F. RUNNING A MENTORING SCHEME OR SETTING UP A MENTOR / MENTEE PAIRING

Several factors can affect the success of a mentoring relationship, including both the mentor and mentee's training, agreeing boundaries and expectations (including time commitment) and matching of trainee to trainer.

Training

Some good mentoring courses exist in many formats, some of which lead to the provision of a cohort of mentors sharing best practice. In addition to traditional taught courses, there are also online courses and courses specifically for doctors. Likewise, it is important that the mentee understands what is required of them and a number of courses and resources address this.

Agreement of boundaries and expectations

There are many local mentoring schemes in operation, and some formal schemes provide a framework in which conversations establishing boundaries and the format of the relationship can be easily held. Mentoring can be interpreted in different ways, so a new pairing cannot assume any unspoken norms. It is better to be explicit in the ground rules and expectations.

Matching the mentor and mentee

Formal schemes will match mentors and mentees in terms of specialty, location, areas of interest, skills or other factors and have the benefit of a pool of mentors from which to draw.

Many surgeons also identify mentors outside a formal scheme, having met them through the course of their working lives. Although such relationships are less formal, the same level of care should be taken to ensure that both the mentor and mentee have agreed the scope and boundaries of the relationship. This protects both parties and ensures a common understanding of the relationship.

G. PRACTICALITIES OF MENTORING

Mentoring takes many forms, ranging from very informal between peers, to highly formalised arrangements with agreed parameters and terms of reference.

The mentor is often senior to the mentee, except in cases where peers form informal co-mentoring relationships. Other mentoring models include 'near-peer' mentoring, in which the mentee is mentored by a colleague one step above them in the professional hierarchy.

The mentoring relationship itself can be conducted via many channels including virtually via phone, Skype or email, and in person. It may be easier for the first meeting to be face-to-face (in person or via Skype). It may be easier to have a mentor away from the local area.

Mentoring interactions may be very brief if the aims are clearly defined but more often than not mentoring is prolonged and requires several sessions in order for the mentee to progress.

H. HOW TO BE A GOOD MENTOR

Mentors' styles will vary according to their personality and the context. There is no single best type of mentor.

Some attributes, behaviours and skills are common to all mentors[6,14] including:

- Taking interest in others and in developing others
- Being approachable
- Being open minded, non-judgemental and objective
- Having integrity
- Being confident
- Practising active listening and observation to enable the mentor to respond to the mentee's comments effectively and to the agenda set by the mentee
- Constructively questioning and challenging to help the mentee develop their thinking without imposing the mentor's view
- Being able to deal positively with challenge and being questioned
- Being able to reflect on their own practice as a mentor, encourage reflection in the mentee and provide helpful feedback.

In addition, Carl Rogers[15] identifies the following qualities of a helper:

- Respect: suspending judgement and evaluation
- Empathy: understanding 'with' not 'about'
- Genuineness: being yourself

A mentor is in a position of trust and must treat the mentoring relationship seriously. The mentor must ensure that she/he is competent to fulfil the role. This is likely to include undertaking appropriate training and ensuring that this knowledge is kept up to date.[10]

It is the responsibility of the mentor to:

- Agree and maintain boundaries with the mentee, including the aim and purpose of the mentoring relationship. Ideally, this should be formalised within a mentoring contract.

- Be reliable in the relationship; acknowledge and protect the time required, avoid cancelling or postponing mentoring sessions.
- Respond to the mentee's agenda (rather than imposing her or his view) and act as a sounding board to the mentee; help the mentee reach their own conclusions.
- Treat the mentoring relationship in confidence (except where patient safety or the duty of candour supersedes this).

It will normally be easier for an individual to fulfil these responsibilities and display these behaviours if they are not responsible for supervising or appraising the mentee. For this reason, it is not recommended that individuals select their appraiser or supervisor as their mentor. Keeping the mentoring relationship separate from that of appraiser or supervisor will also help prevent awkwardness if there is a need to discuss sensitive issues relating to supervision or appraisal.

Some key tips:

- Allow the mentee to set the agenda, while maintaining the ability to question or challenge as equals.
- Allow the mentee to come up with their own solutions to their concerns; solutions should not come from the mentor directly.
- Focus on what the mentee wants and whether there are actual or perceived blocks to this.
- Encourage the mentee to make changes happen to allow personal progress.
- Encourage the mentee to verbalise an issue in order to support self-understanding.
- Encourage the mentee to verbalise their action or intention to help them feel committed to it.
- Use reflective practice and discuss with other mentors to improve your mentoring abilities.
- The following un-blocking questions may be helpful:
  - 'How might you be stopping yourself from making this change?'
  - 'What has worked for you in the past?'
  - 'What can you learn from that success before?'
  - 'What is the first thing you are going to do now?

Table 2 provides a toolkit of skills and behaviours for mentors.

Table 2: Toolkit of skills and behaviours to practise as a mentor (*Adapted from Liz Spencer's work*)[16]

Listening skills	Listening is the most important ability and behaviour. It takes patience, tolerance and practice, especially in order to develop real empathetic listening techniques. Listening is more important than talking. Offering complete objectivity, undivided attention and support promotes intuitive questioning that allows the mentee to explore what is going on. Furthermore, the mentee articulating their concerns and suggestions can be powerful in helping them stick to their intended actions.
Resisting the urge to give advice	Advising tends to be based on the beliefs, values and opinions of the advisor. Your role and the purpose of this conversation is to help the other person find their own solutions, not to have them follow an advisor's recommendations or suggestions. This is a fundamental principle.
Communication skills	Listening is not enough. You need to interpret and reflect back in ways that remove barriers, pre-conceptions, bias, and negativity. Communicating well enables trust and meaningful understanding on both sides. There is a big difference between feeling and meaning, as well as content, and you should be able to communicate both. Avoid judging, and develop the art of probing and summarising.[17]
Rapport-building	Your ability to build rapport with people is vital. You should focus on the mentee and have an intrinsic desire to help them. By displaying empathy and support, rapport develops rapidly and naturally.
Motivating and inspiring	Your aim is to motivate and inspire people. When someone receives attention and personal investment from another towards their well-being and development, this is in itself very motivational and inspirational.
Curiosity, flexibility and courage	People's needs are different. Remembering that every person is different and has different needs is an essential part of being helpful. The mentee leads the conversation, which means that the mentor has to be flexible and react to the mentee's goals. Curiosity and interest in understanding issues in people's lives helps with the interpretative phase.

I. HOW TO BE A GOOD MENTEE

Although the mentee may not think of her/himself as an expert, it is the mentee's responsibility to identify the purpose of the mentoring relationship and to drive the agenda. The mentee should not expect to be a passive recipient of guidance or the mentor's wisdom; they must be active in identifying their needs and working to address these with the mentor.

It is the responsibility of the mentee to:

- Agree and maintain boundaries with the mentor, including the aim and purpose of the mentoring relationship. Ideally, this should be formalised within a mentoring contract.
- Define the mentoring agenda: identify what she/he wants from the mentoring discussions and communicate this clearly with the mentor.
- Be reliable in the relationship; acknowledge and protect the time required, avoid cancelling or postponing mentoring sessions.
- Be self-motivated; complete any actions agreed with the mentor within agreed timeframes.
- Be open to challenge; respond with an open mind, willingness to work to change attitudes and behaviours if needed.

Changing behaviour can be difficult. An individual may be able to identify how they might change, but talking this through is an effective way to develop realistic plans with the motivation to stick to them.[18]

J. STARTING MENTORING

It is important to define the mentoring relationship early on so that both parties are clear about what to expect and how they are expected to behave. Drawing up mentoring contract can be useful and need not be onerous. The contract provides a record of agreed boundaries that can be referred back to later in the relationship if needed (appendix C provides a sample contract that can be adapted for individual use).

Topics to consider and clarify include:

- The mentor and mentee must agree the boundaries of the relationship, ideally clearly defining goals and outcomes.
- The mentor and mentee should agree the time commitment:
  - the expected duration of the relationship
  - the frequency of meetings and
  - when and how meetings will occur.
- There should be agreement that discussions must take place in confidence (except where patient safety or the duty of candour supersedes this).
- Clarify whether the mentor would provide clinical advice.
- Clarify whether the mentor is willing to act as a referee.
- Clarify whether the mentor would intervene on behalf of the mentee (usually the answer to this would be 'no' as mentors facilitate the mentee to explore and address concerns on their own).

These questions should be addressed jointly, and the definition of the relationship should be an ongoing process, with the potential for review as needed. There should be an expectation that either party can end the mentoring relationship with no blame on either side if it ceases to be productive or practical to maintain it.

Stages of each mentoring relationship

When establishing the relationship, consider how long it will last and what you want to achieve in that time. It can be useful to view the mentoring sessions and the mentoring relationship in three stages:[19]

1	Exploration	Exploring issues which are identified by the mentee.
2	New understanding	Gaining greater understanding of these issues, exploring challenges and strengths, establishing priorities.
3	Action planning	Encouraging creative approaches and facilitating an action plan.

These are likely to be followed by review and evaluation and, if appropriate, ending the relationship.

These three stages can also be useful to consider when addressing specific issues within a mentoring relationship. You may go through these stages multiple times within a period of mentoring as new issues arise or are addressed.

K. MODELS OF MENTORING

There are several models of mentoring that can be followed. A brief summary of two of these and further information is provided below. Further information is widely available and should be sought prior to using them.

The Egan model[17]

Egan's model of mentoring is about helping people manage their own problems more effectively. It is about empowerment of the mentee who, crucially, chooses the outcomes of mentoring and hence values them.

The Egan model aims to help the mentee and mentor address three main questions:

1. 'What is going on?'
2. 'What do I want instead?'
3. 'How might I get to what I want?'

Because the focus is on the mentee's empowerment, it is important that the mentor listens, challenges and respects the mentee. Not everyone needs to address all three questions, and at times people may move back to previously answered ones.

The GROW model

This is another model encouraging a step-by-step identification of goals and realistic assessment of how to achieve them.

Goal	Clarify and agree a realistic and motivating outcome
Reality	Work through the reality of what is happening now and where blocks might be
Options	Stimulate ideas and choices about new ways of doing things
What next	What is the first step? And then?

The mentor may use these steps to guide the discussion with the mentee.

L. POTENTIAL PITFALLS AND POSSIBLE SOLUTIONS

As with any relationship, a mentoring relationship may face a number of challenges as the mentor and mentee get to know each other. If problems arise it is better to acknowledge and address them as soon as possible to prevent them from growing and undermining the benefits of mentoring.

In these circumstances, it can be useful to be part of a formal local scheme as this provides the option of seeking input from a third party or, if necessary, seeking an alternative mentor.

In the case of informal mentoring relationships, there is more potential for problems. This means that it is particularly important that boundaries are explicitly established early in the mentoring relationship and, ideally, that a mentoring contract is agreed.

When addressing problems or challenges to the mentoring relationship, the main principles to consider are:

- Problems should be acknowledged and addressed in a positive manner.
- There should be an assumption that there will be no blame and no ill-feeling. The experience should be viewed as opportunity to learn.
- The goal of addressing issues is to improve the relationship to the benefit of both parties.
- Refer back to the contract and discussions about boundaries.
- Agree an approach to address the issue and make this explicit.

Some problems that frequently arise and ways to approach them are outlined below.

The mentee is dependent on the mentor

The mentee is reluctant to end the relationship in the agreed time frame or appears unwilling to take decisions or actions without the explicit guidance of the mentor. Possible actions:

- Revisit the contract and discussions about boundaries and consider revising the end date if needed. Ensure the (new) end date is clearly acknowledged by the mentee.
- Revisit and possibly revise goals and action plans. Make a clear plan of how to achieve goals within the agreed timeframe.
- Discuss the agreed roles and responsibilities of the mentor and of the mentee.

The mentor is instructing / directing

The mentor tries to solve problems or provide answers rather than help the mentee do this. Possible actions:

- Revisit the contract and discussions about the role / responsibilities of each party. Note the role of the mentor as a facilitator and the mentee's duty to drive the relationship and self-motivate.
- Plan meetings and set out goals for the mentee to achieve in each meeting, stressing their own role.

Lack of rapport between the mentor and mentee

The mentor and mentee either lack trust in each other, or simply don't get on. Possible actions:

- Initiate an introductory conversation, even if this is not at the start of the relationship. Take time to talk and understand each other's experiences and areas of expertise.
- Observe and confirm the confidentiality of the relationship.

Overfamiliarity

The mentor and mentee have too much rapport; boundaries are blurred and the relationship slips towards friendship or other personal relationship. Possible actions:

- Explicitly acknowledge this.
- Revisit the contract and discussions about boundaries.
- Consider revising the nature of the relationship. If this is not possible, consider ending the relationship.

If in any of these situations you are unable to resolve the problem and feel you need to end the mentoring relationship, agree to do so with no blame attached to either party. Aim to learn from the experience to inform future mentoring situations.

APPENDIX A: MENTORING MEETING CHECKLIST (MENTEE)

The following questions should be considered before and after each meeting to help you stay on track with achieving the goals your have set for yourself and the mentoring relationship.

Before the meeting:

- What do I want to talk about / achieve in this meeting?
- What are the key issues to cover?
- Is there any background information that will help the mentor understand my situation?

After the meeting:

- Reflect on what was discussed in the meeting:
  - What new perspectives do I have about my situation?
  - Do I need to amend my action plan or goals?
- What do I need to do next and is there any support I need to do this?
- When are we meeting again and do I need to prepare anything for this?

APPENDIX B: ESTABLISHING A MENTORING RELATIONSHIP

Consider these questions before and during your first mentoring meeting and use the answers to inform the mentoring contract.

- What is the mentee's aim for this mentoring relationship?
- What are the characteristics the mentee needs from a mentor? Does the proposed mentor have these?
- Are both mentor and mentee in agreement to maintain confidentiality of their discussions throughout the relationship?
- What are the boundaries of this relationship? Will the mentor:
  - act as a referee?
  - intervene on behalf of the mentee?
  - provide clinical advice?
- Meetings:
  - How frequently will we meet?
  - What form will these meetings take?
  - How will we manage cancelling/ postponing meetings?
- How long do we anticipate this relationship will last?

APPENDIX C: SAMPLE MENTORING CONTRACT

Use the template on the adjacent page to draw up your mentoring contract. Both the mentor and mentee should complete the contract together. You can re-visit and revise this contract at a later date; the mentor and mentee should do this together to ensure they are both working to the same goals and values. There may be other topics that you wish to include.

Mentor:

Mentee:

Frequency of meetings:

Duration of meetings:

End date/ Duration of mentoring:

Cancelling meetings:

Communication between meetings :

Purposes of relationship, including mentee goals:

Content and boundaries:

- *Confidentiality*
- *Will clinical advice be given? Yes/ No*
- *Will mentor act as referee? Yes / No / Not yet certain*

Agreement and contact details			
Mentor name:		*Mentee name:*	
Job role:		*Job role:*	
email address:		*email address:*	
Telephone:		*Telephone:*	
Other telephone:		*Other telephone:*	
Other contact:		*Other contact:*	
Signature:		*Signature:*	
Date:		*Date:*	

APPENDIX D: CASE STUDIES

Career development and problem resolution

Person B has been both a mentor and mentee. She has been mentored informally by colleagues throughout her career, mostly during training. The following relates to her experience as a mentor.

The mentoring relationship started as a training exercise for a formal mentoring scheme and continued by mutual consent. Person B's mentee was a peer at a similar career grade to Person B. Contact with the mentee was via pre-arranged telephone calls for a period of weeks.

The mentee had a specific problem he wanted to address that related to how he would handle his relationship with a colleague whose behaviour and demeanour had changed and deteriorated. The mentee was concerned about the colleague both personally and professionally and wanted to address these concerns before the possibility of clinical error was realised. Person B and the mentee explicitly discussed their roles in the relationship and agreed boundaries within a formal mentoring contract. A main part of Person B's role as mentor was to listen to the mentee and help him focus on one aspect of the situation at a time. She supported the mentee in reflecting on the situation and then considering his ideal outcome and ways he might be able to move towards it.

The mentee found it useful to be able to clarify his thinking and develop clear strategies for action.

Person B found it challenging to keep an open mind, let the mentee talk and reach his own solutions but found it gratifying to witness the mentee's relief at having reached a solution and discovering that help is available.

New consultant

Person A was provided with a mentor when he was a newly appointed consultant, as is routine in his trust. His mentor was from the same organisation but from a different specialty. Discussion was confidential and around professional, non-clinical topics. Meetings took place off site, and outside work time. In this trust, it is not compulsory to maintain a mentoring relationship and the relationship was not formally monitored, but it was clear that the option existed.

Person A found the services of his mentor more useful than he had expected.

Though he had settled well into the new role and did not perceive himself to have any problems, discussions with his mentor revealed topics which, though not critical, were better resolved following discussion. He felt that the scheme was useful from a professional point of view, as difficult issues could be discussed with an informed, non-partisan third party, but also personally, as information could be gained about the department and culture of the trust, and social networks identified. These personal gains helped professional performance and he was able to settle into the role more quickly.

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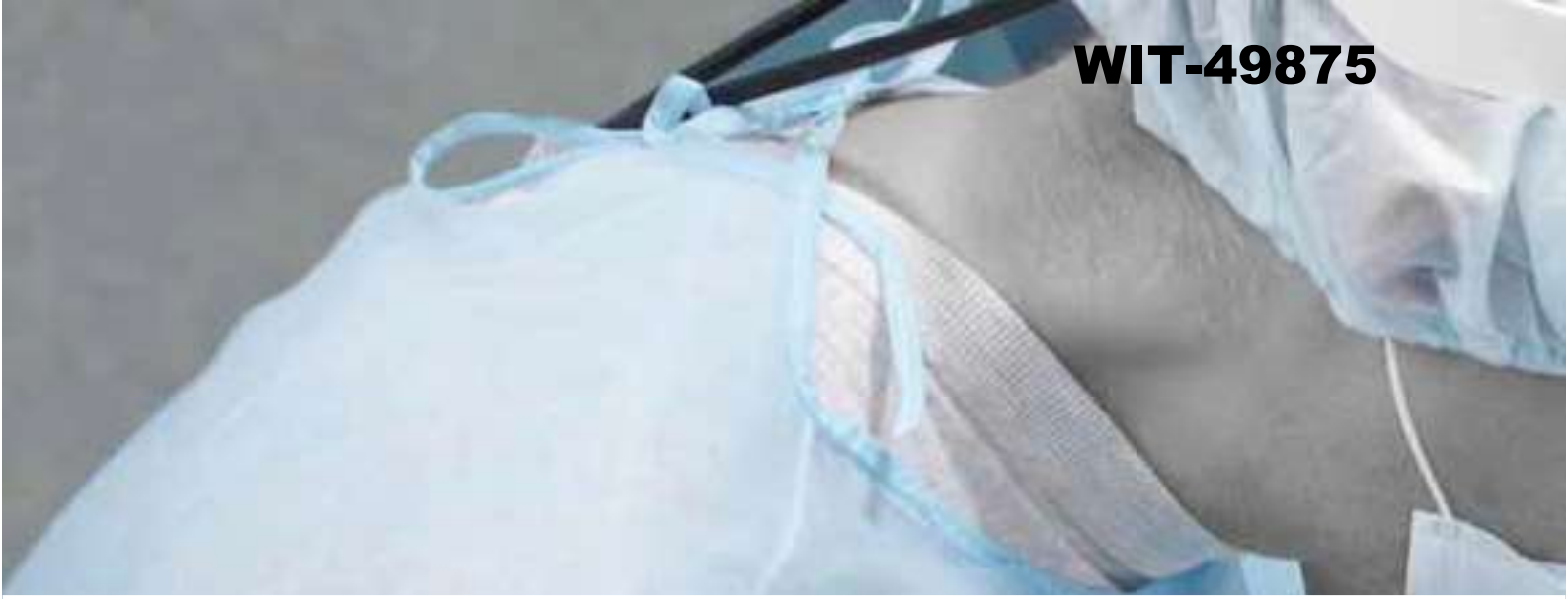


Southern Health and Social Care Trust

HR & MEDICAL DIRECTORATE MEETING - NOTES OF MEETING

Wednesday, 14th April 2021 3:00 – 4:00pm

Dr OKane, V Toal, Dr Diamond, S Hynds, Z Parks, S Morrison (S Wallace for first agenda item)

Apologies Simon G, H Walker.

Medical Leadership Structure / Allowances

Discussed issue regarding management allowance for new medical management roles
UK detail on flexibilities around defining pensionable pay has been passed to DLS and pension branch for clarification. We are awaiting response from DLS.

ACTION: Zoe to feedback to group as soon as we have DLS advice
ACTION: MD office to consider issuing a pre notice for forthcoming recruitment to gauge interest and individual circumstances re this issue.

Also discussed question on current value of our previous management allowances. HR Shared detail to show how the position varies across the region. Will need to clarify if our allowances are to remain unchanged or if a review is necessary? They were originally based on first point of pay-scale at the time of implementation.

ACTION: MD office to confirm if the value of the management allowance is to be reviewed and process.

Job Planning Updates

Shared excellent work by Stephen Morrison - illustrating job planning data in a dashboard summary. This highlighted disparity against General Medicine CD post with regards to their commitments for 1st sign off responsibilities. Not clear that new medical manager structure will alleviate this so may need to consider other CDs being asked to take on additional job plans. E.g. - CD for Cancer services. Average commitment for first sign off is around 10-15 job plans.

ACTION: **Stephen Morrison to attend next AMD meeting to present data for discussion**
Stephen Morrison to contact Katie Shields to ensure we have similar data for appraisal figures to share at this meeting.

Locum Usage / Recommendations

Shared summary reports on locum usage and the main issues being flagged up via our reports, Internal Audit and via the recent CFS report. Key trends: Rising use of long term locums, continued use of agency and off contract agency doctors, escalation of locum rates and the need to review systems for accountability.

Discussed that we may want to consider requiring all long term locum doctors to have job plans
Agreed there needs to be a focus on long term consultant locums as first priority.

ACTION: **Stephen/Zoe to work towards development of AMD Dashboards to summarise key information split by AMD/Directorate**

MD office to bring list of long term locum consultants so this can also be fed down through the CD/AMD forums

Date of next virtual meeting: Wednesday, 16th June 2021 @ 11:00am

PAPERS REFERENCED DURING MEETING

Job Planning Summary.pptx

Job Planning Summary

MEDICAL HR OVERVIEW (LOCUM C

Medical HR overview on Locum Usage Report highlighting volume and escalations

CAH DHH Medical Locum overview For D

Medical HR overview to focus in on Medicine SHSCT

SHSCT Review of Medical Numbers Upd

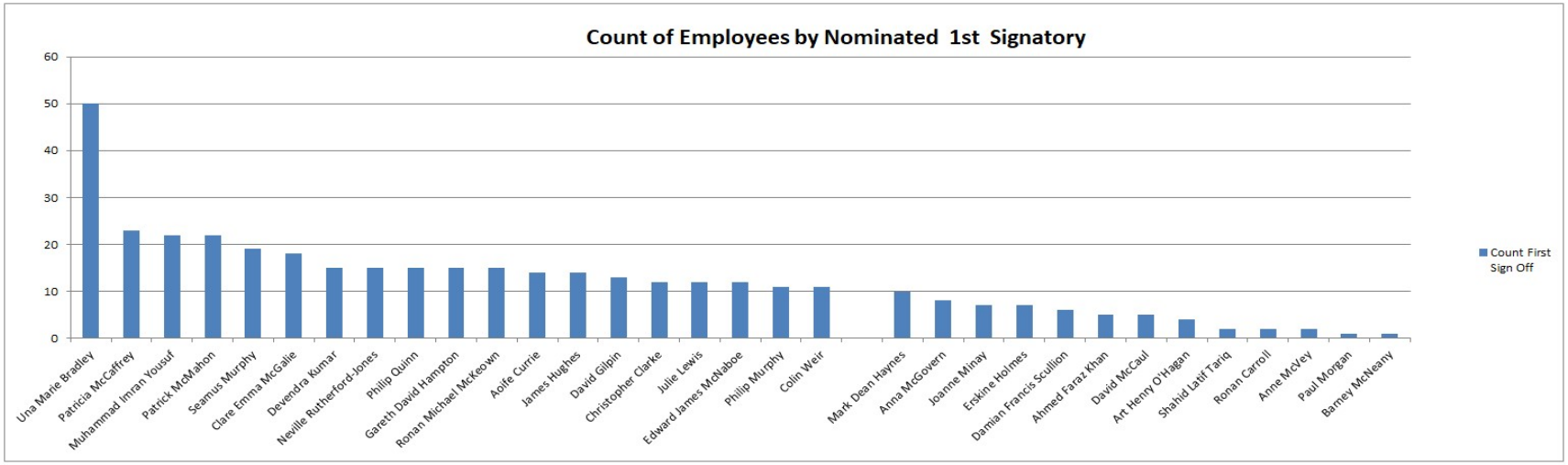
Medical HR Paper to assist Acute with workforce planning to convert to perm spend

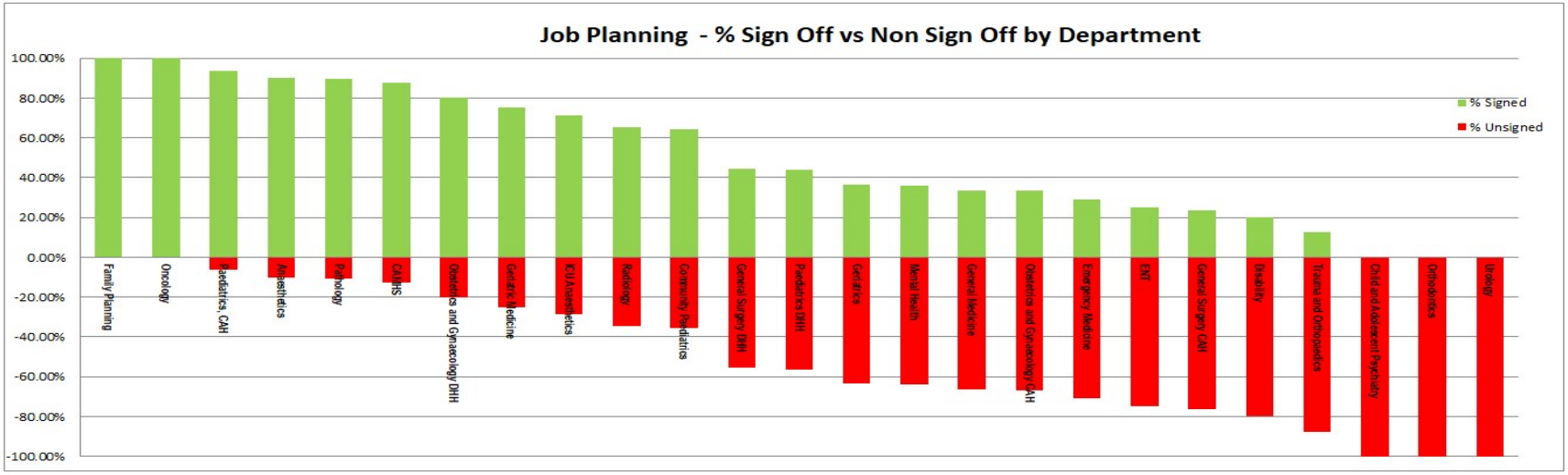
Locum Rates SHSCT updated March 2021.

Medical HR Paper for region to attempt to bring consistency to locum rates

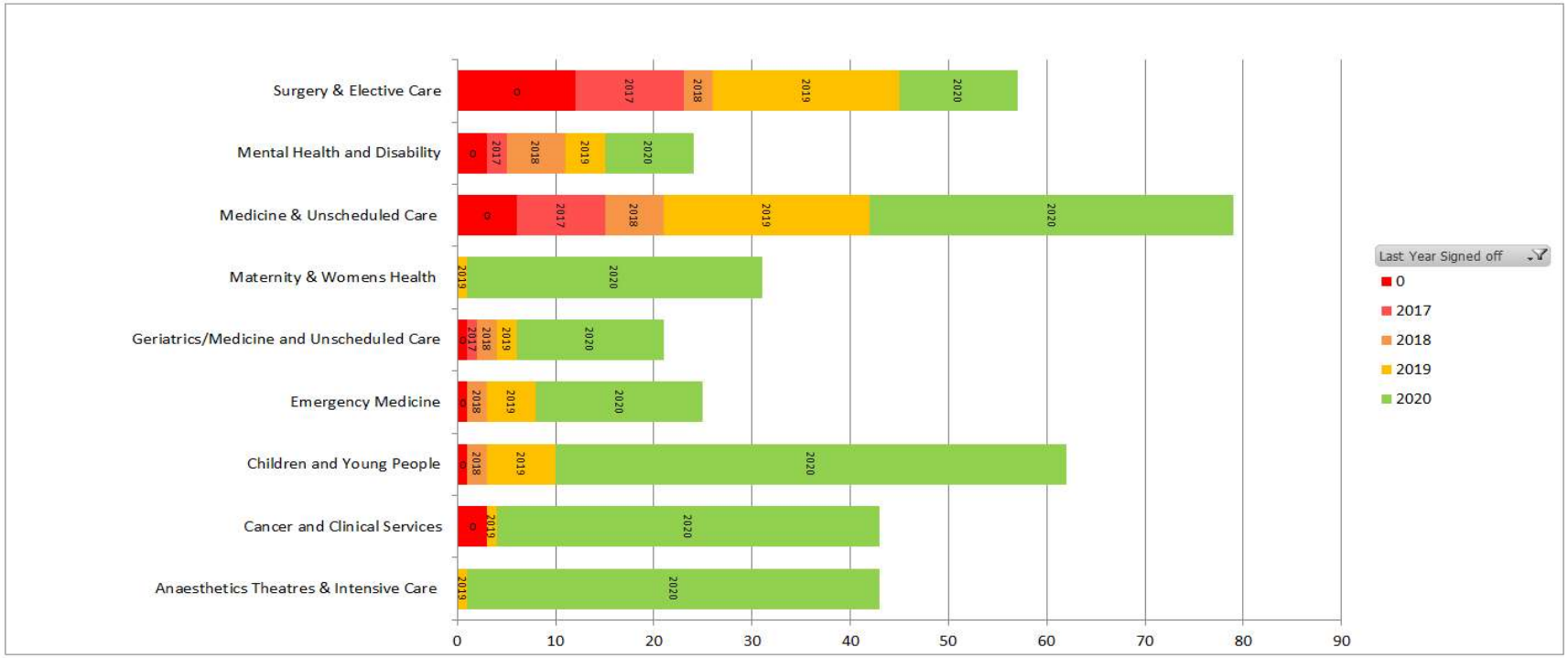
Job Planning

Job planning summary metrics



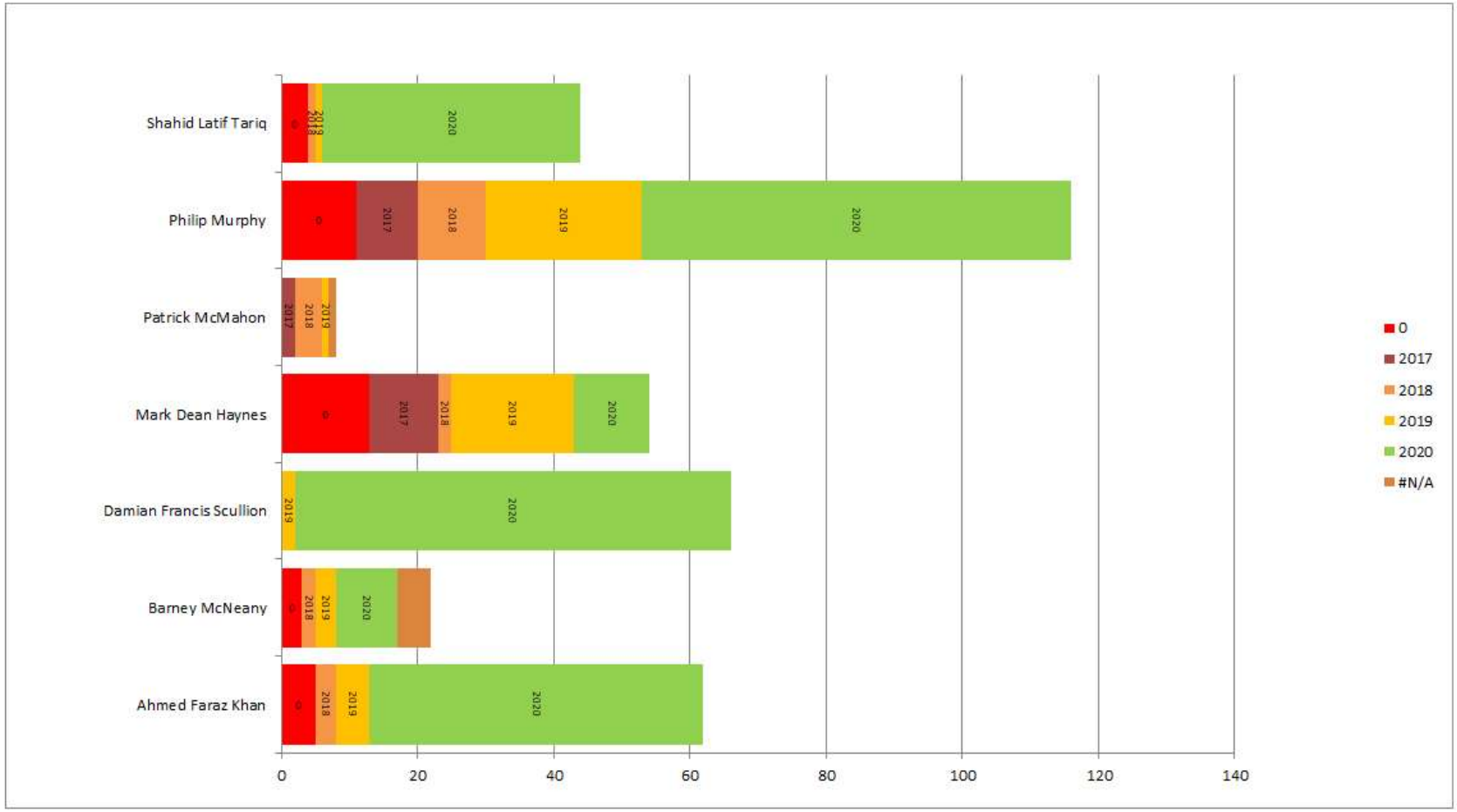


Breakdown of Doctors' last signed off job plan date by Department

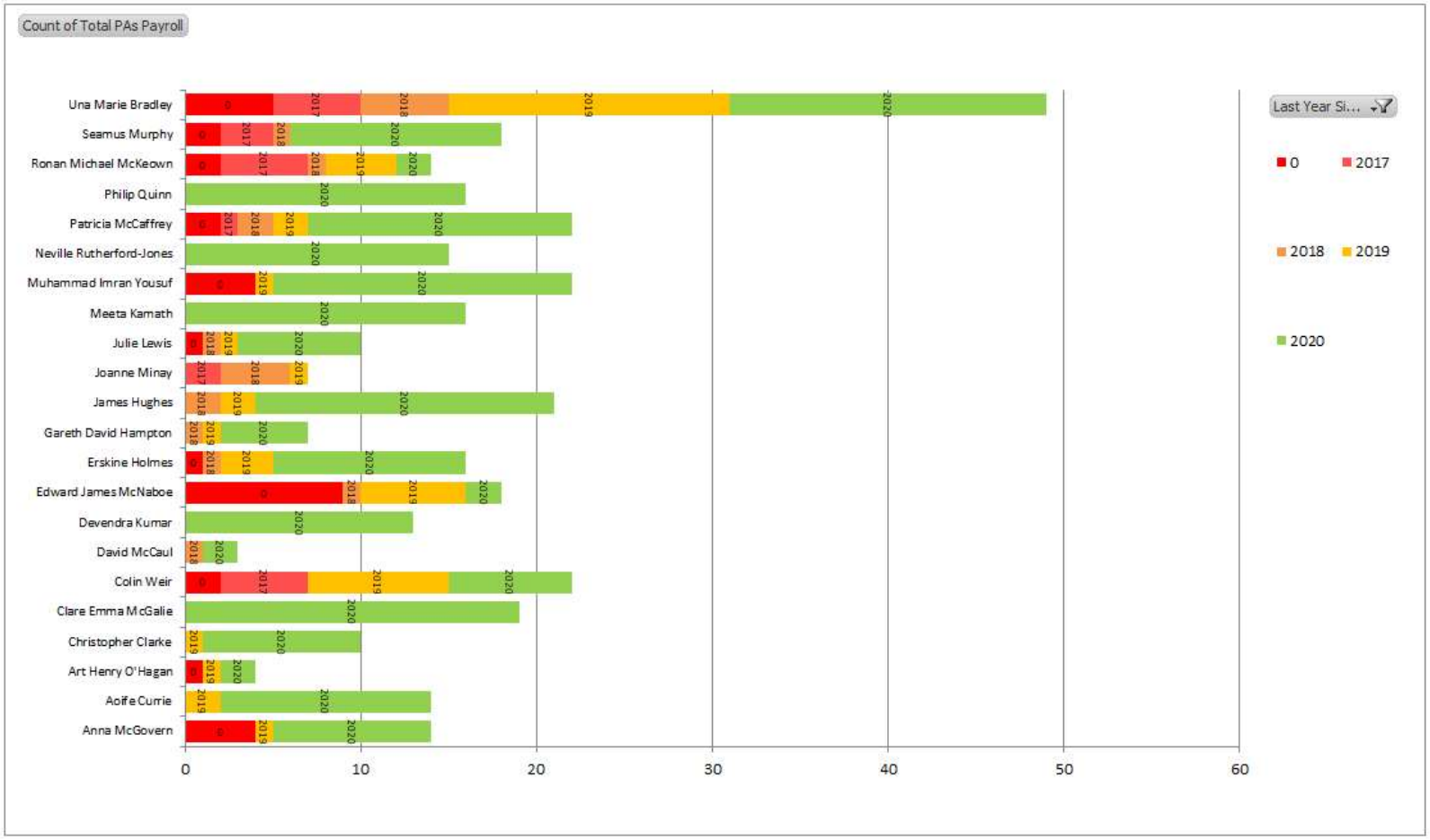


Surgery, Mental Health & Medicine/Unscheduled Care have high levels of doctors that have not had a recent job plan signed off or a job plan ever signed off

Breakdown of Doctors' last signed off job plan date by AMD



Breakdown of Doctors' last signed off job plan date by CD



Doctors who have never had a signed off Job Plan

Department / Specialty	First name	First name	Job Description	Last Signed Off Job Plan Date	Total PAs Payroll
Surgery & Elective Care	Michael	Young	Consultant		12.25
Surgery & Elective Care	Robert	Espey	SAS Doctor		11.37
Surgery & Elective Care	Ronan Michael	McKeown	Consultant		11.25
Surgery & Elective Care	Matthew	Tyson	Consultant		10.96
Medicine & Unscheduled Care	Elizabeth Mae	McConnell	Consultant		10.75
Medicine & Unscheduled Care	Alastair	Gray	Consultant		10.55
Mental Health and Disability	Patrick	McMahon	Consultant		10.50
Surgery & Elective Care	Andrew	Taggart	SAS Doctor		10.25
Surgery & Elective Care	Gavin	McLean	Consultant		10.15
Cancer and Clinical Services	Kathryn	Quinn	Consultant		10.00
Children and Young People	Tanmoy	Chakrabarty	Consultant		10.00
Geriatrics/Medicine and Unscheduled Care	Pauline	Stinson	SAS Doctor		10.00
Medicine & Unscheduled Care	Andrew	Moriarty	SAS Doctor		10.00
Medicine & Unscheduled Care	Ali	Ibrahim	SAS Doctor		10.00
Medicine & Unscheduled Care	Paula Elizabeth	Reid	SAS Doctor		10.00
Medicine & Unscheduled Care	Claire	Brady	SAS Doctor		10.00
Mental Health and Disability	Lauren	Megahey	Consultant		10.00
Surgery & Elective Care	Reem	Salman	Consultant		10.00
Surgery & Elective Care	Peter James	Leyden	Consultant		10.00
Surgery & Elective Care	Eileen	Cheah	SAS Doctor		10.00
Surgery & Elective Care	Ciara	Campbell	Consultant		9.00
Cancer and Clinical Services	Janice	O'Neill	Consultant		8.00
Mental Health and Disability	Judy	Curran	Consultant		7.00
Surgery & Elective Care	Laura	McAuley	SAS Doctor		6.00
Surgery & Elective Care	Angela	McGreevy	SAS Doctor		5.75
Cancer and Clinical Services	Julie Elaine	Yarr	Consultant		5.00

Future steps

- Increased reporting to highlight doctors with no recent signed off job plan
- Improved rigour around completion of process. Clear timeline and follow ups
- Better visibility of departments that are not engaged in process. Oversight process?
- Needs to be bottom up and top down – ie doctors need to be pushing to get job plan complete and AMDs need to pushing to ensure that departments are completing

Annual

Spotlight

Southern Health and Social Care Trust

Quality Care - for you, with you

2020-21

Medical HR Overview

Medical Locum Usage

Working together · Excellence · Openness & Honesty · Compassion

Authors:

Tracey Woods, Medical Locum HR Team Lead

Zoe Parks, Head of Medical HR

Medical Locum Team

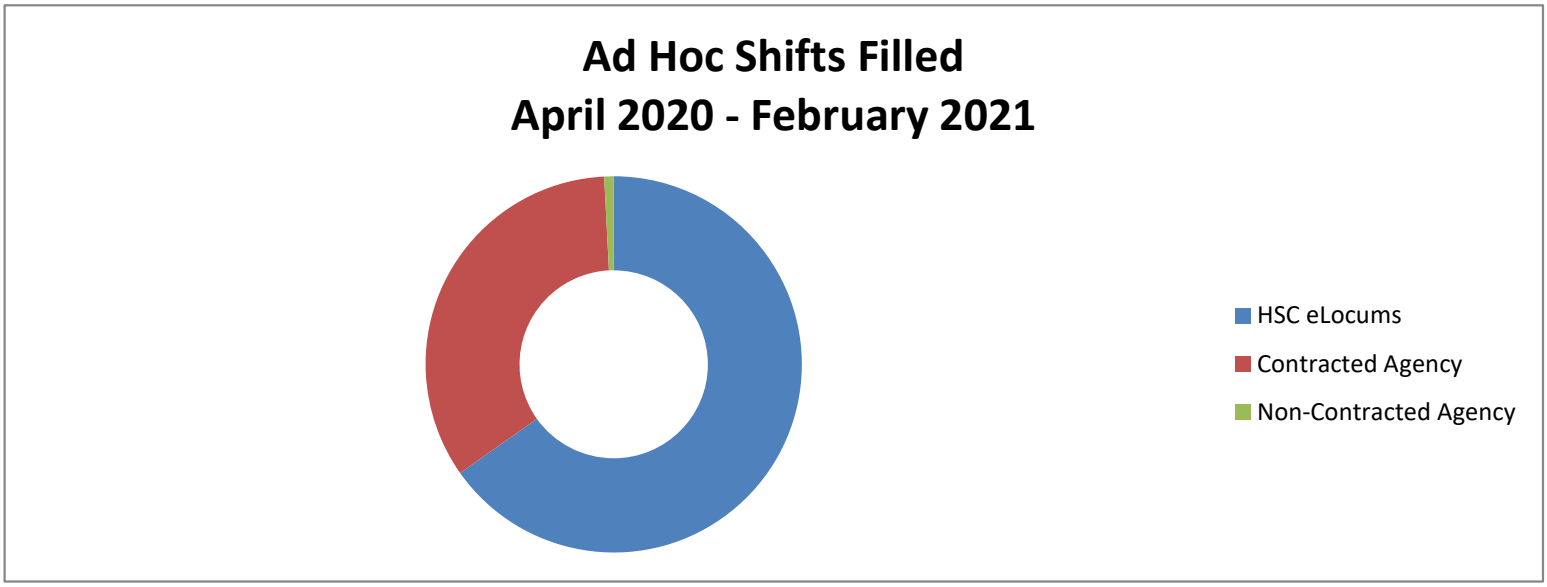
Ad Hoc Locum Requests Overview

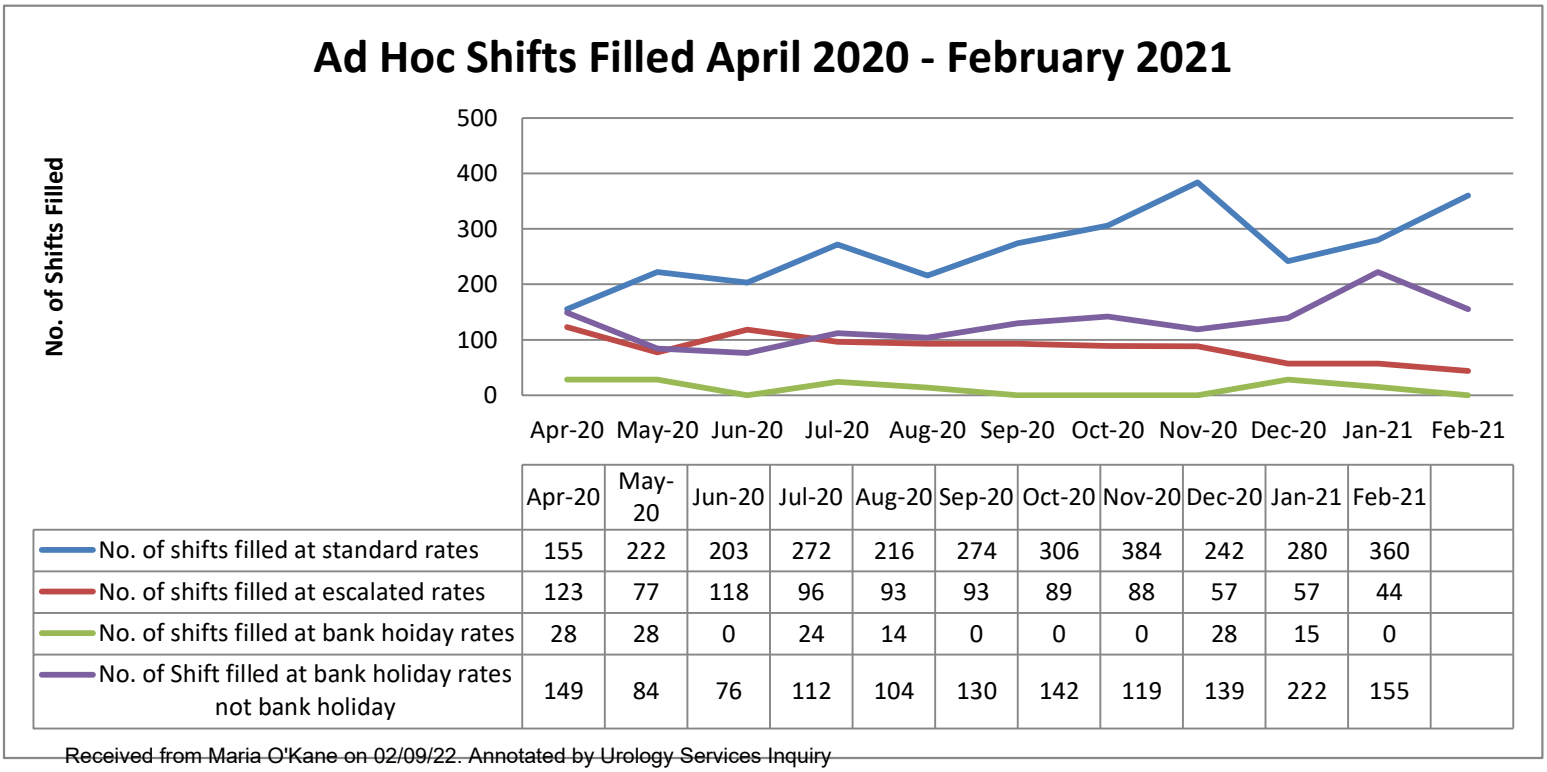
01 April 2020 – 28 February 2021

8,117 shift requests

01 April 2020 – 28 February 2021 fill rate 87.61%.

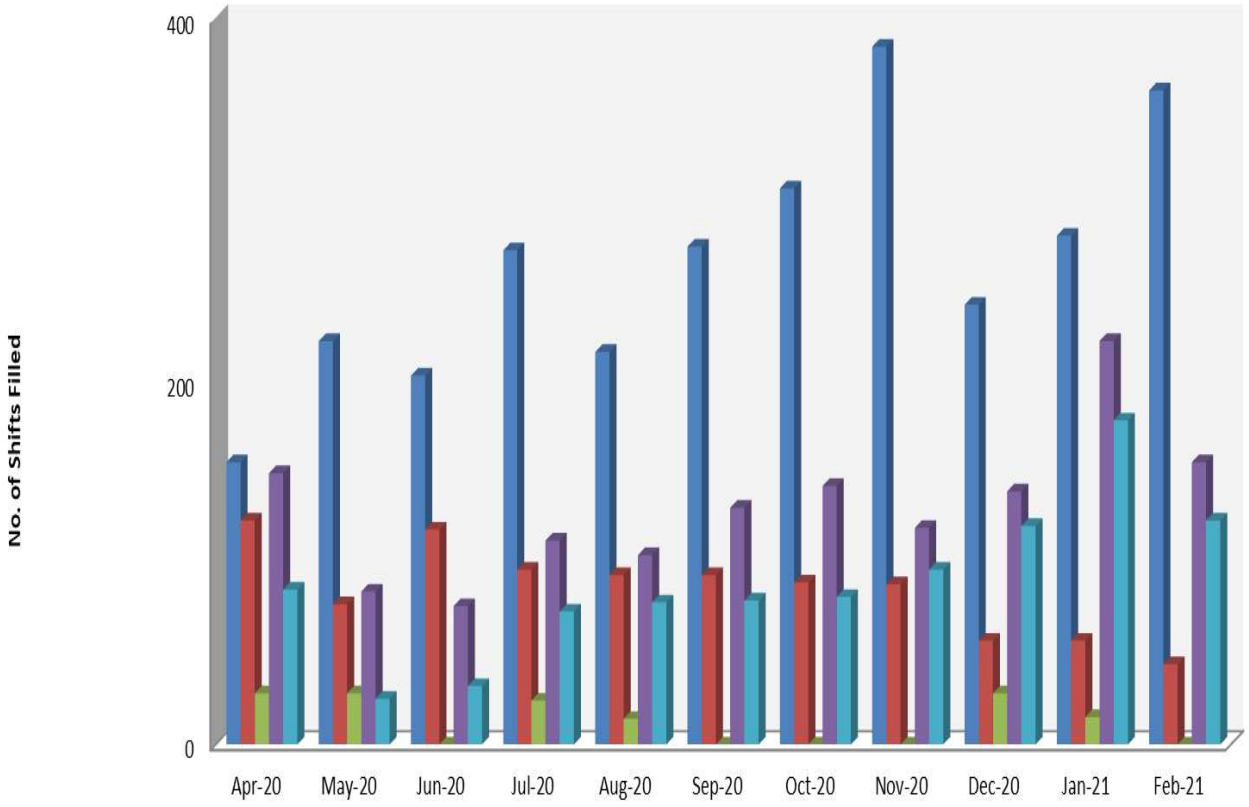
1,071 shift requests were received by the Medical Locum Team specifically in relation to COVID 19 which equates to 13.19% The cost of these shifts are £640,279. (Costs in this document approved by Finance)





	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	
No. of shifts filled at standard rates	155	222	203	272	216	274	306	384	242	280	360	
No. of shifts filled at escalated rates	123	77	118	96	93	93	89	88	57	57	44	
No. of shifts filled at bank hoiday rates	28	28	0	24	14	0	0	0	28	15	0	
No. of Shift filled at bank holiday rates not bank holiday	149	84	76	112	104	130	142	119	139	222	155	

Ad hoc continued ....

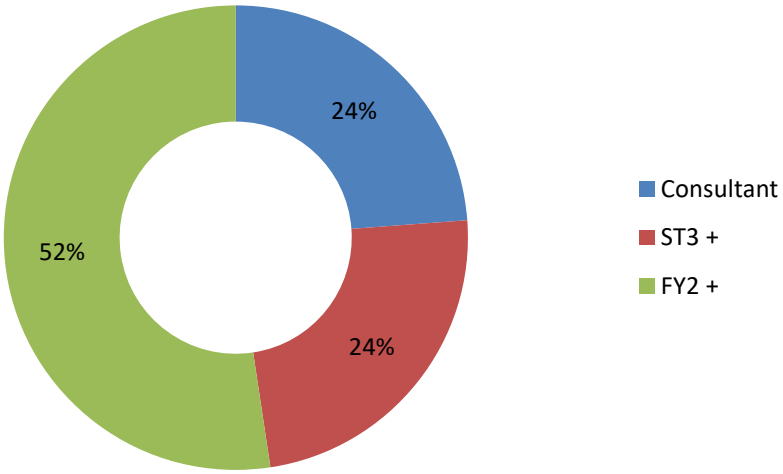


	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
No. of shifts filled at standard rates	155	222	203	272	216	274	306	384	242	280	360
No. of shifts filled at escalated rates	123	77	118	96	93	93	89	88	57	57	44
No. of shifts filled at bank hoiday rates	28	28	0	24	14	0	0	0	28	15	0
No. of Shift filled at bank holiday rates not bank holiday	149	84	76	112	104	130	142	119	139	222	155
No. of shifts filled above framework rates	85	25	32	73	78	79	81	96	120	178	123

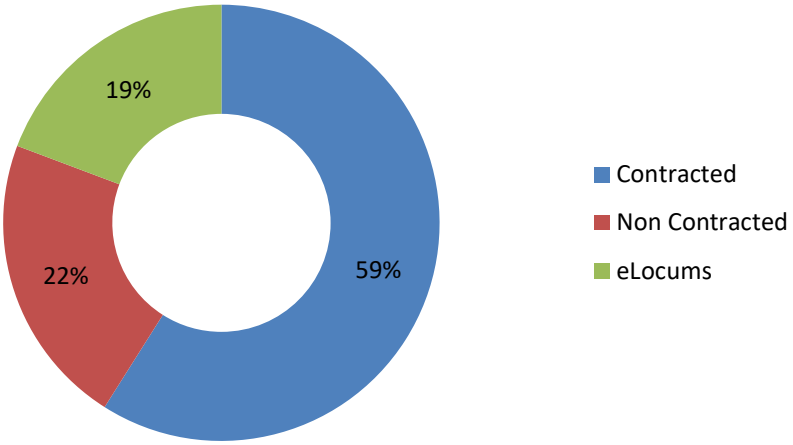
The cost of filling these Ad Hoc Locum Shifts was: **£4,854,275 per year**

Long Term Locum Requests Overview

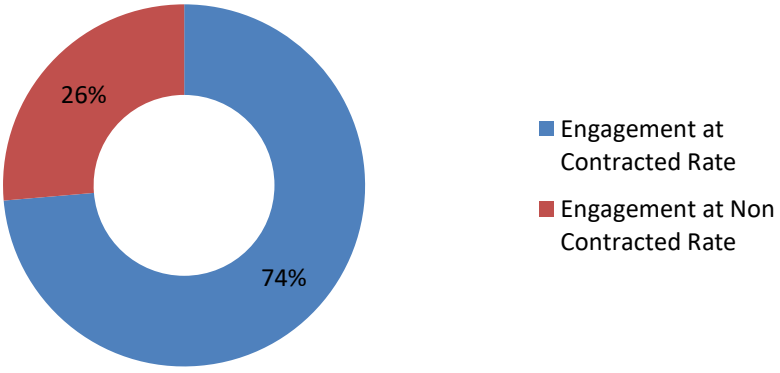
Grades Engaged via Long Term Locum



Long Term Locum Engagment Type



Engagement Rate Contracted/Non Contracted Rate



11th March 2021 we currently have 147 Long Term Locums

FY2 + 52%

Contracted Agencies (59%)

The Cost of Filling these Long Term Locums - **£17,750,269 per year**

DRAFT – THE FIGURES IN THIS DOCUMENT NEED CHECKED BY FINANCE

Craigavon Locum Usage within Medicine

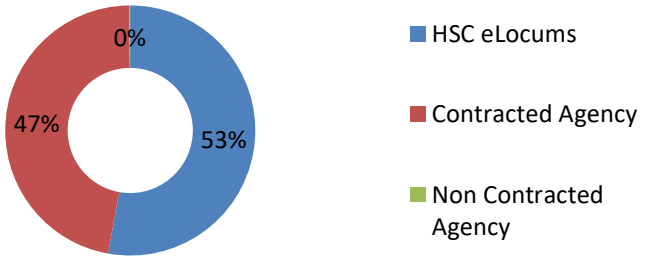
Ad Hoc Locum Requests Overview

01 April 2020 – 28 February 2021

2258 shift requests Medicine within Craigavon Area, Lurgan and South Tyrone Hospital

250 shift requests were received by the Medical Locum Team specifically in relation to COVID 19 which equates to 11.07% The cost of these shifts was £108,697.83.* * exact costs would need to come from Finance.

Ad Hoc Shifts Filled within CAH Medicine April 2020 - February 2021



The cost of filling these Ad Hoc Locum Shifts was: £1,104,604 per year*

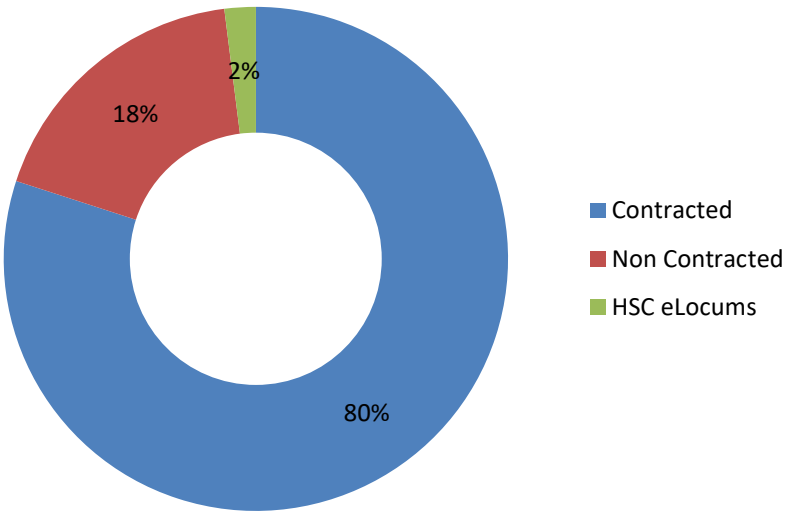
* exact costs would need to come from Finance

Long Term Locum Requests Overview

11th March 2021 we currently have 147 Long Term Locums

34 %

Long Term Locum Engagement Type - Craigavon Medicine



The Cost of Filling these Long Term Locums in Craigavon Medicine was £7,281,960 per year*

* exact costs would need to come from Finance

42%

The Cost of Filling these Long Term Locums in Craigavon Medicine was £3,569,512.74 per year*

* exact costs would need to come from Finance

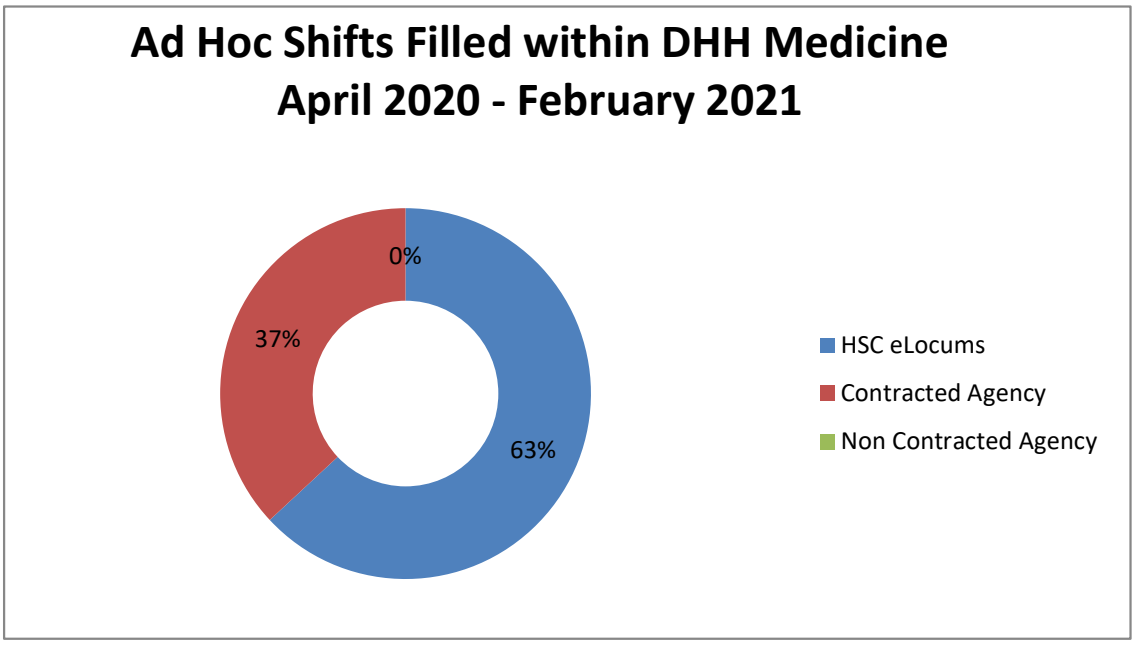
Daisy Hill Locum Usage within Medicine

Ad Hoc Locum Requests Overview

01 April 2020 – 28 February 2021

774 shift requests for Medicine within Daisy Hill Hospital Fill rate 74.16%.

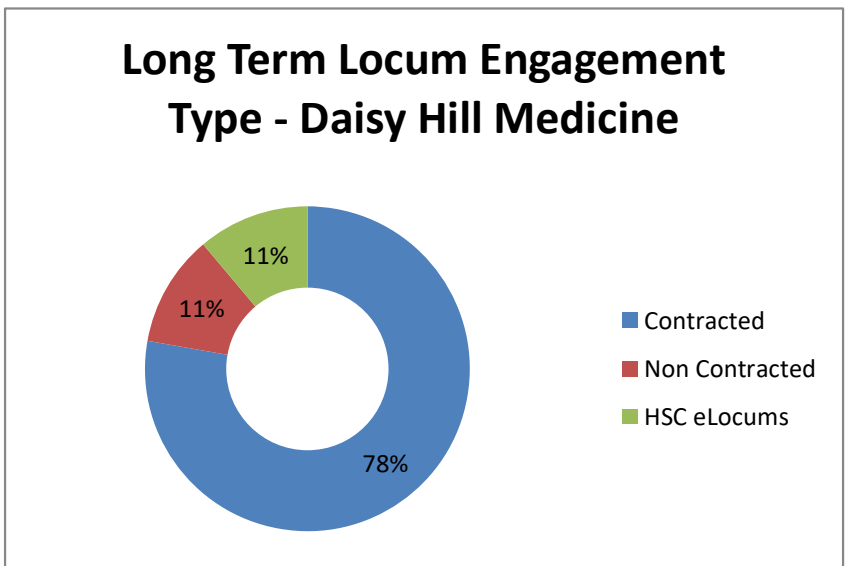
95 shift requests were received by the Medical Locum Team specifically in relation to COVID 19 which equates to 12.27% The cost of these shifts was £41,578.64* * exact costs would need to come from Finance



The cost of filling these Ad Hoc Locum Shifts was: £328,798.21 per year*

* exact costs would need to come from Finance

Long Term Locum Requests Overview



Received from Maria O'Kane on 02/09/22. Annotated by Urology Services Inquiry

11th March 2021 we currently have 147 Long Term Locums

37

6.12%

The Cost of Filling these Long Term Locums in Craigavon Medicine was £1,512,723 per year*

Southern Health and Social Care Trust

Quality Care - for you, with you

Review of Medical Physician Workforce 2020

Focus on General Medicine, Craigavon Area Hospital

DRAFT

September 2020

Authors:
Zoe Parks, Head of Medical HR
Stephen Morrison, Medical HR Manager
Dr Una Bradley, Clinical Director, Medicine
Simon Gibson, Assistant Director MD Office

INTRODUCTION

This paper is seeking to highlight to SMT the current concerns regarding the delivery of acute medical care in Craigavon Area Hospital (CAH) alongside a proposal to mitigate the current deficits.

With the arrival of Covid 19 coupled with the usual ever increasing seasonal pressures, we are now at a critical point. This paper sets to summarise our current position in relation to Medical Staffing – highlighting the key challenges.

ACTIVITY LEVELS

Xxx Service to Add some data here

CURRENT MEDICAL MODEL AT CRAIGAVON

The medical workforce within CAH who contribute to the unscheduled medical take consists of the following specialities:

- Acute Medicine
- Endocrinology
- Gastroenterology
- Respiratory Medicine

Outside this core medical team, there will also be consultants aligned to Geriatric Medicine/Stroke, Rheumatology, Neurology, Renal, Cardiology, Emergency Medicine and Dermatology.

COMPARISON WITH THE REGION

It has been widely recognised over the past number of years that there has been significant underinvestment in medical staffing across the Southern Trust area. The Southern Trust currently has **29** Permanent Consultant across Craigavon and Daisy Hill. (This includes all sub specialties Diabetes /Endo /Gastro /Resp /Geriatrics /Stroke /Rheumatology / Acute) 24 of these permanent doctors in Craigavon, 5 in Daisy Hill. (29 Consultants excludes our Cardiologists, Dermatologists, Neurologists, ED Consultants).

There are also **15 Agency Locum** Consultants

- CAH. 3 in AMU, 3 COTE, 1 Diabetes, 1 Gastro, 3 Gen Med
- DHH 1 DAU, 1 Diabetes, 1 Gastro, 3 Gen Medicine/outliers.

It is very significant to note that in 2016/17 when SMT approval was given for 10 additional permanent consultants, there were 27 permanent consultants in post. The PHA report published in 2018, indicated there were 29 permanent consultants at that time. Even then we were the lowest number in comparison to all other Trusts. Our numbers today in 2020 highlight, despite some success with appointments over the recent past, turnover has meant that we are back to our levels in 2018 with 29 permanent consultants in post!

SOUTHERN TRUST CURRENT NUMBERS IN 2020

BREAKDOWN OF THESE ARE AS FOLLOWS

Craigavon:

Forename	Surname	Contribute to General Medicine	Special Interest	Contribute to General Medicine On call 1 : 14	Department	WTE	PAs (based on WTE)	Total PAs
		Y		Y	General Medicine			11.05
		Y		Y	General Medicine			12.51
		Y		Y	General Medicine			12.25
								11.243
		Y						13.01
		Y						10.46
		Y						11.47
		Y						12.37
								10.5
								9
								4.962
								6
		Y						11.5
		Y						11.68
		Y						13.83
		Y						12.23
								10.66
								8.625
								12.41

	Y		Y				
			Y				

Daisy Hill

Forename	Surname	Contribute to General Medicine	Special Interest	Contribute to General Medicine On call	Department	WTE	PAs (based on WTE)	Total PAs
					General Medicine			11.75
			Diabetes & Endocrinology		General Medicine			10.37
			Gastro Intestinal		General Medicine			10
			Gastro Intestinal		General Medicine			12
			Gastro Intestinal		General Medicine			12
			Respiratory		General Medicine			10.31

***** Acting up as consultant temporarily***

Details of the locum consultants are set out in Appendix section.

CONSULTANTS CONTRIBUTING TO MEDICAL TAKE

Of the **24** consultants on the Craigavon site, the number of Consultants who are currently contributing to the unscheduled medical workload is only **12 consultants on the Craigavon Site**.

COMPARISON WITH SIMILAR TRUST

We have been advised that in the Ulster **28 consultants** are on their acute take medical rota **2020 Job Descriptions confirm this as follows:**

Medical Specialities Directorate

The Post Holder will work within the Ulster Hospital Medical Specialties Directorate, which comprises:

200	General Medical Beds
72	COE Beds
32	Cardiology Beds
35	Haemodialysis Stations

There are currently:

26	Consultant Physicians
7	Consultant Cardiologists
4	Consultant Haematologists
3	Consultant Nephrologists
4	Consultants in Palliative Care
5	Consultant Rheumatologists
8	Consultant Geriatricians
3	Consultant Neurologists
6	Consultant Dermatologists

- Antrim have advised they have **33 Consultants on their acute take** rota.

CURRENT LOCUM AND AGENCY SPEND – Detailed info in Appendix

At present due to significant workforce resource issues the Trust is spending a significant proportion of the budget for Medicine & Unscheduled Care on locum and agency medical staff.

Consultants:

There are currently **15** Locum Consultant Physicians (long term) within the Southern Trust. This incurs a weekly cost of £Personal Information redacted by. The annual cost for these 16 consultants is therefore **£**Personal Information redacted by the USI.

Junior Doctors

We know from a recent paper completed by the Southern Trust that we have the lowest number of training numbers for doctors in training in General Medicine in comparison to all other Trusts at all grades. (FY1, ST, Registrar) It is not surprising then that a large proportion of the budget is also taken up on locum and agency medical staff at junior doctor level also.

AMU: There are currently **6** locums engaged on an AMU rota. This incurs a weekly cost of Personal Informati. Therefore the annual cost of these locums is approx. **£**Personal Information redacted by This historically has never had recurrent funding. We would need to determine what funding there is for SAS doctors in this area and how this compares with the locum spend.

Medical Outliers: Currently **11** Full Time 9am – 5pm Locum SHO doctors Total Weekly cost: **£**[redacted]. Annual cost **£**[redacted]. These are additional to any funded vacancies that we are aware of.

Additional Ward Cover: Currently **11** Full Time 9am – 5pm Locum SHO doctors. Total Weekly cost: **£**[redacted] Annual cost will be **£**[redacted]. These are additional to any funded vacancies that we are aware of.

Ad Hoc Additional Cover frequently requested

- 2 additional doctors for Nights 7 days per week (SHO Rota)
- 1 Additional doctor for Nights 7 days per week (SpR Rota)
- 3 additional doctors for weekend days (SHO Rota)
- 2 additional consultants for weekend days (Consultant rota)

AVERAGE ANNAULISED COST OF CURRENT LOCUM USE

	Current no. locums	Wkly Cost	Annualised cost
Rotational FY2+ (funded vacancies)	5	[redacted]	
Rotational ST3+(funded vacancies)	1		
AMU(unfunded)	6		
Ward Based(unfunded)	11		
Medical Outliers (unfunded)	11		
Ad Hoc Medical Requests (unfunded)	12		
Consultant Locums	15		

SAS MEDICAL WORKFORCE

There are **14** (wte) Specialty grade doctors classed within General Medicine of which **only 4** contribute to the General Medicine wards in CAH.

Craigavon

Forename	Surname	Contribute to General Medicine	Special Interest	Department	WTE	PAs (based on WTE)	Total PAs
							10
							10.25
							12.28
							12
							11.01

							10
							10.62
							10
							10
				Geriatric Medicine	1.00	10	10
				Geriatric Medicine	0.80	9	9

Need to add in Associate Specialists – none of whom contribute to the Gen Medicine Ward work.

N Chapman - Respiratory
V Mcgoldrick - Rheumatology
G Tallon – Geriatrics/Stroke
K Kirk – Orthogeriatrics

Daisy Hill

Forename	Surname	Contribute to General Medicine	Special Interest	Department	WTE	PAs (based on WTE)	Total PAs
	Mustafa			General Medicine	1	10	10
Olivia	Nnamani			General Medicine	1	10	10
Khairunnisa	Abdul Halim			General Medicine	1	10	11
Andrea	Livingstone			General Medicine	1	10	11
Cormac Joseph	Murtagh			General Medicine	1	10	11.49
Lisa	Watt			General Medicine	1	10	10
Sean	McEvoy			Day Care Serv	0.9	9	9
Aileen	Murray			General Medicine	1	10	12

ACTIVE RECRUITMENT DATA (ALL GRADES) – Sept 2020

POST	SPECIALTY	BASE	NEW / REPLACEMENT	DETAILS
Consultant	Geriatrician	CAH	New post	Interviews 6.10.20 – only 1 applicant to be interviewed for both posts. Not appointed to either posts.

Consultant	Genitourinary HIV Medicine	CAH	New post	Pending Royal College approval
Consultant	Physican - Acute Medicine	CAH	New post	Interviews 14.10.20 – 1 applicant
Consultant	Physician – Acute Medicine / DAU	DHH	New post	Job description approved - Pending e-Req
Consultant	Gastroenterology	CAH	New post	**Dr Oliver Reed** appointed – has taken a year out and will not commence post until October 2021
Consultant	Geriatrician – Acute Care at Home	Lurgan Hospital	New post	Interviews 6.10.20 – only 1 applicant not appointed.
Specialty Doctor	Respiratory & Ambulatory Medicine	~~DHH~~ CAH	New post	Closing 17.9.20 – 3 applicants to date – Interviews scheduled 12.10.20
Specialty Doctor	DAU	DHH	Replacement	CD 24.9.20 – 4 applicants pending shortlisting
Specialty Doctor	Stroke Medicine	Lurgan Hospital	New post	CD 1.10.20 – 2 applicants pending shortlisting
Specialty Doctor	Diabetes (Antenatal)	CAH	Replacing Dr Rizwan Haq	Closed – no applicants

NIMDTA PROJECTED CCT NUMBERS FOR CONSULTANT PLANNING

CCT training completed within next 12 months: 10 in medical sub-specialties

- 1 in AIM
- 2 in Diabetes
- 3 in Gastro
- 4 in Respiratory

PROPOSAL TO ENHANCE MEDICAL MODEL IN CAH

This paper is seeking approval in principle to the need for additional investment in the medical model at CAH in line with growing demand for medical unscheduled care services as demonstrated through increased workload associated with Covid, attendances at ED and increased admissions to medical specialities. The ongoing pattern of medical outliers across CAH

needs to be better managed to ensure patients are cared for in the most appropriate place with dedicated medical and nursing staff who best meet their needs for treatment and care.

The proposal is to establish 4 ward based teams. This option would require an **additional 14 medical consultants** (disciplines to be agreed) along with appropriate supporting junior medical and nursing, AHP staff. It is proposed that this option would be implemented on a phased basis in line with availability of consultant staff and other support staff over a number of years.

The aim of this proposal would be to work towards the creation of 4 1:7 specialty teams, who would all contribute to the Physician of the Week model:

- **7 consultants in Amu**
- **7consultants in GI**
- **7 consultants in Respiratory**
- **7 consultants in an "others team" made up of D&E etc**

The proposal would work towards 28 consultants all contributing to 1:7 POW and weekend cover. The benefits of this model will provide continuity of care with the Specialty based teams all in the hospital at the same time. This proposal would require an additional Medical Ward – 36 bedded ward with all the relevant staffing to support.

Important papers in regards Medical Staffing

Name of Paper	***Relevance to this paper***
Proposed Model MUSC April 2013 for I	Old Paper from 2013 – simply included here for reference and may have no significance or use for current exercise. Simoy/Dr Bradley can you update this one to reflect new model???
Acute Medical specialties consultant	Regional Workforce Paper published in 2018 by the PHA.
Proposal to Enhance Medical Staffing withi	Previous SMT paper for additional Consultant Staffing in 2017
Regional Influence to Allocation to Trainees	SHSCT 2019 paper comparing overall rotational training numbers with a focus on Medicine – indicating SHSCT has the least number of training doctors at all grades in General Medicine
7 DAY JOB PLANNING - FUTURE	Future Hospital Journey 2017 and importance of Consultant Job Planning for 7 day service.

APPENDIX SECTION

Medical Staffing Profile across Trusts – Data from SMT Paper collated by SHSCT in 2017

Trust	Total funded posts	Permanent consultants by headcount	Number of locums in permanently funded posts	Number of vacant permanently funded posts	Hospital and speciality of vacant posts
Belfast (Oct 16)	86	77	1 (RVH –acute med)	8	RVH -1 AIM, 1 endo,3 resp,+3 CoE in recruitment
Northern (Oct 16)	44	34	-	10	Antrim-2AIM,2 CoE,1 rheum,C'way-1 diabetes/endo,1 resp, 1 CoE
South Eastern	38	36	-	2	UHD-1 AIM, LVH-1 CoE (to be filled Sept 16)
Southern (Nov 16)	27	27	-	-	-
Western	32	23	4 (Alt-1 AIM, 3 CoE)	5	Altnagelvin -3 AIM,1 gastro, SWAH-1 endo

In 2017 – This Table demonstrated that the Southern Trust has the lowest overall number of funded medical posts of any Trust in Northern Ireland despite the Southern Trust being comparable to the majority of other Trusts in terms of resident population size.

PHA PUBLISHED REPORT REPORTED IN APRIL 2018 - (Full Report attached at end of report)

Consultants in permanently funded posts by speciality and Trust

Trust/ Speciality	Belfast	Northern	South Eastern	Southern	Western	Total
		6	6	2	4	**28**
		3	6	4	3	**24**
		9	6	6	5	**39**
		7	12	8		**55**
		7	7	5		**44**
		3	3	4		**20***
		35	**40**	**29**		**209**

*this group of 20 consultants contains many working part-time

DETAILS OF LOCUM EXPENDITURE

Consultants engaged long term via Agency as at 29th September 2020

Name Of Locum on Rota	Current Speciality	Location	Agency/Trust	Hourly Cost	Weekly Cost
			Agency	Personal Information redacted by the USI	
		DHH	Agency		
		DHH	Agency		
		CAH	Agency		
		DHH	Agency		
	General Medicine	DHH	Agency		
	Medical Outliers	CAH	Agency		
	Medical Outliers	CAH	Agency		
	Medical Outliers	CAH	Agency		

Junior Doctors on AMU Rota

Name Of Locum on Rota	Agency/Trust	Hourly Cost	Weekly Cost
Anna Betts	Agency	Personal Information redacted by the USI	
Niall Ahern	Trust		
Martin Leer	Trust		
Hannah McCullough	Trust		
Jessica Mullholland	Trust		
Ellen Morrison	Trust		

They work the following rota in AMU:

Week	Mon	Tue	Wed	Thu	Fri	Sat	Sun
1	A	A	A	B	B		
2		A	A	A	A		
3	A	A	A	A	A		
4	B	B	B	A	A		
5	A	A		A	A	C	C
6	A	A	A	A	A		

A Shift = Need to add times here
B Shift = Need to add times here
C Shift = Need to add times here

Medical Outliers

		Hourly Cost	
		Personal Information redacted by the USI	

Additional Ward SHO's

Ward	Name Of Locum on Rota	Agency/Trust	Hourly Cost	Weekly Cost
	Laura Carr	Trust	Personal Information redacted by the USI	
	Barry Walls	Trust		
	Plamena Peneva	Agency		
	Opeyemi Foye	Agency		
	Oluwaseun Oludiran	Agency		

Day Clinical Centre, STH	Sarah Hughes	Agency	Personal Information redacted by the USI
Cardio			

Funded NIIMDTA SPR GAPS

There is currently **1** Locum ST3 longer term/block booking on the Registrar rota. This will be against a funded vacancy which would normally cost us per hour

Name Of Locum on Rota	Agency/Trust	Hourly Cost	Weekly Cost
Andrew Gibson	Agency	Personal Information redacted by the USI	

Funded NIMDTA SHO Gaps

There are currently **5** Locum FY2 grade doctors covering funded vacancies on the SHO rota, which would normally cost us per hour.

Name Of Locum on Rota	Agency/Trust	Hourly Cost	Weekly Cost
	Trust	Personal Information redacted by the USI	
	Trust		
	Agency		
	Agency		
	Agency		

NIMDTA CONFIRMED CCT AWARDS IN NEXT 12 MONTHS – SEPT 2020

Detailed breakdown as below:

Row Labels	Count of Person
Acute Internal Medicine	1
Anaesthetics	12
Cardiology	1
Cardio-thoracic Surgery	1
Child and adolescent psychiatry	4
Clinical Oncology	4
Clinical radiology	5
Dermatology	2
Emergency Medicine (run through)	14
Endocrinology and diabetes mellitus	2
Gastroenterology	**3**
General psychiatry	7
General Surgery	4
Genito-urinary medicine	1
Geriatric medicine	5
Haematology	6
Histopathology	9
Infectious diseases	2
Intensive care medicine	1
Medical oncology	5
Neurology	3
Neurosurgery	1
Obstetrics and gynaecology	12
Old age psychiatry	4
Otolaryngology	2
Paediatrics	13
Palliative medicine	2
Plastic Surgery	1
Public health medicine	5
Rehabilitation medicine	1
Renal medicine	2
Respiratory medicine	4
Trauma and Orthopaedic Surgery	7
Vascular Surgery	1
Grand Total	**147**

Medical & Dental

Locum Rates Proposal

2021

Strictly Private & Confidential

Author: Zoe Parks, Head of Medical HR SHSCT

Background

It is widely recognised that there is a spiralling increase in the use of medical agency across Northern Ireland. This is also coupled with a rising trend for many junior doctors to take a break from the NI Training Scheme with some choosing to take up locum placements via external agencies for 6, 12 and sometimes 24 month periods. The NI Audit Office report issued in April 2019 highlighted that value for money is not being achieved in respect of the HSC sectors with high and increasing reliance on locum doctors.

The Regional Medical HR sub group was tasked at reviewing locum rates and in 2019 made contact with Dominic Raymont, the Deputy Director of Agency Intelligence at NHS Improvement and Marcus Riddell, Head of Operations and Governance for Temporary Staffing at NHS England and NHS Improvement. This led to a conference call in April 2019 and more recently a presentation of the HSC E locum System in January 2020.

One of the key factors that NHS Improvement emphasise to tackle agency spend is establishment and promotion of **internal locum banks** (as an alternative to external agencies). They recommend collectively working together within Northern Ireland to tackle locum spend by agreeing and ensuring we only use a set of locally agreed locum rates. London collaborative has been very successful in this regard. NHS Improvement published a '**Guide for Medical Directors on taking control of medical locum spend'**. See below.

Reducing_reliance_o
n_medical_locums_-_

Locum Rates Northern Ireland

The Department of Health issued a pay circular which set out the locum rates that could be payable to junior doctors for **Short Term Cover** back in May 2015. (See below)

HSC _TC8_ 2 2015 -
Increase in Regional F

Unfortunately due to demand and supply; rates for junior doctors have spiralled outside of any circular in recent times, with many Trusts now having to escalate rates and pay to secure cover – creating a level of competition within the system which is driving hourly rates upwards. This includes the rates being offered to doctors working directly for Trusts (internal banks) and also what Trusts are advising they are willing to pay doctors engaged via external Agencies which is invariably driving up the use of off-contract spend.

It is important to be aware that under existing Agency Framework contracts, once a higher rate above contracted rates is negotiated with an agency (even a contracted agency that is known to us); the Trust is immediately 'off contract' – another huge criticism highlighted by the NI Audit office report.

We know rates as high as £90 per hour, are frequently offered for ST1 level shifts. Competition has been allowed to develop by the lack of central control/accountability and consequently the ability to 'negotiate' rates at Trust level – and invariably at specialty level within Trusts.

The Southern Trust has recently agreed a Consultants Covering Absent Colleagues Document with the Local Negotiating Committee of the BMA, setting out acceptable payment rates for consultant medical staff covering internally. It is hoped that this may pave the way for some regional discussions and also helps to set a rate to act as the ceiling from which a sliding scale for other medical grades can be set, to reflect fair and equitable rates for all other grades of junior medical staff.

We would be very keen to see if we can successfully work collaboratively to set the "fair" price for our locum shifts for our junior doctors. We know ultimately that patients are safer if they are treated by our own doctors or doctors appointed by us (internal locum banks). Our ultimate aim therefore is to ensure we can successfully manage our own flexible medical workforce in a manner which provides safe care for our patients.

PROPOSED RATES FOR MEDICS – DRAFT FOR DISCUSSION – (AIM FOR REGIONAL AGREEMENT)

The method we used for reviewing current rates was as follows:

- *Column 1 - Comparison with current 2020 medical pay scales to show how employed doctors are remunerated for daytime who are working alongside the locums*
- *Column 2 - We then calculated the equivalent of Double Time on the maximum of the pay scale by grade – as another comparison. This would be the same as inclusive of band 3. We used 1.78% for the non-training grades as we needed an enhancement on premium time for locum but double salary (given their long pay scales would be disproportionate.)*
- *Column 3 - These are the rates set out within the HSC E Locum circular that was issued setting out the current locum rates and is still in place and hasn't been updated*
- *Column 4 - Proposed Rates - We have set out what we believe are fair and appropriate hourly rates by grade for junior doctors. Work on official Bank Holidays =time plus ½ as before.*

*These rates are for Full Shift. Where an on-call rota is in place. Non-resident rate should be calculated at 75% **It is proposed there would be NO Escalation Rate.***

Break Glass Policy would sit with the Chief Executive who would only have authority to deviate from these rates. May need to consider anti-social and daytime locum rate differentials

SHORT TERM COVER ON INTERNAL LOCUM BANK – ZERO HOURS BANK CONTRACT – PAID VIA HSC E LOCUM SYSTEM

Grade	1. Top Point on NHS Pay scale for this grade per hour (2020/21 Payscale)	2. LATEST 20/21 Circular – Hourly rate on Double Max or 1.75% for non-training grades*	3.Current HSC E Locum Departmental Locum Circular Rate	4. Proposed Maximum Ceiling Internal Locum Rate* (Full Shift Rate) **75% for Non-resident**
FY1	£13.38	£26.76	**£28**	**£28.28**
FY2/CT1-2	£20.86	£41.73	**£38.07**	***New £40***
ST3+ / reg	£24.79	£49.59	**£46.14**	***New £50****
*SAS Junior **(1.78%)**** *(Pt9)*	£30.04	£53.47*	**£46.14**	***New - £53***
*SAS Senior **(1.78%)****	£36.97	*£65.82**	**£46.14**	***New - £65***
*Associate Specialist **(1.78%)****	£45.76	*£81.46**	**£46.14**	***New - £80***
*Consultant **(1.78%)****	£53.33 £71.10(Prem. Time)	£94.93*	**No Circular Rate**	***£90*** ***£75 on-call @ home***

Any new agreement / rates would have to be accompanied with a strong campaign to promote equity and fairness to ensure doctors were aware that these rates would be applied consistently across all specialties and locations in Northern Ireland for all Internal medical bands without escalations to help manage external Agency spend.

FURTHER COMPARISON TABLE

Grade	*Current HSC E Locum Departmental Locum Circular Rate*	*4% Rise on the original HSC E Locum Circular as previously suggested a number of years ago*	*Our Proposal – for comparison as set out above*
FY1	*£28*	*£29.12*	**Keep – £28.28**
SHO / FY2/CT1-2	*£38.07*	*£39.59*	***New £40***
ST3+ / Reg.	*£46.14*	*£47.98*	***New £50****
SAS Junior (1.78%)	*£46.14*	*£47.98*	***New - £53***
SAS Senior (1.78%)	*£46.14*	*£47.98*	***New - £65***
Associate Specialist (1.78%)	*£46.14*	*£47.98*	***New - £80*** **£66 on-call @ home**
Consultant (1.78%)	*No Circular Rate*	*No circular rate*	***£90*** **£75 on-call @ home**

A LIST OF OUR CONTRACTED AGENCY RATES IS SET OUT IN DOCUMENT BELOW

500694
FrameworkPages 201

INTERNAL BANK RATES FOR LONGER TERM BLOCK BOOKINGS ENGAGED UNDER FIXED TERM CONTRACT

As per Medical & Dental Pay Circular - Annex A section 7

Post-graduate Doctors in Training.

In July 2012, a regional locum rate was agreed for the payment of short-term locum appointments. Details of remuneration for these doctors can be found in the HSC (TC8) 2/2015 addendum 22nd January 2016, from the Director of Human Resources.

Foundation House Officer, Core Trainee and Specialist Registrar		
Band	**Working Arrangement**	**Supplement**
LL	Covering a post for one week	1.2 x total salary (basic salary + banding supplement)[18]

Weekly Rates (£) : Band LL [20]								
	Basic Rate[18]	No band	1C	1B	1A	2B	2A	3
Band	**x1**	-	**x1.2**	**x1.4**	**x1.5**	**x1.5**	**x1.8**	**x2.0**
FHO1	606.78	637.30	728.14	849.51	910.16	910.16	1,092.20	1,213.55
FHO2	755.19	755.19	906.22	1,057.25	1,132.78	1,132.78	1,359.33	1,510.38
SpR	978.32	978.32	1,174.00	1,369.66	1,467.48	1,467.48	1,760.97	1,956.63
StR (Higher Rate)	978.32	978.32	1,174.00	1,369.66	1,467.48	1,467.48	1,760.97	1,956.63
StR (Lower Rate)	887.80	887.80	1,065.38	1,242.93	1,331.71	1,331.71	1,598.06	1,775.61

- **LONG TERM BLOCK BOOKINGS 3 MONTHS OR MORE - ST1/2 SHO Rate = £33.29ph & ST3+ rate = £44.02 per hour**
- **Engaged under Fixed Term contract to cover a specific longer term vacancy on a Rota**
- **HOURLY RATE FOR LONGER TERM BOOKINGS BASED ON 1.8 MULTIPLER ABOVE**
- **Contract issued: Entitlement to appropriate allocation of paid annual leave. Sick Leave also applicable as per Bank contract**

Final_Medical Locum Fixed Term Contract (

Appendix Relevant extract from Medical & Dental Pay Circular 2020

ANNEX A: SECTION 1: BASIC RATES OF PAY PER ANNUM effective from 1 April 2020 **NB – End notes appear at Section 12 of Annex A**

Basic Salary (£)										
Grade	Pay Scale Code	Pay threshold								
2004 Consultant Contract			1	2	3	4	5	6	7	8
Period spent on each threshold			(1 year)	(1 year)	(1 year)	(1 year)	(5 years)	(5 years)	(5 years)	(Final)
Consultant appointed on or after 15 January 2004	M400		82,500	85,084	87,668	90,250	92,826	98,964	105,100	111,230
Consultant appointed before 15 January 2004		See Section 2: Table 1 for pay scales								

(2008) M215 and M090 Specialty Doctors and Associate Specialist contract	Pay Scale Code	1	2	3	4	5	6	7	8	9	10	11
Period spent on each threshold (M215 and M090)		(1 year)	(1 year)	(1 year)	(1 year)	(1 year)	(2 years)	(2 years)	(2 years)	(3 years)	(3 years)	(Final)
Specialty Doctor (2008) (see Section 3 for detailed pay scales)	M215	41,357	44,895	49,491	51,955	55,505	59,042	62,658	66,274	69,891	73,507	77,124
Associate Specialist (2008) (closed grade) Section 3 for detailed pay scales)	M090	57,985	62,647	67,306	73,461	78,794	81,007	83,896	86,784	89,671	92,558	95,450

Grade	Pay Scale Code	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Specialty Registrar (full)	M241	32,893	34,907	37,717	39,418	41,467	43,519	45,570	47,620[5]	49,670[5]	51,721[5]				
Specialty Registrar (CT)	M242	32,893	34,907	37,717	39,418	41,467	43,519								
Specialty Registrar (FT)	M240	32,893	34,907	37,717	39,418	41,467	43,519								
Foundation House Officer 2	M230	30,782	32,794	34,808											
Foundation House Officer 1	M220	24,818	26,367	27,914											
Hospital practitioner	M200 - M204	4,992	5,280	5,571	5,859	6,148	6,437	6,726							
Consultant (closed grade)	M027[1]	68,499	73,399	78,302	83,203	88,794									
Associate Specialist (closed grade)	M080[1]	42,355	46,839	51,325	55,811	60,296	64,781	70,707	75,841	77,971[2]	80,750[2]	83,530[2]	86,310[2]	89,089[2]	91,870[2]
Staff Grade Practitioner (closed grade)	M210[1]	38,316	41,356	44,398	47,441	50,482	53,524	56,565	59,605						
Staff Grade Practitioner (closed grade)	M211/ M2121+3	M211	M211	M211	M211	M211	M211	M212	M212	M212	M212	M212	M212		
		38,316	41,356	44,398	47,441	50,482	54,064	56,565[4]	59,605[4]	62,648[4]	65,689[4]	68,731[4]	71,774[4]		
Specialist Registrar (closed	M101	34,318	36,019	37,717	39,418	41,467	43,519	45,570[5]	47,620[5]	49,670[5]	51,721[5]				

Southern Health and Social Care Trust

VIRTUAL HR & MEDICAL DIRECTORATE MEETING

Wednesday, 16th June 2021 @ 11:00am

Join Zoom Meeting

Irrelevant information redacted by the USI

Meeting ID: Irrelevant information redacted by the USI

Passcode: Irrelevant information redacted by the USI

AGENDA

- **HR Medical Dashboard**
- **New SAS Contract 2021**

SHSCT - New Contract for SAS 202

- **Relocation Expenses for Specialty Doctors**
- **Coronial Service – support for staff involved in upcoming inquest**
- **Mentoring/Coaching Service**
- **Clinical Director for Locums**
- **Any Other Business**

Date of next virtual meeting: Wednesday, 11th August 2021 @ 2:00pm

Southern Health and Social Care Trust

Quality Care - for you, with you

NEW Contract for Specialty Doctors and Associate Specialists **2021**

SAS contract reform 2021

Key Changes at a glance...

- Reformed Specialty Doctor Contract which will transition from 11 pay points to a new 5-point scale over a three-year period, starting from 1 April 2021.
- Introduction of a new Specialist grade to extend potential career progression for Specialty Doctors. This role will help to recruit, motivate and retain senior doctors and contribute to SAS grades being a positive and fulfilling career choice. The creation of these roles will be driven by local employer need to meet service requirements and will be advertised for competitive entry through local recruitment processes.
- Choice for individual SAS doctors on national terms and conditions (TCS) to move to the new contracts or stay on existing TCS.

Pay & pay progression

- Higher starting salary for the Specialty Doctor pay scale
- A new Specialist grade with a 3-pay point scale, extending potential earnings for Specialty Doctors who apply for and are appointed to this grade.
- Quicker progression to the top of the pay scale
- Progression occurs at a minimum of every 3 years, dependant on meeting set criteria.
- Introduction of a simple but robust pay progression process to ensure pay progression is achieved where clinical managers are satisfied that the doctor has met the required standards.

Terms & Conditions Changes

Out of Hours	Defined as any time that falls outside of the period 7am to 9pm Monday to Friday and any time on a Saturday and Sunday or Public Holiday.
On-call availability supplement	Introduction of Category A and Category B on-call availability supplements to bring in line with consultants.
Safeguards	Introduction of safeguards that allow work patterns to balance flexibility and support the health and wellbeing of SAS doctors • No more than 40% working time in OOH • Maximum of 13 weekends a year • Maximum of 4 consecutive nights or long day shifts
Annual Leave	An additional day of annual leave after 7 years in the SAS grade.
Temporary Schedules	Removal of the temporary schedules and adoption of the common terms of the NHS TCS Handbook.
Spare Professional Capacity	Removal of the penalty for doctors not offering an additional PA to their employer. Replaced with a provision to strongly encourage doctors to initially offer additional hours of work to the service of the NHS via an NHS staff bank of their choosing.

Timing and Choice

- BMA are currently reviewing NI contract paperwork. DOH will then issue to employers
- Doctors will have until 31 October 2021 to express an interest in moving to new contract
- Transfers all to be completed by end of December 2021. This will involve Job Plan review
- The doctor will be entitled to an amount of pay equivalent to the arrears of pay they would have received had they moved to the contract on 1 April 2021.

https://www.nhsemployers.org/pay-pensions-and-reward/medical-staff/sas-doctors/sas-contract-reform/faqs-for-sas-contract-reform-2021

Southern Health and Social Care Trust

VIRTUAL HR & MEDICAL DIRECTORATE MEETING

Friday, 8th October 2021 @ 3:00pm

Join Zoom Meeting

Irrelevant information redacted by the USI

Meeting ID: Irrelevant information redacted by the USI / **Passcode**: Irrelevant information redacted by the USI

AGENDA

- **HR Medical Dashboard**
- **New SAS/Specialist Contract 2021**
- **Private Practice & Governance Processes** ***(Pending CFS Visit)***
- **Entrance & Exit interviews**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Entrance-Interview-te


LfE
Exit-Interview-templa


HSC Staff Survey
Results - Southern HS

- **Any Other Business**

Date of next virtual meeting: Wednesday, 8th December @ 2:00pm

Entrance interview questionnaire

This is your entrance interview questionnaire. We would like you to answer it at the beginning of your post and use it to guide formation of your personal development plan. We hope you will find it useful to reflect on what you want to bring to your new post, what you would like to achieve during your time with us, and how we can help you to do that. An online version of this form can be found at www.learningfromexcellence.com and if you include your email address a copy of the form will be emailed to you.

What is important to you?

This may be work related, but doesn't have to be. We want you to think about what matters to you so this can be considered in terms of your aims and objectives for the post.

What are your strengths and how would you like to use them in this post?

What is the best thing that you could bring from your previous post to this one?

What can we do together to help you feel valued?

What do you think is going to stretch you in this post? How might you manage this?

Imagine you are at the end of your planned rotation or placement and it has gone really well. What will you have achieved and what will your colleagues have learnt from / about you?

Exit Interview template

This questionnaire is your exit interview from your department. When answering the questions, please consider your whole post. The purpose of the questionnaire is discover insights which can be used to improve the experience of others working in the department, so please include as much information as possible. Thank you very much for your time.

Please return this form to……

What aspects of your time in this post have been particularly good, and why?

What aspects of your time in this post have particularly stretched you?

What helped you to manage those aspects?

Imagine you were returning to the department in the future and the job was improved, what would be different?

… and what would still be here?

What were your most valuable educational or training experiences?

Do you have any other ideas of ways we can improve the experience of those working in the department?

Are there any members of the team you would like to thank that you haven't done already?

If you are willing, please indicate your grade: CT1-2 / ST3-4 / ST5-7 / Speciality doctor / Consultant
Band 1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9

learning from excellence

2019 HSC Staff Survey - Detailed Spreadsheets - Southern HSCT

The detailed spreadsheets contain results at both individual question and Key Finding level. Organisational-level results are also included and are broken down by Directorate/Division, by Personnel Area (as recorded on the HSC payroll system) and by demographic background group (as self-selected in the survey questionnaire).

The Northern Ireland Statistics and Research Agency (NISRA) conducted the 2019 staff survey on behalf of the HSC. The survey went live on 4 March 2019 and remained open for a six-week period, closing on 12 April 2019. It was a full census survey of all staff within the 16 HSC organisations listed below and recorded as employed on the HSC payroll system on 31 January 2019. This represented a total headcount of 77,781 staff being sent a survey invite. Of these, 47,787 (61.4%) were sent a link to their HSC work email address and asked to complete the survey online. The remaining 29,994 (38.6%) staff were sent a paper questionnaire to their home address and asked to complete and return it to NISRA using a prepaid envelope provided. A total of 19,094 completed responses were received by NISRA (13,423 from online and 5,671 paper responses), producing an overall response rate of 24.5% (28.1% for online and 18.9% for paper).

The 16 HSC organisations surveyed in 2019 were as follows: the five Northern Ireland Health and Social Care Trusts (HSCT), the Northern Ireland Ambulance Service HSC Trust (NIAS), Business Services Organisation (BSO), the Health and Social Care Board (HSC Board), the Public Health Agency (PHA), the Northern Ireland Blood Transfusion Service (NIBTS), the Northern Ireland Guardian ad Litem Agency (NIGALA), the Northern Ireland Medical and Dental Training Agency (NIMDTA), the Northern Ireland Social Care Council (NISCC), Patient Client Council (PCC), the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC), and the Regulation and Quality Improvement Authority (RQIA).

For further information on the survey or how the overall staff engagement scores and Key Findings are calculated, please refer to the published 2019 HSC Staff Survey Regional Benchmark Report:

https://www.health-ni.gov.uk/

Note 1: For the results of each question and Key Finding reported by Directorate and Personnel Area, the best and worst scores across the HSC organisation have been highlighted in green and red respectively.

*Note 2: Where a lower score is better, this has also been highlighted with a ' * ' and italicised text.*

Note 3: Where there are less than 11 responses in a group, results are suppressed and replaced with ' # ', likewise, where a result is not available, it is denoted by ' -- '.

2019 HSC Staff Survey Key Findings Data for Personnel Areas within Southern HSC Trust	HSC OVERALL 2019	Southern HSCT Overall 2019	Admin & Clerical	Estates	Medical & Dental	Nursing & Midwifery	Professional & Technical	Social Services	Support Services /User Experience	HSC Overall 2015	Southern HSCT Overall 2015
Invite Count	**77,781**	**12,802**	1,820	102	1,022	4,812	1,587	2,573	886	**69,514**	**10,278**
Response Count	**19,094**	**3,167**	652	22	182	1,040	462	713	96	**17,796**	**2,176**
Response Rate	**24.5%**	**24.7%**	35.8%	21.6%	17.8%	21.6%	29.1%	27.7%	10.8%	**26%**	**21%**
Overall Engagement Score	**3.78**	**3.78**	3.78	3.73	3.66	3.77	3.79	3.84	3.74	**3.72**	**3.81**
Key Finding 1. Staff recommendation of the organisation as a place to work or receive treatment *(1-5)*	**3.75**	**3.71**	3.76	3.74	3.54	3.63	3.66	3.85	3.79	**3.71**	**3.81**
Key Finding 2. Staff satisfaction with the quality of work and care they are able to deliver *(1-5)*	**3.97**	**3.93**	4.03	3.94	3.67	3.87	3.81	4.11	4.12		--
Key Finding 3. Percentage of staff agreeing that their role makes a difference to patients / service users *(%)*	**89.8%**	**90.7%**	77.4%	90.5%	94.4%	93.3%	94.1%	93.5%	88.2%	**89%**	**90%**
Key Finding 4. Staff motivation at work *(1-5)*	**4.00**	**4.05**	3.97	3.74	3.78	4.11	4.03	4.14	4.09	**3.90**	**4.01**
Key Finding 5. Recognition and value of staff by managers and the organisation *(1-5)*	**3.40**	**3.39**	3.51	3.35	3.27	3.32	3.42	3.45	3.08	**3.48**	**3.55**
Key Finding 6. Percentage of staff reporting good communication between senior management and staff *(%)*	**29.5%**	**28.8%**	30.6%	31.8%	22.0%	28.4%	26.2%	30.9%	29.2%	**28%**	**33%**
Key Finding 7. Percentage of staff able to contribute towards improvements at work *(%)*	**64.1%**	**64.2%**	63.9%	72.7%	71.3%	64.0%	70.6%	60.9%	45.8%	**63%**	**67%**
Key Finding 8. Staff satisfaction with the level of responsibility and involvement *(1-5)*	**3.87**	**3.87**	3.83	3.77	3.95	3.88	3.96	3.86	3.65		--
Key Finding 9. Effective team working *(1-5)*	**3.73**	**3.76**	3.64	3.68	3.75	3.79	3.87	3.83	3.35	**3.71**	**3.77**
Key Finding 10. Support from immediate managers *(1-5)*	**3.70**	**3.76**	3.85	3.52	3.60	3.74	3.81	3.78	3.43	**3.65**	**3.75**
Key Finding 11. Percentage of staff appraised in last 12 months *(%)*	**70.7%**	**74.4%**	65.5%	100.0%	89.0%	75.9%	77.8%	77.1%	50.0%	**65%**	**67%**
Key Finding 12. Quality of appraisals *(1-5)*	**3.11**	**3.14**	3.06	2.14	2.56	3.25	3.09	3.31	3.02		--
Key Finding 13. Quality of non-mandatory training, learning or development *(1-5)*	**4.11**	**4.12**	3.79	3.36	4.03	4.25	4.17	4.14	3.93		--
Key Finding 14. Staff satisfaction with resourcing and support *(1-5)*	**3.30**	**3.29**	3.50	3.09	2.96	3.19	3.14	3.41	3.35	**2.95**	**2.88**
Key Finding 15. Percentage of staff satisfied with the opportunities for flexible working patterns (%)	**52.9%**	**52.2%**	63.1%	72.7%	35.9%	47.3%	48.7%	56.4%	42.7%		--
* ***Key Finding 16.*** *Percentage of staff working extra hours (%)*	**68.1%**	**69.1%**	50.4%	76.2%	90.4%	72.4%	71.3%	76.3%	60.9%	**95%**	**95%**
* ***Key Finding 17*** *. Percentage of staff feeling unwell due to work related stress in last 12 months (%)*	**46.7%**	**46.1%**	36.6%	54.5%	49.5%	51.9%	46.7%	45.2%	42.1%	**36%**	**32%**

2019 HSC Staff Survey Key Findings Data for Personnel Areas within Southern HSC Trust	HSC OVERALL 2019	Southern HSCT Overall 2019	Admin & Clerical	Estates	Medical & Dental	Nursing & Midwifery	Professional & Technical	Social Services	Support Services /User Experience	HSC Overall 2015	Southern HSCT Overall 2015
* ***Key Finding 18.*** *Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves (%)*	**60.9%**	**60.4%**	59.6%	63.6%	55.4%	63.6%	63.7%	56.0%	56.0%		--
Key Finding 19. Organisation and management interest in and action on health and wellbeing *(1-5)*	**3.53**	**3.52**	3.74	3.39	3.26	3.42	3.61	3.51	3.29		--
* ***Key Finding 20*** *. Percentage of staff experiencing discrimination at work in the last 12 months (%)*	**12.9%**	**12.2%**	7.8%	13.6%	11.7%	14.3%	11.2%	12.8%	20.0%	**10%**	**9%**
Key Finding 21. Percentage believing that organisation provides equal opportunities for career progression or promotion (%)		--	--	--	--	--	--	--	--	**94%**	**96%**
* ***Key Finding 22.*** *Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months (%)*	**17.9%**	**20.4%**	2.8%	0.0%	19.2%	33.8%	14.1%	22.0%	19.8%	**14%**	**12%**
* ***Key Finding 23.*** *Percentage of staff experiencing physical violence from staff in last 12 months (%)*	**2.2%**	**1.9%**	0.9%	4.5%	0.0%	2.4%	0.9%	1.4%	12.6%	**2%**	**1%**
Key Finding 24. Percentage of staff/colleagues reporting most recent experience of physical violence in last 12 months *(%)*	**78.8%**	**80.1%**	80.6%	100.0%	54.8%	81.9%	61.2%	88.6%	81.5%	**77%**	**73%**
* ***Key Finding 25*** *. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months (%)*	**32.0%**	**35.4%**	19.6%	9.1%	48.6%	43.7%	32.9%	38.1%	26.0%	**25%**	**23%**
Key Finding 26 *. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months (%)*	**27.6%**	**26.5%**	26.4%	36.4%	25.3%	32.5%	21.0%	20.5%	32.6%	**22%**	**20%**
Key Finding 27. Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse in last 12 months *(%)*	**52.0%**	**54.7%**	48.6%	100.0%	29.7%	57.7%	40.0%	68.0%	62.2%	**54%**	**53%**
* ***Key Finding 28*** *. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month (%)*	**26.6%**	**26.0%**	14.0%	27.3%	50.6%	33.9%	22.5%	20.5%	32.6%	**26%**	**21%**
Key Finding 29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month *(%)*	**88.7%**	**88.6%**	73.1%	100.0%	82.4%	92.1%	86.7%	94.0%	90.3%	**95%**	**91%**
Key Finding 30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents *(1-5)*	**3.65**	**3.61**	3.49	3.17	3.34	3.66	3.62	3.70	3.75	**3.53**	**3.55**
Key Finding 31. Staff confidence and security in reporting unsafe clinical practice *(1-5)*	**3.52**	**3.52**	3.43	3.07	3.40	3.57	3.40	3.63	3.53		--
Key Finding 32. Effective use of patient / service user feedback *(1-5)*	**3.58**	**3.53**	3.52	--	3.20	3.60	3.49	3.52	3.57		--
Key Finding 33. Percentage of staff who do not typically feel worn out and feel supported in achieving a work-life balance *(%)*	**5.6%**	**5.2%**	7.7%	4.5%	2.2%	3.8%	4.6%	6.3%	3.2%	‡	‡
Key Finding 34. Percentage of staff who said that HSC is a great place to work and are proud to tell others that they are part of HSC *(%)*	**48.1%**	**47.6%**	49.9%	40.9%	32.0%	43.7%	47.2%	55.1%	52.7%	‡	‡

2019 HSC Staff Survey Key Findings Data for Personnel Areas within Southern HSC Trust	HSC OVERALL 2019	Southern HSCT Overall 2019	Admin & Clerical	Estates	Medical & Dental	Nursing & Midwifery	Professional & Technical	Social Services	Support Services /User Experience	HSC Overall 2015	Southern HSCT Overall 2015
Key finding 35. Percentage of staff who feel that HSC takes effective action if staff are physically attacked, bullied, harassed or abused *(%)*	**31.4%**	**32.4%**	32.8%	18.2%	22.5%	32.0%	24.9%	39.6%	38.5%	ǂ	ǂ

Received from Maria O'Kane on 02/09/22. Annotated by Urology Services Inquiry

2019 HSC Staff Survey Key Findings Data by Organisational Staff Directorate	HSC OVERALL 2019	Southern HSCT Overall 2019	Acute Services	Chief Executive's Office	Children & Young People's Services	Finance & Procurement	HR & Organisational Development	Medical	Mental Health & Disability Services	Older People & Primary Care	Performance & Reform	HSC Overall 2015	Southern HSCT Overall 2015
Invite Count	**77,781**	**12,802**	4,657	14	1,683	247	1,338	46	1,719	2,935	163	**69,514**	**10,278**
Response Count	**19,094**	**3,167**	916	8	519	60	261	22	501	808	72	**17,796**	**2,176**
Response Rate	**24.5%**	**24.7%**	19.7%	57.1%	30.8%	24.3%	19.5%	47.8%	29.1%	27.5%	44.2%	**26%**	**21%**
Overall Engagement Score	**3.78**	**3.78**	3.64	#	3.83	3.73	3.85	3.62	3.84	3.86	3.85	**3.72**	**3.81**
Key Finding 1. Staff recommendation of the organisation as a place to work or receive treatment *(1-5)*	**3.75**	**3.71**	3.52	#	3.75	3.84	3.79	3.27	3.75	3.84	3.80	**3.71**	**3.81**
Key Finding 2. Staff satisfaction with the quality of work and care they are able to deliver *(1-5)*	**3.97**	**3.93**	3.79	#	3.80	4.03	3.87	4.00	4.04	4.13	3.85		--
Key Finding 3. Percentage of staff agreeing that their role makes a difference to patients / service users *(%)*	**89.8%**	**90.7%**	89.3%	#	88.0%	83.7%	91.1%	88.2%	93.3%	93.4%	87.0%	**89%**	**90%**
Key Finding 4. Staff motivation at work *(1-5)*	**4.00**	**4.05**	3.96	#	4.01	3.77	4.11	3.97	4.07	4.17	3.99	**3.90**	**4.01**
Key Finding 5. Recognition and value of staff by managers and the organisation *(1-5)*	**3.40**	**3.39**	3.10	#	3.54	3.46	3.48	3.32	3.48	3.53	3.70	**3.48**	**3.55**
Key Finding 6. Percentage of staff reporting good communication between senior management and staff *(%)*	**29.5%**	**28.8%**	20.6%	#	34.2%	33.3%	28.7%	22.7%	31.6%	31.1%	47.2%	**28%**	**33%**
Key Finding 7. Percentage of staff able to contribute towards improvements at work *(%)*	**64.1%**	**64.2%**	59.3%	#	71.0%	66.7%	66.1%	68.2%	69.1%	60.8%	71.8%	**63%**	**67%**
Key Finding 8. Staff satisfaction with the level of responsibility and involvement *(1-5)*	**3.87**	**3.87**	3.81	#	3.95	3.82	3.92	3.65	3.86	3.90	3.84		--
Key Finding 9. Effective team working *(1-5)*	**3.73**	**3.76**	3.56	#	3.90	3.67	3.79	3.48	3.80	3.87	3.95	**3.71**	**3.77**
Key Finding 10. Support from immediate managers *(1-5)*	**3.70**	**3.76**	3.48	#	3.97	3.69	3.77	3.42	3.94	3.83	3.96	**3.65**	**3.75**
Key Finding 11. Percentage of staff appraised in last 12 months *(%)*	**70.7%**	**74.4%**	70.6%	#	80.0%	74.6%	57.6%	50.0%	76.7%	80.4%	71.8%	**65%**	**67%**
Key Finding 12. Quality of appraisals *(1-5)*	**3.11**	**3.14**	2.81	#	3.13	2.30	3.44	3.40	3.31	3.36	3.33		--
Key Finding 13. Quality of non-mandatory training, learning or development *(1-5)*	**4.11**	**4.12**	4.03	#	4.11	3.69	4.17	4.30	4.17	4.22	4.03		--
Key Finding 14. Staff satisfaction with resourcing and support *(1-5)*	**3.30**	**3.29**	3.11	#	3.27	3.43	3.28	3.21	3.34	3.44	3.49	**2.95**	**2.88**
Key Finding 15. Percentage of staff satisfied with the opportunities for flexible working patterns (%)	**52.9%**	**52.2%**	41.1%	#	61.4%	73.3%	54.7%	72.7%	52.1%	54.1%	73.2%		--
* ***Key Finding 16.*** *Percentage of staff working extra hours (%)*	**68.1%**	**69.1%**	72.3%	#	69.5%	50.0%	60.9%	81.8%	68.1%	70.2%	59.2%	**95%**	**95%**
* ***Key Finding 17*** *. Percentage of staff feeling unwell due to work related stress in last 12 months (%)*	**46.7%**	**46.1%**	51.3%	#	48.4%	48.3%	36.9%	36.4%	48.7%	41.1%	34.7%	**36%**	**32%**
* ***Key Finding 18.*** *Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves (%)*	**60.9%**	**60.4%**	64.9%	#	60.0%	60.0%	51.4%	68.2%	63.9%	57.1%	47.2%		--
Key Finding 19. Organisation and management interest in and action on health and wellbeing *(1-5)*	**3.53**	**3.52**	3.27	#	3.68	3.53	3.55	3.68	3.64	3.58	3.97		--

2019 HSC Staff Survey Key Findings Data by Organisational Staff Directorate	HSC OVERALL 2019	Southern HSCT Overall 2019	Acute Services	Chief Executive's Office	Children & Young People's Services	Finance & Procurement	HR & Organisational Development	Medical	Mental Health & Disability Services	Older People & Primary Care	Performance & Reform	HSC Overall 2015	Southern HSCT Overall 2015
* ***Key Finding 20*** *. Percentage of staff experiencing discrimination at work in the last 12 months (%)*	**12.9%**	**12.2%**	14.9%	#	10.9%	11.7%	13.3%	14.3%	12.3%	10.5%	2.8%	**10%**	**9%**
Key Finding 21. Percentage believing that organisation provides equal opportunities for career progression or promotion (%)		--	--	--	--	--	--	--	--	--	--	**94%**	**96%**
* ***Key Finding 22.*** *Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months (%)*	**17.9%**	**20.4%**	23.3%	#	14.7%	0.0%	25.5%	4.5%	32.5%	15.5%	0.0%	**14%**	**12%**
* ***Key Finding 23.*** *Percentage of staff experiencing physical violence from staff in last 12 months (%)*	**2.2%**	**1.9%**	2.5%	#	1.0%	3.3%	1.2%	0.0%	3.4%	1.0%	0.0%	**2%**	**1%**
Key Finding 24. Percentage of staff/colleagues reporting most recent experience of physical violence in last 12 months *(%)*	**78.8%**	**80.1%**	69.8%	#	78.3%	50.0%	83.8%	50.0%	91.5%	82.5%	--	**77%**	**73%**
* ***Key Finding 25*** *. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months (%)*	**32.0%**	**35.4%**	40.7%	#	34.7%	11.7%	31.0%	22.7%	40.7%	33.1%	4.2%	**25%**	**23%**
****Key Finding 26*** *. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months (%)*	**27.6%**	**26.5%**	35.5%	#	21.9%	28.3%	24.1%	31.8%	24.7%	20.1%	30.6%	**22%**	**20%**
Key Finding 27. Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse in last 12 months *(%)*	**52.0%**	**54.7%**	45.6%	#	59.0%	76.2%	52.0%	66.7%	60.8%	61.8%	18.2%	**54%**	**53%**
* ***Key Finding 28*** *. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month (%)*	**26.6%**	**26.0%**	39.4%	#	15.6%	16.7%	29.4%	27.3%	27.2%	18.6%	2.8%	**26%**	**21%**
Key Finding 29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month *(%)*	**88.7%**	**88.6%**	86.1%	#	81.7%	100.0%	94.9%	83.3%	90.6%	92.9%	50.0%	**95%**	**91%**
Key Finding 30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents *(1-5)*	**3.65**	**3.61**	3.51	#	3.60	3.26	3.56	3.37	3.68	3.74	3.51	**3.53**	**3.55**
Key Finding 31. Staff confidence and security in reporting unsafe clinical practice *(1-5)*	**3.52**	**3.52**	3.35	#	3.52	3.28	3.57	3.30	3.59	3.67	3.42		--
Key Finding 32. Effective use of patient / service user feedback *(1-5)*	**3.58**	**3.53**	3.50	#	3.51	4.00	3.50	3.50	3.56	3.54	3.62		--
Key Finding 33. Percentage of staff who do not typically feel worn out and feel supported in achieving a work-life balance *(%)*	**5.6%**	**5.2%**	3.8%	#	5.6%	8.3%	4.1%	14.3%	4.6%	6.6%	6.9%	‡	‡
Key Finding 34. Percentage of staff who said that HSC is a great place to work and are proud to tell others that they are part of HSC *(%)*	**48.1%**	**47.6%**	38.2%	#	48.7%	48.3%	50.0%	59.1%	47.7%	55.7%	57.7%	‡	‡
Key finding 35. Percentage of staff who feel that HSC takes effective action if staff are physically attacked, bullied, harassed or abused *(%)*	**31.4%**	**32.4%**	24.0%	#	32.9%	30.0%	39.7%	19.0%	33.6%	39.9%	25.0%	‡	‡

2019 HSC Staff Survey - Individual Question Data for Personnel Areas within Southern HSC Trust	HSC OVERALL 2019	Southern HSCT Overall 2019	Admin & Clerical	Estates	Medical & Dental	Nursing & Midwifery	Professional & Technical	Social Services	Support Services /User Experience	HSC Overall 2015	Southern HSCT Overall 2015
Invite Count	**77,781**	**12,802**	1,820	102	1,022	4,812	1,587	2,573	886	**70,213**	**10,278**
Response Count	**19,094**	**3,167**	652	22	182	1,040	462	713	96	**17,796**	**2,176**
Response Rate	**24.5%**	**24.7%**	35.8%	21.6%	17.8%	21.6%	29.1%	27.7%	10.8%	**25.0%**	**21%**
Overall Engagement Score	**3.78**	**3.78**	3.78	3.73	3.65	3.76	3.79	3.84	3.74	**3.72**	**3.81**
Q1. % saying they have face-to-face contact with patients / service users as part of their job	**83.7%**	**88.6%**	55.9%	57.1%	98.9%	97.7%	96.3%	99.0%	87.4%	‡	‡
Q2a. I am proud when I tell others that I am part of HSC.	**62.0%**	**62.4%**	60.8%	54.5%	50.8%	62.9%	62.6%	66.8%	58.5%	‡	‡
Q2b. I recognise HSC as a great place to work.	**53.5%**	**52.6%**	59.1%	45.5%	35.4%	46.8%	52.4%	59.1%	58.1%	‡	‡
Q2c. I look forward to going to work.	**55.5%**	**57.5%**	57.6%	40.9%	42.5%	55.8%	56.5%	64.7%	58.5%	**57.1%**	**62%**
Q2d. I am enthusiastic about my job.	**73.2%**	**75.1%**	69.4%	68.2%	66.3%	77.3%	74.9%	80.1%	72.3%	**71.2%**	**74%**
Q2e. Time passes quickly when I am working.	**80.7%**	**83.0%**	79.2%	72.7%	80.1%	85.6%	83.5%	83.0%	85.4%	**80.1%**	**83%**
Q3a. I always know what my work responsibilities are.	**88.6%**	**89.2%**	86.0%	77.3%	92.8%	89.4%	92.9%	89.7%	82.3%	**91.7%**	**93%**
Q3b. I am trusted to do my job.	**90.2%**	**90.9%**	90.3%	77.3%	95.0%	89.9%	91.8%	91.8%	89.6%	‡	‡
Q3c. I am able to do my job to a standard I am personally pleased with.	**81.4%**	**80.7%**	89.1%	81.8%	70.7%	74.7%	79.4%	84.9%	83.3%	**78.8%**	**81%**

2019 HSC Staff Survey - Individual Question Data for Personnel Areas within Southern HSC Trust	HSC OVERALL 2019	Southern HSCT Overall 2019	Admin & Clerical	Estates	Medical & Dental	Nursing & Midwifery	Professional & Technical	Social Services	Support Services /User Experience	HSC Overall 2015	Southern HSCT Overall 2015
Q4a. There are frequent opportunities for me to show initiative in my role.	**69.7%**	**70.9%**	66.4%	81.8%	69.6%	74.3%	72.9%	70.9%	54.2%	**66.2%**	**68%**
Q4b. I am able to make suggestions to improve the work of my team / department.	**68.3%**	**68.4%**	68.7%	72.7%	76.2%	67.9%	76.4%	64.2%	50.0%	**67.3%**	**70%**
Q4c. I am involved in deciding on changes introduced that affect my work area / team / department.	**46.5%**	**45.2%**	42.7%	59.1%	56.4%	43.4%	57.4%	40.6%	32.3%	**50.1%**	**52%**
Q4d. I am able to make improvements happen in my area of work.	**50.7%**	**48.1%**	50.5%	63.6%	53.0%	45.2%	55.0%	44.9%	39.6%	**55.6%**	**60%**
Q4e. I am able to meet all the conflicting demands on my time at work.	**40.4%**	**37.3%**	49.0%	27.3%	25.4%	32.5%	26.6%	41.9%	53.1%	**44.2%**	**44%**
Q4f. I have adequate materials, supplies and equipment to do my work.	**60.9%**	**61.1%**	75.7%	54.5%	39.2%	56.9%	49.8%	67.3%	59.4%	**60.6%**	**67%**
Q4g. There are enough staff in my work area / team / department for me to do my job properly.	**34.1%**	**32.6%**	41.6%	13.6%	18.2%	27.8%	27.5%	38.4%	35.4%	**34.7%**	**36%**
Q4h. The team I work in has a set of shared objectives.	**73.2%**	**73.4%**	68.7%	68.2%	74.0%	74.8%	79.0%	73.6%	61.5%	**76.5%**	**78%**
Q4i. The team I work in often meets to discuss the team's effectiveness.	**56.6%**	**59.1%**	53.3%	63.6%	59.7%	57.2%	66.5%	65.7%	33.3%	**56.5%**	**62%**
Q4j. Team members have to communicate closely with each other to achieve the team's objectives.	**82.1%**	**83.5%**	77.4%	81.8%	85.6%	87.9%	86.8%	81.8%	71.6%	**80.8%**	**82%**
Q4k. I work as part of a multi-disciplinary team which values the roles and contributions of all colleagues.	**64.9%**	**66.4%**	50.5%	54.5%	84.0%	72.0%	75.1%	65.3%	48.4%	**‡**	**‡**
Q4l. I value the work and contribution of other disciplines in my area of work.	**89.5%**	**91.7%**	86.0%	86.4%	98.3%	94.4%	96.3%	89.8%	80.0%	**‡**	**‡**
Q5a. The recognition or praise I get for good work.	**48.9%**	**48.8%**	53.6%	50.0%	38.1%	47.0%	48.9%	51.8%	33.3%	**45.7%**	**49%**

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Q5b. The support I get from my immediate manager.	**64.4%**	**67.0%**	70.4%	59.1%	63.5%	65.8%	68.6%	66.7%	60.4%	**62.1%**	**66%**
Q5c. The support I get from my work colleagues.	**80.2%**	**81.6%**	78.2%	68.2%	82.9%	81.9%	86.4%	82.6%	69.8%	**75.7%**	**77%**
Q5d. The amount of responsibility I am given.	**72.4%**	**73.3%**	72.0%	81.8%	79.6%	71.2%	79.4%	73.3%	61.5%	**69.0%**	**71%**
Q5e. The opportunities I have to use my skills.	**71.8%**	**72.9%**	66.8%	77.3%	79.6%	77.2%	73.8%	73.2%	47.9%	**67.2%**	**69%**
Q5f. The extent to which my organisation values my work.	**43.1%**	**42.0%**	45.6%	45.5%	35.4%	38.1%	43.3%	46.0%	35.4%	**37.8%**	**43%**
Q5g. The opportunities for flexible working patterns.	**52.9%**	**52.2%**	63.1%	72.7%	35.9%	47.3%	48.7%	56.4%	42.7%	‡	‡
Q6a. I am satisfied with the quality of care I give to patients / service users.	**83.8%**	**83.2%**	83.5%	87.5%	77.1%	81.6%	82.6%	87.3%	82.4%	**85.8%**	**87%**
Q6b. I feel that my role makes a difference to patients / service users.	**89.8%**	**90.7%**	77.4%	90.5%	94.4%	93.3%	94.1%	93.5%	88.2%	**89.3%**	**90%**
Q6c. I am able to deliver the care I aspire to.	**66.8%**	**65.2%**	63.6%	68.8%	56.1%	63.6%	60.6%	73.0%	73.3%	**69.4%**	**72%**
** Q6d. I often think about leaving this organisation.*	**35.0%**	**35.7%**	29.5%	40.0%	36.5%	43.3%	33.8%	31.5%	31.8%	**33.0%**	**29%**
Q6e1. If you are considering leaving your job, please indicate why: Career Development	**32.7%**	**32.6%**	39.2%	37.5%	15.9%	30.0%	42.0%	32.5%	14.8%	**24.6%**	**23%**
Q6e2. If you are considering leaving your job, please indicate why: Change of career *Note: Asked only of those that said "yes" to question Q6d*	**18.2%**	**18.0%**	17.1%	0.0%	12.7%	16.9%	22.7%	18.0%	33.3%	**9.9%**	**9%**
Q6e3. If you are considering leaving your job, please indicate why: Would like more pay *Note: Asked only of those that said "yes" to question Q6d*	**42.2%**	**46.4%**	51.9%	50.0%	17.5%	54.0%	41.3%	35.4%	66.7%	**19.8%**	**19%**

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Q6e4. If you are considering leaving your job, please indicate why: Not being valued for my work *Note: Asked only of those that said "yes" to question Q6d*	**57.8%**	**59.7%**	54.1%	50.0%	57.1%	63.5%	59.3%	56.8%	70.4%	**20.2%**	**20%**
Q6e5. If you are considering leaving your job, please indicate why: Family / personal reasons *Note: Asked only of those that said "yes" to question Q6d*	**17.2%**	**17.9%**	14.9%	25.0%	17.5%	21.5%	16.0%	16.5%	0.0%	**10.6%**	**11%**
Q6e6. If you are considering leaving your job, please indicate why: Health reasons *Note: Asked only of those that said "yes" to question Q6d*	**9.7%**	**8.9%**	7.7%	12.5%	12.7%	8.3%	10.0%	8.7%	11.1%	**5.1%**	**5%**
Q6e7. If you are considering leaving your job, please indicate why: End of contract *Note: Asked only of those that said "yes" to question Q6d*	**0.6%**	**0.5%**	0.6%	0.0%	0.0%	0.5%	0.7%	0.5%	0.0%	**2.0%**	**2%**
Q6e8. If you are considering leaving your job, please indicate why: Retirement *Note: Asked only of those that said "yes" to question Q6d*	**12.8%**	**11.6%**	11.0%	25.0%	15.9%	14.3%	6.0%	9.7%	3.7%	**11.8%**	**12%**
Q6e9. If you are considering leaving your job, please indicate why: Don't want to work in HSC *Note: Asked only of those that said "yes" to question Q6d*	**8.7%**	**10.5%**	10.5%	0.0%	15.9%	11.8%	10.0%	7.8%	3.7%	**2.8%**	**2%**
Q6e10. If you are considering leaving your job, please indicate why: Relationship with manager *Note: Asked only of those that said "yes" to question Q6d*	**19.1%**	**15.1%**	17.1%	37.5%	14.3%	11.1%	18.7%	15.5%	37.0%	**7.4%**	**7%**
Q6e11. If you are considering leaving your job, please indicate why: Other *Note: Asked only of those that said "yes" to question Q6d*	**22.1%**	**21.4%**	18.8%	12.5%	39.7%	20.3%	20.7%	22.2%	14.8%	**8.5%**	**7%**
Q7a. My line manager… encourages those who work for her / him to work as a team.	**72.1%**	**75.4%**	74.3%	59.1%	70.9%	76.3%	75.9%	77.9%	62.5%	**71.8%**	**76%**
Q7b. My line manager… can be counted on to help me with a difficult task at work.	**69.0%**	**70.8%**	73.0%	59.1%	67.6%	68.3%	73.3%	72.7%	66.7%	**69.5%**	**73%**
Q7c. My line manager… gives me clear feedback on my work.	**59.0%**	**61.6%**	63.3%	59.1%	46.7%	63.0%	62.3%	61.6%	59.4%	**57.8%**	**62%**
Q7d. My line manager… asks for my opinion before making decisions that affect my work.	**51.7%**	**52.9%**	53.9%	63.6%	52.7%	49.8%	59.2%	54.3%	35.4%	**54.7%**	**59%**
Q7e. My line manager… is supportive in a personal crisis.	**73.9%**	**75.5%**	83.1%	68.2%	63.2%	72.5%	78.7%	76.0%	61.5%	**74.5%**	**78%**

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Q7f. My line manager… takes a positive interest in my health and well-being.	**63.5%**	**64.4%**	71.4%	54.5%	54.4%	62.5%	69.8%	62.3%	49.0%	**78.3%**	**81%**
Q7g. My line manager… values my work.	**68.4%**	**70.0%**	73.0%	68.2%	70.3%	69.2%	72.9%	68.9%	53.1%	**‡**	**#**
Q7h. My line manager… helps me find a good work life balance.	**53.0%**	**54.8%**	64.2%	50.0%	35.2%	52.7%	56.0%	55.6%	40.6%	**45.5%**	**51%**
Q8a. Communication between senior management and staff is effective.	**34.5%**	**34.0%**	35.5%	40.9%	27.5%	33.5%	33.0%	34.8%	38.5%	**30.0%**	**34%**
Q8b. Senior managers involve staff in a timely manner regarding important decisions.	**28.4%**	**27.4%**	29.8%	31.8%	18.1%	27.2%	25.6%	28.9%	27.1%	**28.7%**	**34%**
Q8c. Senior managers act on staff feedback.	**27.4%**	**26.6%**	28.4%	31.8%	18.1%	25.6%	23.0%	30.7%	27.1%	**37.7%**	**43%**
Q9a. My organisation takes positive action on health and well-being.	**87.1%**	**87.0%**	90.9%	90.9%	83.9%	83.4%	90.2%	87.3%	86.3%	**77.9%**	**83%**
Q9b. My organisation provides advice on mental health and well-being.	**86.5%**	**87.7%**	91.7%	68.2%	89.9%	85.8%	91.9%	84.6%	81.9%	**88.8%**	**94%**
Q9c. My organisation provides advice on diet and nutrition.	**69.5%**	**77.0%**	86.8%	63.6%	78.8%	74.6%	83.0%	68.8%	67.0%	**67.4%**	**81%**
Q9d. My organisation provides advice on drug and alcohol consumption.	**69.6%**	**73.4%**	82.9%	63.6%	77.0%	71.5%	75.1%	66.5%	64.5%	**72.5%**	**81%**
Q9e. My organisation provides advice on exercise.	**77.9%**	**81.8%**	90.0%	68.2%	84.4%	79.3%	87.6%	75.9%	65.6%	**78.1%**	**86%**
Q9f. My organisation provides advice on help for staff that want to stop smoking.	**82.9%**	**85.5%**	90.8%	77.3%	86.9%	86.1%	89.7%	78.2%	76.1%	**90.9%**	**95%**
Q9g. Are you happy with the food / drink / rest facilities provided by your employer?	**50.7%**	**55.5%**	62.2%	81.8%	54.4%	51.0%	58.9%	51.1%	65.6%	**‡**	**‡**

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** Q9h. In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?*	**30.1%**	**30.5%**	25.7%	18.2%	38.5%	35.3%	32.9%	24.7%	29.0%	**18.2%**	**15%**
** Q9i. During the last 12 months have you felt unwell as a result of work related stress?*	**46.7%**	**46.1%**	36.6%	54.5%	49.5%	51.9%	46.7%	45.2%	42.1%	**36.2%**	**32%**
** Q9j. In the last three months have you ever come to work despite not feeling well enough to perform your duties?*	**63.7%**	**63.8%**	63.5%	63.6%	57.1%	66.7%	65.4%	60.7%	60.4%	‡	‡
** Q9k. Have you felt pressure from your manager to come to work?*	**29.2%**	**29.8%**	23.8%	14.3%	22.2%	34.2%	26.4%	32.6%	34.0%	‡	‡
** Q9l. Have you felt pressure from colleagues to come to work?*	**20.7%**	**20.0%**	16.7%	7.1%	30.3%	24.9%	16.1%	17.6%	7.5%	‡	‡
** Q9m. Have you put yourself under pressure to come into work?*	**93.7%**	**93.0%**	91.7%	100.0%	96.0%	93.3%	96.3%	90.7%	89.1%	‡	‡
** Q9n. Do you typically feel worn out at the end of the working day?*	**90.6%**	**91.2%**	88.5%	90.9%	92.8%	93.8%	92.4%	89.0%	88.4%	‡	‡
Q9o. Does your organisation support you in achieving a work-life balance?	**67.9%**	**70.2%**	81.0%	77.3%	55.6%	67.3%	74.1%	66.4%	62.8%	‡	‡
Q10a. How many hours a week are you contracted to work? *(% of respondents that are contracted to work less than 30 hours a week)*	**20.8%**	**24.2%**	22.0%	0.0%	15.7%	21.6%	21.1%	33.3%	37.2%	**21.6%**	**25%**
** Q10b. On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours?*	**34.4%**	**34.9%**	17.3%	59.1%	42.9%	37.4%	30.4%	46.6%	46.2%	**49.8%**	**48%**
** Q10c. On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours?*	**50.3%**	**51.0%**	38.4%	38.1%	79.8%	56.0%	58.3%	46.8%	25.0%	**71.1%**	**72%**
Q10d. Working the extra PAID hours that I do is acceptable to me. (Asked only of those who stated on Q10b that they work additional paid hours)	**75.4%**	**74.7%**	82.6%	84.6%	84.3%	74.6%	67.8%	71.4%	79.2%	‡	‡
Q10e. Working the extra UNPAID hours that I do is acceptable to me. (Asked only of those who stated on Q10c that they work additional unpaid hours)	**26.7%**	**23.7%**	37.3%	25.0%	25.9%	15.4%	23.0%	27.1%	31.3%	‡	‡

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** Q11a. In the last month have you seen any errors, near misses, or incidents that could have hurt staff?*	**17.0%**	**17.4%**	9.7%	22.7%	21.0%	24.8%	11.1%	15.3%	28.4%	**17.4%**	**14%**
** Q11b. In the last month have you seen any errors, near misses, or incidents that could have hurt patients/service users?*	**22.0%**	**21.2%**	10.3%	22.7%	47.8%	28.2%	18.7%	15.2%	25.0%	**22.3%**	**17%**
Q11c. The last time you saw an error, near miss or incident that could have hurt staff or patients / service users, did you or a colleague report it? (Only asked of respondents that said "yes" to either Q11a or Q11b)	**91.7%**	**92.2%**	79.5%	100.0%	91.4%	95.3%	91.5%	92.8%	90.9%	**94.5%**	**91%**
Q12a. My organisation treats staff who are involved in an error, near miss or incident fairly.	**48.4%**	**44.8%**	42.2%	38.9%	36.8%	43.8%	44.7%	49.3%	57.1%	**45.1%**	**48%**
Q12b. My organisation encourages us to report errors, near misses or incidents.	**84.5%**	**84.1%**	77.2%	57.1%	77.2%	86.3%	84.6%	88.2%	92.3%	**77.7%**	**80%**
Q12c. When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.	**67.2%**	**65.9%**	57.1%	57.1%	53.1%	71.3%	64.6%	69.3%	69.0%	**61.4%**	**63%**
Q12d. We are given feedback about changes made in response to reported errors, near misses and incidents.	**55.8%**	**54.0%**	38.8%	40.0%	51.1%	61.2%	52.2%	58.6%	49.4%	**52.3%**	**53%**
Q13a. If you were concerned about negligence, unsafe clinical or professional practice, would you know how to report it?	**86.4%**	**87.9%**	74.5%	47.6%	92.2%	95.1%	83.2%	94.8%	74.5%	**87.7%**	**89%**
Q13b. I would feel secure raising concerns about negligence, unsafe clinical or professional practice.	**61.1%**	**61.5%**	50.8%	40.9%	62.6%	67.7%	55.8%	67.1%	55.2%	**79.7%**	**79%**
Q13c. I am confident that my organisation would address my concern.	**55.1%**	**55.0%**	51.7%	27.3%	50.0%	55.2%	52.6%	61.2%	57.3%	**64.7%**	**70%**
Q13d. Do you understand your responsibility to raise concerns?	**97.3%**	**97.6%**	93.1%	90.9%	100.0%	99.4%	98.3%	98.9%	94.6%	**79.0%**	**85%**
** Q14a In the last 12 months have you personally experienced physical violence at work from…Patients / service users, their relatives or other members of the public?*	**17.9%**	**20.4%**	2.8%	0.0%	19.2%	33.8%	14.1%	22.0%	19.8%	**13.9%**	**12%**
** Q14b. In the last 12 months have you personally experienced physical violence at work from… Managers / Team leaders?*	**0.9%**	**0.8%**	0.3%	4.5%	0.0%	0.9%	0.0%	1.0%	6.3%	**0.5%**	**1%**

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** Q14c. In the last 12 months have you personally experienced physical violence at work from…Other colleagues?*	**2.0%**	**1.6%**	0.8%	4.5%	0.0%	2.1%	0.9%	1.0%	12.6%	**1.4%**	**1%**
Q14d. The last time you experienced physical violence at work, did you or a colleague report it? (*Asked only of respondents who stated on Q14a-c that they had personally experienced physical violence at work in last 12 months*)	**78.8%**	**80.1%**	80.6%	100.0%	54.8%	81.9%	61.2%	88.6%	81.5%	**76.6%**	**73%**
** Q15a. In the last 12 months have you personally experienced harassment, bullying and abuse at work from… Patients / service users, relatives or other members of the public?*	**32.0%**	**35.4%**	19.6%	9.1%	48.6%	43.7%	32.9%	38.1%	26.0%	**24.7%**	**23%**
** Q15b. In the last 12 months have you personally experienced harassment, bullying and abuse at work from… Managers / Team leaders?*	**15.7%**	**14.8%**	12.3%	27.3%	14.8%	19.2%	13.4%	10.7%	17.9%	**12.4%**	**10%**
** Q15c. In the last 12 months have you personally experienced harassment, bullying and abuse at work from… Other colleagues?*	**20.0%**	**19.5%**	18.9%	18.2%	18.7%	24.8%	15.1%	14.7%	24.2%	**15.6%**	**14%**
Q15d. The last time you experienced harassment, bullying and abuse at work, did you or a colleague report it? (*Asked only of respondents who stated on Q15a-c that they had personally experienced harassment, bullying and abuse at work in the last 12 months)*	**52.0%**	**54.7%**	48.6%	100.0%	29.7%	57.7%	40.0%	68.0%	62.2%	**53.5%**	**53%**
Q16a1. Does your organisation take effective action if staff are… Physically attacked by patients / clients / service users, their relatives or other members of the public?	**83.3%**	**84.0%**	91.0%	100.0%	86.4%	76.4%	90.6%	86.3%	86.0%	**57.8%**	**64%**
Q16a2. Does your organisation take effective action if staff are… Physically attacked by other members of staff?	**93.8%**	**95.0%**	95.5%	100.0%	95.8%	93.0%	97.4%	96.5%	91.5%	**61.1%**	**67%**
Q16a3. Does your organisation take effective action if staff are… bullied, harassed or abused by patients / clients / service users, their relatives or other members of the public?	**74.6%**	**75.5%**	83.5%	100.0%	70.2%	71.1%	74.0%	76.2%	82.8%	**51.6%**	**57%**
Q16a4. Does your organisation take effective action if staff are… Bullied, harassed or abused by other members of staff?	**72.3%**	**74.5%**	71.2%	54.5%	69.6%	72.3%	72.7%	81.4%	83.3%	**49.1%**	**52%**
* Q17a. *In the last 12 months have you personally experienced discrimination at work from …Patients / service users, their relatives or other members of the public?*	**4.3%**	**4.8%**	1.5%	0.0%	6.6%	5.9%	3.3%	6.4%	7.3%	**4.5%**	**4%**

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* Q17b. *In the last 12 months have you personally experienced discrimination at work from …Managers / team leaders or other colleagues?*	**9.9%**	**8.5%**	6.6%	13.6%	9.4%	9.4%	9.2%	7.5%	13.7%	**7.6%**	**7%**
* Q17c1. *On what grounds have you experienced discrimination… Ethnic background*	**11.4%**	**11.8%**	9.8%	0.0%	23.8%	13.0%	6.0%	10.8%	16.7%	**12.6%**	**8%**
* Q17c2. *On what grounds have you experienced discrimination… Gender*	**16.0%**	**14.3%**	11.8%	0.0%	42.9%	10.9%	16.0%	12.0%	22.2%	**17.6%**	**19%**
* Q17c3. *On what grounds have you experienced discrimination… Religion*	**19.6%**	**22.5%**	19.6%	0.0%	14.3%	21.7%	32.0%	21.7%	27.8%	**22.2%**	**29%**
* Q17c4. *On what grounds have you experienced discrimination… Sexual orientation*	**3.6%**	**2.5%**	2.0%	0.0%	0.0%	3.6%	0.0%	2.4%	5.6%	**4.3%**	**1%**
* Q17c5. *On what grounds have you experienced discrimination… Disability*	**8.3%**	**10.7%**	13.7%	0.0%	4.8%	9.4%	14.0%	12.0%	5.6%	**8.6%**	**8%**
* Q17c6. *On what grounds have you experienced discrimination… Age*	**14.0%**	**15.7%**	13.7%	0.0%	9.5%	21.7%	18.0%	9.6%	5.6%	**15.1%**	**13%**
* Q17c7. *On what grounds have you experienced discrimination… Other reason(s)*	**37.9%**	**36.2%**	44.2%	100.0%	9.5%	36.2%	40.0%	36.1%	22.2%	**29.2%**	**30%**
Q17d. Did you report the discrimination?	**29.9%**	**29.5%**	25.5%	100.0%	9.5%	31.7%	16.0%	32.1%	64.7%	**27.9%**	**21%**
Q17e. Does your organisation take effective action if discrimination is reported?	**26.3%**	**24.5%**	28.6%	0.0%	16.7%	19.6%	13.3%	35.0%	27.3%	**31.7%**	**53%**
Q18a. Have you had any training, learning or development in the last 12 months?	**78.4%**	**80.7%**	59.1%	63.6%	93.3%	87.5%	86.4%	86.5%	66.3%	**‡**	**‡**
Q18b. My training, learning or development has helped me to do my job more effectively.	**79.8%**	**80.4%**	69.2%	54.5%	82.0%	86.3%	79.0%	82.5%	71.1%	**69.4%**	**71%**
Q18c. My training, learning or development has helped me to stay up-to-date with professional requirements.	**84.7%**	**86.0%**	67.3%	45.5%	90.4%	93.1%	86.6%	89.7%	72.1%	**70.2%**	**73%**

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Q18d. My training, learning or development has helped me to deliver a better patient / service user experience.	**77.5%**	**79.2%**	62.1%	36.4%	78.8%	85.9%	82.2%	82.4%	60.5%	**63.2%**	**66%**
Q19a. Have you had mandatory training in the last 12 months?	**90.7%**	**95.1%**	92.2%	95.5%	91.0%	96.7%	96.5%	96.7%	89.5%	**‡**	**‡**
Q20a. In the last 12 months, have you had an appraisal, annual review, development review, or KSF development review?	**70.7%**	**74.4%**	65.5%	100.0%	89.0%	75.9%	77.8%	77.1%	50.0%	**64.7%**	**67%**
Q20b. My appraisal / review helped me to improve how I do my job.	**74.2%**	**75.1%**	68.2%	47.6%	62.1%	79.6%	75.4%	80.0%	61.7%	**57.9%**	**63%**
Q20c. My appraisal / review helped me agree clear objectives for my work.	**84.4%**	**84.2%**	78.5%	57.1%	78.0%	87.3%	87.0%	87.0%	64.4%	**78.0%**	**80%**
Q20d. My appraisal / review left me feeling that my work is valued by my organisation.	**71.8%**	**72.7%**	75.2%	57.1%	50.3%	74.8%	70.1%	76.8%	73.3%	**62.2%**	**67%**
Q20e. The values of my organisation were discussed as part of the appraisal process.	**73.6%**	**67.8%**	67.1%	52.4%	36.5%	71.0%	62.6%	77.4%	68.2%	**‡**	**‡**
Q20f. My training, learning or development needs were discussed and agreed.	**93.6%**	**94.3%**	91.0%	85.7%	96.9%	96.1%	94.1%	94.9%	86.4%	**79.3%**	**75%**
Q20g. My training, learning and development needs were met.	**85.6%**	**88.6%**	86.1%	66.7%	92.5%	90.6%	83.4%	91.6%	84.4%	**75.0%**	**79%**
Q21a. Care of patients / service users is my organisation's top priority.	**75.2%**	**74.2%**	74.3%	59.1%	66.3%	72.4%	74.5%	78.5%	78.0%	**73.1%**	**76%**
Q21b. I would recommend my organisation as a place to work.	**60.6%**	**59.5%**	64.6%	59.1%	53.9%	53.2%	58.1%	66.1%	64.1%	**60.6%**	**67%**
Q21c. If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	**68.5%**	**67.6%**	68.3%	68.2%	64.4%	65.1%	65.1%	73.1%	68.1%	**67.0%**	**71%**
Q21d1. What way do you prefer to receive information about your organisation… Daily updates on organisation intranet?	**45.9%**	**41.1%**	49.3%	27.3%	22.7%	42.7%	47.9%	32.4%	33.7%	**38.2%**	**34%**

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Q21d2. What way do you prefer to receive information about your organisation…Internet?	**31.2%**	**33.4%**	31.1%	50.0%	25.6%	39.4%	33.3%	27.9%	36.0%	**24.9%**	**29%**
Q21d3. What way do you prefer to receive information about your organisation…Senior management briefings?	**19.3%**	**16.2%**	14.8%	31.8%	21.5%	18.1%	13.9%	14.6%	15.7%	**19.6%**	**16%**
Q21d4. What way do you prefer to receive information about your organisation… Organisation newsletter?	**30.1%**	**37.6%**	53.2%	40.9%	33.5%	34.5%	33.0%	32.9%	27.0%	**12.7%**	**19%**
Q21d5. What way do you prefer to receive information about your organisation… Line managers?	**53.2%**	**54.6%**	50.9%	50.0%	35.8%	57.8%	52.5%	58.5%	63.3%	**55.6%**	**55%**
Q21d6. What way do you prefer to receive information about your organisation… Team meetings?	**64.8%**	**66.8%**	54.2%	63.6%	57.6%	68.0%	73.7%	76.0%	55.1%	**64.1%**	**64%**
Q21d7. What way do you prefer to receive information about your organisation… Chief Executive briefings?	**10.3%**	**10.1%**	14.4%	18.2%	13.6%	9.7%	9.4%	7.1%	2.2%	**7.9%**	**6%**
Q21d8. What way do you prefer to receive information about your organisation… Staff notice boards?	**26.9%**	**23.7%**	19.9%	22.7%	13.6%	35.1%	18.1%	13.3%	48.9%	**22.6%**	**18%**
Q22a. Is patient / service user experience feedback collected within your directorate / department?	**81.1%**	**80.1%**	63.3%	0.0%	89.7%	82.9%	80.3%	85.2%	69.4%	**74.3%**	**75%**
Q22b. I receive regular updates on patient / service user experience feedback in my directorate / department.	**59.1%**	**57.1%**	54.0%	--	35.7%	62.0%	54.4%	58.5%	52.0%	**60.6%**	**60%**
Q22c. Feedback from patients / service users is used to make informed decisions within my service area.	**63.1%**	**61.5%**	62.0%	--	43.8%	63.0%	61.4%	63.4%	61.9%	**66.2%**	**68%**

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Invite Count	**77,781**	**12,802**	4,657	14	1,683	247	1,338	46	1,719	2,935	163	**70,213**	**10,278**
Response Count	**19,094**	**3,167**	916	8	519	60	261	22	501	808	72	**17,796**	**2,176**
Response Rate	**25%**	**24.7%**	19.7%	57.1%	30.8%	24.3%	19.5%	47.8%	29.1%	27.5%	44.2%	**25.0%**	**21%**
Overall Engagement Score	**3.78**	**3.78**	3.64	#	3.83	3.73	3.85	3.62	3.84	3.86	3.85	**3.72**	**3.81**
Q1. % saying they have face-to-face contact with patients / service users as part of their job	**83.7%**	**88.6%**	90.5%	#	94.4%	39.0%	76.8%	68.2%	93.8%	92.8%	32.4%	‡	‡
Q2a. I am proud when I tell others that I am part of HSC.	**62.0%**	**62.4%**	56.7%	#	60.7%	55.0%	65.5%	72.7%	64.9%	67.3%	64.8%	‡	‡
Q2b. I recognise HSC as a great place to work.	**53.5%**	**52.6%**	41.8%	#	54.5%	60.0%	57.4%	63.6%	51.9%	60.4%	66.2%	‡	‡
Q2c. I look forward to going to work.	**55.5%**	**57.5%**	48.7%	#	56.2%	48.3%	59.6%	63.6%	59.9%	66.3%	62.0%	**57.1%**	**62%**
Q2d. I am enthusiastic about my job.	**73.2%**	**75.1%**	70.7%	#	76.6%	65.0%	78.8%	76.2%	75.4%	78.8%	71.8%	**71.2%**	**74%**
Q2e. Time passes quickly when I am working.	**80.7%**	**83.0%**	82.6%	#	82.4%	70.0%	85.3%	81.0%	81.0%	85.0%	85.9%	**80.1%**	**83%**
Q3a. I always know what my work responsibilities are.	**88.6%**	**89.2%**	89.5%	#	90.9%	85.0%	91.2%	81.8%	84.0%	91.0%	85.9%	**91.7%**	**93%**
Q3b. I am trusted to do my job.	**90.2%**	**90.9%**	90.5%	#	93.1%	83.3%	94.6%	81.8%	89.0%	91.7%	80.3%	‡	‡
Q3c. I am able to do my job to a standard I am personally pleased with.	**81.4%**	**80.7%**	76.2%	#	78.6%	90.0%	82.4%	81.8%	82.4%	84.2%	87.3%	**78.8%**	**81%**
Q4a. There are frequent opportunities for me to show initiative in my role.	**69.7%**	**70.9%**	66.6%	#	76.1%	66.7%	76.9%	63.6%	74.3%	68.9%	71.8%	**66.2%**	**68%**
Q4b. I am able to make suggestions to improve the work of my team / department.	**68.3%**	**68.4%**	63.9%	#	74.9%	68.3%	71.5%	81.8%	72.1%	65.1%	78.9%	**67.3%**	**70%**

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Q4c. I am involved in deciding on changes introduced that affect my work area / team / department.	46.5%	45.2%	41.9%	#	50.8%	55.0%	44.4%	40.9%	47.7%	42.4%	56.3%	50.1%	52%
Q4d. I am able to make improvements happen in my area of work.	50.7%	48.1%	41.4%	#	54.6%	61.7%	47.1%	40.9%	53.9%	45.6%	66.2%	55.6%	60%
Q4e. I am able to meet all the conflicting demands on my time at work.	40.4%	37.3%	32.3%	#	34.7%	36.7%	37.3%	47.6%	40.1%	41.7%	45.1%	44.2%	44%
Q4f. I have adequate materials, supplies and equipment to do my work.	60.9%	61.1%	52.7%	#	58.1%	71.7%	64.1%	59.1%	58.1%	71.3%	76.1%	60.6%	67%
Q4g. There are enough staff in my work area / team / department for me to do my job properly.	34.1%	32.6%	24.8%	#	31.5%	40.0%	29.2%	36.4%	34.3%	40.6%	39.4%	34.7%	36%
Q4h. The team I work in has a set of shared objectives.	73.2%	73.4%	67.9%	#	79.3%	68.3%	73.6%	63.6%	73.3%	75.9%	80.3%	76.5%	78%
Q4i. The team I work in often meets to discuss the team's effectiveness.	56.6%	59.1%	46.4%	#	69.7%	51.7%	52.7%	36.4%	61.9%	66.8%	78.9%	56.5%	62%
Q4j. Team members have to communicate closely with each other to achieve the team's objectives.	82.1%	83.5%	79.2%	#	82.4%	75.0%	90.4%	77.3%	86.2%	86.1%	84.5%	80.8%	82%
Q4k. I work as part of a multi-disciplinary team which values the roles and contributions of all colleagues.	64.9%	66.4%	62.7%	#	68.5%	46.7%	63.7%	52.4%	70.7%	70.1%	60.6%	‡	‡
Q4l. I value the work and contribution of other disciplines in my area of work.	89.5%	91.7%	90.5%	#	94.8%	78.3%	92.3%	100.0%	93.0%	90.7%	93.0%	‡	‡
Q5a. The recognition or praise I get for good work.	48.9%	48.8%	36.9%	#	51.5%	55.0%	54.4%	50.0%	50.7%	56.0%	63.4%	45.7%	49%
Q5b. The support I get from my immediate manager.	64.4%	67.0%	55.5%	#	75.7%	68.3%	68.7%	50.0%	73.9%	69.0%	77.5%	62.1%	66%
Q5c. The support I get from my work colleagues.	80.2%	81.6%	76.5%	#	84.0%	73.3%	85.7%	71.4%	85.2%	82.6%	88.7%	75.7%	77%
Q5d. The amount of responsibility I am given.	72.4%	73.3%	68.5%	#	77.8%	75.0%	77.8%	63.6%	71.7%	75.6%	74.6%	69.0%	71%
Q5e. The opportunities I have to use my skills.	71.8%	72.9%	68.9%	#	76.3%	70.0%	82.2%	45.5%	70.1%	75.6%	69.0%	67.2%	69%

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Q5f. The extent to which my organisation values my work.	**43.1%**	**42.0%**	32.4%	#	44.9%	45.0%	46.5%	40.9%	41.3%	48.6%	57.7%	**37.8%**	**43%**
Q5g. The opportunities for flexible working patterns.	**52.9%**	**52.2%**	41.1%	#	61.4%	73.3%	54.7%	72.7%	52.1%	54.1%	73.2%	**‡**	**‡**
Q6a. I am satisfied with the quality of care I give to patients / service users.	**83.8%**	**83.2%**	77.8%	#	80.9%	84.4%	84.3%	100.0%	86.6%	88.4%	78.1%	**85.8%**	**87%**
Q6b. I feel that my role makes a difference to patients / service users.	**89.8%**	**90.7%**	89.3%	#	88.0%	83.7%	91.1%	88.2%	93.3%	93.4%	87.0%	**89.3%**	**90%**
Q6c. I am able to deliver the care I aspire to.	**66.8%**	**65.2%**	58.6%	#	57.3%	71.9%	65.2%	64.3%	68.3%	76.2%	54.8%	**69.4%**	**72%**
** Q6d. I often think about leaving this organisation.*	**35.0%**	**35.7%**	43.5%	#	32.8%	25.5%	32.0%	23.8%	38.9%	29.5%	25.8%	**33.0%**	**29%**
Q6e1. If you are considering leaving your job, please indicate why: Career Development	**32.7%**	**32.6%**	28.9%	#	37.4%	35.7%	21.9%	40.0%	38.6%	32.6%	47.1%	**24.6%**	**23%**
Q6e2. If you are considering leaving your job, please indicate why: Change of career *Note: Asked only of those that said "yes" to question Q6d*	**18.2%**	**18.0%**	16.8%	#	16.0%	0.0%	11.0%	20.0%	21.7%	21.7%	17.6%	**9.9%**	**9%**
Q6e3. If you are considering leaving your job, please indicate why: Would like more pay *Note: Asked only of those that said "yes" to question Q6d*	**42.2%**	**46.4%**	49.9%	#	43.6%	42.9%	54.8%	40.0%	42.4%	44.3%	41.2%	**19.8%**	**19%**
Q6e4. If you are considering leaving your job, please indicate why: Not being valued for my work *Note: Asked only of those that said "yes" to question Q6d*	**57.8%**	**59.7%**	70.5%	#	55.2%	50.0%	53.4%	60.0%	52.2%	54.8%	47.1%	**20.2%**	**20%**
Q6e5. If you are considering leaving your job, please indicate why: Family / personal reasons *Note: Asked only of those that said "yes" to question Q6d*	**17.2%**	**17.9%**	18.9%	#	21.5%	21.4%	20.5%	0.0%	16.8%	14.0%	11.8%	**10.6%**	**11%**
Q6e6. If you are considering leaving your job, please indicate why: Health reasons *Note: Asked only of those that said "yes" to question Q6d*	**9.7%**	**8.9%**	8.8%	#	9.8%	7.1%	12.3%	0.0%	7.1%	10.0%	0.0%	**5.1%**	**5%**
Q6e7. If you are considering leaving your job, please indicate why: End of contract *Note: Asked only of those that said "yes" to question Q6d*	**0.6%**	**0.5%**	0.5%	#	0.0%	7.1%	0.0%	0.0%	0.5%	0.5%	0.0%	**2.0%**	**2%**
Q6e8. If you are considering leaving your job, please indicate why: Retirement *Note: Asked only of those that said "yes" to question Q6d*	**12.8%**	**11.6%**	12.1%	#	10.4%	21.4%	20.5%	20.0%	9.2%	10.4%	0.0%	**11.8%**	**12%**
Q6e9. If you are considering leaving your job, please indicate why: Don't want to work in HSC *Note: Asked only of those that said "yes" to question Q6d*	**8.7%**	**10.5%**	14.0%	#	6.1%	0.0%	9.6%	0.0%	8.7%	11.3%	0.0%	**2.8%**	**2%**

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Q6e10. If you are considering leaving your job, please indicate why: Relationship with manager *Note: Asked only of those that said "yes" to question Q6d*	19.1%	15.1%	18.9%	#	11.0%	21.4%	11.0%	20.0%	9.8%	14.9%	41.2%	7.4%	7%
Q6e11. If you are considering leaving your job, please indicate why: Other *Note: Asked only of those that said "yes" to question Q6d*	22.1%	21.4%	23.3%	#	20.1%	28.6%	20.5%	20.0%	20.1%	19.9%	17.6%	8.5%	7%
Q7a. My line manager… encourages those who work for her / him to work as a team.	72.1%	75.4%	65.2%	#	82.9%	66.7%	75.6%	59.1%	81.8%	78.5%	81.9%	71.8%	76%
Q7b. My line manager… can be counted on to help me with a difficult task at work.	69.0%	70.8%	59.8%	#	78.0%	68.3%	69.8%	54.5%	78.4%	74.4%	76.4%	69.5%	73%
Q7c. My line manager… gives me clear feedback on my work.	59.0%	61.6%	50.9%	#	66.3%	63.3%	59.1%	50.0%	69.8%	65.1%	76.4%	57.8%	62%
Q7d. My line manager… asks for my opinion before making decisions that affect my work.	51.7%	52.9%	41.2%	#	63.2%	58.3%	51.6%	36.4%	55.6%	57.0%	65.3%	54.7%	59%
Q7e. My line manager… is supportive in a personal crisis.	73.9%	75.5%	69.4%	#	81.3%	71.7%	71.0%	77.3%	81.2%	76.1%	81.9%	74.5%	78%
Q7f. My line manager… takes a positive interest in my health and well-being.	63.5%	64.4%	56.3%	#	73.2%	60.0%	57.6%	63.6%	71.2%	64.8%	79.2%	78.3%	81%
Q7g. My line manager… values my work.	68.4%	70.0%	61.2%	#	76.9%	66.7%	70.7%	72.7%	73.6%	72.5%	77.8%	‡	#
Q7h. My line manager… helps me find a good work life balance.	53.0%	54.8%	46.2%	#	62.8%	53.3%	49.2%	59.1%	61.6%	55.7%	68.1%	45.5%	51%
Q8a. Communication between senior management and staff is effective.	34.5%	34.0%	25.7%	#	40.9%	40.0%	33.6%	27.3%	36.2%	35.9%	50.0%	30.0%	34%
Q8b. Senior managers involve staff in a timely manner regarding important decisions.	28.4%	27.4%	19.6%	#	33.3%	31.7%	25.6%	22.7%	32.0%	28.3%	47.2%	28.7%	34%
Q8c. Senior managers act on staff feedback.	27.4%	26.6%	18.4%	#	32.2%	31.7%	28.5%	22.7%	28.6%	28.8%	43.1%	37.7%	43%
Q9a. My organisation takes positive action on health and well-being.	87.1%	87.0%	82.0%	#	90.5%	90.0%	91.9%	95.5%	88.4%	87.0%	94.4%	77.9%	83%
Q9b. My organisation provides advice on mental health and well-being.	86.5%	87.7%	85.7%	#	94.2%	86.7%	85.7%	100.0%	90.8%	83.4%	93.1%	88.8%	94%

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Q9c. My organisation provides advice on diet and nutrition.	69.5%	77.0%	77.6%	#	85.0%	78.3%	73.1%	86.4%	80.6%	68.2%	90.3%	67.4%	81%
Q9d. My organisation provides advice on drug and alcohol consumption.	69.6%	73.4%	72.7%	#	81.3%	73.3%	74.8%	86.4%	76.8%	64.3%	88.9%	72.5%	81%
Q9e. My organisation provides advice on exercise.	77.9%	81.8%	80.3%	#	88.3%	83.3%	81.6%	95.2%	83.1%	76.9%	91.7%	78.1%	86%
Q9f. My organisation provides advice on help for staff that want to stop smoking.	82.9%	85.5%	84.8%	#	90.9%	90.0%	86.5%	95.5%	91.6%	77.3%	91.5%	90.9%	95%
Q9g. Are you happy with the food / drink / rest facilities provided by your employer?	50.7%	55.5%	57.2%	#	58.2%	63.3%	54.7%	59.1%	53.3%	49.7%	77.8%	‡	‡
** Q9h. In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?*	30.1%	30.5%	38.1%	#	26.4%	21.7%	27.4%	18.2%	27.7%	29.4%	22.2%	18.2%	15%
** Q9i. During the last 12 months have you felt unwell as a result of work related stress?*	46.7%	46.1%	51.3%	#	48.4%	48.3%	36.9%	36.4%	48.7%	41.1%	34.7%	36.2%	32%
** Q9j. In the last three months have you ever come to work despite not feeling well enough to perform your duties?*	63.7%	63.8%	67.6%	#	63.1%	61.7%	54.4%	68.2%	68.8%	60.8%	50.0%	‡	‡
** Q9k. Have you felt pressure from your manager to come to work?*	29.2%	29.8%	39.7%	#	21.5%	16.2%	25.6%	20.0%	22.9%	30.4%	25.0%	‡	‡
** Q9l. Have you felt pressure from colleagues to come to work?*	20.7%	20.0%	24.5%	#	16.4%	10.8%	26.3%	20.0%	14.0%	19.3%	25.0%	‡	‡
** Q9m. Have you put yourself under pressure to come into work?*	93.7%	93.0%	93.7%	#	92.3%	97.3%	93.2%	100.0%	91.4%	92.7%	94.4%	‡	‡
** Q9n. Do you typically feel worn out at the end of the working day?*	90.6%	91.2%	93.3%	#	91.1%	83.3%	92.2%	86.4%	92.6%	88.3%	90.3%	‡	‡
Q9o. Does your organisation support you in achieving a work-life balance?	67.9%	70.2%	63.9%	#	77.9%	75.0%	66.8%	71.4%	76.5%	67.6%	86.1%	‡	‡
Q10a. How many hours a week are you contracted to work? *(% of respondents that are contracted to work less than 30 hours a week)*	20.8%	24.2%	17.8%	#	27.5%	8.3%	37.4%	18.2%	10.8%	37.7%	8.3%	21.6%	25%
** Q10b. On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours?* *(% of staff working additional paid hours)*	34.4%	34.9%	41.3%	#	21.5%	30.5%	32.3%	27.3%	30.7%	42.0%	16.9%	49.8%	48%

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** Q10c. On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours? (% of staff working additional unpaid hours)*	**50.3%**	**51.0%**	53.2%	#	60.6%	29.3%	47.0%	72.7%	51.3%	43.9%	50.0%	**71.1%**	**72%**
Q10d. Working the extra PAID hours that I do is acceptable to me. (Asked only of those who stated on Q10b that they work additional paid hours)	**75.4%**	**74.7%**	74.4%	#	67.8%	77.8%	75.8%	85.7%	79.2%	73.7%	92.3%	‡	‡
Q10e. Working the extra UNPAID hours that I do is acceptable to me. (Asked only of those who stated on Q10c that they work additional unpaid hours)	**26.7%**	**23.7%**	17.3%	#	24.0%	41.2%	25.4%	37.5%	25.8%	26.1%	50.0%	‡	‡
** Q11a. In the last month have you seen any errors, near misses, or incidents that could have hurt staff?*	**17.0%**	**17.4%**	22.3%	#	10.9%	15.0%	21.9%	27.3%	23.3%	12.4%	2.8%	**17.4%**	**14%**
** Q11b. In the last month have you seen any errors, near misses, or incidents that could have hurt patients/service users?*	**22.0%**	**21.2%**	34.0%	#	12.2%	10.0%	24.1%	27.3%	19.1%	15.3%	1.4%	**22.3%**	**17%**
Q11c. The last time you saw an error, near miss or incident that could have hurt staff or patients / service users, did you or a colleague report it? (Only asked of respondents that said "yes" to either Q11a or Q11b)	**91.7%**	**92.2%**	92.1%	#	88.2%	100.0%	94.9%	85.7%	95.7%	90.9%	50.0%	**94.5%**	**91%**
Q12a. My organisation treats staff who are involved in an error, near miss or incident fairly.	**48.4%**	**44.8%**	39.9%	#	43.2%	36.6%	44.2%	46.2%	44.7%	52.3%	45.1%	**45.1%**	**48%**
Q12b. My organisation encourages us to report errors, near misses or incidents.	**84.5%**	**84.1%**	79.8%	#	84.5%	63.6%	87.8%	85.0%	84.8%	89.4%	77.6%	**77.7%**	**80%**
Q12c. When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.	**67.2%**	**65.9%**	62.1%	#	64.7%	55.3%	67.4%	47.1%	68.6%	70.9%	56.1%	**61.4%**	**63%**
Q12d. We are given feedback about changes made in response to reported errors, near misses and incidents.	**55.8%**	**54.0%**	50.4%	#	52.5%	28.3%	57.6%	31.3%	61.8%	57.1%	32.8%	**52.3%**	**53%**
Q13a. If you were concerned about negligence, unsafe clinical or professional practice, would you know how to report it?	**86.4%**	**87.9%**	84.6%	#	88.8%	62.7%	89.0%	81.8%	92.2%	91.9%	70.8%	**87.7%**	**89%**
Q13b. I would feel secure raising concerns about negligence, unsafe clinical or professional practice.	**61.1%**	**61.5%**	56.1%	#	60.7%	43.3%	64.9%	63.6%	65.7%	67.0%	50.0%	**79.7%**	**79%**
Q13c. I am confident that my organisation would address my concern.	**55.1%**	**55.0%**	45.4%	#	57.1%	43.3%	56.4%	36.4%	58.5%	64.2%	48.6%	**64.7%**	**70%**
Q13d. Do you understand your responsibility to raise concerns?	**97.3%**	**97.6%**	97.4%	#	98.6%	95.0%	98.8%	95.5%	97.8%	98.2%	87.5%	**79.0%**	**85%**

2019 HSC Staff Survey - Individual Question Data by Organisational Staff Directorate	HSC OVERALL 2019	Southern HSCT Overall 2019	Acute Services	Chief Executive's Office	Children & Young People's Services	Finance & Procurement	HR & Organisational Development	Medical	Mental Health & Disability Services	Older People & Primary Care	Performance & Reform	HSC Overall 2015	Southern HSCT Overall 2015
** Q14a In the last 12 months have you personally experienced physical violence at work from…Patients / service users, their relatives or other members of the public?*	**17.9%**	**20.4%**	23.3%	#	14.7%	0.0%	25.5%	4.5%	32.5%	15.5%	0.0%	**13.9%**	**12%**
** Q14b. In the last 12 months have you personally experienced physical violence at work from… Managers / Team leaders?*	**0.9%**	**0.8%**	1.4%	#	0.6%	1.7%	0.0%	0.0%	0.8%	0.5%	0.0%	**0.5%**	**1%**
** Q14c. In the last 12 months have you personally experienced physical violence at work from…Other colleagues?*	**2.0%**	**1.6%**	2.2%	#	0.4%	3.3%	1.2%	0.0%	3.2%	1.0%	0.0%	**1.4%**	**1%**
Q14d. The last time you experienced physical violence at work, did you or a colleague report it? (*Asked only of respondents who stated on Q14a-c that they had personally experienced physical violence at work in last 12 months*)	**78.8%**	**80.1%**	69.8%	#	78.3%	50.0%	83.8%	50.0%	91.5%	82.5%	0.0%	**76.6%**	**73%**
** Q15a. In the last 12 months have you personally experienced harassment, bullying and abuse at work from… Patients / service users, relatives or other members of the public?*	**32.0%**	**35.4%**	40.7%	#	34.7%	11.7%	31.0%	22.7%	40.7%	33.1%	4.2%	**24.7%**	**23%**
** Q15b. In the last 12 months have you personally experienced harassment, bullying and abuse at work from… Managers / Team leaders?*	**15.7%**	**14.8%**	22.3%	#	9.1%	18.3%	14.3%	31.8%	12.9%	10.1%	16.7%	**12.4%**	**10%**
** Q15c. In the last 12 months have you personally experienced harassment, bullying and abuse at work from… Other colleagues?*	**20.0%**	**19.5%**	26.5%	#	16.8%	15.0%	18.8%	18.2%	18.1%	14.5%	18.1%	**15.6%**	**14%**
Q15d. The last time you experienced harassment, bullying and abuse at work, did you or a colleague report it? (*Asked only of respondents who stated on Q15a-c that they had personally experienced harassment, bullying and abuse at work in the last 12 months)*	**52.0%**	**54.7%**	45.6%	#	59.0%	76.2%	52.0%	66.7%	60.8%	61.8%	18.2%	**53.5%**	**53%**
Q16a1. Does your organisation take effective action if staff are… Physically attacked by patients / clients / service users, their relatives or other members of the public?	**83.3%**	**84.0%**	79.1%	#	89.0%	100.0%	84.1%	81.8%	76.5%	89.6%	100.0%	**57.8%**	**64%**
Q16a2. Does your organisation take effective action if staff are… Physically attacked by other members of staff?	**93.8%**	**95.0%**	91.2%	#	96.6%	100.0%	94.0%	88.9%	97.1%	96.6%	100.0%	**61.1%**	**67%**
Q16a3. Does your organisation take effective action if staff are… bullied, harassed or abused by patients / clients / service users, their relatives or other members of the public?	**74.6%**	**75.5%**	68.6%	#	76.6%	95.5%	82.2%	70.0%	69.4%	81.1%	96.2%	**51.6%**	**57%**
Q16a4. Does your organisation take effective action if staff are… Bullied, harassed or abused by other members of staff?	**72.3%**	**74.5%**	64.7%	#	78.1%	64.7%	80.4%	41.7%	73.3%	84.1%	63.6%	**49.1%**	**52%**
* Q17a. *In the last 12 months have you personally experienced discrimination at work from … Patients / service users, their relatives or other members of the public?*	**4.3%**	**4.8%**	4.7%	#	3.9%	3.3%	5.5%	4.5%	6.6%	4.6%	0.0%	**4.5%**	**4%**

2019 HSC Staff Survey - Individual Question Data by Organisational Staff Directorate	HSC OVERALL 2019	Southern HSCT Overall 2019	Acute Services	Chief Executive's Office	Children & Young People's Services	Finance & Procurement	HR & Organisational Development	Medical	Mental Health & Disability Services	Older People & Primary Care	Performance & Reform	HSC Overall 2015	Southern HSCT Overall 2015
* Q17b. *In the last 12 months have you personally experienced discrimination at work from …Managers / team leaders or other colleagues?*	9.9%	8.5%	11.6%	#	8.2%	8.3%	8.0%	14.3%	7.8%	6.4%	2.8%	7.6%	7%
* Q17c1. *On what grounds have you experienced discrimination… Ethnic background*	11.4%	11.8%	9.9%	#	10.5%	14.3%	7.1%	0.0%	11.7%	18.4%	0.0%	12.6%	8%
* Q17c2. *On what grounds have you experienced discrimination… Gender*	16.0%	14.3%	19.8%	#	12.3%	0.0%	10.7%	0.0%	16.7%	7.9%	0.0%	17.6%	19%
* Q17c3. *On what grounds have you experienced discrimination… Religion*	19.6%	22.5%	19.8%	#	31.6%	0.0%	25.0%	33.3%	21.7%	22.4%	0.0%	22.2%	29%
* Q17c4. *On what grounds have you experienced discrimination… Sexual orientation*	3.6%	2.5%	2.3%	#	5.3%	0.0%	3.6%	0.0%	1.7%	0.0%	50.0%	4.3%	1%
* Q17c5. *On what grounds have you experienced discrimination… Disability*	8.3%	10.7%	11.5%	#	12.3%	14.3%	13.8%	0.0%	10.0%	7.9%	0.0%	8.6%	8%
* Q17c6. *On what grounds have you experienced discrimination… Age*	14.0%	15.7%	17.6%	#	12.3%	14.3%	28.6%	0.0%	15.0%	11.8%	0.0%	15.1%	13%
* Q17c7. *On what grounds have you experienced discrimination… Other reason(s)*	37.9%	36.2%	38.2%	#	38.6%	71.4%	14.3%	66.7%	41.0%	30.3%	50.0%	29.2%	30%
Q17d. Did you report the discrimination?	29.9%	29.5%	26.9%	#	28.6%	57.1%	20.7%	100.0%	33.9%	30.6%	0.0%	27.9%	21%
Q17e. Does your organisation take effective action if discrimination is reported?	26.3%	24.5%	22.4%	#	24.1%	20.0%	11.1%	0.0%	17.4%	40.0%	0.0%	31.7%	53%
Q18a. Have you had any training, learning or development in the last 12 months?	78.4%	80.7%	75.8%	#	89.7%	55.0%	77.3%	70.0%	86.1%	81.6%	69.4%	‡	‡
Q18b. My training, learning or development has helped me to do my job more effectively.	79.8%	80.4%	76.3%	#	78.4%	66.7%	85.1%	81.8%	83.1%	84.7%	80.5%	69.4%	71%
Q18c. My training, learning or development has helped me to stay up-to-date with professional requirements.	84.7%	86.0%	84.6%	#	86.3%	45.8%	86.9%	66.7%	89.1%	88.9%	73.3%	70.2%	73%
Q18d. My training, learning or development has helped me to deliver a better patient / service user experience.	77.5%	79.2%	75.4%	#	77.2%	45.5%	82.4%	83.3%	82.3%	84.3%	79.3%	63.2%	66%
Q19a. Have you had mandatory training in the last 12 months?	90.7%	95.1%	93.3%	#	95.3%	88.3%	94.0%	90.0%	97.8%	96.6%	94.4%	‡	‡

2019 HSC Staff Survey - Individual Question Data by Organisational Staff Directorate	HSC OVERALL 2019	Southern HSCT Overall 2019	Acute Services	Chief Executive's Office	Children & Young People's Services	Finance & Procurement	HR & Organisational Development	Medical	Mental Health & Disability Services	Older People & Primary Care	Performance & Reform	HSC Overall 2015	Southern HSCT Overall 2015
Q20a. In the last 12 months, have you had an appraisal, annual review, development review, or KSF development review?	70.7%	74.4%	70.6%	#	80.0%	74.6%	57.6%	50.0%	76.7%	80.4%	71.8%	64.7%	67%
Q20b. My appraisal / review helped me to improve how I do my job.	74.2%	75.1%	66.6%	#	76.9%	50.0%	83.0%	90.0%	80.6%	79.4%	68.6%	57.9%	63%
Q20c. My appraisal / review helped me agree clear objectives for my work.	84.4%	84.2%	77.4%	#	85.7%	68.2%	88.2%	100.0%	89.5%	87.2%	80.4%	78.0%	80%
Q20d. My appraisal / review left me feeling that my work is valued by my organisation.	71.8%	72.7%	61.8%	#	74.7%	59.1%	79.6%	80.0%	77.9%	78.4%	78.4%	62.2%	67%
Q20e. The values of my organisation were discussed as part of the appraisal process.	73.6%	67.8%	55.1%	#	69.7%	47.7%	70.3%	80.0%	72.4%	77.1%	72.5%	‡	‡
Q20f. My training, learning or development needs were discussed and agreed.	93.6%	94.3%	90.7%	#	97.5%	86.4%	97.1%	100.0%	96.6%	94.8%	92.2%	79.3%	75%
Q20g. My training, learning and development needs were met.	85.6%	88.6%	83.1%	#	91.2%	70.5%	94.2%	100.0%	92.6%	90.5%	84.3%	75.0%	79%
Q21a. Care of patients / service users is my organisation's top priority.	75.2%	74.2%	65.7%	#	76.8%	70.0%	79.4%	55.0%	77.3%	78.4%	81.9%	73.1%	76%
Q21b. I would recommend my organisation as a place to work.	60.6%	59.5%	48.7%	#	64.8%	68.3%	62.9%	55.0%	57.3%	67.0%	72.2%	60.6%	67%
Q21c. If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	68.5%	67.6%	62.5%	#	65.9%	73.3%	69.4%	65.0%	68.0%	73.2%	67.6%	67.0%	71%
Q21d1. What way do you prefer to receive information about your organisation… Daily updates on organisation intranet?	45.9%	41.1%	40.5%	#	45.5%	41.7%	41.4%	40.0%	49.3%	33.9%	38.0%	38.2%	34%
Q21d2. What way do you prefer to receive information about your organisation…Internet?	31.2%	33.4%	37.8%	#	32.5%	36.7%	36.4%	30.0%	32.4%	29.4%	23.9%	24.9%	29%
Q21d3. What way do you prefer to receive information about your organisation… Senior management briefings?	19.3%	16.2%	15.4%	#	15.9%	28.3%	21.0%	35.0%	20.5%	11.1%	23.9%	19.6%	16%
Q21d4. What way do you prefer to receive information about your organisation… Organisation newsletter?	30.1%	37.6%	35.1%	#	40.6%	56.7%	39.1%	65.0%	37.4%	33.5%	59.2%	12.7%	19%
Q21d5. What way do you prefer to receive information about your organisation… Line managers?	53.2%	54.6%	49.8%	#	55.6%	53.3%	56.7%	45.0%	59.0%	57.2%	47.2%	55.6%	55%

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Q21d6. What way do you prefer to receive information about your organisation…Team meetings?	64.8%	66.8%	59.1%	#	69.5%	70.0%	69.4%	50.0%	68.9%	72.4%	63.9%	64.1%	64%
Q21d7. What way do you prefer to receive information about your organisation… Chief Executive briefings?	10.3%	10.1%	9.6%	#	10.5%	16.7%	12.0%	30.0%	10.3%	7.7%	22.5%	7.9%	6%
Q21d8. What way do you prefer to receive information about your organisation… Staff notice boards?	26.9%	23.7%	29.7%	#	16.9%	21.7%	35.7%	10.0%	28.0%	16.0%	14.1%	22.6%	18%
Q22a. Is patient / service user experience feedback collected within your directorate / department?	81.1%	80.1%	73.8%	#	81.4%	17.6%	76.0%	90.9%	89.6%	83.6%	56.0%	74.3%	75%
Q22b. I receive regular updates on patient / service user experience feedback in my directorate / department.	59.1%	57.1%	53.5%	#	55.1%	100.0%	55.3%	70.0%	54.7%	63.3%	64.3%	60.6%	60%
Q22c. Feedback from patients / service users is used to make informed decisions within my service area.	63.1%	61.5%	58.3%	#	61.4%	66.7%	60.2%	40.0%	65.7%	61.4%	76.9%	66.2%	68%

Sheet Title	Description
2019 HSC Staff Survey Key Findings Data for Personnel Areas within HSC Trusts	This sheet contains HSC 2019 Key Finding scores broken down by staff personnel area for each of the five primary Health and Social Care Trusts that took part in the 2019 HSC Staff Survey. For most of the question scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in italics, the lower the score the better. *Note: Key Finding 21 could not be calculated for the HSC Staff Survey '19 as the single question that constitutes this finding was not included within the HSC '19 staff questionnaire (see Appendix I within regional report).*
2019 HSC Staff Survey Key Findings Data by Organisational Staff Directorate	This sheet contains HSC 2019 Key Finding scores broken down by staff directorate area for every organisation that took part in the 2019 HSC Staff Survey. For most of the question scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in italics, the lower the score the better. In order to preserve the confidentiality of individual staff, data is not shown where fewer than 11 responses contribute to a score. Whereby a value is suppressed because fewer than eleven responses were received, this is denoted by the symbol #. *Note: Key Finding 21 could not be calculated for the HSC Staff Survey '19 as the single question that constitutes this finding was not included within the HSC '19 staff questionnaire (see Appendix I within regional report).*
2019 HSC Staff Survey - Employee Engagement Score & Key Findings broken down by background details	This sheet contains Employee Engagement Scores & Key Findings broken down by background details for every organisation that took part in the 2019 HSC Staff Survey. In order to preserve the confidentiality of individual staff, data is not shown where fewer than 11 responses contribute to a score. Whereby a value is suppressed because fewer than eleven responses were received, this is denoted by the symbol #. *Note: Key Finding 21 could not be calculated for the HSC Staff Survey '19 as the single question that constitutes this finding was not included within the HSC '19 staff questionnaire (see Appendix I within regional report).*
2019 HSC Staff Survey - Individual Question Data for Personnel Areas within HSC Trusts	This sheet contains HSC 2019 individual question scores broken down by staff personnel area for each of the five primary Health and Social Care Trusts that took part in the 2019 HSC Staff Survey. For most of the question scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in italics, the lower the score the better. In order to preserve the confidentiality of individual staff, data is not shown where fewer than 11 responses contribute to a score. Whereby a value is suppressed because fewer than eleven responses were received, this is denoted by the symbol #.
2019 HSC Staff Survey - Background Question Data for Personnel Areas within HSC Trusts	This sheet contains questions relating to background information broken down by staff personnel area for each of the five primary Health and Social Care Trusts that took part in the 2019 HSC Staff Survey. In order to preserve the confidentiality of individual staff, data is not shown where fewer than 11 responses contribute to a score. Whereby a value is suppressed because fewer than eleven responses were received, this is denoted by the symbol #.
2019 HSC Staff Survey - Individual Question Data by Organisational Staff Directorate	This sheet contains HSC 2019 individual question scores broken down by staff directorate area for every organisation that took part in the 2019 HSC Staff Survey. For most of the question scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in italics, the lower the score the better. In order to preserve the confidentiality of individual staff, data is not shown where fewer than 11 responses contribute to a score. Whereby a value is suppressed because fewer than eleven responses were received, this is denoted by the symbol #.
2019 HSC Staff Survey - Background Questions Data by Organisational Staff Directorate	This sheet contains questions relating to background information broken down by staff directorate area for every organisation that took part in the 2019 HSC Staff Survey. In order to preserve the confidentiality of individual staff, data is not shown where fewer than 11 responses contribute to a score. Whereby a value is suppressed because fewer than eleven responses were received, this is denoted by the symbol #.
2019 HSC Staff Survey - Individual Questions broken down by background details	This sheet contains individual question results broken down by background details for every organisation that took part in the 2019 HSC Staff Survey. In order to preserve the confidentiality of individual staff, data is not shown where fewer than 11 responses contribute to a score. Whereby a value is suppressed because fewer than eleven responses were received, this is denoted by the symbol #.

Southern Health and Social Care Trust

VIRTUAL HR & MEDICAL DIRECTORATE MEETING

Wednesday, 8th December 2021 @ 2:00pm

Join Zoom Meeting

Irrelevant information redacted by the USI

Meeting ID: Irrelevant information redacted by the USI **/ Passcode:** Irrelevant information redacted by the USI

AGENDA

- **Pension Tax Issue Explanation**

PENSION TAX EXPANATION 2021.p

- **Career Breaks / Worklife Balance Applications**
- **Capacity in Medical HR / Locum Team**
- **Private Practice & Governance (CFS Visit)**
- **MST roles**
- **New SAS Contract 2021**
- **Entrance & Exit interviews**

LfE Entrance-Interview-t

LfE Exit-Interview-templa

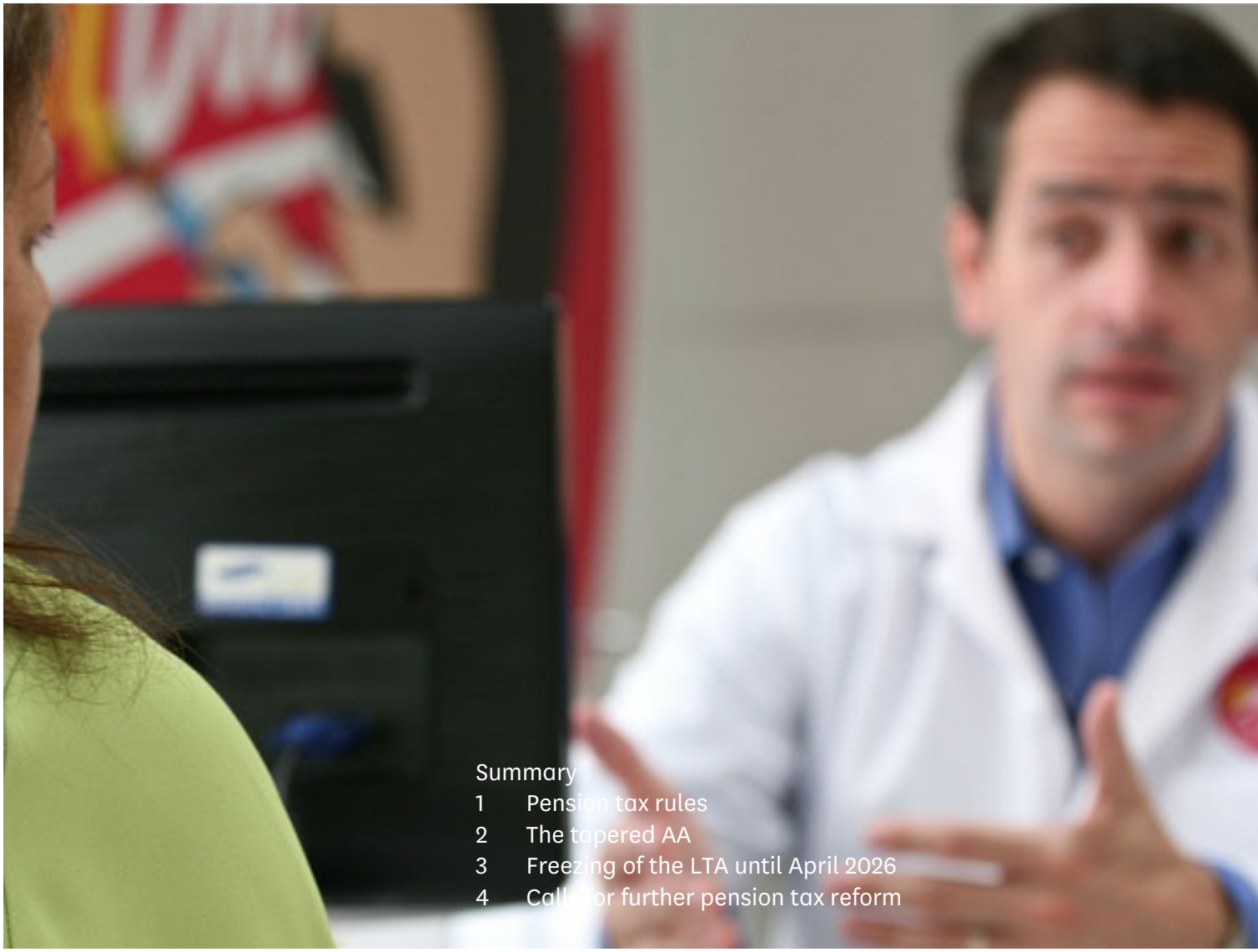
HSC Staff Survey Results - Southern HS

- **Any Other Business**

Date of next virtual meeting: Wednesday, 2nd February 2022 @ 11:00am

By Djuna Thurley

20 August 2021



Summary

Contents

Summary

This note looks at the concerns about the impact of pension tax rules on some senior NHS clinicians and GPs who are members of the NHS Pension Scheme, a defined benefit (DB) public service pension scheme.

The annual allowance and lifetime allowance

Pension tax relief works on the principle that contributions to pensions are exempt from tax when they are made, but taxed when they are paid out. The amount of tax-relieved pension saving an individual can build up is limited by the annual allowance (AA) and lifetime allowance (LTA). Both have been reduced in stages since 2010:

- The standard LTA reduced in stages from £1.8 million in 2010 to £1 million in April 2016. It then rose in line with inflation from April 2018 until April 2021. The Government legislated in the Finance Act 2021 (s28) to freeze it at its current level of £1,073,100 until April 2026.
- The standard AA reduced in stages from £255,000 in 2010 to £40,000 in April 2014. From April 2016, There is also a tapered AA, introduced in April 2016, which reduces the AA of higher earners ('adjusted incomes' above £240,000) to a lower level (a minimum of £4,000).

When making these reductions, the Coalition Government put in place measures to mitigate the impact. For example, people at risk of breaching the AA in a particular year can 'carry forward' unused allowances from the previous three years (FA 04, s228A) and in certain circumstances, people could apply for protection against a reduced LTA (*FA 04,* s218, Sch 36).

For more detail, see Pension tax relief: the annual and lifetime allowances, Commons Library Briefing Paper CBP 5901, March 2021.

Changes the tapered AA in 2020

The tapered AA, introduced in April 2016, reduces the AA of earners with adjusted incomes above a threshold level to a lower minimum than the standard AA. When these rules were introduced, they applied to people with 'adjusted incomes' (taxable income plus the value of pension growth) above £150,000 and 'threshold income' above £110,000. The taper could reduce the AA to a minimum of £10,000 (HMRC, Pension scheme rates, April 2021).

Although these rules applied across all schemes, the nature of many doctors' work (for example, consultants taking on additional work often at short notice to cover service pressures) meant there was a particular impact on the NHS. This was particularly felt in 2019-20 when the capacity to bring forward

unused AAs from the previous three years was largely exhausted (DHSC consultation, July 2019).

In the March 2020 Budget, the Government announced increases of £90,000 in the income thresholds for the tapered AA ('adjusted income' increased to £240,000, 'threshold income' to £200,000) and a decrease in the minimum AA to £4,000 (para 2.183-5; HMRC policy paper, March 2020). The BMA welcomed the announcement – which would mean that the "vast majority of doctors are now removed from the effect of the taper" – but said it was long overdue and that further reform was needed. The changes were legislated for in the Finance Act 2020 (s22).

NHS pension scheme flexibility

Before deciding to change the tapered AA thresholds, the Government considered – but ultimately did not take forward – proposals for more flexibility in pension scheme rules.

The Department of Health and Social Care (DHSC) consulted in September 2019 on proposals to allow senior medical staff to opt to build up pension benefits at a lower rate to reduce the risk of incurring a tax charge. The BMA described the proposals as a 'sticking plaster' and the pension tax rules needed to change.

In Budget 2020, the Government said the flexibility proposals would not be taken forward (para 2.184). This was confirmed in February 2021, when the DHSC responded to the consultation. It said the majority of respondents had "argued that tax reform would be the simplest way of solving the issue of senior clinicians limiting their NHS work for fear of large unexpected annual allowance charges." Changes to the tapered annual allowance in *FA 2020* had achieved "the same intended policy aim as the proposed flexibilities but without the additional complexity that the latter would introduce."

In its 2021 report, the Review Body on Doctors' and Dentists' Remuneration, recommended that employers consider making better advice available and allowing "flexibility for employees to take some of their remuneration as non-pensionable pay, thus reducing their tax liabilities without having to leave their pension scheme" (para 4.86).

Calls for further reform of pension tax rules

In its October 2019 report on Taxation and Life Events, the Office of Tax Simplification said the Lifetime and Annual Allowance charges could present significant complexities for pension savers in different circumstances in either DB or DC schemes. It said that, given the aim of limiting the overall pension tax relief going to any individual, applying both charges might be unnecessary. For DB schemes, – like the NHS Pension Scheme – one option might be to apply the LTA only (para 3.74-5).

In March 2020, the BMA welcomed the changes to the tapered AA, but said that a pay increase or a promotion could still result in doctors facing

significant tax bills as a result of exceeding the standard AA. Responding to the decision in Budget 2021 to freeze the LTA at its current level until April 2026, it said this was "going to push doctors out of the NHS." It argued for the option of a tax-unregistered pension scheme for those affected, pointing to planned reforms for the judiciary.

In a Parliamentary Written Answer on 18 May 2021, the Government rejected this approach on grounds that the circumstances of judicial appointments are unique:

> The unique circumstances of judiciary appointments mean that it is necessary to reform their pension arrangements. Judges are not able to work in private practice after taking up office, and many judges take a significant pay cut to join the judiciary. The combination of these factors is why the Government is committed to introduce a reformed judicial pension scheme. Such a scheme would not benefit the vast majority of NHS staff, as members would receive no tax relief on their contributions.

The BMA continues to call for reform to help address doctor shortages, including "removing punitive pension taxation rules so older doctors can remain in work flexibly."

For more on the reforms to Judges' pensions schemes, see Commons Library Briefing, CBP 8540, April 2021.

1 Pension tax rules

Pension tax relief works on the principle that contributions to pensions are exempt from tax when they are made, but taxed when they are paid out. Pension contributions made by individual employees are usually paid out of pre-tax salary, so tax relief is received at the individual's marginal tax rate. The main limits that apply are:

- The annual allowance (AA) - which limits the amount of annual pension savings that benefit from tax relief. There is a tax charge if contributions, or the value of benefits accrued in a year, exceed the AA.[1] This is broadly intended to recoup the tax relief they would have received on the excess contributions.[2]
- The lifetime allowance (LTA) - which limits the amount of pension saving over an individual's lifetime that can benefit from tax relief. Pension savings are tested against the LTA at 'benefit crystallisation events', for example, when an individual becomes entitled to a lifetime annuity. A breach of the LTA leads to a charge (25%, if the excess is a pension, or 55% if it is a lump sum).[3]

The legislation is in the Finance Act 2004 (pt4, ch5). Detailed guidance is in HMRC's Pension Tax Manual – Lifetime Allowance and Annual Allowance.

For more detail, see Pension tax relief: the annual and lifetime allowances, Commons Library Briefing Paper, CBP 5901, March 2021.

1.1 The annual allowance

At introduction in 2006, the AA was set at £215,000. It was set to increase to £255,000 by 2010.[4] The standard AA was reduced from £255,000 to £50,000 in 2011 and then to £40,000 in 2014. From April 2016, there has been a tapered AA, applying to higher income individuals.

The NHS Pension Scheme – like the other main public sector schemes – is a defined benefit (DB) scheme i.e. one which provides pension benefits based on salary and length of service. Rights in DB schemes are measured against the tax limits not by looking at the contributions made, but at the value of

[1] Finance Act 2004, Pt 4; HMRC Pension Tax Manual – annual allowance
[2] HMRC, Pension Tax Manual - Annual Allowance: tax charge/rate of tax charge/general
[3] Pension Tax Manual – Pension Tax Manual – The Lifetime Allowance charge
[4] HM Treasury, Budget 2004, para 5.45

annual pension benefits that have been built up and multiplying it by a set figure. In the case of the AA, this set figure is 16. [5]

When bringing forward its proposals to reduce the standard AA in October 2010, the Coalition Government said those who could "save more than an AA in the range of £30,000 to £45,000 in a year are concentrated among the highest earners." [6] However, the nature of DB schemes could lead to some individuals on low to moderate incomes exceeding the AA (for example, on promotion). [7] In particular circumstances, a combination of factors (including length of service, scheme accrual rate, level of salary, and rate of salary increase) could create uneven, and potentially sizeable, annual increases in pension in a particular year. [8] To mitigate the impact of this, the Coalition Government decided to allow individuals to "offset excess contributions against unused allowance from up to the previous three years." [9]

At the time, the Government recognised that there would still be cases where a tax charge would arise that would be difficult to meet out of current income. [10] It therefore introduced "scheme pays", whereby members who have exceeded the standard AA (£40,000) and have a tax charge of more than £40,000 can elect for the charge to be met from their pension benefits. [11] This involves the scheme effectively making a loan to the individual to pay the charge, which they must later repay with interest. [12] Pension schemes have discretion to offer 'scheme pays' in a wider range of circumstances. [13]

The tapered AA

The tapered annual allowance (AA) was introduced in April 2016. The rules at that time were summarised in the following Parliamentary Written Answer:

> tapering applies to individuals whose taxable income exceeds £110,000 and whose adjusted income exceeds £150,000. Adjusted income is taxable income plus the value of annual pension growth. The standard annual allowance is reduced by £1 for every £2 of

[5] *Finance Act 2004*, s234; Gov.UK, Work out your reduced (tapered) annual allowance/work out your pension savings. In the case of the LTA, a multiplier of 20 applies (*Finance Act 2004*, s212 and 276)

[6] HM Treasury, Restriction of pension tax relief: a discussion document on the alternative approach, July 2010, para 3.1

[7] Ibid, para 3.4

[8] HM Treasury, Options to meet high annual allowance charges from pension benefits: a discussion document, November 2010

[9] HM Treasury, Restricting pensions tax relief through existing allowances: a summary of the discussion document responses, October 2010, summary and para 3.6

[10] HM Treasury, Options to meet high annual allowance charges from pension benefits: a discussion document, November 2010, para 1.7

[11] HC Deb, 3 March 2011, c31-2WS; HMRC's Pensions Tax Manual – Annual allowance: tax charge: scheme pays: general

[12] HL 17506, PQ 6 August 2019; NHSBA/Member Hub/Annual Alllowance/Scheme Pays FAQs. See also NHSBA 'Scheme Pays Election Guide'

[13] Ibid; NHS Pension Scheme, Annual Allowance – scheme pays election

adjusted income over £150,000, tapering down to a minimum allowance of £10,000.[14]

The rationale for introducing the tapered AA was "to control the cost of pensions tax relief" by ensuring that "the support provided to pension savers is affordable and targeted where it is needed most."[15] The Government of the time estimated that it would save some £4bn over the six years to 2020-21, with the annual saving rising to £1.28 billion in 2020-21.[16] The measure was "focused on the wealthiest pension savers, to ensure that the benefit they receive is not disproportionate to that of other pension savers."[17]

For guidance on the rules, see:

- NHS Pensions: Annual allowance
- NHS Employers: Pension tax resources
- Scottish Public Pensions Agency: Annual Allowance FAQs
- HMRC, Work out your reduced (tapered) annual allowance, (updated April 2020)
- BMA, NHS Pension annual allowance, updated 2 June 2021

1.2 The lifetime allowance

At introduction in 2006, the LTA was set at £1.5 million, to increase in stages, £1.8 million by 2010.[18] It reduced from £1.8 million to £1.5m in April 2012, to £1.25 million in 2014 and to £1 million in April 2016.[19]

The protections available to protect individuals affected by these reductions are discussed in Pension tax relief: the annual and lifetime allowances, Commons Library Briefing Paper, CBP 5901, March 2021.

The Finance Act 2016 (s19) provided for the LTA to rise in line with CPI inflation from £1 million from 2018/19.[20] This happened until it reached £1,073,000 in 2021/22.[21] However, in Budget 2021 the Chancellor announced that it would be frozen at its current level of £1,073,100 until April 2026.[22] This was legislated for in the Finance Act 2021 (s28).

[14] PQ 207, 9 January 2020
[15] HM Treasury, Summer 2015 Budget, HC 264, July 2015
[16] HM Treasury, Overview of tax legislation and rates, July 2015, p62
[17] PBC Deb 13 October 2015 c83
[18] HM Treasury, Budget 2004, para 5.45
[19] *FA11*, s67 & Sch18; *FA13*, s48; *FA16*, s19
[20] *FA16*, s19
[21] There is a table showing the rates in each year since 2006 in CBP 5901, section 2
[22] HM Treasury, Budget 2021, March 2021, para 2.77

2 The tapered AA

2.1 Impact in the NHS

In March 2019, the British Medical Association (BMA) wrote to the then Chancellor of the Exchequer, Philip Hammond, saying that the rules were "forcing some of our most experienced doctors to retire, reduce their workload, abandon leadership positions and stop covering vacancies." The operation of the tapered annual allowance meant some of its members were facing "significant – four, five and six figure - charges, in addition to PAYE and other tax charges."[23]

In July 2019, the Review Body on Doctors' and Dentists' Remuneration said the combination of reductions in the AA and the introduction of the taper meant that "staff are now much more likely than they were before to find themselves having breached annual allowances, and hence to be in receipt of sometimes substantial tax charges."[24]

The Department of Health & Social Care (DHSC) said that the nature of work in the NHS meant the tapered AA was having a particular impact there. It was having an impact in 2019/20 because the capacity to carry forward unused annual allowances from previous years had by then been greatly reduced:

> 1.12 NHS consultants and GPs have the opportunity to take on additional work each year and can flex their income up or down. Consultants typically volunteer for additional non-pensionable sessions of work, often at short notice, to cover service pressures. As payment for this work counts towards the tapered annual allowance, many more senior clinicians are being caught by pension tax. The design of the taper also creates cliff edges. It has been argued by some that the operation of the taper is difficult to predict, particularly when a senior clinician is unsure what level of income that they will earn within a tax year. Around a third of NHS consultants and GP practice partners have earnings from the NHS that could potentially lead to them being affected by the tapering annual allowance.[25]

The effect for some high earners – particularly NHS consultants and GPs - was that their total reward package was diminished compared with members at lower earnings levels. There was evidence that some senior clinicians were

[23] BMA letter to Chancellor to the Exchequer, Philip Hamond, March 2019

[24] Review Body on Doctors' and Dentists' Remuneration, 47th Report, CP148, July 2019, para 1.17

[25] DHSC, NHS Pension Scheme: proposed flexibility, 22 July 2019

"managing their annual allowance tax charge liability by reducing their workload, turning down extra responsibilities or opportunities and/or retiring early." Consequently, there was a reduction in NHS service capacity and patient care was adversely affected. [26]

Professional bodies highlighted concerns. In October 2019, the Royal College of Physicians said a survey of its members had revealed that almost half (45%) had decided to retire at a younger age than previously planned, with 86% of them citing pension concerns as one of their reasons. [27]

On 4 November 2020, the Academy of Royal Medical Colleges wrote to the Government with evidence that it said painted "a stark picture of the negative impact across different specialties and across the UK." It urged the Government to consider reform of the pension tax rules. It was particularly concerned with the taper on the annual allowance. [28] The Royal College of Surgeons also highlighted concerns from a survey of its members. [29] In January 2020, a report by NHS Providers highlighted the impact on non-clinical and well as clinical staff. [30]

Impact elsewhere

This was not just an issue for the NHS. The pension tax rules apply in the same way across registered pension schemes in the public and private sector. However, the nature of work in the NHS - with consultants having the opportunity to volunteer for additional sessions of work, often at short notice, to cover service pressures – may mean there is more of an impact in this area. The BMA also raised concerns about the impact on doctors in the Defence Medical Services. [31] The impact on other public servants – including the senior military, the judiciary, and senior civil servants – had featured in reports of the pay review bodies. [32]

In evidence to the Treasury Select Committee in 2019, the then Chancellor of the Exchequer, Philip Hammond said there appeared to have been less of an impact in the private sector, possibly because increased flexibility in private sector remuneration packages meant that someone at risk of a tapered annual allowance charge "change to their remuneration package, so they get more pay and less pension contribution." [33]

[26] Ibid para 1.2

[27] Pension tax driving doctors to retire early, Royal College of Physicians, October 2019

[28] Academy response to doctors' pension tax issue, Academy of Royal Medical Colleges, November 2019

[29] RCS Survey on the NHS Pension Scheme, 7 November 2019; Royal College of Surgeons press release, 22 November 2019

[30] NHS Providers, An unnecessary divide, Jan 2020

[31] BMA, Armed forces committee: report to ARM 2020

[32] For example, Review Body on Senior Salaries, Cm 9694, Sept 2018, para 3.89-90; Review Body on Doctors' and Dentists' Remuneration, Cm 9670, July 2018

[33] Evidence to the Treasury Select Committee, 24 April 2019, Q336 [Philip Hammond]

2.2 The Government's response

A number of commentators argued strongly that making the NHS pension scheme more flexible would not go far enough - changes to pension tax rules, particularly in relation to the tapered annual allowance, were needed. Royal London for example, has said the "best solution would be to remove a complex and unpredictable feature of the tax system – the tapered annual allowance – even if this required a reduction in the overall annual allowance."[34] On 6 August 2019, the then Chancellor of the Exchequer, Sajid Javid, said HM Treasury would "review how the tapered annual allowance supports the delivery of public services such as the NHS."[35] NHS Providers argued that the outcome of the review should not be limited to NHS clinicians.[36] Trade unions called for it to apply equally across the public sector.[37]

In Budget 2020, the Government announced that it would increase the income limits used to calculate a tapered annual allowance and reduce the minimum tapered annual allowance:

- The threshold income (broadly net income before tax, excluding pension contributions), would increase from £110,000 to £200,000.
- The adjusted income (broadly net income, plus pension accrual) would increase from £150,000 to £240,000.
- The minimum tapered annual allowance would decrease from £10,000 to £4,000.[38]

The Government estimated that the changes announced in Budget 2020 would impact an estimated 250,000 individuals then affected by the tapered annual allowance and cost the Exchequer £2.175 billion over the five years to 2024/25.[39]

In its November 2020 report, the Office for Budget Responsibility produced a revised estimate, reducing the expected yield by an average of £0.1 billion a year (14%) from 2022-23 onwards, to reflect its lower CPI inflation and earnings forecasts.[40]

[34] Letter to the Prime Minister on July 2019: Royal London, Finding the right medicine, May 2019.

[35] NHS pensions for senior clinicians – new changes announced to improve care, DHSC and HM Treasury, August 2019

[36] NHS Providers, An unnecessary divide: the impact of pensions taxation on NHS Trust leaders, January 2020

[37] 'Unions threaten legal challenge over pension measures', *Financial Times*, 7 August 2019 (£); FDA calls on Cabinet Office for greater pensions flexibility, August 2019

[38] HMRC policy paper, March 2020

[39] HMRC policy paper, Pension tax changes for income thresholds for calculating the tapered annual allowance from 6 April 2020, 11 March 2020

[40] OBR, Economic and Fiscal outlook, November 2020, p188, para A.38

Finance Act 2020

Finance Act 2020 (s22) amended the definition of "high-income individual" in FA04 s228ZA so that the tapered AA would only apply to individuals whose adjusted income was greater than £240,000 (previously £150,000) and whose threshold income was greater than £200,000 (previously £110,000). It also decreased the minimum tapered annual allowance from £10,000 to £4,000.[41]

2.3 Compensation in 2019/20

To address the impact of the tapered AA in 2019/20, governments introduced compensation schemes for senior NHS clinicians incurring an annual allowance charge.

England

On 18 November 2019, Chief Executive of the NHS, Simon Stevens, wrote to Health Secretary Matt Hancock asking for his agreement to a proposal to compensate certain senior NHS clinicians who would incur a tapered annual allowance charge arising from their membership of the NHS Pension Scheme in 2019/20.[42] In a letter of 22 November, Mr Hancock gave his consent to these proposals. He advised that that in drafting the details of the scheme, the NHS should take steps to minimise the risk of it constituting tax avoidance.[43]

The *Financial Times* reported that the BMA was seeking a "legal guarantee from the National Health Service that it will cover pension tax bills as front-line staff appear sceptical about a government plan to convince them to work extra shifts to prevent a winter care crisis."[44] On 7 December 2019, the Secretary of State for Health confirmed that these contractual commitments would be honoured when clinicians retired.[45] However, the majority of respondents to a survey by NHS providers did not think this would encourage clinical staff to work additional shifts again.[46]

The Office for Budget Responsibility was unclear what the compensation package would cost: it would depend how clinicians respond to the offer (for example in terms of opting back into the scheme if they had left it to avoid such charges or increasing their hours if they had been turning down shifts for the same reason).[47]

[41] Finance Bill 2019-20 – Explanatory Notes
[42] Letter from Simon Stevens to Matt Hancock, 18 November 2019
[43] Letter from Matt Hancock to Simon Stevens, 22 November 2019
[44] 'Doctors seek legal guarantee from NHS on pensions tax', *FT*, 28 November 2019
[45] Gov.UK, Statement from the Secretary of State on the Clinician Pension Tax Scheme; 7 December 2019; Gov.UK, Senior Clinicians Pensions, Letters between DHSC and NHS England; NHS England, Pension tax annual allowance
[46] NHS Providers, An unnecessary divide, Jan 2020
[47] OBR, Economic and fiscal outlook, March 2020, p175

Wales

On 13 November 2019, Health Minister in the Welsh Government, Vaughan Gething, expressed significant concern over the impact the rules were having and advised health bodies in Wales to use the available pension flexibilities while the UK Government conducted its review of the tax rules:

> I had previously requested an urgent review of these arrangements in the context of increasing clinical and other workforce challenges in the NHS of all four UK nations. Hospital consultant staff within NHS Wales, as with other parts of the United Kingdom, have been affected by the changes made. This has meant that a number of senior consultants have been unwilling to carry out additional work above their contracted hours as the additional work would trigger a tax liability. [48]

NHS Employers Wales produced guidance explaining that affected staff could opt out of the NHS pension scheme mid-year and that their employers could use discretionary flexibility to maintain the value of the clinicians' total reward packages. [49]

On 22 January 2020 Mr Gething wrote to Health Secretary Matt Hancock saying that, although he fundamentally disagreed, he had been left with no option but to consider compensating senior clinicians from the NHS Budget, as had been done in England. He said the harm being done by the issue was undeniable:

> The significant loss of activity is felt by our patients and it is is hard to understate the loss of goodwill from our staff. In the period from April to the end of December, Health Boards in Wales have reported that they have lost around 3,200 sessions which has affected nearly 27,000 outpatients, inpatients/daycare of diagnostics. [50]

Guidance on NHS Wales' Pensions Annual Allowance Charge Compensation Policy explained that "staff who go over their annual allowance for the 2019/20 tax year and who use scheme pays to pay the tax charge can be compensated in retirement for any reduction to their NHS Pension Scheme benefits." [51]

[48] Written Statement, Vaughan Gething AM, 13 November 2019

[49] NHS Wales Employers, Pension tax guidance from employers, October 2019

[50] Vaughan Gething, Letter to Matt Hancock, 22 January 2020

[51] NHS Wales 2019/20 Pensions Annual Allowance Charge Compensation Policy - information for members (viewed 27 May 2021)

Scotland

The Scottish Government has the power to make regulations for the NHS Pension Scheme in Scotland.[52] Pension tax legislation is reserved to the UK Government.[53]

In August 2019, BMA Scotland called on it to "respond rapidly to ensure Scottish doctors are in no way disadvantaged compared to UK counterparts."[54] In November 2019, the Scottish Government announced a short-term scheme to mitigate the impact: NHS Scotland staff would have the option of opting out of the NHS Scotland Pension Scheme and receiving the employer contributions, net of employer National Insurance Contributions, for tax year 2019-20.[55] BMA Scotland described it as "fiendishly complicated," with several hoops to jump through, but "a welcome step in the right direction."[56] On 17 December, the BMA called for the compensation scheme for senior clinicians in England also to be an option in Scotland, until a longer-term resolution was found.[57] However, this did not happen.[58]
On 3 February 2020, Scottish Health Secretary, Jeanne Freeman, called on the UK Chancellor to "take decisive action to ensure pension and taxation rules no longer undermine delivery of frontline health services for the people of Scotland and other UK nations."[59]

Guidance

There is guidance on the rules in the different countries:

- NHS England -2019/20 Pensions Annual Allowance Charge Compensation Policy
- NHS Pensions – annual allowance FAQs
- NHS Wales - Pensions Annual Allowance Charge Compensation Policy - information for employers
- BMA - Guidance on the NHS England and NHS Wales annual allowance repayment scheme 2019/20
- NHS Scotland staff pension policy on recycling employer contributions circular, NHS circular PCS (PP) 19/1

[52] *Public Service Pensions Act 2013,* s2 AND Sch 2

[53] *Finance Act 2004*, Part 4; *Scotland Act 1998,* (as amended), Sch 5 (II) (A1); Library Briefing Paper CBP 8544

[54] BMA Scotland respond to Westminster Pension Tax Announcement, 7 August 2019

[55] NHS circular PCS (PP) 19/1

[56] BMA Scotland blog, Pensions update – a small step forward, November 2019

[57] Scottish doctors must have access to all options to mitigate pension tax charges, BMA press release,17 December 2019

[58] What do I need to do about annual allowance charges relating to the NHS Pension Scheme? PWS financial services, October 2020

[59] Permanent solution required for NHS Pensions, Scottish Government, 3 Feb 2020

2.4 Proposals for flexibility in scheme rules

Before deciding to change the rules on the tapered annual allowance in *Finance Act 2020*, the Government considered introducing flexibility in pension scheme rules. These proposals were not taken forward for reasons discussed below.

On 10 April 2019, the then Health Minister Stephen Hammond said scope of the 'voluntary scheme pays' facility in the NHS scheme would be extended to cover the payment of tax charges from breaches of the tapered AA (i.e. individuals could apply to have a charge arising from the tapered annual allowance to be paid from their pension benefits). [60]

On 22 July 2019, the DHSC launched a consultation on introducing more flexibility into the NHS Pension Scheme – in the form of a "50:50 option whereby senior clinicians who expect to be affected by the annual allowance can elect at the beginning of the year to reduce their contributions and their pension accrual by 50%." [61] However, in August, it said it would replace this with a further consultation for more flexibility. [62] This further consultation, launched on 11 September, included proposals that would allow clinicians whose 'work patterns meant they have a reasonable prospect of incurring an annual allowance tax charge' to:

- Choose before the start of each scheme year (1 April) a personal accrual level and pay correspondingly lower employee contributions. The accrual level chosen would be a percentage of the normal scheme accrual level in 10% increments. For example, 50% accrual with 50% contributions, 30%:30% or 70%:70%.

- Fine tune their pension growth towards the end of the scheme year by updating their chosen accrual level when they are clearer on total earnings. For example, go from 50%:50% to 60%:60%. The updated accrual level would be higher than initial level and have retrospective effect from the start of the scheme year. Contribution arrears from the higher accrual level would be payable by the member and employer before the end of the scheme year.

Where clinicians use the flexibilities to choose a lower accrual level than the full rate, the employer will also pay lower contributions. Employers have the discretion to pay to the member unused employer contributions in these circumstances, although this would be a decision for individual employers. Unused employer contributions could be paid by nonrecurrent

[60] PQ 239952, 10 April 2019

[61] Ibid, para 1.21

[62] HMT, NHS pensions for senior clinicians: new changes announced to improve care, 7 Aug 2019

> lump sum at the end of the scheme year after any updating of the chosen accrual level for that year. [63]

The Department would also work on measures to help those affected "understand their tax liability and how these new flexibilities can be best used to support individual circumstances and preferences." In its response to the consultation published on 23 October 2019, the BMA described the proposals as a 'sticking plaster' and said changes in the pension tax rules were needed. [64]

In Budget 2020, the Government said that proposals to offer greater pay in lieu of pensions for senior clinicians in the NHS pension scheme would not be taken forward. [65]

In its report on public service pensions in March 2021, the National Audit Office looked at the impact of public service pension rules on recruitment and retention. It referred to the particular operational difficulties experienced by the DHSC and the NHS resulting from some senior clinicians not wishing to continue working paid overtime because pension payments would trigger a significant tax liability. HM Treasury had said there were limits to the flexibility it could provide:

> 3.19 Employers told us that they have looked at options for more flexible pension arrangements. In September 2019, DHSC consulted on proposed changes to the NHS Pension Scheme that would provide greater flexibility. HM Treasury has rejected proposals for more general flexibility, although it has allowed some employers to implement more flexible arrangements in specific cases. HM Treasury told us that because pensions are relatively inflexible, it has used other approaches to recruit and retain staff – for example, introducing pension tax measures to help avoid senior clinicians reducing their overtime hours and retiring early. HM Treasury told us there are some limits to the flexibility that it can provide because of the government's commitment to making no major changes to public service pensions for 25 years and the need for an enhanced consultation process on some elements of the schemes (such as accrual rates and normal pension age). HM Treasury also told us that, as with all other areas of policy, it must consider the short-term impact on the public finances of any proposals. [66]

The DHSC published its response to the consultation in February 2021. It said that most respondents took the view that providing flexibility was no substitute for tax reform:

[63] NHS Pension Scheme: increased flexibility, September 2019

[64] 'Government pension plans threaten 'significant' cuts in doctors' pay, warns BMA', GP online, 24 October 2019

[65] HM Treasury, Budget 2020, para 2.185

[66] NAO, Public service pensions, HC 1242 2019-21, 19 March 2021, para 3.19

> The British Medical Association (BMA) did not consider it possible for the impact of pension tax legislation to be resolved by changes to an individual pension scheme. They concluded that even the most appropriate and creative flexibilities would only be a workaround in the absence of tax reform. The NHS Pension Board offered similar views, recognising that the proposals were driven primarily by the impact of tax laws rather than being particularly matters of scheme design. The Royal College of Nursing welcomed an announcement by the Treasury to review the operation of the taper, concluding that reforming the tax system is a more effective approach to addressing the impact on NHS services. The Royal College of General Practitioners agreed with this view, suggesting that flexibility in the NHS Pension Scheme would not be needed if not for the consequences of features of the wider pension tax system. [67]

In its response to the consultation in February 2021, the DHSC said that the majority of consultation responses had "argued that tax reform would be the simplest way of solving the issue of senior clinicians limiting their NHS work for fear of large unexpected annual allowance charges." It confirmed that it would not be proceeding with proposals for increased flexibility in NHS Pensions. This was because changes to the tapered annual allowance in *FA 2020* had achieved "the same intended policy aim as the proposed flexibilities but without the additional complexity that the latter would introduce." It would concentrate on improving information about the interaction of the pension scheme and the pension tax rules:

> Where individuals breach their annual allowance, the Scheme Pays facility provides a proportionate way of meeting the charge without needing to find funds up front. Analysis by the Government Actuary's Department shows that at retirement the Scheme Pays deduction is expected to be a relatively small proportion of the pension growth achieved that year. It may therefore be considered a sound financial decision to incur an annual allowance charge and use Scheme Pays, because the pension accrued that year once the deduction is applied still represents a good return on the contributions made. Members are encouraged to seek regulated finance advice to explore their tax position and make informed choices about their pension. It will therefore be important to improve the transparency of the Scheme Pays facility so that members can see the interaction with their benefits. [68]

[67] DHSC, NHS Pension Scheme: Pension flexibility: response to consultation, Feb 2021

[68] Ibid

3 Freezing of the LTA until April 2026

In the March 2020 Budget, the Government said the Lifetime Allowance would be frozen at its current level of £1,073,100 until April 2026. [69]

The BMA said this was "going to push doctors out of the NHS":

> Unlike in the private sector, doctors' only real mechanism to avoid tax bills running in to the tens of thousands of pounds, as a result of taking on extra work, was to reduce their working commitments or to leave the profession. We know that the lifetime allowance is a potent driver of early retirement. Our survey ahead of the Budget asked what impact a freeze on the level of the lifetime allowance would have on their retirement plans and work patterns. 72% of doctors said that they are likely to retire even earlier as a result of the lifetime allowance being frozen. In addition, 61% of doctors said they would reduce their hours and over 40% indicated they would give up additional roles and responsibilities within the NHS as a result of these changes. [70]

The Review Body on Doctors' and Dentists' Remuneration also expressed concern about "the potential for issues of retention for the most senior doctors to be exacerbated by changes to the pensions taxation system, most recently the freezing of the Lifetime Allowance until 2025-26." It expected the Government and employers to "explain how they anticipate this and other changes to the pensions system to affect retention and what can be done to address this and help to improve retention amongst the medical and dental workforces." One option, already used at times in Scotland and some NHS Trusts in England, was "the practice of 'recycling' – paying unused employer contribution as salary to those who opt out of the NHS Pension Scheme as a result of having reached the annual or lifetime allowance." Better information and advice to support decision-making was also needed. [71]

The impact on retention of senior public servants was raised by Liberal Democrat Peer, Baroness Kramer, when the Finance Bill was before Parliament. [72] For the Government, Lord Agnew said that "maintaining the pensions lifetime allowance at current levels affects only those with the largest pensions—those worth more than £1 million." [73]

[69] HM Treasury, Budget 2021, March 2021, para 2.67

[70] BMA, Impact of freezing the Lifetime Allowance on the NHS workforce, March 2021

[71] Ibid, para 4.86

[72] HL Deb 8 June 2021 c1396

[73] Ibid c1367

In response to PQs, Ministers have pointed to the cost of pension tax relief:

> Pensions tax relief is one of the most expensive reliefs in the personal tax system. In 2017-18 income tax and employer National Insurance Contributions reliefs cost £54 billion, with around 60 per cent going to higher and additional rate taxpayers. 92% of individuals approaching retirement over the next 5 years will have a pension below the lifetime allowance and so will not be affected by this change.[74]

[74] PQ835, 18 May 2021

4 Calls for further pension tax reform

In a report in October 2019, the Office of Tax Simplification (OTS) published its report on Taxation and Life Events, looking at ways to improve people's experience of the tax system at key events in their lives. It suggested removing the application of the Annual Allowance from defined benefit pension schemes (such as the NHS scheme):

> 3.73 The Lifetime Allowance Charge and the Annual Allowance Charge can present significant complexities for pension savers in different circumstances, and in either DB or DC schemes.
>
> 3.74 Given the policy aim of limiting the overall amount of pensions savings tax relief available to any one individual, applying both the AA and LTA charges to pensions may be unnecessary.
>
> 3.75 One possibility would be for the AA to apply in relation to DC schemes and the LTA in relation to DB schemes, reflecting the most natural operational and administrative fit between the two approaches and the type of scheme involved. [75]

As discussed above, the Government made changes in the Finance Act 2020 to mitigate the impact of the tapered AA. Although these changes were welcomed by stakeholders, they argued that more needed to be done. The BMA argued that the Government should have gone further and removed the AA from defined benefit schemes altogether:

> We believe that the annual allowance is unsuited to defined benefit schemes such as the NHS. Many doctors with incomes far below the new threshold income will face tax bills as a result of exceeding the standard annual allowance which remains at £40,000. This can happen simply following a modest rise in pensionable pay, for example when receiving a pay increment, taking on a leadership role or being recognised for clinical excellence. In addition, there is no change to the Lifetime Allowance and many doctors will still need to consider taking early retirement. Furthermore, there remains an essential requirement to speed up the delivery of information to GPs about their annual pension contributions.
>
> Raising the level of the threshold income for all workers, including those in the private sector, will ultimately prove more costly to the Treasury than the BMA's proposed solution of removing the annual allowance from defined benefit pension schemes, a proposal also

[75] Office of Tax Simplification, Taxation and Life Events, October 2019 and para 3.57

> suggested by the Government's own independent advisors, the Office of Tax Simplification. However, the fact that Government has committed to significant taxation reform demonstrates that our campaigning on behalf of members has been effective and will help the majority of doctors. [76]

Industry commentators agreed that more was needed. The ABI said that "further tinkering with pensions tax relief is not a long-term solution. The system needs fundamental reform." [77]

The Review Body on Doctors' and Dentists' Remuneration's 2021 report said:

> 4.31 The BMA said that repeated surveys had demonstrated that pensions taxation was one of the major factors causing doctors to either retire early or reduce their hours, and that the current taxation system was unfair and punitive to doctors working in the NHS. They said that the pension taxation system must be urgently reformed to avoid the NHS further feeling the consequences, and that whilst the changes announced in March 2020 offered some mitigation, the fundamental problems remained. They said that the decision to freeze the lifetime allowance until 2025-26 would exacerbate the already precarious workforce situation, and that the age discrimination remedy proposed by the government added a further layer of complexity to an already complicated pension scheme. [78]

This is not just an issue in the NHS. In its 2021 report, the Review Body on Senior Salaries [79] recommended making better advice available and considering flexibility for employees to take some of their remuneration as non-pensionable pay. It noted, for example, that "nearly all members of the senior military will still incur breaches of the lifetime allowance." [80]

4.1 The option of a tax un-registered scheme

The BMA has called for the same approach to be taken for senior NHS staff as has been taken for judges, who are to be offered a tax-unregistered scheme:

> An exemption to the punitive effects of pension taxation was agreed by the Government in February for the judiciary, by introducing a tax-unregistered scheme. An unregistered defined benefit pensions scheme is one where the member does not receive tax relief on their contributions, and therefore in exchange these benefits are not

[76] BMA says Government has 'finally listened' to months of lobbying to fix pension taxation crisis and improve patient care, 11 March 2020

[77] ABI responds to Budget 2020, March 2020; Budget 2020, Professional Adviser, March 2020

[78] Review Body on Doctors' and Dentists' Remuneration, Forty-Ninth Report 2021, CP 479, July 2021; NHS in midst of workforce shortfall, BMA, 12 July 2021

[79] Remit group includes senior civil service (SCS), the senior military and the judiciary

[80] Forty-third annual report on senior salaries, CP 494, July 2021

> tested against the annual or lifetime allowance. This scheme was introduced for the judiciary as they faced very similar issues with recruitment and retention to doctors, and the BMA firmly believes that the government should offer a similar tax unregistered defined benefit pension scheme for those affected in the NHS.
>
> This view was supported by our member survey which showed that 77% of doctors responding would be less likely to leave the NHS if they were exempt from the impact of the lifetime allowance, and 73% said if offered a similar scheme to the judiciary they would be more likely to work for more years than previously planned. [81]

The position with judges is that the 1981 and 1993 judges' pension schemes were tax-unregistered. This means that contributions to the scheme do not attract tax relief and that the annual and lifetime allowances do not apply. [82]

However, the new scheme introduced in 2015 under the Public Service Pensions Act 2013 was not. Under transitional protection arrangements in the Act, those judges 'closest to retirement' in April 2012 were allowed to remain in the legacy schemes, whereas younger members were transferred to the reform scheme. [83] In January 2017, the Employment Tribunal held in McCloud v Ministry of Justice that the transitional arrangements for the introduction of NJPS 2015 constituted unlawful discrimination. The tax-registered status of the reform was a key issue. [84] In December 2018, the Court of Appeal held that the transitional protections for both judges and firefighters were unlawfully discriminatory on grounds of age. [85] Having been denied leave to appeal, the Government accepted that the discrimination would need to be remedied across public service pension schemes. [86]

In relation to the judges, the Government intends to:

- Introduce a new pension scheme for future service from April 2022 that will not be tax un-registered. [87]
- Those judges within scope of the McCloud remedy will be given the option, once the new scheme has been introduced, of whether to have built up benefits in either the 2015 scheme or one of the legacy schemes between April 2015 and April 2022. [88]

In relation to the main unfunded public service pension schemes – including the NHS scheme - the Government is proposing to move all active scheme

[81] BMA press release, Lifetime allowance freeze, March 2021

[82] HL Deb 15 December 2005, cc WS151-152; For more on the background, see Library Briefing Paper SN-3308, *Judicial Pensions Bill 2005-06* (December 2005)

[83] *Public Service Pensions Act 2013*, s18

[84] McCloud and Others-v-Ministry of Justice, January 2017, para 31-2

[85] Lord Chancellor and Secretary of State for Justice v McCloud and Mostyn, Home Secretary and Welsh Ministers v Sargeant, 2018 EWCA Civ 2844

[86] HCWS 1725, 15 July 2019

[87] MoJ, Proposals for a reformed judicial pension scheme consultation, July 2020; MoJ, A reformed judicial pension scheme, Response to consultation, Feb 2021

[88] MoJ, Consultation on the proposed response to McCloud, July 2020

members to the (tax-registered) 2015 schemes in April 2022. Those within scope of the McCloud remedy, are to have the option (to be exercised at the point at which benefits come into payment) of whether to have built up benefits in the relevant reform or legacy scheme between April 2015 and April 2022. [89]

The BMA has argued that there are important parallels between the situation faced by judges and by many doctors:

> The unfair taxation on pensions that has caused retention and recruitment issues for judges, are the very same taxes that are having a terrible impact on the NHS with doctors having to reduce the work they do for patients or retire early, despite doctors wanting to provide more care for patients,' he said.
>
> Given the very similar problems faced by doctors to those in the judiciary, it is only correct that the Government look to provide doctors with a long-term solution to enable them to care for their patients without detriment. [90]

The Government's view is that the circumstances of the judiciary are unique:

> The unique circumstances of judiciary appointments mean that it is necessary to reform their pension arrangements. Judges are not able to work in private practice after taking up office, and many judges take a significant pay cut to join the judiciary. The combination of these factors is why the Government is committed to introduce a reformed judicial pension scheme. Such a scheme would not benefit the vast majority of NHS staff, as members would receive no tax relief on their contributions. [91]

[89] HM Treasury, Public service pension schemes: changes to the transitional arrangements to the 2015 schemes. Government response to consultation, Feb 2021

[90] BMA press release, 26 February 2021

[91] PQ835, 18 May 2021

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Entrance interview questionnaire

This is your entrance interview questionnaire. We would like you to answer it at the beginning of your post and use it to guide formation of your personal development plan. We hope you will find it useful to reflect on what you want to bring to your new post, what you would like to achieve during your time with us, and how we can help you to do that. An online version of this form can be found at www.learningfromexcellence.com and if you include your email address a copy of the form will be emailed to you.

What is important to you?

This may be work related, but doesn't have to be. We want you to think about what matters to you so this can be considered in terms of your aims and objectives for the post.

What are your strengths and how would you like to use them in this post?

What is the best thing that you could bring from your previous post to this one?

What can we do together to help you feel valued?

What do you think is going to stretch you in this post? How might you manage this?

Imagine you are at the end of your planned rotation or placement and it has gone really well. What will you have achieved and what will your colleagues have learnt from / about you?

Exit Interview template

This questionnaire is your exit interview from your department. When answering the questions, please consider your whole post. The purpose of the questionnaire is discover insights which can be used to improve the experience of others working in the department, so please include as much information as possible. Thank you very much for your time.

Please return this form to……

What aspects of your time in this post have been particularly good, and why?

What aspects of your time in this post have particularly stretched you?

What helped you to manage those aspects?

Imagine you were returning to the department in the future and the job was improved, what would be different?

… and what would still be here?

What were your most valuable educational or training experiences?

Do you have any other ideas of ways we can improve the experience of those working in the department?

Are there any members of the team you would like to thank that you haven't done already?

If you are willing, please indicate your grade: CT1-2 / ST3-4 / ST5-7 / Speciality doctor / Consultant
Band 1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9

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2019 HSC Staff Survey - Detailed Spreadsheets - Southern HSCT

The detailed spreadsheets contain results at both individual question and Key Finding level. Organisational-level results are also included and are broken down by Directorate/Division, by Personnel Area (as recorded on the HSC payroll system) and by demographic background group (as self-selected in the survey questionnaire).

The Northern Ireland Statistics and Research Agency (NISRA) conducted the 2019 staff survey on behalf of the HSC. The survey went live on 4 March 2019 and remained open for a six-week period, closing on 12 April 2019. It was a full census survey of all staff within the 16 HSC organisations listed below and recorded as employed on the HSC payroll system on 31 January 2019. This represented a total headcount of 77,781 staff being sent a survey invite. Of these, 47,787 (61.4%) were sent a link to their HSC work email address and asked to complete the survey online. The remaining 29,994 (38.6%) staff were sent a paper questionnaire to their home address and asked to complete and return it to NISRA using a prepaid envelope provided. A total of 19,094 completed responses were received by NISRA (13,423 from online and 5,671 paper responses), producing an overall response rate of 24.5% (28.1% for online and 18.9% for paper).

The 16 HSC organisations surveyed in 2019 were as follows: the five Northern Ireland Health and Social Care Trusts (HSCT), the Northern Ireland Ambulance Service HSC Trust (NIAS), Business Services Organisation (BSO), the Health and Social Care Board (HSC Board), the Public Health Agency (PHA), the Northern Ireland Blood Transfusion Service (NIBTS), the Northern Ireland Guardian ad Litem Agency (NIGALA), the Northern Ireland Medical and Dental Training Agency (NIMDTA), the Northern Ireland Social Care Council (NISCC), Patient Client Council (PCC), the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC), and the Regulation and Quality Improvement Authority (RQIA).

For further information on the survey or how the overall staff engagement scores and Key Findings are calculated, please refer to the published 2019 HSC Staff Survey Regional Benchmark Report:

https://www.health-ni.gov.uk/

Note 1: For the results of each question and Key Finding reported by Directorate and Personnel Area, the best and worst scores across the HSC organisation have been highlighted in green and red respectively.

*Note 2: Where a lower score is better, this has also been highlighted with a ' * ' and italicised text.*

Note 3: Where there are less than 11 responses in a group, results are suppressed and replaced with ' # ', likewise, where a result is not available, it is denoted by ' -- '.

2019 HSC Staff Survey Key Findings Data for Personnel Areas within Southern HSC Trust	HSC OVERALL 2019	Southern HSCT Overall 2019	Admin & Clerical	Estates	Medical & Dental	Nursing & Midwifery	Professional & Technical	Social Services	Support Services /User Experience	HSC Overall 2015	Southern HSCT Overall 2015
Invite Count	**77,781**	**12,802**	1,820	102	1,022	4,812	1,587	2,573	886	**69,514**	**10,278**
Response Count	**19,094**	**3,167**	652	22	182	1,040	462	713	96	**17,796**	**2,176**
Response Rate	**24.5%**	**24.7%**	35.8%	21.6%	17.8%	21.6%	29.1%	27.7%	10.8%	**26%**	**21%**
Overall Engagement Score	**3.78**	**3.78**	3.78	3.73	3.66	3.77	3.79	3.84	3.74	**3.72**	**3.81**
Key Finding 1. Staff recommendation of the organisation as a place to work or receive treatment *(1-5)*	**3.75**	**3.71**	3.76	3.74	3.54	3.63	3.66	3.85	3.79	**3.71**	**3.81**
Key Finding 2. Staff satisfaction with the quality of work and care they are able to deliver *(1-5)*	**3.97**	**3.93**	4.03	3.94	3.67	3.87	3.81	4.11	4.12		--
Key Finding 3. Percentage of staff agreeing that their role makes a difference to patients / service users *(%)*	**89.8%**	**90.7%**	77.4%	90.5%	94.4%	93.3%	94.1%	93.5%	88.2%	**89%**	**90%**
Key Finding 4. Staff motivation at work *(1-5)*	**4.00**	**4.05**	3.97	3.74	3.78	4.11	4.03	4.14	4.09	**3.90**	**4.01**
Key Finding 5. Recognition and value of staff by managers and the organisation *(1-5)*	**3.40**	**3.39**	3.51	3.35	3.27	3.32	3.42	3.45	3.08	**3.48**	**3.55**
Key Finding 6. Percentage of staff reporting good communication between senior management and staff *(%)*	**29.5%**	**28.8%**	30.6%	31.8%	22.0%	28.4%	26.2%	30.9%	29.2%	**28%**	**33%**
Key Finding 7. Percentage of staff able to contribute towards improvements at work *(%)*	**64.1%**	**64.2%**	63.9%	72.7%	71.3%	64.0%	70.6%	60.9%	45.8%	**63%**	**67%**
Key Finding 8. Staff satisfaction with the level of responsibility and involvement *(1-5)*	**3.87**	**3.87**	3.83	3.77	3.95	3.88	3.96	3.86	3.65		--
Key Finding 9. Effective team working *(1-5)*	**3.73**	**3.76**	3.64	3.68	3.75	3.79	3.87	3.83	3.35	**3.71**	**3.77**
Key Finding 10. Support from immediate managers *(1-5)*	**3.70**	**3.76**	3.85	3.52	3.60	3.74	3.81	3.78	3.43	**3.65**	**3.75**
Key Finding 11. Percentage of staff appraised in last 12 months *(%)*	**70.7%**	**74.4%**	65.5%	100.0%	89.0%	75.9%	77.8%	77.1%	50.0%	**65%**	**67%**
Key Finding 12. Quality of appraisals *(1-5)*	**3.11**	**3.14**	3.06	2.14	2.56	3.25	3.09	3.31	3.02		--
Key Finding 13. Quality of non-mandatory training, learning or development *(1-5)*	**4.11**	**4.12**	3.79	3.36	4.03	4.25	4.17	4.14	3.93		--
Key Finding 14. Staff satisfaction with resourcing and support *(1-5)*	**3.30**	**3.29**	3.50	3.09	2.96	3.19	3.14	3.41	3.35	**2.95**	**2.88**
Key Finding 15. Percentage of staff satisfied with the opportunities for flexible working patterns (%)	**52.9%**	**52.2%**	63.1%	72.7%	35.9%	47.3%	48.7%	56.4%	42.7%		--
* ***Key Finding 16.*** *Percentage of staff working extra hours (%)*	**68.1%**	**69.1%**	50.4%	76.2%	90.4%	72.4%	71.3%	76.3%	60.9%	**95%**	**95%**
* ***Key Finding 17*** *. Percentage of staff feeling unwell due to work related stress in last 12 months (%)*	**46.7%**	**46.1%**	36.6%	54.5%	49.5%	51.9%	46.7%	45.2%	42.1%	**36%**	**32%**

2019 HSC Staff Survey Key Findings Data for Personnel Areas within Southern HSC Trust	HSC OVERALL 2019	Southern HSCT Overall 2019	Admin & Clerical	Estates	Medical & Dental	Nursing & Midwifery	Professional & Technical	Social Services	Support Services /User Experience	HSC Overall 2015	Southern HSCT Overall 2015
* ***Key Finding 18.*** *Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves (%)*	**60.9%**	**60.4%**	59.6%	63.6%	55.4%	63.6%	63.7%	56.0%	56.0%		--
Key Finding 19. Organisation and management interest in and action on health and wellbeing *(1-5)*	**3.53**	**3.52**	3.74	3.39	3.26	3.42	3.61	3.51	3.29		--
* ***Key Finding 20*** *. Percentage of staff experiencing discrimination at work in the last 12 months (%)*	**12.9%**	**12.2%**	7.8%	13.6%	11.7%	14.3%	11.2%	12.8%	20.0%	**10%**	**9%**
Key Finding 21. Percentage believing that organisation provides equal opportunities for career progression or promotion (%)		--	--	--	--	--	--	--	--	**94%**	**96%**
* ***Key Finding 22.*** *Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months (%)*	**17.9%**	**20.4%**	2.8%	0.0%	19.2%	33.8%	14.1%	22.0%	19.8%	**14%**	**12%**
* ***Key Finding 23.*** *Percentage of staff experiencing physical violence from staff in last 12 months (%)*	**2.2%**	**1.9%**	0.9%	4.5%	0.0%	2.4%	0.9%	1.4%	12.6%	**2%**	**1%**
Key Finding 24. Percentage of staff/colleagues reporting most recent experience of physical violence in last 12 months *(%)*	**78.8%**	**80.1%**	80.6%	100.0%	54.8%	81.9%	61.2%	88.6%	81.5%	**77%**	**73%**
* ***Key Finding 25*** *. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months (%)*	**32.0%**	**35.4%**	19.6%	9.1%	48.6%	43.7%	32.9%	38.1%	26.0%	**25%**	**23%**
Key Finding 26 *. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months (%)*	**27.6%**	**26.5%**	26.4%	36.4%	25.3%	32.5%	21.0%	20.5%	32.6%	**22%**	**20%**
Key Finding 27. Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse in last 12 months *(%)*	**52.0%**	**54.7%**	48.6%	100.0%	29.7%	57.7%	40.0%	68.0%	62.2%	**54%**	**53%**
* ***Key Finding 28*** *. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month (%)*	**26.6%**	**26.0%**	14.0%	27.3%	50.6%	33.9%	22.5%	20.5%	32.6%	**26%**	**21%**
Key Finding 29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month *(%)*	**88.7%**	**88.6%**	73.1%	100.0%	82.4%	92.1%	86.7%	94.0%	90.3%	**95%**	**91%**
Key Finding 30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents *(1-5)*	**3.65**	**3.61**	3.49	3.17	3.34	3.66	3.62	3.70	3.75	**3.53**	**3.55**
Key Finding 31. Staff confidence and security in reporting unsafe clinical practice *(1-5)*	**3.52**	**3.52**	3.43	3.07	3.40	3.57	3.40	3.63	3.53		--
Key Finding 32. Effective use of patient / service user feedback *(1-5)*	**3.58**	**3.53**	3.52	--	3.20	3.60	3.49	3.52	3.57		--
Key Finding 33. Percentage of staff who do not typically feel worn out and feel supported in achieving a work-life balance *(%)*	**5.6%**	**5.2%**	7.7%	4.5%	2.2%	3.8%	4.6%	6.3%	3.2%	‡	‡
Key Finding 34. Percentage of staff who said that HSC is a great place to work and are proud to tell others that they are part of HSC *(%)*	**48.1%**	**47.6%**	49.9%	40.9%	32.0%	43.7%	47.2%	55.1%	52.7%	‡	‡

2019 HSC Staff Survey Key Findings Data for Personnel Areas within Southern HSC Trust	HSC OVERALL 2019	Southern HSCT Overall 2019	Admin & Clerical	Estates	Medical & Dental	Nursing & Midwifery	Professional & Technical	Social Services	Support Services /User Experience	HSC Overall 2015	Southern HSCT Overall 2015
Key finding 35. Percentage of staff who feel that HSC takes effective action if staff are physically attacked, bullied, harassed or abused *(%)*	**31.4%**	**32.4%**	32.8%	18.2%	22.5%	32.0%	24.9%	39.6%	38.5%	ǂ	ǂ

Received from Maria O'Kane on 02/09/22. Annotated by Urology Services Inquiry

2019 HSC Staff Survey Key Findings Data by Organisational Staff Directorate	HSC OVERALL 2019	Southern HSCT Overall 2019	Acute Services	Chief Executive's Office	Children & Young People's Services	Finance & Procurement	HR & Organisational Development	Medical	Mental Health & Disability Services	Older People & Primary Care	Performance & Reform	HSC Overall 2015	Southern HSCT Overall 2015
Invite Count	**77,781**	**12,802**	4,657	14	1,683	247	1,338	46	1,719	2,935	163	**69,514**	**10,278**
Response Count	**19,094**	**3,167**	916	8	519	60	261	22	501	808	72	**17,796**	**2,176**
Response Rate	**24.5%**	**24.7%**	19.7%	57.1%	30.8%	24.3%	19.5%	47.8%	29.1%	27.5%	44.2%	**26%**	**21%**
Overall Engagement Score	**3.78**	**3.78**	3.64	#	3.83	3.73	3.85	3.62	3.84	3.86	3.85	**3.72**	**3.81**
Key Finding 1. Staff recommendation of the organisation as a place to work or receive treatment *(1-5)*	**3.75**	**3.71**	3.52	#	3.75	3.84	3.79	3.27	3.75	3.84	3.80	**3.71**	**3.81**
Key Finding 2. Staff satisfaction with the quality of work and care they are able to deliver *(1-5)*	**3.97**	**3.93**	3.79	#	3.80	4.03	3.87	4.00	4.04	4.13	3.85		--
Key Finding 3. Percentage of staff agreeing that their role makes a difference to patients / service users *(%)*	**89.8%**	**90.7%**	89.3%	#	88.0%	83.7%	91.1%	88.2%	93.3%	93.4%	87.0%	**89%**	**90%**
Key Finding 4. Staff motivation at work *(1-5)*	**4.00**	**4.05**	3.96	#	4.01	3.77	4.11	3.97	4.07	4.17	3.99	**3.90**	**4.01**
Key Finding 5. Recognition and value of staff by managers and the organisation *(1-5)*	**3.40**	**3.39**	3.10	#	3.54	3.46	3.48	3.32	3.48	3.53	3.70	**3.48**	**3.55**
Key Finding 6. Percentage of staff reporting good communication between senior management and staff *(%)*	**29.5%**	**28.8%**	20.6%	#	34.2%	33.3%	28.7%	22.7%	31.6%	31.1%	47.2%	**28%**	**33%**
Key Finding 7. Percentage of staff able to contribute towards improvements at work *(%)*	**64.1%**	**64.2%**	59.3%	#	71.0%	66.7%	66.1%	68.2%	69.1%	60.8%	71.8%	**63%**	**67%**
Key Finding 8. Staff satisfaction with the level of responsibility and involvement *(1-5)*	**3.87**	**3.87**	3.81	#	3.95	3.82	3.92	3.65	3.86	3.90	3.84		--
Key Finding 9. Effective team working *(1-5)*	**3.73**	**3.76**	3.56	#	3.90	3.67	3.79	3.48	3.80	3.87	3.95	**3.71**	**3.77**
Key Finding 10. Support from immediate managers *(1-5)*	**3.70**	**3.76**	3.48	#	3.97	3.69	3.77	3.42	3.94	3.83	3.96	**3.65**	**3.75**
Key Finding 11. Percentage of staff appraised in last 12 months *(%)*	**70.7%**	**74.4%**	70.6%	#	80.0%	74.6%	57.6%	50.0%	76.7%	80.4%	71.8%	**65%**	**67%**
Key Finding 12. Quality of appraisals *(1-5)*	**3.11**	**3.14**	2.81	#	3.13	2.30	3.44	3.40	3.31	3.36	3.33		--
Key Finding 13. Quality of non-mandatory training, learning or development *(1-5)*	**4.11**	**4.12**	4.03	#	4.11	3.69	4.17	4.30	4.17	4.22	4.03		--
Key Finding 14. Staff satisfaction with resourcing and support *(1-5)*	**3.30**	**3.29**	3.11	#	3.27	3.43	3.28	3.21	3.34	3.44	3.49	**2.95**	**2.88**
Key Finding 15. Percentage of staff satisfied with the opportunities for flexible working patterns (%)	**52.9%**	**52.2%**	41.1%	#	61.4%	73.3%	54.7%	72.7%	52.1%	54.1%	73.2%		--
* ***Key Finding 16.*** *Percentage of staff working extra hours (%)*	**68.1%**	**69.1%**	72.3%	#	69.5%	50.0%	60.9%	81.8%	68.1%	70.2%	59.2%	**95%**	**95%**
* ***Key Finding 17*** *. Percentage of staff feeling unwell due to work related stress in last 12 months (%)*	**46.7%**	**46.1%**	51.3%	#	48.4%	48.3%	36.9%	36.4%	48.7%	41.1%	34.7%	**36%**	**32%**
* ***Key Finding 18.*** *Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves (%)*	**60.9%**	**60.4%**	64.9%	#	60.0%	60.0%	51.4%	68.2%	63.9%	57.1%	47.2%		--
Key Finding 19. Organisation and management interest in and action on health and wellbeing *(1-5)*	**3.53**	**3.52**	3.27	#	3.68	3.53	3.55	3.68	3.64	3.58	3.97		--

2019 HSC Staff Survey Key Findings Data by Organisational Staff Directorate	HSC OVERALL 2019	Southern HSCT Overall 2019	Acute Services	Chief Executive's Office	Children & Young People's Services	Finance & Procurement	HR & Organisational Development	Medical	Mental Health & Disability Services	Older People & Primary Care	Performance & Reform	HSC Overall 2015	Southern HSCT Overall 2015
* ***Key Finding 20*** *. Percentage of staff experiencing discrimination at work in the last 12 months (%)*	**12.9%**	**12.2%**	14.9%	#	10.9%	11.7%	13.3%	14.3%	12.3%	10.5%	2.8%	**10%**	**9%**
Key Finding 21. Percentage believing that organisation provides equal opportunities for career progression or promotion (%)		--	--	--	--	--	--	--	--	--	--	**94%**	**96%**
* ***Key Finding 22.*** *Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months (%)*	**17.9%**	**20.4%**	23.3%	#	14.7%	0.0%	25.5%	4.5%	32.5%	15.5%	0.0%	**14%**	**12%**
* ***Key Finding 23.*** *Percentage of staff experiencing physical violence from staff in last 12 months (%)*	**2.2%**	**1.9%**	2.5%	#	1.0%	3.3%	1.2%	0.0%	3.4%	1.0%	0.0%	**2%**	**1%**
Key Finding 24. Percentage of staff/colleagues reporting most recent experience of physical violence in last 12 months *(%)*	**78.8%**	**80.1%**	69.8%	#	78.3%	50.0%	83.8%	50.0%	91.5%	82.5%	--	**77%**	**73%**
* ***Key Finding 25*** *. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months (%)*	**32.0%**	**35.4%**	40.7%	#	34.7%	11.7%	31.0%	22.7%	40.7%	33.1%	4.2%	**25%**	**23%**
****Key Finding 26*** *. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months (%)*	**27.6%**	**26.5%**	35.5%	#	21.9%	28.3%	24.1%	31.8%	24.7%	20.1%	30.6%	**22%**	**20%**
Key Finding 27. Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse in last 12 months *(%)*	**52.0%**	**54.7%**	45.6%	#	59.0%	76.2%	52.0%	66.7%	60.8%	61.8%	18.2%	**54%**	**53%**
* ***Key Finding 28*** *. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month (%)*	**26.6%**	**26.0%**	39.4%	#	15.6%	16.7%	29.4%	27.3%	27.2%	18.6%	2.8%	**26%**	**21%**
Key Finding 29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month *(%)*	**88.7%**	**88.6%**	86.1%	#	81.7%	100.0%	94.9%	83.3%	90.6%	92.9%	50.0%	**95%**	**91%**
Key Finding 30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents *(1-5)*	**3.65**	**3.61**	3.51	#	3.60	3.26	3.56	3.37	3.68	3.74	3.51	**3.53**	**3.55**
Key Finding 31. Staff confidence and security in reporting unsafe clinical practice *(1-5)*	**3.52**	**3.52**	3.35	#	3.52	3.28	3.57	3.30	3.59	3.67	3.42		--
Key Finding 32. Effective use of patient / service user feedback *(1-5)*	**3.58**	**3.53**	3.50	#	3.51	4.00	3.50	3.50	3.56	3.54	3.62		--
Key Finding 33. Percentage of staff who do not typically feel worn out and feel supported in achieving a work-life balance *(%)*	**5.6%**	**5.2%**	3.8%	#	5.6%	8.3%	4.1%	14.3%	4.6%	6.6%	6.9%	‡	‡
Key Finding 34. Percentage of staff who said that HSC is a great place to work and are proud to tell others that they are part of HSC *(%)*	**48.1%**	**47.6%**	38.2%	#	48.7%	48.3%	50.0%	59.1%	47.7%	55.7%	57.7%	‡	‡
Key finding 35. Percentage of staff who feel that HSC takes effective action if staff are physically attacked, bullied, harassed or abused *(%)*	**31.4%**	**32.4%**	24.0%	#	32.9%	30.0%	39.7%	19.0%	33.6%	39.9%	25.0%	‡	‡

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Invite Count	**77,781**	**12,802**	1,820	102	1,022	4,812	1,587	2,573	886	**70,213**	**10,278**
Response Count	**19,094**	**3,167**	652	22	182	1,040	462	713	96	**17,796**	**2,176**
Response Rate	**24.5%**	**24.7%**	35.8%	21.6%	17.8%	21.6%	29.1%	27.7%	10.8%	**25.0%**	**21%**
Overall Engagement Score	**3.78**	**3.78**	3.78	3.73	3.65	3.76	3.79	3.84	3.74	**3.72**	**3.81**
Q1. % saying they have face-to-face contact with patients / service users as part of their job	**83.7%**	**88.6%**	55.9%	57.1%	98.9%	97.7%	96.3%	99.0%	87.4%	‡	‡
Q2a. I am proud when I tell others that I am part of HSC.	**62.0%**	**62.4%**	60.8%	54.5%	50.8%	62.9%	62.6%	66.8%	58.5%	‡	‡
Q2b. I recognise HSC as a great place to work.	**53.5%**	**52.6%**	59.1%	45.5%	35.4%	46.8%	52.4%	59.1%	58.1%	‡	‡
Q2c. I look forward to going to work.	**55.5%**	**57.5%**	57.6%	40.9%	42.5%	55.8%	56.5%	64.7%	58.5%	**57.1%**	**62%**
Q2d. I am enthusiastic about my job.	**73.2%**	**75.1%**	69.4%	68.2%	66.3%	77.3%	74.9%	80.1%	72.3%	**71.2%**	**74%**
Q2e. Time passes quickly when I am working.	**80.7%**	**83.0%**	79.2%	72.7%	80.1%	85.6%	83.5%	83.0%	85.4%	**80.1%**	**83%**
Q3a. I always know what my work responsibilities are.	**88.6%**	**89.2%**	86.0%	77.3%	92.8%	89.4%	92.9%	89.7%	82.3%	**91.7%**	**93%**
Q3b. I am trusted to do my job.	**90.2%**	**90.9%**	90.3%	77.3%	95.0%	89.9%	91.8%	91.8%	89.6%	‡	‡
Q3c. I am able to do my job to a standard I am personally pleased with.	**81.4%**	**80.7%**	89.1%	81.8%	70.7%	74.7%	79.4%	84.9%	83.3%	**78.8%**	**81%**

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Q4a. There are frequent opportunities for me to show initiative in my role.	**69.7%**	**70.9%**	66.4%	81.8%	69.6%	74.3%	72.9%	70.9%	54.2%	**66.2%**	**68%**
Q4b. I am able to make suggestions to improve the work of my team / department.	**68.3%**	**68.4%**	68.7%	72.7%	76.2%	67.9%	76.4%	64.2%	50.0%	**67.3%**	**70%**
Q4c. I am involved in deciding on changes introduced that affect my work area / team / department.	**46.5%**	**45.2%**	42.7%	59.1%	56.4%	43.4%	57.4%	40.6%	32.3%	**50.1%**	**52%**
Q4d. I am able to make improvements happen in my area of work.	**50.7%**	**48.1%**	50.5%	63.6%	53.0%	45.2%	55.0%	44.9%	39.6%	**55.6%**	**60%**
Q4e. I am able to meet all the conflicting demands on my time at work.	**40.4%**	**37.3%**	49.0%	27.3%	25.4%	32.5%	26.6%	41.9%	53.1%	**44.2%**	**44%**
Q4f. I have adequate materials, supplies and equipment to do my work.	**60.9%**	**61.1%**	75.7%	54.5%	39.2%	56.9%	49.8%	67.3%	59.4%	**60.6%**	**67%**
Q4g. There are enough staff in my work area / team / department for me to do my job properly.	**34.1%**	**32.6%**	41.6%	13.6%	18.2%	27.8%	27.5%	38.4%	35.4%	**34.7%**	**36%**
Q4h. The team I work in has a set of shared objectives.	**73.2%**	**73.4%**	68.7%	68.2%	74.0%	74.8%	79.0%	73.6%	61.5%	**76.5%**	**78%**
Q4i. The team I work in often meets to discuss the team's effectiveness.	**56.6%**	**59.1%**	53.3%	63.6%	59.7%	57.2%	66.5%	65.7%	33.3%	**56.5%**	**62%**
Q4j. Team members have to communicate closely with each other to achieve the team's objectives.	**82.1%**	**83.5%**	77.4%	81.8%	85.6%	87.9%	86.8%	81.8%	71.6%	**80.8%**	**82%**
Q4k. I work as part of a multi-disciplinary team which values the roles and contributions of all colleagues.	**64.9%**	**66.4%**	50.5%	54.5%	84.0%	72.0%	75.1%	65.3%	48.4%	**‡**	**‡**
Q4l. I value the work and contribution of other disciplines in my area of work.	**89.5%**	**91.7%**	86.0%	86.4%	98.3%	94.4%	96.3%	89.8%	80.0%	**‡**	**‡**
Q5a. The recognition or praise I get for good work.	**48.9%**	**48.8%**	53.6%	50.0%	38.1%	47.0%	48.9%	51.8%	33.3%	**45.7%**	**49%**

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Q5b. The support I get from my immediate manager.	**64.4%**	**67.0%**	70.4%	59.1%	63.5%	65.8%	68.6%	66.7%	60.4%	**62.1%**	**66%**
Q5c. The support I get from my work colleagues.	**80.2%**	**81.6%**	78.2%	68.2%	82.9%	81.9%	86.4%	82.6%	69.8%	**75.7%**	**77%**
Q5d. The amount of responsibility I am given.	**72.4%**	**73.3%**	72.0%	81.8%	79.6%	71.2%	79.4%	73.3%	61.5%	**69.0%**	**71%**
Q5e. The opportunities I have to use my skills.	**71.8%**	**72.9%**	66.8%	77.3%	79.6%	77.2%	73.8%	73.2%	47.9%	**67.2%**	**69%**
Q5f. The extent to which my organisation values my work.	**43.1%**	**42.0%**	45.6%	45.5%	35.4%	38.1%	43.3%	46.0%	35.4%	**37.8%**	**43%**
Q5g. The opportunities for flexible working patterns.	**52.9%**	**52.2%**	63.1%	72.7%	35.9%	47.3%	48.7%	56.4%	42.7%	‡	‡
Q6a. I am satisfied with the quality of care I give to patients / service users.	**83.8%**	**83.2%**	83.5%	87.5%	77.1%	81.6%	82.6%	87.3%	82.4%	**85.8%**	**87%**
Q6b. I feel that my role makes a difference to patients / service users.	**89.8%**	**90.7%**	77.4%	90.5%	94.4%	93.3%	94.1%	93.5%	88.2%	**89.3%**	**90%**
Q6c. I am able to deliver the care I aspire to.	**66.8%**	**65.2%**	63.6%	68.8%	56.1%	63.6%	60.6%	73.0%	73.3%	**69.4%**	**72%**
** Q6d. I often think about leaving this organisation.*	**35.0%**	**35.7%**	29.5%	40.0%	36.5%	43.3%	33.8%	31.5%	31.8%	**33.0%**	**29%**
Q6e1. If you are considering leaving your job, please indicate why: Career Development	**32.7%**	**32.6%**	39.2%	37.5%	15.9%	30.0%	42.0%	32.5%	14.8%	**24.6%**	**23%**
Q6e2. If you are considering leaving your job, please indicate why: Change of career *Note: Asked only of those that said "yes" to question Q6d*	**18.2%**	**18.0%**	17.1%	0.0%	12.7%	16.9%	22.7%	18.0%	33.3%	**9.9%**	**9%**
Q6e3. If you are considering leaving your job, please indicate why: Would like more pay *Note: Asked only of those that said "yes" to question Q6d*	**42.2%**	**46.4%**	51.9%	50.0%	17.5%	54.0%	41.3%	35.4%	66.7%	**19.8%**	**19%**

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Q6e4. If you are considering leaving your job, please indicate why: Not being valued for my work *Note: Asked only of those that said "yes" to question Q6d*	**57.8%**	**59.7%**	54.1%	50.0%	57.1%	63.5%	59.3%	56.8%	70.4%	**20.2%**	**20%**
Q6e5. If you are considering leaving your job, please indicate why: Family / personal reasons *Note: Asked only of those that said "yes" to question Q6d*	**17.2%**	**17.9%**	14.9%	25.0%	17.5%	21.5%	16.0%	16.5%	0.0%	**10.6%**	**11%**
Q6e6. If you are considering leaving your job, please indicate why: Health reasons *Note: Asked only of those that said "yes" to question Q6d*	**9.7%**	**8.9%**	7.7%	12.5%	12.7%	8.3%	10.0%	8.7%	11.1%	**5.1%**	**5%**
Q6e7. If you are considering leaving your job, please indicate why: End of contract *Note: Asked only of those that said "yes" to question Q6d*	**0.6%**	**0.5%**	0.6%	0.0%	0.0%	0.5%	0.7%	0.5%	0.0%	**2.0%**	**2%**
Q6e8. If you are considering leaving your job, please indicate why: Retirement *Note: Asked only of those that said "yes" to question Q6d*	**12.8%**	**11.6%**	11.0%	25.0%	15.9%	14.3%	6.0%	9.7%	3.7%	**11.8%**	**12%**
Q6e9. If you are considering leaving your job, please indicate why: Don't want to work in HSC *Note: Asked only of those that said "yes" to question Q6d*	**8.7%**	**10.5%**	10.5%	0.0%	15.9%	11.8%	10.0%	7.8%	3.7%	**2.8%**	**2%**
Q6e10. If you are considering leaving your job, please indicate why: Relationship with manager *Note: Asked only of those that said "yes" to question Q6d*	**19.1%**	**15.1%**	17.1%	37.5%	14.3%	11.1%	18.7%	15.5%	37.0%	**7.4%**	**7%**
Q6e11. If you are considering leaving your job, please indicate why: Other *Note: Asked only of those that said "yes" to question Q6d*	**22.1%**	**21.4%**	18.8%	12.5%	39.7%	20.3%	20.7%	22.2%	14.8%	**8.5%**	**7%**
Q7a. My line manager… encourages those who work for her / him to work as a team.	**72.1%**	**75.4%**	74.3%	59.1%	70.9%	76.3%	75.9%	77.9%	62.5%	**71.8%**	**76%**
Q7b. My line manager… can be counted on to help me with a difficult task at work.	**69.0%**	**70.8%**	73.0%	59.1%	67.6%	68.3%	73.3%	72.7%	66.7%	**69.5%**	**73%**
Q7c. My line manager… gives me clear feedback on my work.	**59.0%**	**61.6%**	63.3%	59.1%	46.7%	63.0%	62.3%	61.6%	59.4%	**57.8%**	**62%**
Q7d. My line manager… asks for my opinion before making decisions that affect my work.	**51.7%**	**52.9%**	53.9%	63.6%	52.7%	49.8%	59.2%	54.3%	35.4%	**54.7%**	**59%**
Q7e. My line manager… is supportive in a personal crisis.	**73.9%**	**75.5%**	83.1%	68.2%	63.2%	72.5%	78.7%	76.0%	61.5%	**74.5%**	**78%**

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Q7f. My line manager… takes a positive interest in my health and well-being.	**63.5%**	**64.4%**	71.4%	54.5%	54.4%	62.5%	69.8%	62.3%	49.0%	**78.3%**	**81%**
Q7g. My line manager… values my work.	**68.4%**	**70.0%**	73.0%	68.2%	70.3%	69.2%	72.9%	68.9%	53.1%	**‡**	**#**
Q7h. My line manager… helps me find a good work life balance.	**53.0%**	**54.8%**	64.2%	50.0%	35.2%	52.7%	56.0%	55.6%	40.6%	**45.5%**	**51%**
Q8a. Communication between senior management and staff is effective.	**34.5%**	**34.0%**	35.5%	40.9%	27.5%	33.5%	33.0%	34.8%	38.5%	**30.0%**	**34%**
Q8b. Senior managers involve staff in a timely manner regarding important decisions.	**28.4%**	**27.4%**	29.8%	31.8%	18.1%	27.2%	25.6%	28.9%	27.1%	**28.7%**	**34%**
Q8c. Senior managers act on staff feedback.	**27.4%**	**26.6%**	28.4%	31.8%	18.1%	25.6%	23.0%	30.7%	27.1%	**37.7%**	**43%**
Q9a. My organisation takes positive action on health and well-being.	**87.1%**	**87.0%**	90.9%	90.9%	83.9%	83.4%	90.2%	87.3%	86.3%	**77.9%**	**83%**
Q9b. My organisation provides advice on mental health and well-being.	**86.5%**	**87.7%**	91.7%	68.2%	89.9%	85.8%	91.9%	84.6%	81.9%	**88.8%**	**94%**
Q9c. My organisation provides advice on diet and nutrition.	**69.5%**	**77.0%**	86.8%	63.6%	78.8%	74.6%	83.0%	68.8%	67.0%	**67.4%**	**81%**
Q9d. My organisation provides advice on drug and alcohol consumption.	**69.6%**	**73.4%**	82.9%	63.6%	77.0%	71.5%	75.1%	66.5%	64.5%	**72.5%**	**81%**
Q9e. My organisation provides advice on exercise.	**77.9%**	**81.8%**	90.0%	68.2%	84.4%	79.3%	87.6%	75.9%	65.6%	**78.1%**	**86%**
Q9f. My organisation provides advice on help for staff that want to stop smoking.	**82.9%**	**85.5%**	90.8%	77.3%	86.9%	86.1%	89.7%	78.2%	76.1%	**90.9%**	**95%**
Q9g. Are you happy with the food / drink / rest facilities provided by your employer?	**50.7%**	**55.5%**	62.2%	81.8%	54.4%	51.0%	58.9%	51.1%	65.6%	**‡**	**‡**

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** Q9h. In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?*	**30.1%**	**30.5%**	25.7%	18.2%	38.5%	35.3%	32.9%	24.7%	29.0%	**18.2%**	**15%**
** Q9i. During the last 12 months have you felt unwell as a result of work related stress?*	**46.7%**	**46.1%**	36.6%	54.5%	49.5%	51.9%	46.7%	45.2%	42.1%	**36.2%**	**32%**
** Q9j. In the last three months have you ever come to work despite not feeling well enough to perform your duties?*	**63.7%**	**63.8%**	63.5%	63.6%	57.1%	66.7%	65.4%	60.7%	60.4%	‡	‡
** Q9k. Have you felt pressure from your manager to come to work?*	**29.2%**	**29.8%**	23.8%	14.3%	22.2%	34.2%	26.4%	32.6%	34.0%	‡	‡
** Q9l. Have you felt pressure from colleagues to come to work?*	**20.7%**	**20.0%**	16.7%	7.1%	30.3%	24.9%	16.1%	17.6%	7.5%	‡	‡
** Q9m. Have you put yourself under pressure to come into work?*	**93.7%**	**93.0%**	91.7%	100.0%	96.0%	93.3%	96.3%	90.7%	89.1%	‡	‡
** Q9n. Do you typically feel worn out at the end of the working day?*	**90.6%**	**91.2%**	88.5%	90.9%	92.8%	93.8%	92.4%	89.0%	88.4%	‡	‡
Q9o. Does your organisation support you in achieving a work-life balance?	**67.9%**	**70.2%**	81.0%	77.3%	55.6%	67.3%	74.1%	66.4%	62.8%	‡	‡
Q10a. How many hours a week are you contracted to work? *(% of respondents that are contracted to work less than 30 hours a week)*	**20.8%**	**24.2%**	22.0%	0.0%	15.7%	21.6%	21.1%	33.3%	37.2%	**21.6%**	**25%**
** Q10b. On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours?*	**34.4%**	**34.9%**	17.3%	59.1%	42.9%	37.4%	30.4%	46.6%	46.2%	**49.8%**	**48%**
** Q10c. On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours?*	**50.3%**	**51.0%**	38.4%	38.1%	79.8%	56.0%	58.3%	46.8%	25.0%	**71.1%**	**72%**
Q10d. Working the extra PAID hours that I do is acceptable to me. (Asked only of those who stated on Q10b that they work additional paid hours)	**75.4%**	**74.7%**	82.6%	84.6%	84.3%	74.6%	67.8%	71.4%	79.2%	‡	‡
Q10e. Working the extra UNPAID hours that I do is acceptable to me. (Asked only of those who stated on Q10c that they work additional unpaid hours)	**26.7%**	**23.7%**	37.3%	25.0%	25.9%	15.4%	23.0%	27.1%	31.3%	‡	‡

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** Q11a. In the last month have you seen any errors, near misses, or incidents that could have hurt staff?*	**17.0%**	**17.4%**	9.7%	22.7%	21.0%	24.8%	11.1%	15.3%	28.4%	**17.4%**	**14%**
** Q11b. In the last month have you seen any errors, near misses, or incidents that could have hurt patients/service users?*	**22.0%**	**21.2%**	10.3%	22.7%	47.8%	28.2%	18.7%	15.2%	25.0%	**22.3%**	**17%**
Q11c. The last time you saw an error, near miss or incident that could have hurt staff or patients / service users, did you or a colleague report it? (Only asked of respondents that said "yes" to either Q11a or Q11b)	**91.7%**	**92.2%**	79.5%	100.0%	91.4%	95.3%	91.5%	92.8%	90.9%	**94.5%**	**91%**
Q12a. My organisation treats staff who are involved in an error, near miss or incident fairly.	**48.4%**	**44.8%**	42.2%	38.9%	36.8%	43.8%	44.7%	49.3%	57.1%	**45.1%**	**48%**
Q12b. My organisation encourages us to report errors, near misses or incidents.	**84.5%**	**84.1%**	77.2%	57.1%	77.2%	86.3%	84.6%	88.2%	92.3%	**77.7%**	**80%**
Q12c. When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.	**67.2%**	**65.9%**	57.1%	57.1%	53.1%	71.3%	64.6%	69.3%	69.0%	**61.4%**	**63%**
Q12d. We are given feedback about changes made in response to reported errors, near misses and incidents.	**55.8%**	**54.0%**	38.8%	40.0%	51.1%	61.2%	52.2%	58.6%	49.4%	**52.3%**	**53%**
Q13a. If you were concerned about negligence, unsafe clinical or professional practice, would you know how to report it?	**86.4%**	**87.9%**	74.5%	47.6%	92.2%	95.1%	83.2%	94.8%	74.5%	**87.7%**	**89%**
Q13b. I would feel secure raising concerns about negligence, unsafe clinical or professional practice.	**61.1%**	**61.5%**	50.8%	40.9%	62.6%	67.7%	55.8%	67.1%	55.2%	**79.7%**	**79%**
Q13c. I am confident that my organisation would address my concern.	**55.1%**	**55.0%**	51.7%	27.3%	50.0%	55.2%	52.6%	61.2%	57.3%	**64.7%**	**70%**
Q13d. Do you understand your responsibility to raise concerns?	**97.3%**	**97.6%**	93.1%	90.9%	100.0%	99.4%	98.3%	98.9%	94.6%	**79.0%**	**85%**
** Q14a In the last 12 months have you personally experienced physical violence at work from…Patients / service users, their relatives or other members of the public?*	**17.9%**	**20.4%**	2.8%	0.0%	19.2%	33.8%	14.1%	22.0%	19.8%	**13.9%**	**12%**
** Q14b. In the last 12 months have you personally experienced physical violence at work from… Managers / Team leaders?*	**0.9%**	**0.8%**	0.3%	4.5%	0.0%	0.9%	0.0%	1.0%	6.3%	**0.5%**	**1%**

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** Q14c. In the last 12 months have you personally experienced physical violence at work from…Other colleagues?*	**2.0%**	**1.6%**	0.8%	4.5%	0.0%	2.1%	0.9%	1.0%	12.6%	**1.4%**	**1%**
Q14d. The last time you experienced physical violence at work, did you or a colleague report it? (*Asked only of respondents who stated on Q14a-c that they had personally experienced physical violence at work in last 12 months*)	**78.8%**	**80.1%**	80.6%	100.0%	54.8%	81.9%	61.2%	88.6%	81.5%	**76.6%**	**73%**
** Q15a. In the last 12 months have you personally experienced harassment, bullying and abuse at work from… Patients / service users, relatives or other members of the public?*	**32.0%**	**35.4%**	19.6%	9.1%	48.6%	43.7%	32.9%	38.1%	26.0%	**24.7%**	**23%**
** Q15b. In the last 12 months have you personally experienced harassment, bullying and abuse at work from… Managers / Team leaders?*	**15.7%**	**14.8%**	12.3%	27.3%	14.8%	19.2%	13.4%	10.7%	17.9%	**12.4%**	**10%**
** Q15c. In the last 12 months have you personally experienced harassment, bullying and abuse at work from… Other colleagues?*	**20.0%**	**19.5%**	18.9%	18.2%	18.7%	24.8%	15.1%	14.7%	24.2%	**15.6%**	**14%**
Q15d. The last time you experienced harassment, bullying and abuse at work, did you or a colleague report it? (*Asked only of respondents who stated on Q15a-c that they had personally experienced harassment, bullying and abuse at work in the last 12 months)*	**52.0%**	**54.7%**	48.6%	100.0%	29.7%	57.7%	40.0%	68.0%	62.2%	**53.5%**	**53%**
Q16a1. Does your organisation take effective action if staff are… Physically attacked by patients / clients / service users, their relatives or other members of the public?	**83.3%**	**84.0%**	91.0%	100.0%	86.4%	76.4%	90.6%	86.3%	86.0%	**57.8%**	**64%**
Q16a2. Does your organisation take effective action if staff are… Physically attacked by other members of staff?	**93.8%**	**95.0%**	95.5%	100.0%	95.8%	93.0%	97.4%	96.5%	91.5%	**61.1%**	**67%**
Q16a3. Does your organisation take effective action if staff are… bullied, harassed or abused by patients / clients / service users, their relatives or other members of the public?	**74.6%**	**75.5%**	83.5%	100.0%	70.2%	71.1%	74.0%	76.2%	82.8%	**51.6%**	**57%**
Q16a4. Does your organisation take effective action if staff are… Bullied, harassed or abused by other members of staff?	**72.3%**	**74.5%**	71.2%	54.5%	69.6%	72.3%	72.7%	81.4%	83.3%	**49.1%**	**52%**
* Q17a. *In the last 12 months have you personally experienced discrimination at work from …Patients / service users, their relatives or other members of the public?*	**4.3%**	**4.8%**	1.5%	0.0%	6.6%	5.9%	3.3%	6.4%	7.3%	**4.5%**	**4%**

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* Q17b. *In the last 12 months have you personally experienced discrimination at work from …Managers / team leaders or other colleagues?*	**9.9%**	**8.5%**	6.6%	13.6%	9.4%	9.4%	9.2%	7.5%	13.7%	**7.6%**	**7%**
* Q17c1. *On what grounds have you experienced discrimination… Ethnic background*	**11.4%**	**11.8%**	9.8%	0.0%	23.8%	13.0%	6.0%	10.8%	16.7%	**12.6%**	**8%**
* Q17c2. *On what grounds have you experienced discrimination… Gender*	**16.0%**	**14.3%**	11.8%	0.0%	42.9%	10.9%	16.0%	12.0%	22.2%	**17.6%**	**19%**
* Q17c3. *On what grounds have you experienced discrimination… Religion*	**19.6%**	**22.5%**	19.6%	0.0%	14.3%	21.7%	32.0%	21.7%	27.8%	**22.2%**	**29%**
* Q17c4. *On what grounds have you experienced discrimination… Sexual orientation*	**3.6%**	**2.5%**	2.0%	0.0%	0.0%	3.6%	0.0%	2.4%	5.6%	**4.3%**	**1%**
* Q17c5. *On what grounds have you experienced discrimination… Disability*	**8.3%**	**10.7%**	13.7%	0.0%	4.8%	9.4%	14.0%	12.0%	5.6%	**8.6%**	**8%**
* Q17c6. *On what grounds have you experienced discrimination… Age*	**14.0%**	**15.7%**	13.7%	0.0%	9.5%	21.7%	18.0%	9.6%	5.6%	**15.1%**	**13%**
* Q17c7. *On what grounds have you experienced discrimination… Other reason(s)*	**37.9%**	**36.2%**	44.2%	100.0%	9.5%	36.2%	40.0%	36.1%	22.2%	**29.2%**	**30%**
Q17d. Did you report the discrimination?	**29.9%**	**29.5%**	25.5%	100.0%	9.5%	31.7%	16.0%	32.1%	64.7%	**27.9%**	**21%**
Q17e. Does your organisation take effective action if discrimination is reported?	**26.3%**	**24.5%**	28.6%	0.0%	16.7%	19.6%	13.3%	35.0%	27.3%	**31.7%**	**53%**
Q18a. Have you had any training, learning or development in the last 12 months?	**78.4%**	**80.7%**	59.1%	63.6%	93.3%	87.5%	86.4%	86.5%	66.3%	**‡**	**‡**
Q18b. My training, learning or development has helped me to do my job more effectively.	**79.8%**	**80.4%**	69.2%	54.5%	82.0%	86.3%	79.0%	82.5%	71.1%	**69.4%**	**71%**
Q18c. My training, learning or development has helped me to stay up-to-date with professional requirements.	**84.7%**	**86.0%**	67.3%	45.5%	90.4%	93.1%	86.6%	89.7%	72.1%	**70.2%**	**73%**

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Q18d. My training, learning or development has helped me to deliver a better patient / service user experience.	**77.5%**	**79.2%**	62.1%	36.4%	78.8%	85.9%	82.2%	82.4%	60.5%	**63.2%**	**66%**
Q19a. Have you had mandatory training in the last 12 months?	**90.7%**	**95.1%**	92.2%	95.5%	91.0%	96.7%	96.5%	96.7%	89.5%	**‡**	**‡**
Q20a. In the last 12 months, have you had an appraisal, annual review, development review, or KSF development review?	**70.7%**	**74.4%**	65.5%	100.0%	89.0%	75.9%	77.8%	77.1%	50.0%	**64.7%**	**67%**
Q20b. My appraisal / review helped me to improve how I do my job.	**74.2%**	**75.1%**	68.2%	47.6%	62.1%	79.6%	75.4%	80.0%	61.7%	**57.9%**	**63%**
Q20c. My appraisal / review helped me agree clear objectives for my work.	**84.4%**	**84.2%**	78.5%	57.1%	78.0%	87.3%	87.0%	87.0%	64.4%	**78.0%**	**80%**
Q20d. My appraisal / review left me feeling that my work is valued by my organisation.	**71.8%**	**72.7%**	75.2%	57.1%	50.3%	74.8%	70.1%	76.8%	73.3%	**62.2%**	**67%**
Q20e. The values of my organisation were discussed as part of the appraisal process.	**73.6%**	**67.8%**	67.1%	52.4%	36.5%	71.0%	62.6%	77.4%	68.2%	**‡**	**‡**
Q20f. My training, learning or development needs were discussed and agreed.	**93.6%**	**94.3%**	91.0%	85.7%	96.9%	96.1%	94.1%	94.9%	86.4%	**79.3%**	**75%**
Q20g. My training, learning and development needs were met.	**85.6%**	**88.6%**	86.1%	66.7%	92.5%	90.6%	83.4%	91.6%	84.4%	**75.0%**	**79%**
Q21a. Care of patients / service users is my organisation's top priority.	**75.2%**	**74.2%**	74.3%	59.1%	66.3%	72.4%	74.5%	78.5%	78.0%	**73.1%**	**76%**
Q21b. I would recommend my organisation as a place to work.	**60.6%**	**59.5%**	64.6%	59.1%	53.9%	53.2%	58.1%	66.1%	64.1%	**60.6%**	**67%**
Q21c. If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	**68.5%**	**67.6%**	68.3%	68.2%	64.4%	65.1%	65.1%	73.1%	68.1%	**67.0%**	**71%**
Q21d1. What way do you prefer to receive information about your organisation… Daily updates on organisation intranet?	**45.9%**	**41.1%**	49.3%	27.3%	22.7%	42.7%	47.9%	32.4%	33.7%	**38.2%**	**34%**

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Q21d2. What way do you prefer to receive information about your organisation…Internet?	**31.2%**	**33.4%**	31.1%	50.0%	25.6%	39.4%	33.3%	27.9%	36.0%	**24.9%**	**29%**
Q21d3. What way do you prefer to receive information about your organisation…Senior management briefings?	**19.3%**	**16.2%**	14.8%	31.8%	21.5%	18.1%	13.9%	14.6%	15.7%	**19.6%**	**16%**
Q21d4. What way do you prefer to receive information about your organisation… Organisation newsletter?	**30.1%**	**37.6%**	53.2%	40.9%	33.5%	34.5%	33.0%	32.9%	27.0%	**12.7%**	**19%**
Q21d5. What way do you prefer to receive information about your organisation… Line managers?	**53.2%**	**54.6%**	50.9%	50.0%	35.8%	57.8%	52.5%	58.5%	63.3%	**55.6%**	**55%**
Q21d6. What way do you prefer to receive information about your organisation… Team meetings?	**64.8%**	**66.8%**	54.2%	63.6%	57.6%	68.0%	73.7%	76.0%	55.1%	**64.1%**	**64%**
Q21d7. What way do you prefer to receive information about your organisation… Chief Executive briefings?	**10.3%**	**10.1%**	14.4%	18.2%	13.6%	9.7%	9.4%	7.1%	2.2%	**7.9%**	**6%**
Q21d8. What way do you prefer to receive information about your organisation… Staff notice boards?	**26.9%**	**23.7%**	19.9%	22.7%	13.6%	35.1%	18.1%	13.3%	48.9%	**22.6%**	**18%**
Q22a. Is patient / service user experience feedback collected within your directorate / department?	**81.1%**	**80.1%**	63.3%	0.0%	89.7%	82.9%	80.3%	85.2%	69.4%	**74.3%**	**75%**
Q22b. I receive regular updates on patient / service user experience feedback in my directorate / department.	**59.1%**	**57.1%**	54.0%	--	35.7%	62.0%	54.4%	58.5%	52.0%	**60.6%**	**60%**
Q22c. Feedback from patients / service users is used to make informed decisions within my service area.	**63.1%**	**61.5%**	62.0%	--	43.8%	63.0%	61.4%	63.4%	61.9%	**66.2%**	**68%**

2019 HSC Staff Survey - Individual Question Data by Organisational Staff Directorate	HSC OVERALL 2019	Southern HSCT Overall 2019	Acute Services	Chief Executive's Office	Children & Young People's Services	Finance & Procurement	HR & Organisational Development	Medical	Mental Health & Disability Services	Older People & Primary Care	Performance & Reform	HSC Overall 2015	Southern HSCT Overall 2015
Invite Count	**77,781**	**12,802**	4,657	14	1,683	247	1,338	46	1,719	2,935	163	**70,213**	**10,278**
Response Count	**19,094**	**3,167**	916	8	519	60	261	22	501	808	72	**17,796**	**2,176**
Response Rate	**25%**	**24.7%**	19.7%	57.1%	30.8%	24.3%	19.5%	47.8%	29.1%	27.5%	44.2%	**25.0%**	**21%**
Overall Engagement Score	**3.78**	**3.78**	3.64	#	3.83	3.73	3.85	3.62	3.84	3.86	3.85	**3.72**	**3.81**
Q1. % saying they have face-to-face contact with patients / service users as part of their job	**83.7%**	**88.6%**	90.5%	#	94.4%	39.0%	76.8%	68.2%	93.8%	92.8%	32.4%	‡	‡
Q2a. I am proud when I tell others that I am part of HSC.	**62.0%**	**62.4%**	56.7%	#	60.7%	55.0%	65.5%	72.7%	64.9%	67.3%	64.8%	‡	‡
Q2b. I recognise HSC as a great place to work.	**53.5%**	**52.6%**	41.8%	#	54.5%	60.0%	57.4%	63.6%	51.9%	60.4%	66.2%	‡	‡
Q2c. I look forward to going to work.	**55.5%**	**57.5%**	48.7%	#	56.2%	48.3%	59.6%	63.6%	59.9%	66.3%	62.0%	**57.1%**	**62%**
Q2d. I am enthusiastic about my job.	**73.2%**	**75.1%**	70.7%	#	76.6%	65.0%	78.8%	76.2%	75.4%	78.8%	71.8%	**71.2%**	**74%**
Q2e. Time passes quickly when I am working.	**80.7%**	**83.0%**	82.6%	#	82.4%	70.0%	85.3%	81.0%	81.0%	85.0%	85.9%	**80.1%**	**83%**
Q3a. I always know what my work responsibilities are.	**88.6%**	**89.2%**	89.5%	#	90.9%	85.0%	91.2%	81.8%	84.0%	91.0%	85.9%	**91.7%**	**93%**
Q3b. I am trusted to do my job.	**90.2%**	**90.9%**	90.5%	#	93.1%	83.3%	94.6%	81.8%	89.0%	91.7%	80.3%	‡	‡
Q3c. I am able to do my job to a standard I am personally pleased with.	**81.4%**	**80.7%**	76.2%	#	78.6%	90.0%	82.4%	81.8%	82.4%	84.2%	87.3%	**78.8%**	**81%**
Q4a. There are frequent opportunities for me to show initiative in my role.	**69.7%**	**70.9%**	66.6%	#	76.1%	66.7%	76.9%	63.6%	74.3%	68.9%	71.8%	**66.2%**	**68%**
Q4b. I am able to make suggestions to improve the work of my team / department.	**68.3%**	**68.4%**	63.9%	#	74.9%	68.3%	71.5%	81.8%	72.1%	65.1%	78.9%	**67.3%**	**70%**

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Q4c. I am involved in deciding on changes introduced that affect my work area / team / department.	46.5%	45.2%	41.9%	#	50.8%	55.0%	44.4%	40.9%	47.7%	42.4%	56.3%	50.1%	52%
Q4d. I am able to make improvements happen in my area of work.	50.7%	48.1%	41.4%	#	54.6%	61.7%	47.1%	40.9%	53.9%	45.6%	66.2%	55.6%	60%
Q4e. I am able to meet all the conflicting demands on my time at work.	40.4%	37.3%	32.3%	#	34.7%	36.7%	37.3%	47.6%	40.1%	41.7%	45.1%	44.2%	44%
Q4f. I have adequate materials, supplies and equipment to do my work.	60.9%	61.1%	52.7%	#	58.1%	71.7%	64.1%	59.1%	58.1%	71.3%	76.1%	60.6%	67%
Q4g. There are enough staff in my work area / team / department for me to do my job properly.	34.1%	32.6%	24.8%	#	31.5%	40.0%	29.2%	36.4%	34.3%	40.6%	39.4%	34.7%	36%
Q4h. The team I work in has a set of shared objectives.	73.2%	73.4%	67.9%	#	79.3%	68.3%	73.6%	63.6%	73.3%	75.9%	80.3%	76.5%	78%
Q4i. The team I work in often meets to discuss the team's effectiveness.	56.6%	59.1%	46.4%	#	69.7%	51.7%	52.7%	36.4%	61.9%	66.8%	78.9%	56.5%	62%
Q4j. Team members have to communicate closely with each other to achieve the team's objectives.	82.1%	83.5%	79.2%	#	82.4%	75.0%	90.4%	77.3%	86.2%	86.1%	84.5%	80.8%	82%
Q4k. I work as part of a multi-disciplinary team which values the roles and contributions of all colleagues.	64.9%	66.4%	62.7%	#	68.5%	46.7%	63.7%	52.4%	70.7%	70.1%	60.6%	‡	‡
Q4l. I value the work and contribution of other disciplines in my area of work.	89.5%	91.7%	90.5%	#	94.8%	78.3%	92.3%	100.0%	93.0%	90.7%	93.0%	‡	‡
Q5a. The recognition or praise I get for good work.	48.9%	48.8%	36.9%	#	51.5%	55.0%	54.4%	50.0%	50.7%	56.0%	63.4%	45.7%	49%
Q5b. The support I get from my immediate manager.	64.4%	67.0%	55.5%	#	75.7%	68.3%	68.7%	50.0%	73.9%	69.0%	77.5%	62.1%	66%
Q5c. The support I get from my work colleagues.	80.2%	81.6%	76.5%	#	84.0%	73.3%	85.7%	71.4%	85.2%	82.6%	88.7%	75.7%	77%
Q5d. The amount of responsibility I am given.	72.4%	73.3%	68.5%	#	77.8%	75.0%	77.8%	63.6%	71.7%	75.6%	74.6%	69.0%	71%
Q5e. The opportunities I have to use my skills.	71.8%	72.9%	68.9%	#	76.3%	70.0%	82.2%	45.5%	70.1%	75.6%	69.0%	67.2%	69%

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Q5f. The extent to which my organisation values my work.	43.1%	42.0%	32.4%	#	44.9%	45.0%	46.5%	40.9%	41.3%	48.6%	57.7%	37.8%	43%
Q5g. The opportunities for flexible working patterns.	52.9%	52.2%	41.1%	#	61.4%	73.3%	54.7%	72.7%	52.1%	54.1%	73.2%	‡	‡
Q6a. I am satisfied with the quality of care I give to patients / service users.	83.8%	83.2%	77.8%	#	80.9%	84.4%	84.3%	100.0%	86.6%	88.4%	78.1%	85.8%	87%
Q6b. I feel that my role makes a difference to patients / service users.	89.8%	90.7%	89.3%	#	88.0%	83.7%	91.1%	88.2%	93.3%	93.4%	87.0%	89.3%	90%
Q6c. I am able to deliver the care I aspire to.	66.8%	65.2%	58.6%	#	57.3%	71.9%	65.2%	64.3%	68.3%	76.2%	54.8%	69.4%	72%
* *Q6d. I often think about leaving this organisation.*	35.0%	35.7%	43.5%	#	32.8%	25.5%	32.0%	23.8%	38.9%	29.5%	25.8%	33.0%	29%
Q6e1. If you are considering leaving your job, please indicate why: Career Development	32.7%	32.6%	28.9%	#	37.4%	35.7%	21.9%	40.0%	38.6%	32.6%	47.1%	24.6%	23%
Q6e2. If you are considering leaving your job, please indicate why: Change of career *Note: Asked only of those that said "yes" to question Q6d*	18.2%	18.0%	16.8%	#	16.0%	0.0%	11.0%	20.0%	21.7%	21.7%	17.6%	9.9%	9%
Q6e3. If you are considering leaving your job, please indicate why: Would like more pay *Note: Asked only of those that said "yes" to question Q6d*	42.2%	46.4%	49.9%	#	43.6%	42.9%	54.8%	40.0%	42.4%	44.3%	41.2%	19.8%	19%
Q6e4. If you are considering leaving your job, please indicate why: Not being valued for my work *Note: Asked only of those that said "yes" to question Q6d*	57.8%	59.7%	70.5%	#	55.2%	50.0%	53.4%	60.0%	52.2%	54.8%	47.1%	20.2%	20%
Q6e5. If you are considering leaving your job, please indicate why: Family / personal reasons *Note: Asked only of those that said "yes" to question Q6d*	17.2%	17.9%	18.9%	#	21.5%	21.4%	20.5%	0.0%	16.8%	14.0%	11.8%	10.6%	11%
Q6e6. If you are considering leaving your job, please indicate why: Health reasons *Note: Asked only of those that said "yes" to question Q6d*	9.7%	8.9%	8.8%	#	9.8%	7.1%	12.3%	0.0%	7.1%	10.0%	0.0%	5.1%	5%
Q6e7. If you are considering leaving your job, please indicate why: End of contract *Note: Asked only of those that said "yes" to question Q6d*	0.6%	0.5%	0.5%	#	0.0%	7.1%	0.0%	0.0%	0.5%	0.5%	0.0%	2.0%	2%
Q6e8. If you are considering leaving your job, please indicate why: Retirement *Note: Asked only of those that said "yes" to question Q6d*	12.8%	11.6%	12.1%	#	10.4%	21.4%	20.5%	20.0%	9.2%	10.4%	0.0%	11.8%	12%
Q6e9. If you are considering leaving your job, please indicate why: Don't want to work in HSC *Note: Asked only of those that said "yes" to question Q6d*	8.7%	10.5%	14.0%	#	6.1%	0.0%	9.6%	0.0%	8.7%	11.3%	0.0%	2.8%	2%

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Q6e10. If you are considering leaving your job, please indicate why: Relationship with manager *Note: Asked only of those that said "yes" to question Q6d*	**19.1%**	**15.1%**	18.9%	#	11.0%	21.4%	11.0%	20.0%	9.8%	14.9%	41.2%	**7.4%**	**7%**
Q6e11. If you are considering leaving your job, please indicate why: Other *Note: Asked only of those that said "yes" to question Q6d*	**22.1%**	**21.4%**	23.3%	#	20.1%	28.6%	20.5%	20.0%	20.1%	19.9%	17.6%	**8.5%**	**7%**
Q7a. My line manager… encourages those who work for her / him to work as a team.	**72.1%**	**75.4%**	65.2%	#	82.9%	66.7%	75.6%	59.1%	81.8%	78.5%	81.9%	**71.8%**	**76%**
Q7b. My line manager… can be counted on to help me with a difficult task at work.	**69.0%**	**70.8%**	59.8%	#	78.0%	68.3%	69.8%	54.5%	78.4%	74.4%	76.4%	**69.5%**	**73%**
Q7c. My line manager… gives me clear feedback on my work.	**59.0%**	**61.6%**	50.9%	#	66.3%	63.3%	59.1%	50.0%	69.8%	65.1%	76.4%	**57.8%**	**62%**
Q7d. My line manager… asks for my opinion before making decisions that affect my work.	**51.7%**	**52.9%**	41.2%	#	63.2%	58.3%	51.6%	36.4%	55.6%	57.0%	65.3%	**54.7%**	**59%**
Q7e. My line manager… is supportive in a personal crisis.	**73.9%**	**75.5%**	69.4%	#	81.3%	71.7%	71.0%	77.3%	81.2%	76.1%	81.9%	**74.5%**	**78%**
Q7f. My line manager… takes a positive interest in my health and well-being.	**63.5%**	**64.4%**	56.3%	#	73.2%	60.0%	57.6%	63.6%	71.2%	64.8%	79.2%	**78.3%**	**81%**
Q7g. My line manager… values my work.	**68.4%**	**70.0%**	61.2%	#	76.9%	66.7%	70.7%	72.7%	73.6%	72.5%	77.8%	‡	#
Q7h. My line manager… helps me find a good work life balance.	**53.0%**	**54.8%**	46.2%	#	62.8%	53.3%	49.2%	59.1%	61.6%	55.7%	68.1%	**45.5%**	**51%**
Q8a. Communication between senior management and staff is effective.	**34.5%**	**34.0%**	25.7%	#	40.9%	40.0%	33.6%	27.3%	36.2%	35.9%	50.0%	**30.0%**	**34%**
Q8b. Senior managers involve staff in a timely manner regarding important decisions.	**28.4%**	**27.4%**	19.6%	#	33.3%	31.7%	25.6%	22.7%	32.0%	28.3%	47.2%	**28.7%**	**34%**
Q8c. Senior managers act on staff feedback.	**27.4%**	**26.6%**	18.4%	#	32.2%	31.7%	28.5%	22.7%	28.6%	28.8%	43.1%	**37.7%**	**43%**
Q9a. My organisation takes positive action on health and well-being.	**87.1%**	**87.0%**	82.0%	#	90.5%	90.0%	91.9%	95.5%	88.4%	87.0%	94.4%	**77.9%**	**83%**
Q9b. My organisation provides advice on mental health and well-being.	**86.5%**	**87.7%**	85.7%	#	94.2%	86.7%	85.7%	100.0%	90.8%	83.4%	93.1%	**88.8%**	**94%**

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Q9c. My organisation provides advice on diet and nutrition.	69.5%	77.0%	77.6%	#	85.0%	78.3%	73.1%	86.4%	80.6%	68.2%	90.3%	67.4%	81%
Q9d. My organisation provides advice on drug and alcohol consumption.	69.6%	73.4%	72.7%	#	81.3%	73.3%	74.8%	86.4%	76.8%	64.3%	88.9%	72.5%	81%
Q9e. My organisation provides advice on exercise.	77.9%	81.8%	80.3%	#	88.3%	83.3%	81.6%	95.2%	83.1%	76.9%	91.7%	78.1%	86%
Q9f. My organisation provides advice on help for staff that want to stop smoking.	82.9%	85.5%	84.8%	#	90.9%	90.0%	86.5%	95.5%	91.6%	77.3%	91.5%	90.9%	95%
Q9g. Are you happy with the food / drink / rest facilities provided by your employer?	50.7%	55.5%	57.2%	#	58.2%	63.3%	54.7%	59.1%	53.3%	49.7%	77.8%	‡	‡
** Q9h. In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?*	30.1%	30.5%	38.1%	#	26.4%	21.7%	27.4%	18.2%	27.7%	29.4%	22.2%	18.2%	15%
** Q9i. During the last 12 months have you felt unwell as a result of work related stress?*	46.7%	46.1%	51.3%	#	48.4%	48.3%	36.9%	36.4%	48.7%	41.1%	34.7%	36.2%	32%
** Q9j. In the last three months have you ever come to work despite not feeling well enough to perform your duties?*	63.7%	63.8%	67.6%	#	63.1%	61.7%	54.4%	68.2%	68.8%	60.8%	50.0%	‡	‡
** Q9k. Have you felt pressure from your manager to come to work?*	29.2%	29.8%	39.7%	#	21.5%	16.2%	25.6%	20.0%	22.9%	30.4%	25.0%	‡	‡
** Q9l. Have you felt pressure from colleagues to come to work?*	20.7%	20.0%	24.5%	#	16.4%	10.8%	26.3%	20.0%	14.0%	19.3%	25.0%	‡	‡
** Q9m. Have you put yourself under pressure to come into work?*	93.7%	93.0%	93.7%	#	92.3%	97.3%	93.2%	100.0%	91.4%	92.7%	94.4%	‡	‡
** Q9n. Do you typically feel worn out at the end of the working day?*	90.6%	91.2%	93.3%	#	91.1%	83.3%	92.2%	86.4%	92.6%	88.3%	90.3%	‡	‡
Q9o. Does your organisation support you in achieving a work-life balance?	67.9%	70.2%	63.9%	#	77.9%	75.0%	66.8%	71.4%	76.5%	67.6%	86.1%	‡	‡
Q10a. How many hours a week are you contracted to work? *(% of respondents that are contracted to work less than 30 hours a week)*	20.8%	24.2%	17.8%	#	27.5%	8.3%	37.4%	18.2%	10.8%	37.7%	8.3%	21.6%	25%
** Q10b. On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours?* *(% of staff working additional paid hours)*	34.4%	34.9%	41.3%	#	21.5%	30.5%	32.3%	27.3%	30.7%	42.0%	16.9%	49.8%	48%

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** Q10c. On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours? (% of staff working additional unpaid hours)*	**50.3%**	**51.0%**	53.2%	#	60.6%	29.3%	47.0%	72.7%	51.3%	43.9%	50.0%	**71.1%**	**72%**
Q10d. Working the extra PAID hours that I do is acceptable to me. (Asked only of those who stated on Q10b that they work additional paid hours)	**75.4%**	**74.7%**	74.4%	#	67.8%	77.8%	75.8%	85.7%	79.2%	73.7%	92.3%	‡	‡
Q10e. Working the extra UNPAID hours that I do is acceptable to me. (Asked only of those who stated on Q10c that they work additional unpaid hours)	**26.7%**	**23.7%**	17.3%	#	24.0%	41.2%	25.4%	37.5%	25.8%	26.1%	50.0%	‡	‡
** Q11a. In the last month have you seen any errors, near misses, or incidents that could have hurt staff?*	**17.0%**	**17.4%**	22.3%	#	10.9%	15.0%	21.9%	27.3%	23.3%	12.4%	2.8%	**17.4%**	**14%**
** Q11b. In the last month have you seen any errors, near misses, or incidents that could have hurt patients/service users?*	**22.0%**	**21.2%**	34.0%	#	12.2%	10.0%	24.1%	27.3%	19.1%	15.3%	1.4%	**22.3%**	**17%**
Q11c. The last time you saw an error, near miss or incident that could have hurt staff or patients / service users, did you or a colleague report it? (Only asked of respondents that said "yes" to either Q11a or Q11b)	**91.7%**	**92.2%**	92.1%	#	88.2%	100.0%	94.9%	85.7%	95.7%	90.9%	50.0%	**94.5%**	**91%**
Q12a. My organisation treats staff who are involved in an error, near miss or incident fairly.	**48.4%**	**44.8%**	39.9%	#	43.2%	36.6%	44.2%	46.2%	44.7%	52.3%	45.1%	**45.1%**	**48%**
Q12b. My organisation encourages us to report errors, near misses or incidents.	**84.5%**	**84.1%**	79.8%	#	84.5%	63.6%	87.8%	85.0%	84.8%	89.4%	77.6%	**77.7%**	**80%**
Q12c. When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.	**67.2%**	**65.9%**	62.1%	#	64.7%	55.3%	67.4%	47.1%	68.6%	70.9%	56.1%	**61.4%**	**63%**
Q12d. We are given feedback about changes made in response to reported errors, near misses and incidents.	**55.8%**	**54.0%**	50.4%	#	52.5%	28.3%	57.6%	31.3%	61.8%	57.1%	32.8%	**52.3%**	**53%**
Q13a. If you were concerned about negligence, unsafe clinical or professional practice, would you know how to report it?	**86.4%**	**87.9%**	84.6%	#	88.8%	62.7%	89.0%	81.8%	92.2%	91.9%	70.8%	**87.7%**	**89%**
Q13b. I would feel secure raising concerns about negligence, unsafe clinical or professional practice.	**61.1%**	**61.5%**	56.1%	#	60.7%	43.3%	64.9%	63.6%	65.7%	67.0%	50.0%	**79.7%**	**79%**
Q13c. I am confident that my organisation would address my concern.	**55.1%**	**55.0%**	45.4%	#	57.1%	43.3%	56.4%	36.4%	58.5%	64.2%	48.6%	**64.7%**	**70%**
Q13d. Do you understand your responsibility to raise concerns?	**97.3%**	**97.6%**	97.4%	#	98.6%	95.0%	98.8%	95.5%	97.8%	98.2%	87.5%	**79.0%**	**85%**

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** Q14a In the last 12 months have you personally experienced physical violence at work from…Patients / service users, their relatives or other members of the public?*	**17.9%**	**20.4%**	23.3%	#	14.7%	0.0%	25.5%	4.5%	32.5%	15.5%	0.0%	**13.9%**	**12%**
** Q14b. In the last 12 months have you personally experienced physical violence at work from… Managers / Team leaders?*	**0.9%**	**0.8%**	1.4%	#	0.6%	1.7%	0.0%	0.0%	0.8%	0.5%	0.0%	**0.5%**	**1%**
** Q14c. In the last 12 months have you personally experienced physical violence at work from…Other colleagues?*	**2.0%**	**1.6%**	2.2%	#	0.4%	3.3%	1.2%	0.0%	3.2%	1.0%	0.0%	**1.4%**	**1%**
Q14d. The last time you experienced physical violence at work, did you or a colleague report it? (*Asked only of respondents who stated on Q14a-c that they had personally experienced physical violence at work in last 12 months*)	**78.8%**	**80.1%**	69.8%	#	78.3%	50.0%	83.8%	50.0%	91.5%	82.5%	0.0%	**76.6%**	**73%**
** Q15a. In the last 12 months have you personally experienced harassment, bullying and abuse at work from… Patients / service users, relatives or other members of the public?*	**32.0%**	**35.4%**	40.7%	#	34.7%	11.7%	31.0%	22.7%	40.7%	33.1%	4.2%	**24.7%**	**23%**
** Q15b. In the last 12 months have you personally experienced harassment, bullying and abuse at work from… Managers / Team leaders?*	**15.7%**	**14.8%**	22.3%	#	9.1%	18.3%	14.3%	31.8%	12.9%	10.1%	16.7%	**12.4%**	**10%**
** Q15c. In the last 12 months have you personally experienced harassment, bullying and abuse at work from… Other colleagues?*	**20.0%**	**19.5%**	26.5%	#	16.8%	15.0%	18.8%	18.2%	18.1%	14.5%	18.1%	**15.6%**	**14%**
Q15d. The last time you experienced harassment, bullying and abuse at work, did you or a colleague report it? (*Asked only of respondents who stated on Q15a-c that they had personally experienced harassment, bullying and abuse at work in the last 12 months)*	**52.0%**	**54.7%**	45.6%	#	59.0%	76.2%	52.0%	66.7%	60.8%	61.8%	18.2%	**53.5%**	**53%**
Q16a1. Does your organisation take effective action if staff are… Physically attacked by patients / clients / service users, their relatives or other members of the public?	**83.3%**	**84.0%**	79.1%	#	89.0%	100.0%	84.1%	81.8%	76.5%	89.6%	100.0%	**57.8%**	**64%**
Q16a2. Does your organisation take effective action if staff are… Physically attacked by other members of staff?	**93.8%**	**95.0%**	91.2%	#	96.6%	100.0%	94.0%	88.9%	97.1%	96.6%	100.0%	**61.1%**	**67%**
Q16a3. Does your organisation take effective action if staff are… bullied, harassed or abused by patients / clients / service users, their relatives or other members of the public?	**74.6%**	**75.5%**	68.6%	#	76.6%	95.5%	82.2%	70.0%	69.4%	81.1%	96.2%	**51.6%**	**57%**
Q16a4. Does your organisation take effective action if staff are… Bullied, harassed or abused by other members of staff?	**72.3%**	**74.5%**	64.7%	#	78.1%	64.7%	80.4%	41.7%	73.3%	84.1%	63.6%	**49.1%**	**52%**
* Q17a. *In the last 12 months have you personally experienced discrimination at work from … Patients / service users, their relatives or other members of the public?*	**4.3%**	**4.8%**	4.7%	#	3.9%	3.3%	5.5%	4.5%	6.6%	4.6%	0.0%	**4.5%**	**4%**

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* Q17b. *In the last 12 months have you personally experienced discrimination at work from …Managers / team leaders or other colleagues?*	9.9%	8.5%	11.6%	#	8.2%	8.3%	8.0%	14.3%	7.8%	6.4%	2.8%	7.6%	7%
* Q17c1. *On what grounds have you experienced discrimination… Ethnic background*	11.4%	11.8%	9.9%	#	10.5%	14.3%	7.1%	0.0%	11.7%	18.4%	0.0%	12.6%	8%
* Q17c2. *On what grounds have you experienced discrimination… Gender*	16.0%	14.3%	19.8%	#	12.3%	0.0%	10.7%	0.0%	16.7%	7.9%	0.0%	17.6%	19%
* Q17c3. *On what grounds have you experienced discrimination… Religion*	19.6%	22.5%	19.8%	#	31.6%	0.0%	25.0%	33.3%	21.7%	22.4%	0.0%	22.2%	29%
* Q17c4. *On what grounds have you experienced discrimination… Sexual orientation*	3.6%	2.5%	2.3%	#	5.3%	0.0%	3.6%	0.0%	1.7%	0.0%	50.0%	4.3%	1%
* Q17c5. *On what grounds have you experienced discrimination… Disability*	8.3%	10.7%	11.5%	#	12.3%	14.3%	13.8%	0.0%	10.0%	7.9%	0.0%	8.6%	8%
* Q17c6. *On what grounds have you experienced discrimination… Age*	14.0%	15.7%	17.6%	#	12.3%	14.3%	28.6%	0.0%	15.0%	11.8%	0.0%	15.1%	13%
* Q17c7. *On what grounds have you experienced discrimination… Other reason(s)*	37.9%	36.2%	38.2%	#	38.6%	71.4%	14.3%	66.7%	41.0%	30.3%	50.0%	29.2%	30%
Q17d. Did you report the discrimination?	29.9%	29.5%	26.9%	#	28.6%	57.1%	20.7%	100.0%	33.9%	30.6%	0.0%	27.9%	21%
Q17e. Does your organisation take effective action if discrimination is reported?	26.3%	24.5%	22.4%	#	24.1%	20.0%	11.1%	0.0%	17.4%	40.0%	0.0%	31.7%	53%
Q18a. Have you had any training, learning or development in the last 12 months?	78.4%	80.7%	75.8%	#	89.7%	55.0%	77.3%	70.0%	86.1%	81.6%	69.4%	‡	‡
Q18b. My training, learning or development has helped me to do my job more effectively.	79.8%	80.4%	76.3%	#	78.4%	66.7%	85.1%	81.8%	83.1%	84.7%	80.5%	69.4%	71%
Q18c. My training, learning or development has helped me to stay up-to-date with professional requirements.	84.7%	86.0%	84.6%	#	86.3%	45.8%	86.9%	66.7%	89.1%	88.9%	73.3%	70.2%	73%
Q18d. My training, learning or development has helped me to deliver a better patient / service user experience.	77.5%	79.2%	75.4%	#	77.2%	45.5%	82.4%	83.3%	82.3%	84.3%	79.3%	63.2%	66%
Q19a. Have you had mandatory training in the last 12 months?	90.7%	95.1%	93.3%	#	95.3%	88.3%	94.0%	90.0%	97.8%	96.6%	94.4%	‡	‡

2019 HSC Staff Survey - Individual Question Data by Organisational Staff Directorate	HSC OVERALL 2019	Southern HSCT Overall 2019	Acute Services	Chief Executive's Office	Children & Young People's Services	Finance & Procurement	HR & Organisational Development	Medical	Mental Health & Disability Services	Older People & Primary Care	Performance & Reform	HSC Overall 2015	Southern HSCT Overall 2015
Q20a. In the last 12 months, have you had an appraisal, annual review, development review, or KSF development review?	70.7%	74.4%	70.6%	#	80.0%	74.6%	57.6%	50.0%	76.7%	80.4%	71.8%	64.7%	67%
Q20b. My appraisal / review helped me to improve how I do my job.	74.2%	75.1%	66.6%	#	76.9%	50.0%	83.0%	90.0%	80.6%	79.4%	68.6%	57.9%	63%
Q20c. My appraisal / review helped me agree clear objectives for my work.	84.4%	84.2%	77.4%	#	85.7%	68.2%	88.2%	100.0%	89.5%	87.2%	80.4%	78.0%	80%
Q20d. My appraisal / review left me feeling that my work is valued by my organisation.	71.8%	72.7%	61.8%	#	74.7%	59.1%	79.6%	80.0%	77.9%	78.4%	78.4%	62.2%	67%
Q20e. The values of my organisation were discussed as part of the appraisal process.	73.6%	67.8%	55.1%	#	69.7%	47.7%	70.3%	80.0%	72.4%	77.1%	72.5%	‡	‡
Q20f. My training, learning or development needs were discussed and agreed.	93.6%	94.3%	90.7%	#	97.5%	86.4%	97.1%	100.0%	96.6%	94.8%	92.2%	79.3%	75%
Q20g. My training, learning and development needs were met.	85.6%	88.6%	83.1%	#	91.2%	70.5%	94.2%	100.0%	92.6%	90.5%	84.3%	75.0%	79%
Q21a. Care of patients / service users is my organisation's top priority.	75.2%	74.2%	65.7%	#	76.8%	70.0%	79.4%	55.0%	77.3%	78.4%	81.9%	73.1%	76%
Q21b. I would recommend my organisation as a place to work.	60.6%	59.5%	48.7%	#	64.8%	68.3%	62.9%	55.0%	57.3%	67.0%	72.2%	60.6%	67%
Q21c. If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	68.5%	67.6%	62.5%	#	65.9%	73.3%	69.4%	65.0%	68.0%	73.2%	67.6%	67.0%	71%
Q21d1. What way do you prefer to receive information about your organisation… Daily updates on organisation intranet?	45.9%	41.1%	40.5%	#	45.5%	41.7%	41.4%	40.0%	49.3%	33.9%	38.0%	38.2%	34%
Q21d2. What way do you prefer to receive information about your organisation…Internet?	31.2%	33.4%	37.8%	#	32.5%	36.7%	36.4%	30.0%	32.4%	29.4%	23.9%	24.9%	29%
Q21d3. What way do you prefer to receive information about your organisation… Senior management briefings?	19.3%	16.2%	15.4%	#	15.9%	28.3%	21.0%	35.0%	20.5%	11.1%	23.9%	19.6%	16%
Q21d4. What way do you prefer to receive information about your organisation… Organisation newsletter?	30.1%	37.6%	35.1%	#	40.6%	56.7%	39.1%	65.0%	37.4%	33.5%	59.2%	12.7%	19%
Q21d5. What way do you prefer to receive information about your organisation… Line managers?	53.2%	54.6%	49.8%	#	55.6%	53.3%	56.7%	45.0%	59.0%	57.2%	47.2%	55.6%	55%

2019 HSC Staff Survey - Individual Question Data by Organisational Staff Directorate	HSC OVERALL 2019	Southern HSCT Overall 2019	Acute Services	Chief Executive's Office	Children & Young People's Services	Finance & Procurement	HR & Organisational Development	Medical	Mental Health & Disability Services	Older People & Primary Care	Performance & Reform	HSC Overall 2015	Southern HSCT Overall 2015
Q21d6. What way do you prefer to receive information about your organisation…Team meetings?	64.8%	66.8%	59.1%	#	69.5%	70.0%	69.4%	50.0%	68.9%	72.4%	63.9%	64.1%	64%
Q21d7. What way do you prefer to receive information about your organisation… Chief Executive briefings?	10.3%	10.1%	9.6%	#	10.5%	16.7%	12.0%	30.0%	10.3%	7.7%	22.5%	7.9%	6%
Q21d8. What way do you prefer to receive information about your organisation… Staff notice boards?	26.9%	23.7%	29.7%	#	16.9%	21.7%	35.7%	10.0%	28.0%	16.0%	14.1%	22.6%	18%
Q22a. Is patient / service user experience feedback collected within your directorate / department?	81.1%	80.1%	73.8%	#	81.4%	17.6%	76.0%	90.9%	89.6%	83.6%	56.0%	74.3%	75%
Q22b. I receive regular updates on patient / service user experience feedback in my directorate / department.	59.1%	57.1%	53.5%	#	55.1%	100.0%	55.3%	70.0%	54.7%	63.3%	64.3%	60.6%	60%
Q22c. Feedback from patients / service users is used to make informed decisions within my service area.	63.1%	61.5%	58.3%	#	61.4%	66.7%	60.2%	40.0%	65.7%	61.4%	76.9%	66.2%	68%

Sheet Title	Description
2019 HSC Staff Survey Key Findings Data for Personnel Areas within HSC Trusts	This sheet contains HSC 2019 Key Finding scores broken down by staff personnel area for each of the five primary Health and Social Care Trusts that took part in the 2019 HSC Staff Survey. For most of the question scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in italics, the lower the score the better. *Note: Key Finding 21 could not be calculated for the HSC Staff Survey '19 as the single question that constitutes this finding was not included within the HSC '19 staff questionnaire (see Appendix I within regional report).*
2019 HSC Staff Survey Key Findings Data by Organisational Staff Directorate	This sheet contains HSC 2019 Key Finding scores broken down by staff directorate area for every organisation that took part in the 2019 HSC Staff Survey. For most of the question scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in italics, the lower the score the better. In order to preserve the confidentiality of individual staff, data is not shown where fewer than 11 responses contribute to a score. Whereby a value is suppressed because fewer than eleven responses were received, this is denoted by the symbol #. *Note: Key Finding 21 could not be calculated for the HSC Staff Survey '19 as the single question that constitutes this finding was not included within the HSC '19 staff questionnaire (see Appendix I within regional report).*
2019 HSC Staff Survey - Employee Engagement Score & Key Findings broken down by background details	This sheet contains Employee Engagement Scores & Key Findings broken down by background details for every organisation that took part in the 2019 HSC Staff Survey. In order to preserve the confidentiality of individual staff, data is not shown where fewer than 11 responses contribute to a score. Whereby a value is suppressed because fewer than eleven responses were received, this is denoted by the symbol #. *Note: Key Finding 21 could not be calculated for the HSC Staff Survey '19 as the single question that constitutes this finding was not included within the HSC '19 staff questionnaire (see Appendix I within regional report).*
2019 HSC Staff Survey - Individual Question Data for Personnel Areas within HSC Trusts	This sheet contains HSC 2019 individual question scores broken down by staff personnel area for each of the five primary Health and Social Care Trusts that took part in the 2019 HSC Staff Survey. For most of the question scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in italics, the lower the score the better. In order to preserve the confidentiality of individual staff, data is not shown where fewer than 11 responses contribute to a score. Whereby a value is suppressed because fewer than eleven responses were received, this is denoted by the symbol #.
2019 HSC Staff Survey - Background Question Data for Personnel Areas within HSC Trusts	This sheet contains questions relating to background information broken down by staff personnel area for each of the five primary Health and Social Care Trusts that took part in the 2019 HSC Staff Survey. In order to preserve the confidentiality of individual staff, data is not shown where fewer than 11 responses contribute to a score. Whereby a value is suppressed because fewer than eleven responses were received, this is denoted by the symbol #.
2019 HSC Staff Survey - Individual Question Data by Organisational Staff Directorate	This sheet contains HSC 2019 individual question scores broken down by staff directorate area for every organisation that took part in the 2019 HSC Staff Survey. For most of the question scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in italics, the lower the score the better. In order to preserve the confidentiality of individual staff, data is not shown where fewer than 11 responses contribute to a score. Whereby a value is suppressed because fewer than eleven responses were received, this is denoted by the symbol #.
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2019 HSC Staff Survey - Individual Questions broken down by background details	This sheet contains individual question results broken down by background details for every organisation that took part in the 2019 HSC Staff Survey. In order to preserve the confidentiality of individual staff, data is not shown where fewer than 11 responses contribute to a score. Whereby a value is suppressed because fewer than eleven responses were received, this is denoted by the symbol #.

HR & Medical Directorate Meeting

Wednesday 13th April 2022

Present: Vivienne Toal, Zoe Parks, Simon Gibson and Zoe Parks and Dr Aisling Diamond

Apologies: Siobhan Hynds, Dr Maria O'Kane

Note Taker: Cara Matchett

Process for welcoming new Doctors to Southern Trust

Dr Diamond updated the group that she has a system in place to meet with new Consultant/SAS doctors. Once a new doctor is due to commence his/her post in the Southern Trust, Medical HR(Joanne McMullen) emails Dr Diamond who subsequently meets the new doctor via zoom to welcome them to the Trust and address any questions they may have such as (job role including salary, job planning, clinical supervisors and the appraisal process). They are now building onto this a further meeting after 3months when Dr Damian Scullion will meet with the new doctor to reinforce the importance of mandatory training and the appraisal process that has to be underway within the first 3 months of taking up post. They will also check if Job Plans have been updated.

Dr Diamond stated that there are interviews scheduled for tomorrow for a clinical lead to support the Southern Academy and a Clinical Fellow starting in August is going to support the international medics that are due to start the same month

Changes to Foundation Programme

The Trust had been advised previously by the DME's that we could expect an additional 10 FY1s to the Southern Trust. However, we were recently contacted by the DOH to advise that this was no longer the case as they could not identify funding to support this. Further correspondence was then received from the DOH to ask if Trusts would be willing to fund these. A recent meeting within the Trust looked at ways this could be facilitated for an additional 14 FY1 doctors which we feel is needed to meet demand. Correspondence was issued to the DOH with emphasis on the fact that SHSCT already have the least number of FY1 posts funded and we would see this disparity to be addressed when new funding released.

Simon mentioned that both he and Dr Diamond are due to meet with Debbie (the new Foundation programme Director) this Friday and they could discuss how this number could be split between CAH and DHH if this comes to fruition.

Action: Simon to identify how FY1 would be split with any increase in numbers to allow rotas to be developed now – as this is important to avoid pay protection.

Allocation Process for Obstetrics & Gynaecology (August 2019) - potential loss of funding for posts

The WHSCT had initially raised the above concern when they were advised by NIMDTA that the DOH may be seeking to withdraw funding for post historically unfilled by training programmes.

Zoe shared her screen showing the initial email in which the removal of funding for posts that have been unfilled for more than 2 years was first raised

Simon mentioned that NIMDTA had flagged this to the Trust but nothing has come into the Trust recently that would raise concerns

Action: **At the next Regional meeting on Friday 22nd, both Simon & Dr Diamond are to seek clarification from NIMDTA on this.**

NHS Resolution Practitioner Performance Advice (PPA) Service – Northern Ireland

Dr Diamond updated the group that Dr O'Kane had sent this out to Divisional Medical Leads.

Regional Review of PA role

Zoe updated the group that there is a regional faculty group set up along with [redacted] is the chair of this group however he has been absent from the meetings recently attended by HR.

Vivienne had mentioned the push back from Belfast in terms of the PA role. Dr Diamond stated that when working in Belfast there was a lot of push back from Clinicians, with some issues being that a PA is not registered to prescribe or order medication

Vivienne highlighted that if all Trusts are not engaging with this, it is concerning if the system is not engaging with the Ulster Programme which has been running to provide this PA support.

Simon mentioned that it would be of benefit if a review of the PA role could be conducted. Vivienne agreed that a review would be beneficial; however, the people who are carrying out this review need to understand both the background and the context of this – to ensure it is an effective review of what is happening on the ground.

Dr Diamond suggested asking a Clinical Fellow to conduct the review. Simon questioned a Clinical Fellows experience in doing a review like this. Dr Diamond mentioned that in terms of producing metrics etc. a Clinical Fellow might have the expertise to carry this out

Zoe highlighted the importance of this review being a regional one. Vivienne mentioned the importance of having the Department linked in across to the University perspective also.

Vivienne raised a question as to how PA's have been integrated into the UK. Dr Diamond mentioned a US review that has been conducted and plans to share this with the group. Dr Diamond continued in stating that in England, PA's report down the nursing line for management, however, for performance and governance this is done down the medical line.

Action: Dr Diamond to share US review on PA
Action: Vivienne to flag this with Phil Rogers in DOH

Medical Management Pension Tax Issues

The group agreed to postpone discussion on this agenda item until they receive the response from June in DLS on the matter

Medical Staff who were not included in recent pay award

Zoe updated the group that there are a group of doctors who sit outside the Medical and Dental pay circular who are unhappy their rates have not been uplifted. The original circular from Primary Care DOH was issued in 2006.

Action: Zoe to email Vivienne to summarise position and attempts to raise with DOH so this can be escalated.

SAS Advocate Role

Zoe updated the group that there is an implementation group to see if a specialist role can be set up. Zoe continued by highlighting that the LNC will be expecting the Trust to ascertain whether they are going to implement the SAS Advocate role. The Trust will have to fund this to approx. 0.5PA's. This new role has originated from the new SAS Contract and it seems to relate to a health and well-being role.

Zoe shared her screen of the NHS Employers website, showing information on the SAS Advocate role and a SAS strategy from the Royal College of Physicians. This fed neatly into our Trust People Plan priorities.

Zoe reiterated the importance of the Trust giving serious consideration to this role to support the SAS group

Vivienne mentioned that this role could be combined with the freedom to speak up role alongside the People Plan priorities.

Zoe mentioned the need for the Trust to work collaboratively on this project with the LNC

Zoe updated the group of the implementation group set up with Mark Feenan, Clodagh Corrigan and Claire Brady, discussions are on the need for both a specialist role in specialties and a SAS advocate role. If there was a SAS Advocate role, this group could cease as the person in the advocate role could work with Claire in supporting SAS.

Vivienne highlighted that the SAS advocate role is really a supportive role with a real link to the people plan. Vivienne advised Zoe to look at Maxine's slides on the people plan and to see where this role would fit with the three priorities. Vivienne asked Zoe to raise this with the SAS implementation group to see if this could be the way forward for this role. It was agreed that the Trust would likely support such a role.

Any other Business?

Zoe updated the group of the professional support group that NIMDTA currently have to support the trainee doctors. Zoe suggested that it might be a good idea if the Trust had something similar, this would be good to support clinical managers and help nip issues in the bug by sign posting the support a doctor might need i.e. mentoring, OH, coaching, enhanced induction, additional clinical training.

Zoe advised that the professional group in NIMDTA have 1-2-1 meetings with doctors for example if they are falling behind, providing the support and guidance at an early stage before it would be a major concern. This person providing the support is a clinical lead

Simon mentioned that this would be a good idea in providing structure as to where a medic will need to go to receive support. MDO office would provide support when doctors going through inquests, GMC hearings etc but it is all very informal.

Zoe advised that she could seek a copy of the TOR from NIMDTA to see what this might look like for the Trust. It may be an idea to tie in some of the recent clinical leads/retired consultants appointed to provide the support into such a structure.

Vivienne encouraged Zoe to obtain the terms of reference from NIMDTA to see what this would look like in our Trust

Action: Zoe to get Terms of Reference for the NIMDTA professional group

Zoe emphasised the request from LNC that we switch our meetings to be more business focused. She suggested we identify pieces of work that both the LNC and the Trust can work collaboratively for example, retirement Options paper, team job planning and the SAS strategy.

Zoe mentioned the ongoing issues with the Trusts rosters and rotas and digital rostering may be needed in DHH as currently the visibility does not seem to be there in terms of where the gaps are in the rota.

Action: Dr Diamond to pick this up with Seamus, Kay and Zoe around the ongoing cover issues in DHH

Action: Zoe to meet with Lucinda from LNC around business focus of LNC agendas

Southern Health and Social Care Trust

VIRTUAL HR & MEDICAL DIRECTORATE MEETING

Friday, 5th February 2021 @ 2:00pm

Join Zoom Meeting

Join Zoom Meeting
https://southerntrust-hscni.zoom.us/j/84752777629?pwd=Z2FZTXEyNGw3dUs2SVJnaFFJc1RqZz09

Meeting ID: Irrelevant information redacted by the USI
Passcode: Irrelevant information redacted by the USI

AGENDA

- **COVID Payments**

SHSCT Covid Resident Rate FINAL

- **Development Triggers:**
  Indicate deployment required / phased out
- **Regional Annual Leave Buy Back Proposal**

Regional Proposal - Payment of Annual Le

- **Additional Payments: PHE England & Wales**

PHE.pdf

wales doc.pdf

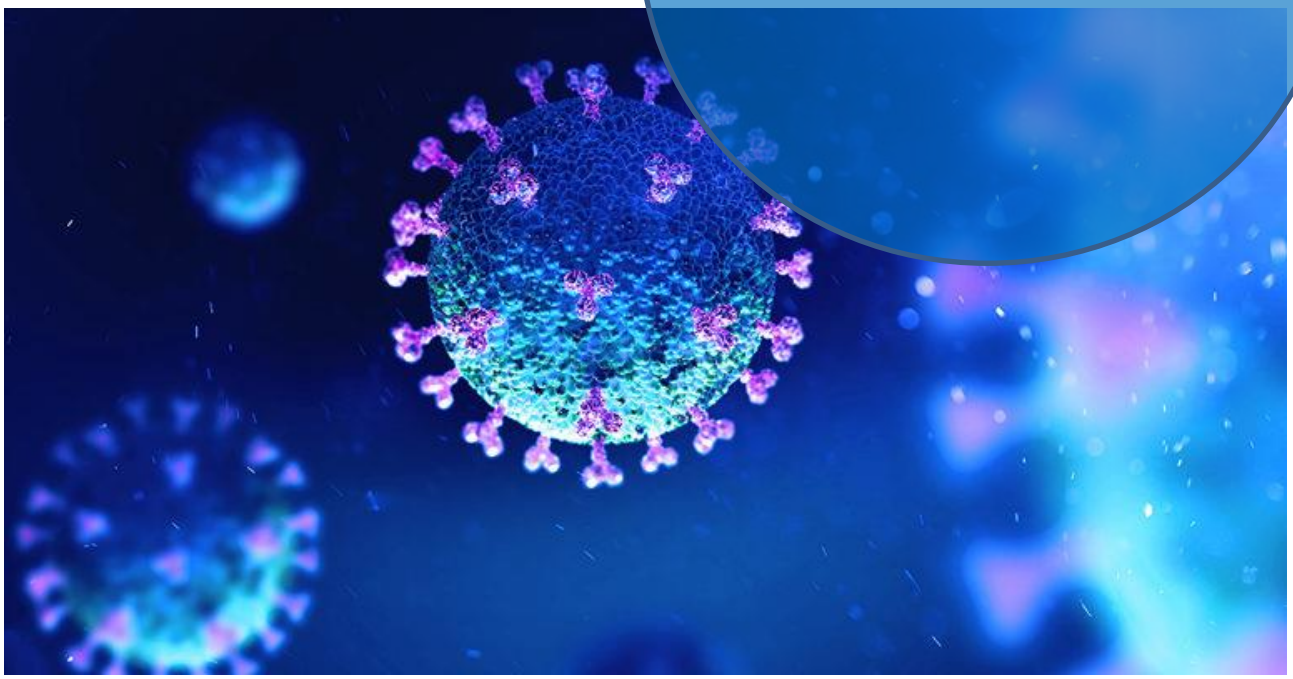
- **Any Other Business**

Date of next virtual meeting: ***To be confirmed***

Southern Health and Social Care Trust

Quality Care - for you, with you

Medical & Dental Covid Resident Rate



Remuneration Agreement (Medical Staff) for Covid-19 Pandemic Response

2020/21

Zoe Parks, Head of Medical HR

Approved by LNC on – 1 February 2021

Medical HR Department Southern Trust

INTRODUCTION

This paper sets out the remuneration that has been agreed for consultants who changed to a resident on call role during the Covid pandemic.

PRINCIPLES

The Trust has worked closely with the Local Negotiating Committee to ensure this agreement (which applies specifically to the Covid Response) promotes the following principles:

- Work when **resident in premium time on Covid** rotas for doctors, not normally required to be resident, or work more resident hours than usual will be paid at £Personal / hour. (Consultant Rate)
- Promotes consistency and fairness for all consultants undertaking this much valued work
- Avoids ambiguity around work that has already been paid for within job plans.
- Recognises all consultants equally for the work undertaken resident overnight, weekends and BHs
- Complies with the principle of no detriment
- Will be applied to work completed retrospectively and to work going forward prospectively.
- Will be reviewed by the Trust and LNC on a regular basis

REMUNERATION

The total pay for each week of the Covid Escalation Response will be the sum of work done in resident premium time (7pm to 7am Monday to Friday, weekends, bank holidays).

It will be calculated as follows:

Total number of resident hours, worked on the Covid Response in premium time x £Personal per hour

- Where work was time-shifted from job plans to work resident out of hours, the hourly rate* for job plan activity, , will be netted off the Resident Covid hourly rate of £Personal. The rate is based on 3 hour PA in premium time. This effectively means that the hourly rate '*already paid'*, will be uplifted to the £Personal per hour to reflect that the work was undertaken resident out of hours.

*To promote fairness and equity; this hourly rate used to nett off, will be on the mid-point of the scale – which equates to £Personal per hour. Therefore when work is time-shifted from job plans, all hours worked resident in premium time will be paid at £Personal extra per hour (i.e. the difference between £Personal minus £Personal per hour (already paid). This will apply to all consultants undertaking this work, regardless of seniority, content of job plans or WTE.

TIME IN LIEU

There is an option for consultants to take a part of any additional remuneration as time in lieu. This will be limited to 20 PAs total to be taken at any time extended to April 2023. The PAs of time in lieu should be taken against the total weekly PAs in the job plan (DCC plus SPA) and be applied for in the normal way as annual leave. When this option is chosen, for every 3 hours worked resident out of hours in premium time on the Covid Response Rota, consultants can claim 1 PA as Time off in Lieu up to the cap of 20 PA's.

WORKING EXAMPLE - COVID RESIDENT RATE

During a week in March in the Covid ICU, a consultant worked 16 hours resident out of hours (premium time).

1. Calculate the total number of resident hours: 16 hours x £[redacted] per hour = £[redacted]

2. As this work would have been time shifted from Job Plan time already paid for, Nett off the hourly rate for premium time. To promote fairness and consistency, the rate of £[redacted] per hour is to be used for netting off. Therefore 16 hour x £[redacted] = £[redacted]

3. Calculate the difference between the two calculations above. Payment of **£[redacted] is due.**

WORKING EXAMPLE – SIMPLE VERSION

During a week in March in the Covid ICU, a consultant worked 16 hours resident out of hours (premium time).

This work was undertaken as a result of time shifted activity within the Job Plan

4. Calculate the total number of resident hours: 16 hours x £[redacted] = **£[redacted] is due for payment**

WORKING EXAMPLE – ADDITIONAL ACTIVITY

When a consultant fulfills all the commitment in their job plan but agrees to provide Additional resident cover out of hours/in premium time. For instance, if a consultant agreed to work a 16 hour resident shift in premium time in response to Covid in addition to their Job Plan:

- Calculate the total number of resident hours: 16 hours x £[redacted] per hour = £[redacted]

AUTHORISATION PAYMENT OF RESIDENT COVID RATE

On completion of the calculation of the Covid Resident Rate, it must be submitted on an appropriate claim form and signed off by both the consultant and their AMD.

Health and Social Care

Regional Proposal: Response to Emergency Covid-19 Pandemic

Voluntary Scheme for the Extra-Ordinary Payment of Unused Contractual Leave Entitlement

1.0 Introduction

1.1 COVID-19 has brought unprecedented challenges to all HSC Trust services and staff. Many of our staff have been very flexible in terms of their leave arrangements over the last number of months. Again within the current third surge, some staff are being asked to postpone leave to support service delivery and to maximise our staff capacity. Staff, across the region, may have been asked to revisit leave arrangements and postpone leave booked and approved during 2020/2021.

1.2 Staff health and well-being is of paramount importance to HSC employers and we are committed to ensuring staff can avail of leave for rest and recuperation. In some of our services, staff may have been able to take accrued leave throughout the year as normal. Where this has been possible, the normal discretionary carryover of 1 contractual week applies. Staff should be encouraged to continue to use their leave entitlement during this leave year where it is possible.

1.3 However for some staff this will not be possible due to intense service pressures and we recognise that some staff will not be able to avail of all their leave entitlement within the current leave year.

1.4 For these staff, they can be assured that they will not lose leave as we move towards the end of the financial year. Under new measures introduced by Government aimed at alleviating the pressure on organisations employing key workers, staff who cannot take all their holiday entitlement due to COVID-19 will be able to carry over leave, into the next 2 leave years, 2021/2022 and 2022/2023. https://www.gov.uk/government/news/rules-on-carrying-over-annual-leave-to-be-relaxed-to-support-key-industries-during-covid-19 (min entitlement for employees along

1.5 The European Working Time Regulations (WTR) outlines a statutory minimum requirement of 5.6 weeks (28 days) leave for all employees for rest which is a combination of contractual annual leave and general public holidays.

1.6 In each leave year, HSC staff are entitled to contractual annual leave and general public holidays. HSC contractual leave entitlement includes an element which increases based on length of service (pro-rata). *Appendix 1 sets out the leave entitlement for HSC staff.*

1.7 All HSC organisations have received requests from staff to be paid for accrued leave rather than carrying leave forward into subsequent leave years. The HSC organisations have given significant consideration to this matter and have consulted with trade unions to seek an agreed way forward.

1.8 Whilst it will not be possible for HSC organisations to pay staff in respect of untaken leave below the minimum statutory WTR leave requirements (i.e. 5.6 weeks leave), it is proposed that, as a one-off decision, given the current unprecedented circumstances, HSC organisations will consider payment for the balance of any contractual leave above the statutory minimum (i.e. above the 5.6 weeks) that staff have been unable to use during the 2020/2021 financial year (see option 2 and 3 below). Any untaken leave below the minimum statutory requirements may be carried forward into the next 2 leave years, i.e. 2021-2022 and 2022-2023 (see point 1.4 above and option 1 below).

2.0 Principles of the Voluntary Scheme

The principles for the extra-ordinary payment of unused contractual leave entitlement are:

- This scheme is voluntary and open to all employees of the **Insert Trust name** Health & Social Care Trust.

- Where staff can avail of leave they should be encouraged to use their leave within the current leave year in line with normal annual leave provisions.

- The voluntary opportunity for payment of contractual leave is being offered to all staff as a one off to assist in managing workforce during ongoing pandemic pressures.

- Payment of leave applies only to contractual leave accrued during the 2020/2021 financial year only.

- No staff member will have a contractual right to receive any future payment in respect of contractual leave. As highlighted above, this proposal is in response to the very unique situation currently faced by HSC organisations in response to the pandemic.

3.0 Proposal

3.1 For staff unable to avail of leave in line with normal provisions due to service pressures, it is proposed that staff can be facilitated with the following extra-ordinary options in regards to their outstanding leave.

- Option 1: Carryover of leave into the next 2 leave years

Under the new Government Guidelines, those staff who have not used all of their leave, or have had leave cancelled due to the pandemic, can carry forward their unused leave into the next 2 leave years. All leave carried forward must be taken by 31 March 2023.

- Option 2: Payment of Contractual Leave

Staff can voluntarily opt to receive payment for unused leave above the statutory minimum of 5.6 weeks. See Appendix 1 for table of contractual leave entitlement.

- Option 3: Carryover and Payment of Contractual Leave

Staff can voluntarily opt to receive payment for some of their unused leave above the statutory minimum of 5.6 weeks and carry forward the remaining leave (for which a payment has not been made) into the next 2 years. All leave carried forward must be taken by 31 March 2023.

4.0 Payment of Contractual Leave

The principles for payment of contractual leave are:

- Staff can expect to be paid leave in line with their contractual arrangements (Band and Pay point) as of 31 March 2021 at the appropriate rate.

- This exceptional payment in lieu of taking contractual leave is non-pensionable.

- This exceptional payment in lieu of taking contractual leave is taxable and subject to National Insurance Contributions.

- All requests for payment of contractual leave must be agreed no later than 31 March 2021 to be processed for payment in a timely manner thereafter. The scheme will close for any new requests on 31 March 2021.

- Requests for payment of leave must be completed on the attached form in Appendix 2.

- Where leave is paid, it must be deducted from the overall 2020-2021 leave entitlement to ensure it is not credited to a staff member twice. This is the responsibility of both the line manager and the staff member.

5.0 Next Steps

To progress this proposal it requires discussion and agreement with;

- Department of Health
- Directors of HR and Finance
- Senior Management Team
- Regional Trade Union colleagues

Table of Contractual Leave (in Hours)

Table 1: Staff Paid on Agenda for Change Terms & Conditions

Contractual Leave Entitlement *(Full time equivalent)*	Statutory Annual Leave Entitlement *(including Public Holidays)*	Potential Unused Contractual Leave Available for Payment *(Full time equivalent)*
27 days Annual Leave plus 10 days Public Holidays i.e. 277.5 hours	28 days i.e. 210 hours	9 days i.e. 67.5 hours
29 days Annual Leave plus 10 days Public Holidays i.e. 292.5 hours	28 days i.e. 210 hours	11 days i.e. 82.5 hours
33 days Annual Leave plus 10 days Public Holidays i.e. 322.5 hours	28 days i.e. 210 hours	15 days i.e. 112.5 hours

Table 2: Medical & Dental Staff

Contractual Leave Entitlement *(Full time equivalent)*	Statutory Annual Leave Entitlement *(including Public Holidays)*	Potential Unused Contractual Leave Available for Payment *(Full time equivalent)*
25 days Annual Leave plus 12 days Public Holidays i.e. 277.5 hours	28 days i.e. 210 hours	9 days i.e. 67.5 hours
30 days Annual Leave plus 12 days Public Holidays i.e. 315 hours	28 days i.e. 210 hours	14 days i.e. 105 hours
32 days Annual Leave plus 10 days Public Holidays i.e. 315 hours	28 days i.e. 210 hours	14 days i.e. 105 hours
34 days Annual Leave plus 10 days Public Holidays i.e. 330 hours	28 days i.e. 210 hours	16 days i.e. 120 hours

Appendix 2

RESPONSE TO EMERGENCY COVID-19 PANDEMIC

REQUEST FOR PAYMENT OF UNUSED CONTRACTUAL LEAVE

Employee Information *To be completed by employee*	
Name	Click here to enter text.
Staff No	Click here to enter text.
Job	Click here to enter text.
Department	Click here to enter text.
Location	Click here to enter text.

Details of leave *To be completed by employee*	
Number of Leave Hours to be paid (must be stated in hours). **Cannot include payment for untaken leave below the 5.6 week statutory minimum provisions**	Click here to enter text.
Employee Declaration **I acknowledge that, by signing this request for payment of unused contractual leave that I confirm my agreement to the temporary variation to my terms and conditions of employment as outlined in the Regional Proposal (of which this is a copy). I acknowledge that this temporary variation is as a result of the exceptional circumstances which the HSC organisations have faced in light of the covid-19 pandemic and is a one-off payment. I acknowledge that this scheme closes on 31 March 2021 and, following that date, I will have no contractual right to request payment in respect of my leave entitlement.**	
Employee Signature	Click here to enter text.
Date	Click here to enter a date.

Manager Authorisation *To be completed by Direct Line Manager*	
Request Approved	Yes ☐ No ☐
If no, please detail reason	Click here to enter text.
Number of Leave Hours approved for payment	Click here to enter text.
Manager Signature	Click here to enter text.
Date	Click here to enter a date.

NOTES

- Payment of leave applies to contractual leave accrued and untaken during the 2020/2021 financial year only.
- All requests for payment of contractual leave must be agreed no later than 31 March 2021. The scheme will close for any new requests at this date.
- Where leave is paid - the manager must deduct the hours paid from the staff members 2020-2021 leave entitlement to ensure this is not credited to the staff member twice.

PLEASE FORWARD TO HUMAN RESOURCES – INSERT EMAIL ADDRESS

Message from PHE

Following a period of negotiation with the Local Negotiating Committee (LNC) staff side PHE has made an offer for an enhanced rate of payment for medical and dental consultants for extra hours worked, beyond contracted hours, in response to an enhanced incident. The PHE offer is to pay 1.5 X standard rate (4 hours worked would equate to 1.5 PAs) and 2.0 X standard rate for public holidays for any additional hours worked (4 hours worked would equate to 2 PAs). As an alternative to payment 'time off in lieu' (TOIL) would be available at the same enhanced rate of 1.5X standard rate which is also an improvement on the current customary arrangement. In addition for any hours worked on public holidays staff would be entitled to TOIL at 1.5X standard rate in addition to any payment. It is further proposed to increase the period during which TOIL should be taken from 3 to 6 months.

In making this offer PHE would like staff to note that the principle of fairness to medical and dental staff and staff employed on other terms and conditions has been the primary consideration. In addition PHE would point out that the offer is a significant enhancement on the current contractual payment situation for medical and dental staff which is: standard rate for any hours worked in the period 7am – 7pm Monday to Friday and 1.33 X standard rate for hours worked outside this period (3 hours worked equates to 1PA).

Medical and dental colleagues are encouraged to consider this offer carefully and accept that it represents a fair and reasonable outcome.

Advisory Notice
Consultants and SAS doctors pay during COVID-19

Welsh Government, NHS Wales Employers and BMA Cymru Wales would like to express their support and thanks to all consultants and SAS doctors during this ongoing COVID-19 crisis.

We are aware that consultants and SAS doctors are again being asked at short notice to take on considerable extra or new clinical duties which are not in line with their agreed, pre-COVID-19 Job Plans in order to respond to the increased clinical demands of the ongoing coronavirus pandemic. We acknowledge that demand on clinicians has also increased as a result of the backlog of work which was displaced by COVID-19, rising numbers of inpatients in hospital during the winter period, and the need to cover for colleagues who may be unwell or self-isolating.

This may mean temporary changes to working hours and rota patterns, as well as out of hours working. Any changes must be agreed in advance and in collaboration with the clinician concerned, although it is acknowledged that due to operational challenges there may be instances where immediate responses are required such as a session over-running.

SPA time continues to be essential and should continue at the agreed level in the original job plan. Where temporary job plans are agreed these should include SPA time at an agreed level.

Where SPA activity can be undertaken or delivered remotely, it may be possible for this to be performed off site with prior agreement. Appropriate expected outcomes will need to be agreed for such work, as with other aspects of a consultant's commitments. This will support compliance with the physical-distancing requirements within workplaces and with Welsh Government guidance to work from home when possible. As with any SPA time delivered at home, there may be a requirement to return to the workplace should that be required and clinicians should therefore remain contactable and available to respond should this be necessary.

We wish to make it clear that clinicians who temporarily agree changes to their working patterns will be doing so without any variation to the Amendment to the National Consultant Contract in Wales or the Specialty Doctor and Associate Specialist terms and conditions of service, or any nationally agreed Terms and Conditions. These continue to apply and no clinician should suffer financial detriment for their flexibility.

Such arrangements should continue for no longer than is necessary to respond to the extraordinary clinical demands posed by the COVID-19 crisis.

This notice confirms a doctor's right to return to their previously agreed, pre-COVID-19 Job Plan, which is to be held in abeyance for the duration of the emergency arrangements.

These pay arrangements will commence on 1 November 2020 and will apply until 31 March 2021. As an alternative to receiving pay under these arrangements, with prior

agreement by their line manager, clinicians may request to take time off in lieu on the same basis i.e. time and a half/ double time.

Consultants

All amended hours worked as a result of responding to the COVID-19 pandemic together with work undertaken which has been displaced by COVID-19 outside Monday- Friday 9am-5pm (including all on call hours actually worked) will be paid at the following rates.

Monday – Friday 5pm – 9am: 1.5 x individual's standard hourly rate (including commitment awards)

Friday 5pm – Monday 9am: 2 x individual's standard hourly rate (including commitment awards)

Bank Holidays – 2 x individual's standard hourly rate (including commitment awards)

Specialty Doctor and Associate Specialists

The enhanced rates paid for all amended hours worked as a result of responding to the COVID-19 pandemic or for undertaking work which has been displaced by COVID-19 outside Monday- Friday 7am-7pm (including all on call hours actually worked) (or recognised by a sessional time reduction under Schedule 8 of the Specialty Doctor and Associate Specialist terms and conditions of service for out of hours work) will be increased to the following rates:

Monday – Friday 7.00pm – 7.00am: 1.5 x individual's standard hourly rate

Friday 7.00pm – Monday 7.00am: 2 x individual's standard hourly rate

Bank Holidays – 2 x individual's standard hourly rate

Part-time (Consultants/SAS)

If a Part-time clinician is asked and agrees to increase their normal hours of work, they will be paid for the additional hours worked during the period Monday – Friday 9am-5pm for consultants and 7am – 7pm for SAS doctors at their standard normal hourly rate. At all other times hours worked will be paid as set out above.

Stand-by/additional non-resident on call (Consultants/SAS)

It is not anticipated that "stand-by" non-resident on call patterns will need to be established to deal with Covid-19 work. However, clinicians undertaking additional on-call (e.g. increased frequency of an on-call rota, or supplemental stand-by on-calls) to support COVID-19 work (including the effects of Covid 19 such as increased absence) will be paid as follows:-

1. Direct clinical care will be paid in line with the rates above for the hours actually worked, and

2. For the non-resident element of these duties an 'on call allowance' of 50% of the clinician's normal hourly rate will be paid for the period during which the clinician is available.

Any individual agreements made prior to this Advisory Notice will still stand and can only be varied by both parties through agreement.

NOTES OF PREVIOUS MEDICAL HR / MD MEETING

Dr O'Kane,

Unfortunately I can't locate the formal notes taken from the last Medical HR/MD meeting. I believe this was because it was relatively short online meeting which was on junior doctor changeover day, so I think the formal write up of the notes was missed. However looking back over my notes, I can confirm there was a discussion on

The paper for the Covid resident rates in ICU was discussed as agreement recently given to proceed with our new approach in SHSCT which differed from Belfast approach. **Update: Payments have all been processed now in line with this for Anaesthetics and ICU –Finance have been informed of total value of claims. Approx 79K**

There was a discussion around the buy-back proposal on annual leave and the communication that was to be circulated to medical staff for this. Update: This was communicated to medical staff via MD office and Global email and applications processed for those received.

The issue of additional payments was discussed briefly as this had been referenced at our last LNC meeting. **Update: No formal ask was ever received from our LNC for further consideration**

The rest of the meeting was taken up by a discussion around a very recent email concern that had been raised in O&G DHH by a SAS doctor. It was agreed at our meeting that Simon would contact Dr V and Dr Diamond would contact the Clinical Director Dr K immediately after the meeting to determine more details. **Update: Both doctors were contacted and in the end we allocated Mr Brown to complete an informal mediation process between these doctors and the consultant to whom the concern related.**

Name	Date Claim Received	Date of Incident	Solicitors Name	Nature of Claim	Additional Comments	Current Stage of Claim
Patient 108	12-Jan-16	Personal Information	Personal Information redacted by the USI	Failure to monitor patient after surgery to remove tumour and part of kidney. Failure to examine when complained of pain in stomach. PI collapsed due to organ failure and required emergency surgery to remove kidney.	Involvement report was not provided by Mr O'Brien despite a number of requests and this was escalated to AMD /AD	LPP Information redacted by the USI
Personal Information redacted by the USI	24-Nov-17	Personal Information	Personal Information redacted by the USI	Alleged failure to consent to perform operation (optical urethrotomy) and alleged negligent treatment thereafter	LPP Information redacted by the USI	LPP Information redacted by the USI
Patient 90	02/02/2021	Personal Information	Personal Information redacted by the USI	Failure to carry out a full preoperative assessment of patient, who died following procedure (cystoscopy, replacement of ureteric stents and bilateral ureterolysis)	Mr O'Brien had provided a statement for Coroner's process. (had undertaken procedure) Coroner's Office advised Personal Information no inquest to be held. PM Cause of Death - Intra-abdominal and Retroperitoneal Haemorrhage following Cystoscopy and Insertion of Urinary Stents ; Cardiomegaly. LPP Information redacted by the USI	LPP Information redacted by the USI
Patient 3	16/05/2022	Personal Information	Personal Information redacted by the USI	The Letter of Claim summarises the key findings of the SAI Personal Information redacted by the USI and refers to omissions identified in the SAI Report and the clear evidence that the failure to arrange surgical staging following clinical staging in Personal Information reduced the likelihood of 5 years survival from 90% to less than 40%.	Patient had been referred to Urology in Personal Information - reason was for a mass palpable on his foreskin. Referred for urgent circumcision performed on Personal Information redacted by the USI and squamous cell carcinoma confirmed following analysis. Personal Information states Mr A O'Brien as an involved employee	LPP Information redacted by the USI .
Personal Information redacted by the USI	09/03/2021	Unknown	Personal Information redacted by the USI	Unknown. Writ served (no detail of claim provided)	As per check of NIECR, Mr A O'Brien had involvement with this patient. Will have to await further particulars to determine if the claim relates to this involvement. To be kept under review.	LPP Information redacted by the USI

Patient 92	19/04/2021	Personal Information	Personal Information redacted by the USI	Failure to treat appropriately following results of a scan undertaken Personal Information redacted by the USI . Diagnosed with kidney cancer and advised Personal Information redacted by the USI that surgery required. Alleged that if appropriate treatment had been provided following scan in Personal Information , less invasive treatment would have been an option.	Personal Information redacted by the USI . Acute Governance confirmed that Mr O'Brien involved in treatment.	Personal Information redacted by the USI
Personal Information	07/06/2018	Personal Information	Personal Information redacted by the USI	Plaintiff admitted Personal Information to 3 South, Craigavon Area Hospital Plaintiff alleges clinical negligence in treatment of Kidney stones	clinic letters within Personal Information dated Personal Information confirm that patient was admitted under the care of Mr A O'Brien	LPP Information redacted by the USI
Personal Information redacted by the USI	21/06/2022	Personal Information	Personal Information redacted by the USI	Plaintiff attended Craigavon Area Hospital Personal Information when he underwent circumcision, which was carried out by Dr A O'Brien. Allegation of Failure to take adequate care of the Plaintiff Alleged failing to exercise a level of skill and care that would have accorded with a reasonable body of medical opinion.	Mr A O'Brien specifically mentioned in Letter of claim and NIECR confirms AOB's involvement.	LPP Information redacted by the USI
Personal Information redacted by the USI	28/04/2021	Personal Information	Personal Information	Joint claim with Western Trust. Alleged failure to diagnose hernia. Loc refers to having been referred to Mr O'Brien and remaining on waiting list for approx 3 years	Mr O'Brien specifically mentioned in LOC. No chart / information available for patient as not seen in Southern Trust. Attended Consultant privately.	Personal Information redacted by the USI
Personal Information redacted by the USI	28/07/2016	Personal Information	Personal Information	Plaintiff alleges bowel was pierced twice during procedure to insert supra pubic catheter and inject botox into the bladder wall.	Dr Tyson & Dr Young are named surgeons on operation notes dated 1 Personal Information Plaintiff subsequently admitted to 3 South on Personal Information under care of A O'Brien.	LPP Information redacted by the USI
Patient 1	22/06/2021	Personal Information	Personal Information redacted by the USI	The letter is not a letter of claim per se but is to register interest in the Public Inquiry. Letter does state that the legal proceedings in due course are not being ruled out. The patient is deceased. Letter indicates that patient had a diagnosis of prostrate cancer. It refers to SAI (trust ID - Personal Information) carried out and states that treatment provided did not conform to protocol, was unlicensed and not subject to any valid consent process; that referral to oncology did not take place; community care was non-existent and follow-up MDM did not occur notwithstanding progression of the disease. Letter states care was unprofessional despite multi-professional resources being made available, and that opportunity to provide radical treatment was lost. Letter states that due to failures in care, patient suffered disease progression.	Mr O'Brien specifically mentioned in the letter as was the SAI. This patient was one of the 9 families involved in SAI	LPP Information redacted by the USI
Personal Information redacted by the USI	30/11/2021	Personal Information	Personal Information redacted by the USI	It is alleged that surgical intervention of a minor (circumcision) was undertaken by Mr O'Brien without parental consent, and that this surgery was not required. It is alleged that Mr O'Brien has been negligent in his diagnosis, prognosis, work and practice in the treatment of the minor patient	Mr O'Brien specifically mentioned in the letter.	LPP Information redacted by the USI

CRAIGAVON AREA HOSPITAL GROUP TRUST

Caring Through Commitment

17 July 2006.

Mr. J. Templeton,
Chief Executive,
Craigavon Area Hospital Group Trust,
Craigavon Area Hospital,
Craigavon,
BT63 5QQ.

Dear John,

I do hope that you will have received a copy of my letter of 13 July 2006, addressed to Dr. Ian Orr, Medical Director, accepting the Trust's last New Consultant Contractual offer, and the *ex gratia* payment in recognition of my additionally working as a Registrar up to inception of the New Contract.

Now that both issues have been satisfactorily resolved, I would like to enquire again whether it would be possible to receive an advance payment. For a number of reasons, about which I would be happy to discuss with you, it would make an enormous difference if it were possible to receive an advance payment, of even a relatively small amount, before the end of July.

I would be most grateful if you would advise me whether this is possible

Yours Sincer Personal Information redacted by the USI

Aidan O'Brien,
Consultant Urologist.

Headquarters:
Craigavon Area Hospital Group HSS Trust
Craigavon, BT63 5QQ

copies 2 Maggie

CRAIGAVON AREA HOSPITAL GROUP TRUST

Caring Through Commitment

3 July 2006.

Dr. Ian Orr,
Medical Director,
Office of the Medical Executive,
Craigavon Area Hospital Group Trust.

Dear Ian, JOHN

Re: New Consultant Contract Offer and *Ex Gratia* Payment.

Thank you for your letter of 10 July 2006. I write to confirm that I am pleased to accept the Trust's offer of 5.5 sessions of Programmed Activities, in recognition of additional workload over and above the 10 sessions that constitute my standard contractual duties under the New Consultant Contract. I also confirm my acceptance of your determination of my on-call category and commitment.

I also write to confirm my acceptance of the Trust's offer of an *ex gratia* payment of Personal Information redacted by the USI in recognition of my extra contribution during the period from August 1998 until inception of the New Contract. Pursuant to Section 74 of the Finance Act 1988, I should be pleased if you would have confirmed that this amount shall be paid gross of all income tax, statutory or other deductions.

Lastly, I wish to avail of this opportunity to compliment you for the resolve with which you approached the above matters, and to thank you for the fair and balanced manner in which you conducted recent discussions. I do believe that the outcome is fair to both Trust and both consultant urologists. I do hope that the Trust also believes it to be so. I am pleased that these issues have been resolved to our mutual satisfaction, and that all can look forward to working together, with renewed vigour, to further develop urological services,

Personal information redacted by USI

Aidan O'Brien,
Consultant Urologist.

Craigavon Area Hospital
13 JUL 2006
Chief Executive

cc: Mr. J. Templeton, Chief Executive, CAHGT.
Mrs. M. Richardson, Director of Human Resources, CAHGT.
Mr. L. Stead, Director of Finance, CAHGT.

Headquarters:
Craigavon Area Hospital Group HSS Trust
Craigavon, BT63 5QQ
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CRAIGAVON
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10 July 2006

STRICTLY PRIVATE & CONFIDENTIAL

Mr A O'Brien
Consultant Urologist
Urology Department
CAH

Dear Adan O'Brien

Further to the discussions which we have had, I now wish to confirm the Trust's intention that you will be offered 5.5PA's in recognition of additional workload over and above the 10 Programmed Activities that constitute your standard contractual duties under the New Consultant Contract. The additional PA's are reflected in the job (copy attached).

In the event of you deciding to transfer to the new contract, the requirement for you to undertake additional PA's will be reviewed annually as part of your job plan review. Termination of the contract for additional PA's is subject to a three month notice period and will have no effect on your main contract of employment. It should be noted that additional programmed activities are not subject to pay protection arrangements.

The Trust is also making you an offer of an ex gratia payment of Personal Information redacted by the in recognition of your extra contribution during the period 1998 until inception of the new contract.

Following discussion with your Clinical Director, your on call category has been determined as 'A' with your on call commitment being 1 in 2.

It is important to appreciate that this proposed offer is based on the understanding that the attached job plan schedule is a reflection of the time commitment given as a team member to HPSS work during 2004/05. Your acceptance will be taken as confirmation of this and also of the accuracy of the attached declaration of external duties/private practice which you have been involved in.

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Since I would like to get this matter finalised, I would be grateful if you would indicate in writing to the Office of the Medical Executive, whether you wish to progress to the next stage on the basis outlined above. In that event, I will make arrangements for Finance to finalise their calculation and for HR to prepare the necessary formal contract documentation. Your final acceptance of the contract will, of course, be subject to confirmation at that stage.

Yours sincerely

Dr I Orr
Medical Director

cc: Mrs M Richardson
Mr L Stead
Mr J W Templeton

19 April 2006

STRICTLY PRIVATE & CONFIDENTIAL

Mr A O'Brien
Consultant Urologist

Dear Mr O'Brien,

ASSIMILATION TO THE NEW CONSULTANT CONTRACT

Following my recent correspondence, I would advise you that the job planning process for 2004/05 has to be drawn to a conclusion.

Since you have not provided details of your nominee so that an appeal can be arranged I have to assume that you have decided not to transfer onto the new consultant contract and will therefore remain on your existing Terms and Conditions of Service. In order for your documentation to be finalised, I would ask you to confirm your decision to Miss Zoë Magee, Medical Staffing Support Officer, by Friday 28th April.

You will be aware that job plan reviews are an important feature of both the old and new contract. It is therefore intended that the 2006 review will take place at the earliest opportunity.

Yours sincerely,

Mr J Templeton
Chief Executive

CRAIGAVON
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Caring Through Commitment

Mr. J. Templeton,
Chief Executive,
Craigavon Area Hospital Group Trust,
Craigavon Area Hospital,
Craigavon,
BT63 5HQ.

28 November 2005

Dear John,

Thank you for your letter of 16th November 2005, and for the revised contractual offer contained therein. I regret to advise you that I am dissatisfied with the outcome of the facilitation process, and that I do wish to proceed to a formal appeal.

In doing so, I enclose for your information, a copy of my letter of response of 22nd September 2005, addressed to Mrs. Betty Williamson, following the initial contractual offer of 9th September 2005. As you will note from that letter, I felt then unable to accept the initial offer as I could not believe that it reflected fairly and accurately my total time commitment to HPSS work during 2004/5.

I met with Dr. Gaston for facilitation on 10th October 2005. I found Dr. Gaston courteous and genuine, but in retrospect, I found the meeting to be rushed. It may not have seemed so to Dr. Gaston, particularly as he was so au fait with all of the issues involved, whereas I felt relatively disadvantaged, particularly as I had not had a copy of my diary cards, or of the Trust's analysis. In essence, I did explain to Dr. Gaston that it had been my understanding that the analysis of the diary cards had calculated that I had committed 17.99 mean sessions weekly to total direct patient care, and that I was unable to understand how or why I was offered a contract of 14 sessions. Dr. Gaston then scrutinised my diary cards, and concluded that sessions of direct patient care totalled 13 plus 1 predictable on call plus 1 unpredictable on call. As this exercise resulted in yet another variation, I requested that I be provided with copies of my original diary cards so that I could arrive at my own calculation.

I enclose those copies. In making my own calculation, I have completely excluded, to the benefit of the Trust, all time allocated to telephone calls received at or made from home concerning patient care. I have also excluded, to the benefit of the Trust, all time allocated when periods of time included travel between hospital and home, in addition to patient care. I have made annotations in pencil. Calculations are made for a period of 3.2 weeks, as 4 days were spent attending annual meeting of the European Association of Urology in Vienna, from 24.03.04 to 27.03.04 (supporting professional activity).

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By so doing, I have calculated 140.5 hours in normal time in 3.2 weeks (43.9 hours per week = 11 sessions) and 64.5 hours in premium time in 3.2 weeks (20.2 hours per week = 6.5 sessions). Once again, this mean weekly total of 17.5 sessions corresponds quite accurately to the estimated total time commitment to HPSS work as indicated in my letter of 22nd September 2005.

One particular aspect of the contractual offer that I cannot understanding is that it would seem that total on call clinical care would appear to be limited to a total of 2 sessions, even if actual sessions worked while on call is significantly in excess of that number. I cannot understand how a contractual offer can be a fair and accurate reflection of total time commitment if a significant element is so limited in any offer. In the Trust's analysis, total weekly sessions in direct patient care while on call were calculated to be 4.4 sessions. It would appear to me that it is unjust and unfair that 2.4 sessions should have been worked without remuneration. Perhaps this is the unremunerated work performed as a Registrar from 1998 to 2004?

I do believe that it is both accurate and fair that 0.5 SPA sessions should be additionally offered in the contract, as 2 hours per week would have been a fair and accurate reflection of time committed to SPA, as evidenced by the four days spent attending the EAU.

Lastly, I do most sincerely and respectfully hope that proceeding to formal appeal will not take several more months to conclude. It is now one year since I was promised by Mrs. Richardson that contractual offers would be received by December 2004, and the entire process concluded by March 2005, at the latest,

Yours Sincerely

Personal information redacted by USI

Aidan O'Brien,
Consultant Urologist.

CRAIGAVON
AREA HOSPITAL
GROUP TRUST
Caring Through Commitment

16th November 2005

Mr A O'Brien
Consultant Urologist
Craigavon Area Hospital

PRIVATE AND CONFIDENTIAL

Dear Aidan,

RE: OUTCOME OF THE FACILITATION PROCESS

I am writing to advise you that following your facilitation meeting on Monday 10th October, Dr Gaston has considered the issues you raised and reviewed all the necessary information. As a result, he has suggested that the Trust review the existing PA offer made to you. He has recommended that for 2004/2005, you should be offered an additional 0.5 PA. This will result in a total of 4.5 PA's over and above 10 programmed activities. This recommendation has been accepted by the Trust and has been reflected in the amended proforma attached.

On a more general note, he has highlighted that the allocation of supporting professional activities in a number of areas across the Trust is lower than what might be expected and will need to be addressed. It is planned that for the future, this will be adjusted through the prospective job planning process. This is likely to involve verification of SPA activity and agreed redistribution where appropriate. As part of the review of SPAs, the Trust will discuss the allocation of time given to the essential elements, in particular identifying appropriate allocation for clinical management, education, CPD and appraisal etc.

In the meantime, it is important for you to be aware that if you are not satisfied with the outcome of the facilitation process and wish to proceed to a formal appeal, you must notify me in writing by Tuesday 29th November 2005.

Personal information redacted by USI

Mr J W Templeton
Chief Executive

Headquarters:
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Craigavon, BT63 5QQ
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Text No. Personal Information redacted by the USI

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Mrs. B. Williamson,
Directorate of Human Resources,
Craigavon Area Hospital Group Trust,
Craigavon Area Hospital,
Craigavon,
BT63 5QQ.

22 September 2005.

Dear Betty,

Re: New Consultant Contractual Offer.

I write in relation to the New Consultant Contractual offer for the year 2004/5, issued by Dr. Caroline Humphrey, former Medical Director, on 9 September 2005, and delivered by internal mail to my secretary's office on 15 September 2005. Dr. Humphrey confirmed that it was the Trust's intention that I would be offered 4 sessions of Programmed Activities in recognition of additional workload over and above the 10 sessions of Programmed Activities that constitute standard contractual duties under the New Consultant Contract. I write to advise you that I cannot accept the Trust's offer for the following reasons.

Dr. Humphrey stated in her letter of 09 September 2005 that the additional 4 sessions of Programmed Activities are reflected in my job plan schedule agreed between me and my Clinical Director, and submitted to her by the Clinical Director. I fail to see how the additional 4 sessions are reflected in the job plan schedule at all, as the schedule is none other than a record of programmed activities, during normal office hours, between approximately 9am and 5pm, Monday to Friday, during the year 2004/5. It is in fact mathematically impossible to have additional sessions of Programmed Activities reflected in a schedule that only records any activities that took place during the times of the standard 10 sessions.

Perhaps this has arisen due to a misunderstanding on my part of precisely that which was requested of me by my Clinical Director when he requested the job plan schedule. I never could fully understand the utility of a job plan schedule of arranged or programmed activities during normal working hours, Monday to Friday, only, particularly when only a proportion of the total time commitment took place during those hours, and when the Trust had a more useful and reliable record of the total time spent working in its own analysis of the diary card record conducted in March / April 2004. Perhaps therefore, I should have included all of the predictable, necessary work performed outside of normal office hours. If I had done so, then additional sessions would have been reflected in the schedule.

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Text No.: Personal Information redacted by the USI

Futhermore, though probably not of any significant relevance, the job plan schedule was not agreed between me and my Clinical Director, as Dr. Humphrey stated in her letter. There was neither agreement nor disagreement.

Most importantly, Dr. Humphrey stated in her letter that the proposed offer was based on the understanding that the job plan schedule was a fair and accurate reflection of the time commitment given by me to HPSS work during 2004/05, and that my acceptance of it would be taken as confirmation of this. For the reasons outlined above, the job plan schedule submitted to her is an inadequate, and therefore inaccurate, reflection of the time commitment given. As a consequence, the proposed offer is neither accurate or fair.

I honestly do believe that the most accurate and fairest assessment of the total time commitment given by me to HPSS work during 2004/05 was that of the Trust's analysis of the diary card record of work during March / April 2004. The record was entirely honest on my part, and as accurate as the diary card permitted. To the best of my knowledge, the only factors which could have had any inflationary effects were that the time slots available would have allocated inaccurately excessive times to consultations by telephone, that my analysis was conducted over a period of 3 weeks and 2 days due to my attending EAU conference in Vienna, and lastly, due to my having worked particularly long hours during one weekend during the period analysed. As I recall, and as I do not have a copy of the analysis to hand, it concluded that my total time commitment was in excess of 18 sessions. It is my honest view that a maximum reduction of one session could be considered appropriate for any such inflationary effects, and that an offer of a minimum of 7 sessions, in addition to the standard 10 sessions, would be a safely accurate and fair reflection of the total time commitment. Any less will certainly be inaccurate and unfair.

All of the evidence accessible to the Trust, accrued by it or presented to it in recent years, is entirely supportive of such a claim and of such an offer. We two urologists at Craigavon Area Hospital are providing a service for a population of over 310,000. This consultant / population ratio is lower than any one of the 30 member countries of the European Board of Urology. This ratio is not only a function of the inadequacy of the service, it also translates into overwork by those providing the service relative to the workload of those providing a better staffed service.

That this is true has been confirmed by the findings of the External Service Review conducted in 2004, and presented to the Trust then. When compared with urological services in Scotland, our throughput was equivalent to that provided by 3.7 consultants there, we each providing a throughput equivalent to 1.85 consultants in Scotland. Similar calculations are made when comparing throughputs with those

of other urologists in Northern Ireland. I have enclosed most recently available data from 2003/04. For example, there were a 1530 deaths and discharges at Craigavon Area Hospital during that year, a throughput of 765 per consultant. During that same year, there was a total of 3734 deaths and discharges in all other specialist urological departments in Northern Ireland, and provided with the 9 other consultant urologists: a throughput of 415 per consultant. Remarkably, but not surprisingly, our throughput per consultant was the equivalent of 1.8 consultants throughout the remainder of Northern Ireland. However, as in Scotland, our colleagues in Northern Ireland have already been offered contracts for totals of at least 12 sessions!

All of the comparative evidence that I know of wholly supports a claim that we would have been required to have committed total time of the order of 17.5 to 18.5 sessions in order to provide a service reflected in such throughputs. In fact, I find it quite remarkable that we should be considered able to have done so. In truth, the estimates and the claim has not taken into account all of the annual leave not taken, or the work done during annual leave. I write this letter towards the end of a week of supposed annual leave, and during which I have already done 17 hours of HPSS work, including 7 hours of operating!

Lastly, in any case, I cannot accept the proposed offer as it would be dishonest of me to do so, as it certainly and indisputably is neither a fair or accurate reflection of the total time committed to HPSS work during 2004/05. Moreover, it will also certainly not be possible to deliver current workload with a total of 14 sessions of Programmed Activities,

Yours Sincerely,

Aidan O'Brien,
Consultant Urologist.

CRAIGAVON
AREA HOSPITAL
GROUP TRUST
Caring Through Commitment

9 September 2005

STRICTLY PRIVATE & CONFIDENTIAL

Mr A O'Brien
Consultant Urologist
Urology Department
CAH

Dear Mr O'Brien

Further to the discussions which I have had with your Clinical Director, I now wish to confirm the Trust's intention that for the year 2004/05 you will be offered 4 PA's in recognition of additional workload over and above the 10 Programmed Activities that constitute your standard contractual duties under the New Consultant Contract. The additional PA's are reflected in the job plan schedule agreed between you and your Clinical Director and submitted to me by your Clinical Director (copy attached).

In the event of you deciding to transfer to the new contract, the requirement for you to undertake additional PA's will be reviewed annually as part of your job plan review. Termination of the contract for additional PA's is subject to a three month notice period and will have no effect on your main contract of employment. It should be noted that additional programmed activities are not subject to pay protection arrangements.

Following discussion with your Clinical Director, your on call category has been determined as 'A' with your on call commitment being 1 in 2.

It is important to appreciate that this proposed offer is based on the understanding that the attached job plan schedule is a fair and accurate reflection of the time commitment given by you to HPSS work during 2004/05. Your acceptance will be taken as confirmation of this and also of the accuracy of the attached declaration of external duties/private practice which you have been involved in.

Headquarters:
Craigavon Area Hospital Group HSS Trust
Craigavon, BT63 5QQ
Tel: Personal Information redacted by the USI
Text No.: Personal Information redacted by the USI

Since I would like to get this matter finalised, I would be grateful if you would indicate in writing to the Office of the Medical Executive, enclosing a signed copy of the attached job plan, whether you wish to progress to the next stage on the basis outlined above. In that event, I will make arrangements for Finance to finalise their calculation and for HR to prepare the necessary formal contract documentation. Your final acceptance of the contract will, of course, be subject to confirmation at that stage.

Yours sincerely

C Humphrey
Medical Director

cc: Mrs M Richardson
Mr L Stead
Mr J W Templeton

Clegg Malcolm

From: aidanpobrier [Personal Information redacted by the USI]
Sent: 10 November 2011 00:56
To: Clegg, Malcolm
Subject: Re: Amended 2011/12 Job Plan

Malcolm,

Thank you for your email of 03/11/11, and for clarifying that the total PAs accompanying the Amended Job Plan will be 12.75.

As discussed with you yesterday, I am by now disappointed, disillusioned and cynical of Job Planning and Facilitation. Even though I has brought attention, in writing and verbally, and over a period of two months, to the physical impossibility of earlier Job Plans offered, a possible (whether acceptable) Job Plan was submitted for the first time on 31 October 2011. If acceptable, it was to further defy all possibility by being effective retroactively from 1 September 2011. Upon query, now it is to be effective from 1 October 2011, a month before it was offered, and on the grounds that another consultant's job plan, presumably both possible and accepted, had become effective from that date. Surreal relativism comes to mind!

By now, I feel compelled to accept the Amended Job Plan effective from 01/10/2011, even though I neither agree with it or find it acceptable. I have endeavoured to ensure that management is fully aware of the time which I believe was required to undertake the clinical duties and responsibilities included in the Job Plan, to completion and with safety. Particularly during the coming months leading to the further reduction in allocated time, I will make every effort to ensure that I will spend only that time allocated, whilst believing that it will be inadequate.

Aidan O'Brien

-----Original Message-----
From: Clegg, Malcolm <[Personal Information redacted by the USI]
To: aidanpobrien <[Personal Information redacted by the USI]
Sent: Thu, 3 Nov 2011 12:16
Subject: RE: Amended 2011/12 Job Plan

Mr O'Brien,

The hours in the amended job plan total 12.63 PAs, so when this is rounded to the nearest 0.25 PA it results in a total of 12.75 PAs.

With reference to the effective date of the job plan, it had originally been intended that your job plan would be effective from 1st September 2011; however because of delays with Facilitation etc this will no longer be appropriate. If you are prepared to accept the amended job plan it is expected that this will become effective from 1st October 2011. This is the same date that has been applied to one of your consultant colleagues who has also accepted a reduced job plan in Urology.

I trust this helps to clarify your queries.

Regards

Malcc

Malcolm Clegg

Medical Staffing Department

Southern Health and Social Care Trust

Craigavon Area Hospital

BT63 5QQ

Tel: Personal Information redacted by the USI

From: aidanpobrien Personal Information redacted by the USI [mailto: Personal Information redacted by the USI
Sent: 03 November 2011 12:10
To: Clegg, Malcolm
Subject: Re: Amended 2011/12 Job Plan

Hello Malcolm,

Just noted your email this morning.

I would be grateful if you would clarify or explain why amended job plan attracts a total of 12.63 PAs when it should be 12.75 PAs?

Could you also explain for me how the job plan can have been effective from 01 September 2011, when it hasn't?

Thanks,

Aidan O'Brien

-----Original Message-----
From: Clegg, Malcolm <Personal Information redacted by the USI>
To: aidanpobrien <Personal Information redacted by the USI>
CC: O'Brien, Aidan <Personal Information redacted by the USI>; Murphy, Philip <Personal Information redacted by the USI>
Sent: Mon, 31 Oct 2011 14:01
Subject: Amended 2011/12 Job Plan

Dear Mr O'Brien,

Following your Facilitation meeting on 28 September you were advised by Dr Murphy that he felt it appropriate to offer you an additional 0.75 PA per week for administration until 28 February 2012; however from 1 March 2012 you would then reduce to 12 PAs per week.

I have attached an amended 12.75 PA job plan which reflects the additional 0.75 PA per week until the end of February 2012 and your request to have lunch breaks included in the job plan. Your specialist clinic has also been moved from Friday morning to Friday afternoon.

I would be grateful if you could sign the amended job plan and return this to me by Friday 4 November 2011. If I do not hear from you by Friday 4 November, I will assume you have accepted this job plan.

Regards

Malcolm

Malcolm Clegg

Medical Staffing Department

Southern Health and Social Care Trust

Craigavon Area Hospital

BT63 5QQ

Tel: Personal Information redacted by the USI

Clegg, Malcolm

From: Clegg, Malcolm
Sent: 15 November 2011 12:30
To: Gannon, Oonagh
Cc: Porter, Pamela
Subject: Mr Aidan O'Brien - change of PAs
Attachments: O'Brien. Aidan - 12.75 PAs from 1.10.11 - 28.2.12.pdf

Oonagh,

Please find attached notification of change to PAs for Mr Aidan O'Brien [Personal Information redacted by the USI].

Mr O'Brien's PAs should reduce from 15 PAs to 12.75 PAs from 1st October 2011 until 28 February 2012. On 1st March 2012 he should further reduce to 12 PAs.

He should continue to receive his 8% on call supplement and clinical excellence award.

If you require any additional information please let me know.

Sorry that this is so late, but I have just returned to work today [Personal Information redacted by the USI]

Regards

Malcolm

Malcolm Clegg
Medical Staffing Department
Southern Health and Social Care Trust
Craigavon Area Hospital
BT63 5QQ

Tel: [Personal Information redacted by the USI]

Southern Health and Social Care Trust

CONSULTANT CONTRACT PAYMENT

The details below summarise the payment information regarding the contract for the consultant named below, following receipt of a signed job plan authorised by the Clinical Director and Associate MD/Medical Director, by the Medical Staffing Department.

This reflects the total salary that should be paid to this Consultant. Salaries and wages to advise Medical Staffing if they are paying anything additional on a regular basis.

Consultant:	Mr Aidan O'Brien
Staff No:	Personal Information redacted by the USI
Basic PA's Payable: (i.e. 10PAs for full time)	10
Additional PA's Payable:[1] ***(Payable under Code 926)*** (If Full time Temporary Additional PA's over 10PA's)	2.75
Total PA's Payable:	**12.75**

If applicable:

On-call Category:	A
On-call Frequency:	1 in 3
On-call % Supplement: ***(Payable under Codes 920 – 925)***	8%
Clinical Excellence Awards/Discretionary Points/Distinction Awards ***(Payable under Code 159 / 160 / 120)***	To continue
Responsibility Allowance Payments ***(Payable under Code 087)***	N/A
Additional Information (if required):	• **2.75 APA to be paid under Code 926**
Changes effective from:	1 October 2011
End Date (if applicable): ***(S&W to action any changes at this point)***	28 February 2012 • ***Please note that Mr O'Brien's PAs should further reduce from 12.75 to 12 PAs from 1st March 2012 until further notice.***

Completed by:	Malcolm Clegg
Authorised by:	Personal information redacted by USI
Date Processed to Salaries & Wages:	15 November 2011

[1] Weekly value of an APA = (1) Value of "basic" FT Pay (no other payments added) divided by 10 & divided by 52 weeks PLUS (2) Value of CEA/Discretionary divided by 10 & divided by 52 weeks. The pro rata increase for Distinction Awards should be based on the maximum level of Discretionary Points (i.e. Point 8).

OUTCOME OF FACILITATION PROCESS

Name:	**Mr A O'Brien**
Directorate:	**Surgery**
Specialty:	**Urology**

Breakdown Of PA's:

Emergency Work		
- Predictable:	**1 PA**	
- Unpredictable:	**1 PA**	
Travelling Time:	PA's	**12 PA's**
Theatre Sessions:	PA's	
Outpatient Clinics:	PA's	
Ward Rounds:	PA's	
Other:	PA's	

Total Direct Clinical Care:	**14 PA's**
Supporting Professional Activities: (breakdown where appropriate)	**0.5 PA***
Total no. of PA's offered:	**14.5 PA's**

Any additional information:
**0.5 PA has been allocated for Supporting Professional Activities*

Job plans and summary screenshot

Aidan		O'Brien	Consultant	1394911			Resume Publish Edit and Publish
Start Date	End Date	Department	Status	Total PAs	Core PAs	APA	Clinical (%)
01 Jan 2020		Urology	In Discussion	8.930	8.930	0.000	83
01 Apr 2018	On-going	Urology	Locked Down	11.733	11.733	0.000	88
01 Apr 2013	31 Mar 2018	Urology	Locked Down	11.275	11.275	0.000	87
01 Apr 2012	31 Mar 2013	Urology	Locked Down	11.275	11.275	0.000	87
01 Apr 2011	31 Mar 2012	Urology	Locked Down	12.544	12.544	0.000	88

Job plan for Mr Aidan O'Brien

Current status:	In Discussion
Start date:	01/01/2020
Cycle:	5 weeks
Owner:	Mr Aidan O'Brien
Organisation:	Southern Health and Social Care Trust, , Northern Ireland
Department:	Urology
Role:	Consultant
Sign off level:	3
First sign off:	Dr Edward James McNaboe
Second sign off:	Mr Mark Dean Haynes
Third sign off:	Mr Stephen Morrison

Total Hours

Core:	35:43
APA:	0:00
Total:	35:43

Total PAs

Core:	8.930
APA:	0.000
Total:	8.930

Sign off timeline

Date and time	Action	User	Comment
09/12/2019 16:14	Published By:	Dr Edward James McNaboe	

General Information

Start date	01/01/2020
Employment type	FullTime
Usual place of work	
Contract version	2003
Alternative employer	No
Name of alternative employer	/
Medical title	
Name of the university	/
Private practice	No
Number of weeks available for work	42 Weeks 0 Days
Documents	

Trust Objectives

Service Objectives

Personal Objectives

Resources

Staff

Equipment

Clinical Space

Other

Hot Activity

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
No activities						

Activity	Category	Day	Time	Travel time	Activity type	Entry method	Cycle Length	Activity location	Worked in weeks	Num/Yr	PA	Hrs/Wk	Hrs/Yr
No activities													
										Core	0.000	0:00	0:00
										APA	0.000	0:00	0:00

Routine Work

Direct Clinical Care | Supporting Professional Activities | Additional HPSS Responsibilities | External Duties | Fee Paying Services | Private Professional Services | Non-Working Time

Week 1

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	Pre-op ward round 08:30 - 09:00 Day surgery 09:00 - 13:00 Review Outpatients clinic 13:30 - 17:00	Planned in-patient operating sessions 13:00 - 18:00	Core SPA 09:00 - 13:30 Admin other (please specify) 14:30 - 16:30	Urodynamics 09:00 - 13:00 Sub Specialty clinic 13:00 - 17:00		

Week 2

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Review Outpatients clinic 09:00 - 13:00 Admin other (please specify) 13:00 - 17:00	Core SPA 09:00 - 13:00 Admin other (please specify) 13:30 - 17:00	Planned in-patient operating sessions 13:00 - 18:00	Core SPA 09:00 - 13:30 Admin other (please specify) 14:30 - 16:30	Urodynamics 09:00 - 13:00 Sub Specialty clinic 13:00 - 17:00		

Week 3

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

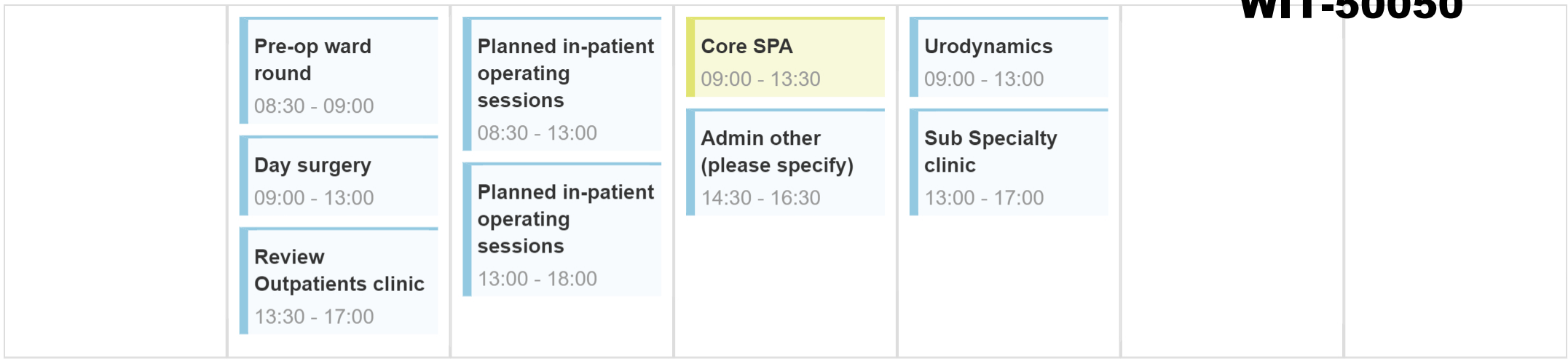
	Pre-op ward round 08:30 - 09:00 Day surgery 09:00 - 13:00 Review Outpatients clinic 13:30 - 17:00	Planned in-patient operating sessions 13:00 - 18:00	Core SPA 09:00 - 13:30 Admin other (please specify) 14:30 - 16:30	Urodynamics 09:00 - 13:00 Sub Specialty clinic 13:00 - 17:00		

Week 4

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
New patient Clinic 09:00 - 17:00	Core SPA 09:00 - 13:00 Admin other (please specify) 13:30 - 17:00	Planned in-patient operating sessions 13:00 - 18:00	Core SPA 09:00 - 13:30 Admin other (please specify) 14:30 - 16:30	Urodynamics 09:00 - 13:00 Sub Specialty clinic 13:00 - 17:00		

Week 5

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday



Activity	Category	Day	Time	Travel time	Activity type	Entry method	Overlapped by hot activity	Activity location	Worked in weeks	Num/Yr	PA	Hrs/Wk	Hrs/Yr
New patient Clinic	DCC	Monday	09:00 - 17:00	0:00	Core	Weekly timetabled	No		4	8.40	0.400	1:36	67:12
Review Outpatients clinic	DCC	Monday	09:00 - 13:00	0:00	Core	Weekly timetabled	No		2	8.40	0.200	0:48	33:36
Admin other (please specify)	DCC	Monday	13:00 - 17:00	0:00	Core	Weekly timetabled	No		2	8.40	0.200	0:48	33:36
Pre-op ward round	DCC	Tuesday	08:30 - 09:00	0:00	Core	Weekly timetabled	No		1, 3, 5	25.20	0.075	0:18	12:36
Core SPA	SPA	Tuesday	09:00 - 13:00	0:00	Core	Weekly timetabled	No		2, 4	16.80	0.400	1:36	67:12
Day surgery	DCC	Tuesday	09:00 - 13:00	0:00	Core	Weekly timetabled	No		1, 3, 5	25.20	0.600	2:24	100:48