | said they had had concerns about patient safety while working in their post – a lower figure than that for all doctors in training across the UK (12.3%).                                                                                                            |
| <b>88.8%</b> | agreed or strongly agreed that the department, unit, or practice where they were training provided a supportive environment for everyone regardless of background, beliefs, or identity – the same figure as that for all doctors in training across the UK (88.8%). |
| <b>5.5%</b>  | said they had been the victim of, or had witnessed, bullying or harassment in their post – a lower figure than that for all doctors in training across the UK (7.9%).                                                                                                |

The full 2025 GMC NTS findings are published on the GMC's website<sup>41</sup>

<sup>41</sup> [website.](#)