

NHS Employers' submission to the Doctors' and Dentists' Review Body 2022/23

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Contents

Context	3
Key messages	7
Section 1: Informing our evidence	12
Section 2: The impact of COVID-19 and recovery	14
Section 3: Workforce challenges	20
Section 4: Transformation	32
Section 5: The remit groups	36
Doctors in training	36
Specialty and specialist doctors	39
Consultants	45
Salaried primary care dentists	50
Section 6: Pensions and reward	53

Context

Policy and financial

The ongoing effects of the COVID-19 pandemic together with long-term under investment in health and social care services, continue to present the NHS with the biggest set of challenges that it has ever faced.

The NHS is still operating under the most severe strain. There are significant numbers of patients with COVID-19 being admitted for treatment into hospitals. As of 19 January 2022, there were 15,742 patients with COVID-19 in hospital in England¹. Care for other patients is again disrupted and the legacy of long COVID is also becoming clearer.

The workforce is exhausted and in many situations it is struggling to cope. The NHS entered the crisis with a shortage of at least 100,000 clinical staff².

The NHS Confederation's, representation to the Spending Review 2021³, includes the following key asks of government:

- **Finish the service funding task started by the September funding announcement** – We need at least £10 billion in service funding next year to cover ongoing COVID-19 costs

¹ [GOV.UK, Coronavirus \(COVID-19\) in the UK, \[online\] accessed January 2022.](#)

² [NHS Confederation \(2021\), Representation to the Spending Review 2021.](#)

³ [Ibid.](#)

(£4.6 billion), recover care backlogs (£4-£5 billion), and make appropriate allowance for lost efficiency savings, with inflation and demand adjusted settlements to 2024/25.

- **Create a multi-year capital funding settlement for the entire NHS** - To reduce the backlog, ensure the safety of the NHS estate, embed positive pandemic-era changes and truly make inroads to reducing inequalities by transforming models of care, the Department of Health and Social Care (DHSC) capital departmental expenditure limit (CDEL) budget should rise to at least £10.3 billion in 2024/25. This funding will also help drive the NHS towards the UK's net zero target.
- **Address workforce issues such as lack of a multi-year funding settlement to create and support a sustainable workforce plan, introduction of greater flexibilities to pension savings, properly funded sustainable pay uplifts and unclear future commissioning arrangements** – To reduce the elective backlog and meet increasing demand, the workforce must increase by around a fifth by 2024/25. This means increasing Health Education England's (HEE) budget to £5.5 billion by 2024/25.

At the same time, the NHS in England is completing the formalisation of integrated and system working, which the NHS Confederation sees as the most important set of reforms the NHS has had in a decade⁴. The proposals set out in the white paper will play an important role in meeting longer-term health and social care challenges and improving population health.

⁴ [NHS Confederation \(2021\), Integration and Innovation: Working Together to Improve Health and Social Care for All.](#)

Reward factors

Our members are clear that any medical and dental pay awards must remain fully funded.

The NHS in England employs 1.5 million people (around 124,000 of these are doctors), with employee costs accounting for around two-thirds of NHS providers' expenditure⁵. Anecdotally, employers have told us that not fully funding the award would force trusts to make cuts to staffing and clinical services, leading to overstretched staff and potential harm to patients. If employers did not make these cuts, this would increase the overspend and contribute to a breach of their duty to balance the books. Any unfunded pay awards would simply add to the pressures at a time when local NHS leadership is already under enormous pressure.

The DHSC is currently consulting on changes to employee pension scheme contributions to make the contribution structure more appropriate for the career average revalued earnings (CARE) 2015 scheme. Proposals will see some lower paid member pension contributions increase, which we anticipate will impact doctors in training by reducing take-home pay, while higher earners and part-time staff are likely to see a reduction in contributions. There are proposals to phase the changes across several years.

Removing age discrimination from the NHS Pension Scheme through the McCloud remedy will begin in April 2022, with all active members being moved into the (CARE) 2015 scheme. We continue to work with employers to help provide clear staff-facing communications about the impact of the remedy. Those with pension savings built up in the legacy schemes will retain their final salary linkage. Results of the 2016 scheme valuation include the costs of the remedy being met by scheme members. This position is being challenged by trade union colleagues.

⁵ [Nuffield Trust \(2019\). The NHS Workforce in Numbers.](#)

With rises to National Insurance contributions, freezing of personal allowance tax thresholds until 2026, and increased NHS Pension Scheme contributions for some, there is potential for members to experience a compounded negative impact on their take-home pay.

These policy decisions, while separate from each other, will make it difficult for members to decouple the impact and message that their take-home pay will be negatively affected. There is potential for this to have a knock-on effect on staff morale, NHS Pension Scheme membership and staff recruitment and retention.

Pension tax remains a concern for some higher earners. While raising the income thresholds for annual allowance tapering in 2020 removed the majority of consultants and GPs from the effects of tapered annual allowance (based on earnings from NHS work), pension tax issues remain an area of concern for medical representative organisations in relation to the standard annual allowance and lifetime allowance.

At the same time, employers continue to argue that the NHS Pension Scheme should offer greater flexibility. In particular, it should allow for partial membership for all grades of staff to encourage membership and to support retention.

Key messages

COVID-19 and recovery

- The COVID-19 pandemic has presented one of the biggest challenges that the NHS has ever faced, with work demands peaking and services being adapted, impacting negatively on staff health and wellbeing⁶.
- The pandemic has greatly exacerbated access problems in all non-COVID-19 services, with waiting list numbers currently at 5,995,196⁷. The Secretary of State, on his first day in office, talked about a waiting list that could grow to 13 million patients with perhaps seven million patients missing from waiting lists⁸. We don't feel that it will go that high, but believe that the current operating environment, where elective capacity is reduced by the Omicron wave, will inevitably lead to significant increases this winter.
- The pandemic has also impacted on training, with employers working to support doctors to catch up on missed training opportunities.

⁶ [NHS Digital \(2021\), NHS Vacancy Statistics England April 2015 – June 2021 Experimental Statistics.](#)

⁷ [NHS England and NHS Improvement \(2021\), Consultant-led Referral to Treatment Waiting Times Data 2021-22.](#)

⁸ [The Telegraph \(2021\), Hospital Waiting Lists Could Top 13 Million in Months, Warns Sajid Javid.](#)

Workforce challenges

- There are not enough staff to meet demand⁹. The significant gaps in the workforce must be addressed at a national level; new and sustainable workforce planning activities with regular planned review processes are urgently required.
- International recruitment will remain a vital source of medical and dental workforce supply. While the pandemic has impacted on this, we acknowledge the recent initiatives such as the continuation of all medical practitioners on the shortage occupation list, have helped to support recruitment activity from overseas.
- Levels of stress, ill health and staff burnout have risen, however staff engagement levels have remained relatively stable¹⁰. Doctors in training are under intense pressure and are at risk of burnout¹¹. Employers are focusing on staff health and wellbeing despite the ongoing pressures, to ensure they are fulfilling the NHS People Promise's strand of looking after our people¹².
- The pandemic has caused an increase in the numbers of staff indicating that they may be considering leaving the NHS¹³, with risks of consultants and SAS doctors leaving in the next five years¹⁴. Satisfaction with pay has improved overall, as has satisfaction with how valued staff feel by their employers.
- Black and minority ethnic (BME) doctors report a worse experience at work than their white counterparts and are less likely to be working in consultant roles.

⁹ [Ibid.](#)

¹⁰ [NHS Staff Survey \(2020\), NHS Staff Survey.](#)

¹¹ [General Medical Council \(2021\), National Training Survey 2021 Results.](#)

¹² [NHS England and NHS Improvement \(2020\), Our NHS People Promise.](#)

¹³ [Ibid.](#)

¹⁴ [Royal College of Anaesthetists \(2021\), Respected, Valued, Retained: Working Together to Improve Retention in Anaesthesia.](#)

- The gender pay gap in medicine is large for a single professional group¹⁵.

Doctors in training

- All outstanding provisions from the 2019 framework agreement for doctors in training have been agreed. Morale and motivation of trainees remains variable.
- Exception reporting on trainee hours, when used as intended, is a valuable process that raises safety issues and initiates positive change within organisations.
- Employers are offering flexible working opportunities but taking time out of training has become increasingly common and can, at times, lead to difficulties in recruitment.
- HEE has agreed two new annual review of competence progression (ARCP) outcomes, to recognise the impact of the pandemic on training and education¹⁶.

Specialty and specialist doctors

- The new specialty doctor and specialist (SAS) contracts were introduced in April 2021. The overall aim for SAS contract reform was to support employers to attract, motivate and retain SAS doctors.
- For most specialty doctors, transferring to the new contract still represents a benefit in terms of their basic pay over their career.

¹⁵ [Department of Health and Social Care \(2020\), Mend the Gap: the Independent Review into Gender Pay Gaps in Medicine in England.](#)

¹⁶ [The Royal College of Anaesthetists \(2021\), Implementing ARCP Outcomes 10.1 and 10.2 during COVID-19.](#)

However, uptake of the new contracts has been a lot lower than was hoped, mainly due to the implementation of the 3 per cent uplift in pay that was awarded in 2021 to SAS doctors on the old contracts. Securing the benefits associated with the introduction of the new SAS contract remains a priority for employers.

Recommendations on future pay uplifts for SAS doctors should be prioritised onto the new contract and pay system. This will encourage movement of SAS doctors over time onto the new contract and pay arrangements as originally expected and planned.

- There has been a slow uptake of doctors entering the new specialist grade, with employers creating roles where there is a workforce need.
- Contract reform has, as anticipated, partly addressed issues with SAS career development and progression, but further work needs to be done.
- The SAS workforce is one of the most diverse in the NHS and parties made changes to support equality through the new SAS advocate role and the shortening of the specialty doctor pay scale.

Consultants

- Retaining consultants to deliver an increasing demand in services and catch up with backlogs is critical. Consultants want less intense work and more flexibility, especially those in the later stages of their career. Pension tax issues remain a factor in consultants working less and retiring early.
- Employers still believe that wider contract reform is important. This was highlighted as a key recommendation in the independent review into the gender pay gaps in medicine¹⁷, which recommends reducing the current emphasis on years of service as a driver in

¹⁷ [Ibid.](#)

medical pay and addressing the very long pay scales that exist in the consultant grade. Employers would support more investment to be provided, which would enable consultant contract reform.

- Parties continue to progress the reform of local clinical excellence awards, with the intention of introducing new arrangements from 2022/2023. The aim of the arrangements is to recognise and reward outstanding contributions more equally across all areas of consultant activity.

Salaried primary care dentists

- Recruitment is a particular issue for salaried dentists, with some employers also struggling to retain dentists.
- The morale and motivation of dentists is mixed. Dental teams have worked tirelessly throughout the pandemic and now face a huge urgent care demand.

Section 1: Informing our evidence

We welcome the opportunity to submit our evidence on behalf of healthcare employers in England. We continue to value the role of the Doctors' and Dentists' Pay Review Body (DDRB) in bringing an independent and expert view on remuneration and wider issues in relation to doctors and dentists.

Our evidence has been informed by a continuous cycle of engagement with a full range of NHS organisations about their priorities. We have:

- engaged with our regional network meetings of human resources directors
- engaged with employers who sit on our joint negotiating committees for consultants, trainees and dentists
- engaged with our guardians of safe working hours network
- met with our contracts experts group and the medical and dental workforce forum sub-committee of the NHS Employers policy board.

NHS Employers acts as a link between national policy and local systems, sharing intelligence and operating networks for trusts and other employers to share successful strategies. We are part of the

NHS Confederation, the membership organisation that brings together, supports and speaks for the whole healthcare system.

Our submission reflects the views of employers on the combined effect of the financial, workforce and transformation challenges faced by the NHS and the impact of recovery from the pandemic. It considers the impact of the NHS People Plan, the current backlog and the move towards integrated care systems (ICSs).

Section 2: The impact of COVID-19 and recovery

Workload pressures

The outbreak of the COVID-19 pandemic has presented one of the biggest challenges that the NHS has ever faced. The third wave of the pandemic (January-March 2021) placed the NHS under unprecedented pressures and employers told us that work demand peaked during this wave. This was felt most intensely in COVID-19 wards, but all parts of the service were affected with many doctors redeployed from their specialty onto COVID-19-related work at some point. As the service adapted, employers changed how services were delivered via development of online consultations, remote working and COVID-19 safe service provision. This brought its own challenges, as well as impacting the education of doctors through lost or inaccessible training opportunities.

As the service gradually returned to more normal working over the summer, work built up as 'delayed demand' emerged, the waiting list elective backlog was tackled and demand for emergency services reached winter levels in early autumn. With COVID-19 levels rising and a severe winter flu season expected, staff remained under huge pressure. This is demonstrated by the fact that stress, anxiety,

depression and mental health remain the biggest causes of sickness absence across the health service¹⁸. NHS employers are very concerned about the relentless demand being placed on their teams.

The exceptional challenges for the system¹⁹ mean that almost six million people are now on treatment waiting lists,²⁰ compared to 4.45 million before the pandemic²¹ and the efficiency targets from the NHS Long Term Plan remain unmet in the previous two years²². The challenge now is how to catch up on the backlog of work at the same time as trying to deliver on the priorities of the NHS Long Term Plan²³. Rising rates of coronavirus and the unknown impact of the Omicron variant, alongside flu and other respiratory illnesses, will place an untenable pressure on the NHS this winter^{24/25}.

The Health and Social Care Committee's report on workforce burnout and resilience²⁶ describes the increased workforce demand the pandemic has created which has led to widespread concerns about staff wellbeing, stress and burnout.

Commenting on the Health and Social Care Committee's report, Clearing the Backlog Caused by the Pandemic²⁷, the NHS Confederation reports that NHS staff absences are double what they traditionally would be at this time of year and that more trusts are declaring critical incidents²⁸. The NHS Confederation has called for urgent steps to avoid a staffing crisis in light of the

¹⁸ [NHS Digital \(2021\), NHS Vacancy Statistics England April 2015 – June 2021 Experimental Statistics.](#)

¹⁹ [NHS Confederation \(2022\), Analysis: January Release of NHS Performance Statistics.](#)

²⁰ [Ibid.](#)

²¹ [NHS England and NHS Improvement \(2020\), Consultant-led Referral to Treatment Waiting Times Data 2019-20.](#)

²² [Ibid.](#)

²³ [NHS Confederation \(2021\), A System Approach to the Demand Crunch.](#)

²⁴ [NHS Confederation \(2021\), Rising Rates of Coronavirus, Alongside Flu and Other respiratory Illness, will Place an Untenable Demand on the NHS this Autumn and Winter.](#)

²⁵ [Devine J \(2021\), Are we Addressing the Workforce Risks in Managing the Backlog?, NHS Voices, NHS Confederation.](#)

²⁶ [House of Commons \(2021\), Health and Social Care Committee, Workforce Burnout and Resilience in the NHS and Social Care.](#)

²⁷ [UK Parliament \(2021\), Health and Social Care Committee, Clearing the Backlog Caused by the Pandemic.](#)

²⁸ [NHS Confederation \(2022\), NHS Confederation responds to the HSCSC Inquiry on the Backlog of Care Caused by the Pandemic.](#)

Omicron variant and its impact on staff absences²⁹. The NHS Confederation has commented that:

‘The NHS is under such pressure right now that two years into this pandemic the government has felt it necessary to deploy military personnel to help out once again. Staff sickness and self-isolation levels are sky high, whilst access to testing for NHS staff is still patchy, which is making the situation very difficult.’³⁰

Staff who have been going above and beyond have become exhausted and the GMC’s annual report, the state of medical education and practice³¹ underlines:

‘rising burnout, declining job satisfaction and growing workloads.’

Over two thirds of doctors who responded to the survey, which underpins the GMC’s report, said, that workload pressure was a barrier to patient care. The Royal College of Physicians reports similar findings, that one in five doctors feels overwhelmed at work every day³².

Employers do not believe that is fair to expect staff to move from working in crisis mode during COVID-19, to working in crisis mode to deal with waiting lists on top of the usual acute and urgent activity³³.

Our engagement team has received information about additional costs associated with waiting list work, with some medical staff locally negotiating higher rates. This is a mixed picture but the majority of employers we talked to are paying rates that are higher than the nationally agreed contractual rates.

²⁹ [NHS Confederation \(2022\), Urgent Steps Needed Now to Avoid Staffing Crisis in the NHS.](#)

³⁰ [NHS Confederation \(2022\), NHS Confederation Responds to Latest NHS Data.](#)

³¹ [General medical Council \(2021\), The State of Medical Education and Practice in the UK.](#)

³² [Royal College of Physicians \(2022\), One in Five Doctors Feels Overwhelmed at Work Every Day.](#)

³³ [NHS Confederation \(2021\), Tackling Accelerating Waiting Lists: A Letter to the Secretary of State.](#)

Employers are clear that the beneficial changes brought about by the pandemic should not be lost. The NHS Confederation's NHS Reset campaign³⁴ reports that understaffing is putting patient safety at risk. The campaign calls for sustained action to address vacancies and provide ongoing support for staff wellbeing. The King's Fund³⁵ flags:

'strong indications that the pressures and experiences of the last year are leading to increased stress, exhaustion and burnout.'

The King's Fund calls for improved recruitment and retention, wellbeing support and compassionate cultures.

Training recovery

The pandemic had a significant impact on foundation and specialty programme recruitment processes, training placements, rotations, assessment and progression. Therefore, the impact threatened the security of the continuous supply of this essential workforce but also the confidence and educational experience of doctors in training. While HEE, the General Medical Council (GMC) and the Royal Colleges worked together with stakeholders to make essential adjustments to training to meet the needs of the situation, some doctors are facing the challenge of catching up on missed educational requirements, while others who have met the required competences may not always be fully confident in undertaking their new roles.

Employers are working with local and national HEE colleagues to tackle the challenge of supporting doctors to catch up on training opportunities lost during the pandemic, while delivering service commitments and managing the care backlog in an extremely challenging environment.

³⁴ [NHS Confederation \(2021\) NHS Reset Campaign.](#)

³⁵ [The King's Fund \(2020\), The Road to Renewal: Five Priorities for Health and Care.](#)

In the GMC's 2021 national training survey report³⁶, we were encouraged to hear that 88 per cent of trainees reported that their supervision was good or very good. The quality of teaching was rated good or very good by 76 per cent of trainees, and 74 per cent reported that virtual environments were being used effectively to support training. However, while 81 per cent of trainees are confident that they are on track to meet their 2021 training requirements, and 10 per cent are neutral, the report also highlights uncertainty and concern amongst some trainees about whether they will gain enough experience and training opportunities to progress this year. Nationally approved derogations from the curricula and gold guide continue to be helpful in minimising disruption to training progression.

We will continue to work closely with HEE on its COVID-19 training recovery programme³⁷, which is currently focused on integrating training recovery with workforce wellbeing recovery, alongside the recovery of service provision. This also requires supporting and training educators and we are particularly keen to see more opportunities for SAS doctors to undertake educational supervision roles.

Training recovery, service recovery and workforce recovery must be considered together. NHS England and NHS Improvement's (NHSEI) 2021/22 priorities and operational planning guidance³⁸ set out its priorities for the year. Employers have been particularly supportive of two of the measures that aim to sustainably increase the size of the workforce in line with measures set out in the NHS Long Term Plan:

- Support the recovery of the education and training pipeline by putting in place the right amount of clinical placement capacity to

³⁶ [Ibid.](#)

³⁷ [Health Education England \(2021\), COVID-19 Training Recovery Programme Interim Report.](#)

³⁸ [NHS England and NHS Improvement \(2021\), 2021/22 Priorities and Operational Planning Guidance.](#)

allow students to qualify and register as close to their initial expected date as possible.

- Develop and implement robust postgraduate (medical and dental) training recovery plans that integrate local training needs into service delivery planning.

Section 3: Workforce challenges

The NHS has experienced workforce challenges for a number of years that have been further exacerbated since March 2020 by the COVID-19 pandemic. While the medical workforce has grown, there are not enough doctors to meet the current and expected growth in demand for NHS services, and certain geographical areas and specialties are impacted more than others.

General practitioners and consultants in oncology, acute medicine, care of the elderly and interventional radiology are specific occupational groups with pre-existing staffing gaps.

In September 2021 there were 8,333 medical vacancies in the NHS in England³⁹. Vacancies create gaps in rotas which result in increased workloads for medical staff and reduced learning opportunities for doctors in training.

It is not realistic to expect the workforce, which has been exhausted through the pandemic, to work even harder for even longer, to reduce waiting times and tackle the backlog of elective care. More fully trained staff would create more sustainable changes to capacity for providers to manage staff workloads effectively, allowing doctors

³⁹ [NHS Digital \(2021\), NHS Vacancy Statistics England April 2015 – September 2021 Experimental Statistics.](#)

to have more reasonable workloads and a better quality of experience at work.

Alongside pre-existing staffing shortages and the impact of the pandemic, the expectations of staff employed in the medical workforce has continued to change, with doctors wanting to work more flexibly, take breaks in training to pursue different interests and build portfolio careers, which means more doctors will be needed to deliver the same care as before.

Workforce supply

Understanding the workforce supply needs for the longer term is critical. There has been a continued absence of a published workforce plan, but we welcome the opportunity to engage with HEE following its consultation on updating Framework 15, the existing 15-year strategic framework for workforce planning⁴⁰.

The NHS Confederation, alongside other representative organisations, has been calling for the workforce provisions in the present legislation to be strengthened and given a clear mandate for workforce planning to be:

- undertaken every two years with a five, ten and 15-year focus
- based on population need
- informed by the data and intelligence from integrated care boards and integrated care partnerships
- published in the public domain.

⁴⁰ [Health Education England \(2013\). Framework 15.](#)

Our members welcome the commitments in the NHS Long Term Plan and the government's current manifesto to grow parts of the workforce, including medical school place expansion and in primary care. This has gone some way to bridging the significant gaps in the workforce but despite best efforts, there is a reluctance to set out the impact of the interventions made to date on workforce supply in the next five to ten years (with the HEE 15-year framework setting out principles not numbers).

Work is being done to understand and make the distribution of medical posts more equitable within the country. It has long been understood that certain geographies (in particular the capital and its surrounding areas) have a larger concentration of doctors in training both at undergraduate and postgraduate levels, which impacts on availability of career-grade doctors.

Funding settlements need to prioritise planned and sustainable workforce growth to continue to bridge the immediate gaps we see in all settings and help alleviate the pressures on our existing staff.

International recruitment

The COVID-19 pandemic has continued to have an impact on the numbers of overseas doctors able to travel to the UK. Border closures and restrictions throughout the first half of 2021 made it difficult for candidates to travel. However, this also included British doctors who, under different circumstances, may have chosen to work overseas.

As described in last year's report, the Home Office and regulators put in place several measures to enable overseas candidates already here in the UK to extend their visas and join temporary registers to enable them to help support the pandemic. Work has continued to ensure doctors can transition from temporary registers to permanent.

The GMC has indicated that the number of international medical graduates (IMGs), joining the UK workforce fell by a third in the last year, but there were also fewer IMG leavers and the total number of IMGs actually grew⁴¹. International recruitment remains a vital source of workforce supply for the NHS and there is a need to ensure that the UK remains an attractive place to live and work both for EEA nationals and colleagues from across the world. The NHS Employers international recruitment toolkit⁴² helps employers to improve their international recruitment approach, from planning to onboarding and supporting new doctors to settle into their new roles and communities in the UK.

When looking at the makeup of the medical workforce, 70 per cent (90,204) of hospital doctors are British⁴³ and 14 per cent (18,620) are of Asian nationality, with nearly two thirds of these (12,075) originating from India or Pakistan. EU doctors fell to 8.7 per cent of the total in March 2021, from 9.7 per cent in June 2016.

There have been several changes over recent years that support the health and social care sector to recruit the doctors it needs from overseas. These include:

- the continuation of all medical practitioners on the shortage occupation list
- removal of the requirement for employers to demonstrate the resident labour market test
- removal of the cap on the number of certificates of sponsorship issued each year

⁴¹ [Ibid.](#)

⁴² [NHS Employers \(2021\), International Recruitment Toolkit.](#)

⁴³ [House of Commons Library \(2021\), NHS Staff from Overseas: Statistics.](#)

- introduction of a new health and care visa, which benefits from quicker three-week processing times, a lower salary threshold, lower fees and exemption from the immigration health surcharge.

While international recruitment is vital, ethical overseas recruitment is a key government priority across England and the code of practice for international recruitment⁴⁴ was updated in 2021. The code provides safeguards against active recruitment from 47 countries on the World Health Organisation's (WHO) Health Workforce Support and Safeguards List 2020. Previously, 152 countries featured on the list.

Wellbeing and engagement

As discussed in section two, the increased workforce pressures created by the pandemic have led to widespread concerns about staff wellbeing and stress. Earlier in 2021, HEE revised its approach to the roll out of less-than-full-time training (LTFT) category 3, to try and mitigate against stress and burnout. Doctors in training can now request the opportunity to undertake a period LTFT for reasons of personal choice. This is designed to increase flexibility in postgraduate medical training for all trainees. Employers support the approach in general, although it creates a challenge for rostering and service delivery.

The NHS Staff Survey is the largest data source on staff experience. The 2020 staff survey⁴⁵ was conducted in October to November 2020 and it demonstrated the impact of the demand described in section two. Levels of ill health due to stress rose to its highest level (up from 38 to 40 per cent) and eight out of ten staff reported they worked unpaid beyond contracted hours.

⁴⁴ [Department of Health and Social Care \(2021\), Code of Practice for the International Recruitment of Health and Social Care Personnel in England.](#)

⁴⁵ [Ibid.](#)

Despite these demands, staff remained highly motivated and positive about their jobs. Medical staff levels of staff engagement remained stable (at 7.1 out of ten) and the morale theme indicator also held up well (at 6.4 out of ten). Although staff experienced pressures on health and wellbeing, there was an improvement in the health and wellbeing indicator in the survey as more staff reported their employer taking positive action on health and wellbeing (up from 28 to 29 per cent). On the overall indicator of willingness to recommend the NHS as a place to work, there was an increase from 67 to 70 per cent.

Rates of bullying and harassment of staff remained at unacceptably high levels and did not shift during the pandemic. Patient-related violence fell slightly, likely due to restricted visiting conditions, but appears to have risen in recent months. Violence, bullying and harassment are experienced at greater rates by staff with protected characteristics and only a small number of trusts made progress reducing this disparity.

The historical differences in experience between different groups within the medical workforce continued to show up in the survey. Overall, levels of staff engagement are highest for consultants (7.2 out of ten) and lower for other medical groups (seven out of ten) and those in training (6.9 out of ten).

The results of the NHS Staff Survey 2021 will be published in spring 2022. Around 30 questions in the 2021 survey have been changed to increase alignment with the NHS People Promise, which means there will be limitations on comparability at theme level with past data.

The GMC's national training survey 2021⁴⁶ reports that:

'Intense workplace pressures have caused burnout rates to increase to their highest levels since we started tracking them in 2018. A third

⁴⁶[bid.](#)

of trainees told us they felt burnt out to a high or very high degree because of their work, as did a quarter of secondary care trainers and more than a fifth of GP trainers.’

Anecdotally, employers and guardians of safe working hours tell us that engagement of junior doctors is fair, but that there are some growing concerns about burnout and fatigue.

The GMC asked seven questions about burnout and trainees gave more negative answers to every question than in previous years. The GMC’s indicator, measuring overall risk of burnout, showed a clear swing towards negative responses, with 15 per cent of trainees at high risk compared to 10 per cent in pre-pandemic surveys. These statistics show the emergence of health and wellbeing issues for doctors in training with the potential, if not addressed, to impact on retention. HEE has developed an action plan on these training issues and NHSEI has identified doctors in training as a key risk group for whom support needs to be provided.

Employers sought to improve staff experience in 2021 despite the ongoing operational pressures, including calm rooms, improved physical provision (for example, around-the-clock catering and hydration), mental health and psychological support. The ongoing national package of health and wellbeing support, including online counselling and resources, has also had an impact and has been extended in 2021 with regional health and wellbeing hubs.

NHS Employers has an extensive programme of support for employers on health and wellbeing. We are seeing that employers have continued to adapt their approaches to ensure they are seeking out and acting on staff feedback. For example, use of virtual feedback tools such as MS Teams meetings and staff-led Facebook groups. Many trusts have adapted their local surveys and/or joined in using the NHSEI NHS People Pulse survey, and the new National Quarterly Pulse Survey which was implemented in July 2021.

There are significant health and wellbeing issues in the service arising from COVID-19, including the longer-term psychological impact and direct impact of long COVID. Specialist support services have been developed to address these issues and will need to be sustained.

Retention

Growing the workforce to meet increasing demand also includes retaining our existing staff at all stages of their career. Improving retention is not only supported by satisfaction with reward, but also strongly linked to the experience, culture and environment of where staff work.

The experience of working during the pandemic had an impact on the numbers of staff indicating they may be considering leaving the NHS. The NHS Staff Survey showed there was an increase in staff saying they would leave as soon as another job became available (up from 9 to 10 per cent). In its latest report, The Royal College of Anaesthetists⁴⁷ also warns of the potential shortages in the workforce, as one in four of the consultants and one in five of the SAS doctors who responded to the survey reported that they planned to leave the NHS within five years. We discuss the retention of consultants further in the remit sections below.

The Royal College of Anaesthetists survey is one of many over the years that highlights what makes doctors want to leave the NHS and what might help make them stay. A global survey published by the GMC in October 2021⁴⁸ also highlighted factors that have led to doctors leaving the NHS and how they could be supported to return.

The GMC survey shows that the reasons for leaving UK practice are varied, but they range from personal reasons such as retirement, to

⁴⁷ [Ibid.](#)

⁴⁸ [General Medical Council \(2021\), Completing the Picture Report.](#)

more negative pressures such as bullying, dissatisfaction and burnout. Other respondents cited not feeling valued, wanting to improve wellbeing and reduce stress, lack of flexibility, and concerns about taxes and pension tax, as reasons for wanting to leave the NHS.

Actions that could encourage doctors to stay include supporting them to work more flexibly and allowing them to reduce their on-call work or adjust their clinical practice to account for physical changes with age. However, understanding why doctors want to leave the NHS is the first step, but the real challenge is being able to put some of these measures in place when there are insufficient staffing levels to maintain services.

The NHS Staff Survey showed that overall satisfaction with pay improved from 55 to 56 per cent and there was also an improvement in the percentage of staff reporting satisfaction with how valued they feel by their organisation. However, there are notable differences in views on pay from different areas of the medical workforce. Consultants are most satisfied (65 per cent) compared to 47 per cent for those in training and 43 per cent for other groups.

NHSEI's generational retention programme⁴⁹ aims to work with multiple NHS organisations to share examples of their retention interventions, focusing on key topics such as flexible working, health and wellbeing, and pensions support. Trusts have implemented various strategies to support staff retention in the different stages of their careers. One example of this can be found in a case study with University Hospitals of Derby and Burton NHS Foundation Trust. The trust has reduced overall staff turnover and increased retire-and-return rates by supporting staff to stay in work for longer⁵⁰.

⁴⁹ [NHS England and NHS Improvement \(2021\), Generational Retention in the NHS – Generational Programme for 2021.](#)

⁵⁰ [NHS Employers \(2020\), Supporting Staff to Work Longer.](#)

Medical Workforce Race Equality Standard

In July 2021, the first Medical Workforce Race Equality Standard (MWRES) data was reported⁵¹, showing that across almost all 11 indicators, BME doctors reported a worse experience at work compared to white doctors.

The data indicates that BME doctors are less likely to be working in consultant roles, have to apply for more consultant posts before they are appointed, and are less likely to be shortlisted and offered a consultant post. They also have a worse experience with examinations and regulatory processes, and a worse experience regarding bullying, abuse and discrimination from other NHS staff.

The report acts as a stark reminder to the inequalities BME doctors face and the work that must be done to ensure that BME doctors have the same positive experience as their white colleagues.

Employers are already playing an active role to drive change, but it remains a fact that a disproportionate percentage of BME doctors are referred to the GMC by their employer compared to white doctors, and BME doctors do not receive the same opportunities for career development and progression.

The MWRES is expected to be a regular data report to hold stakeholders to account for their crucial part in addressing race inequalities amongst the medical workforce in the NHS. For our part we are committed to supporting action which:

- reduces regulatory referrals for BME doctors
- improves recruitment processes to ensure fairness

⁵¹ [NHS Medical Workforce Race Equality Standard \(2021\), WRES Indicators for the Medical Workforce.](#)

- maximises the contribution of SAS doctors, many of whom are international medical graduates.

Gender pay gap

The Independent Review into Gender Pay Gaps in Medicine⁵² was commissioned in 2017 by the DHSC. This commission responded to two primary concerns at that time:

- The gender pay gap in medicine, as reported in the national press, which was large for a single professional group
- The new NHS contract for doctors and dentists in training, which had a potentially negative impact on the pay gap due to a loss of increments during maternity leave.

In December 2020, the independent review published its findings that addressed these issues and many other related factors. The report contained 47 recommendations designed to address seven key areas. It identified the most critical factors contributing to the gender pay gap in medicine as hours, age and grade, and noted that the majority of the full-time equivalent (FTE) corrected pay gap is related to the fact that male doctors are currently, on average, older and in better-paid grades. The review recommended:

‘considering job evaluation in medical contracts, shorter pay scales to allow women to progress more quickly and the introduction of LTFT options across all NHS.’

The report also noted that age, experience and specialty do not fully explain the disparities in clinical excellence awards, which account for approximately 20 per cent of the gender pay gap in total pay for

⁵² [Department of Health and Social Care \(2020\), Independent Review into Gender Pay Gaps in Medicine in England.](#)

consultants. Negotiations on the redesign of the local clinical excellence awards scheme are currently ongoing.

A cross-sector panel, including representatives from NHS Employers, HEE, the British Medical Association (BMA) and the Academy of Medical Royal Colleges (AoMRC) among others, was established in September 2021 to oversee the effective implementation of these recommendations. The panel is directly responsible to the Minister of State for Care and will report annually on the progress of its work. Current priorities include creating workplaces where all doctors feel valued and welcome. This is especially in relation to caring responsibilities and ensuring that the influence of specialty on the gender pay gap in total decreases, by introducing policies to reduce gender segregation and supporting men and women to work more equally across all specialties.

Section 4: Transformation

Integrated care systems

On 11 February 2021, DHSC published its white paper on integration and innovation⁵³, which set out legislative proposals for a health and care bill. The NHS Confederation sees these as the most important set of reforms the NHS has had in a decade and broadly believes they are to be welcomed⁵⁴. It argues that:

‘With the NHS at tipping point and nine out of ten health leaders reporting unsustainable pressure, it’s clear that the health and care system must change dramatically. The NHS cannot sustain the burden of our country’s health alone – integration is the only way forward.’⁵⁵

Health and care leaders tell us that the pandemic has strengthened their resolve to realise the benefits of collaboration between sectors and organisations, which has been ongoing for the last five years. Although the need for legislation is acknowledged, leaders want it to

⁵³ [Department of Health and Social Care \(2021\), Integration and Innovation: Working Together to Improve Health and Care for All.](#)

⁵⁴ [Ibid.](#)

⁵⁵ [NHS Confederation \(2021\), Integration is the Only Way Forward for a Sustainable Health Care System.](#)

provide scope for them to direct resources to deliver the outcomes they have determined through knowledge of, and consultation and collaboration with, local communities and populations.

We support the recommendations in the Health and Social Care Committee's report and the government's white paper proposals for the reform of health and social care⁵⁶, for better information and reporting on workforce planning and for a national workforce strategy. We believe that provisions for workforce planning need to be strengthened, to ensure the NHS has the people it needs to provide high-quality care⁵⁷. In the same document, we state that the Secretary of State's duty to set out how workforce planning responsibilities are to be discharged once every five years, is insufficient and not frequent enough.

The NHS People Plan

The NHS People Plan⁵⁸ (published in July 2020 along with Our People Promise) remains the focus for workforce change in the coming years and employers continue to work on the actions set out in the plan, which are focused around the four pillars:

- Looking after our people – with quality health and wellbeing support for everyone.
- Belonging in the NHS – with a particular focus on tackling the discrimination that some staff face.
- New ways of working and delivering care – making effective use of the full range of our people's skills and experience.

⁵⁶ [House of Commons Health and Social Care Committee \(2021\), The Government's White Paper Proposals for the Reform of Health and Social Care.](#)

⁵⁷ [NHS Confederation \(2021\) Consultation Response to HEE Workforce Planning Call for Evidence.](#)

⁵⁸ [NHS England and NHS Improvement \(2020\), We are the NHS: People Plan 2020/21: Action for Us All.](#)

- Growing for the future – how we recruit and keep our people, and welcome back colleagues who want to return.

NHSEI refreshed the NHS People Promise⁵⁹ in July 2021. It sets out aims for improved staff experience within the NHS and provides a framework for action by individual employers and NHSEI. To support delivery of the NHS People Promise, NHS Employers has supported the negotiation through the NHS Staff Council of changes to the NHS staff handbook and supporting resources that promote and enhance flexible working options within the NHS. NHSEI has focused on health and wellbeing as a priority area, including the development of regional health and wellbeing hubs, a national health and wellbeing offer, the development of health and wellbeing guardians, health and wellbeing conversations for staff, and a programme of work designed to grow occupational health services.

In addition, the National Quarterly Pulse Survey has been implemented to support additional feedback from staff and NHSEI has a programme of work to support compassionate and inclusive cultures in the NHS. There has also been a significant realignment of the NHS Staff Survey to focus on the NHS People Promise, and implementation of the National Quarterly Pulse Survey to provide regular feedback on staff outlook.

Transformation as an opportunity

The NHS Confederation has reported that over 5.6 million people are now on treatment waiting lists⁶⁰. The Health Foundation sets out that transformation can be used to increase productivity to help recover from the aftermath of COVID-19 through skill mix change, patient activation, improving flow and the use of technology⁶¹.

⁵⁹ [Ibid.](#)

⁶⁰ [Ibid.](#)

⁶¹ [The Health Foundation \(2021\), Agility: The Missing Ingredient for NHS Productivity.](#)

Employers tell us that they are using, Getting It Right First Time⁶², the High Volume Low Complexity Programme⁶³ and The Productive Operating Theatre⁶⁴, to help clear the backlog and to improve ways of working. The Shelford Group flags greater use of technology in its organisations, particularly in the outpatient space, to diagnose and treat patients more quickly⁶⁵.

⁶² [Getting It Right First Time, \[online\], accessed January 2022.](#)

⁶³ [Getting It Right First Time, High Volume Complexity surgery programme, \[online\], accessed January 2022.](#)

⁶⁴ [NHS England and NHS Improvement \(2020\), The Productive Operating Theatre.](#)

⁶⁵ [The Shelford Group \(2021\). Transforming Care Through Technology.](#)

Section 5: The remit groups

Doctors in training

NHS Employers and the BMA have agreed all outstanding provisions from the 2019 framework agreement for doctors in training⁶⁶. These are set out in the 2016 terms and conditions of service (TCS) for doctors and dentists in training⁶⁷. The parties have resumed their formal negotiation and maintenance of the terms and conditions process. As part of these discussions, issues relating to the introduction of nodal point five and how this affects dentists in training, are still ongoing. Additionally, the parties are discussing pay protection, LTFT and safety of working hours related issues.

Employers report that the morale and motivation of doctors and dentists in training is variable. In some areas this is reasonably good, while others are more fatigued. Employers have ensured that there are mechanisms in place to address concerns raised by doctors.

Concerns regarding lack of flexibility with the new contractual limits, particularly in relation to the limits on weekend working, have been raised by employers both pre- and post-COVID-19. This has led to rota gaps and increased costs in areas like emergency medicine, neonatal care and intensive care units. This is an additional cost to

⁶⁶ [NHS Employers \(2019\), Framework Agreement for Doctors in Training.](#)

⁶⁷ [NHS Employers \(2021\), Doctors and Dentists in Training Terms and Conditions \(England\) 2016.](#)

employers and was not costed as part of the £90 million investment. This change was due to be implemented across all trusts by August 2020, but due to COVID-19, many organisations paused the introduction, so the full financial impact may take some time to emerge.

The parties have also agreed to explore further thematic working groups as part of the maintenance discussions, to review the following:

- The health and wellbeing of doctors in training.
- Non-resident on call.
- Annual leave.
- Recruitment and retention of trainees in general practice and pay parity with hospital medicine.

The BMA plans to re-engage with their trainee membership in spring 2022 to gather further views on what action, if any, they may want to take in relation to the 2021 pay award announcement.

Exception reporting and guardians of safe working hours

Effectiveness of the exception reporting system is part of NHS Employers' ongoing discussions with employing organisations and the guardians of safe working hours (GoSWH). We continue to support the GoSWH role and host regular network meetings with regional GoSWH representatives to address significant issues relating to safe working hours for junior doctors.

We also provide an extensive range of resources and information, including an annual national conference for GoSWH. This is an opportunity for guardians to network, share learning, discuss any key

challenges in their roles and collectively explore potential solutions. Through regular engagement with the networks, guardians agreed that exception reporting, when used as intended, is a valuable process that raises safety issues and initiates positive change within organisations. As the take up of exception reporting has increased over time, there are several areas that require further discussion to further improve the system. This includes streamlined technological solutions that will support the system with the smooth running of exception reporting.

Trainees taking time out of training

Employers tell us that, as it becomes more common for doctors to take time out of training, this could lead to difficulties in recruitment. It can add extra pressure to the service and to the medical staffing teams who are supporting with the implementation of these initiatives. Employers recognise that many doctors taking time out of the training continue to provide NHS services and would welcome structure and clear processes for doctors taking time out and for employing organisations who are offering the opportunities.

NHS organisations are offering roles to support trainees with taking time out of training initiatives and training more flexibly. When taken after completion of the foundation programme this is often known as Foundation Year 3 (FY3). However, jobs have a range of titles including clinical education fellow, clinical specialty fellow, locally employed doctor, junior specialty doctor or trust doctor. While this can have an impact on local workforce planning, employers find that offering non-training posts such as FY3 roles can retain capacity within the NHS at the same time as meeting the evolving needs of doctors in training. Such roles offer a range of incentives such as additional training, research opportunities and study leave, so that doctors choose to join them and provide vital service activity, as well as fulfilling the wish to work more flexibly and do something different. Anecdotal feedback from employers and GoSWH tells us that locally employed doctors are engaged on contracts that mirror national

arrangements and are treated equally to doctors in training. The out-of-programme pause programme (OOPP) being piloted by HEE is intended to create more structure for this break from training while retaining doctors within patient-facing roles.

Impacts on pay progression due to COVID-19

In recognition of the impact that COVID-19 has had on training and education activities, HEE agreed two new ARCP outcomes that were awarded to trainees⁶⁸. These are outcome 10.1 and outcome 10.2. These outcomes are defined by HEE as being to recognise that progress of the trainee has been satisfactory but that acquisition of competences/capabilities by the trainee has been delayed by COVID-19 disruption. These are therefore 'no-fault' outcomes⁶⁹.

NHS Employers, the BMA and the DHSC have been discussing the impact for trainees who received these outcomes, in particular outcome 10.2. It is likely that due to the delay with progression this has prevented the trainee from progressing to their next training grade/role and therefore has had an impact on their pay progression. An outcome 10.2 should have only affected the pay progression for trainee at FY1, FY2, CT2/ST2, ST5, or trainees who were due to CCT. Discussions on this topic are ongoing with the relevant stakeholders.

Specialty and specialist doctors

The new specialty doctor and specialist (SAS) contracts were introduced in April 2021. Since then, the joint negotiating committee for SAS (JNC (SAS)), has been monitoring the transition of doctors onto the new contract.

⁶⁸ [Ibid.](#)

⁶⁹ [Ibid.](#)

The overall aim for SAS contract reform was to support employers to attract, motivate and retain SAS doctors. The development of the new contracts aimed to improve and support SAS doctors with a positive and fulfilling career choice and to ensure they are a supported and valued part of the workforce.

Existing SAS doctors were given until the end of September 2021 to express their interest to transfer, or they could stay on their existing contract. All new appointments into SAS grades from April 2021 must be via the new contracts and the 2008 specialty doctor contract is now closed to new entrants.

Specialty doctors

The review body has asked for intelligence on new contract implementation. While numbers on the new specialty doctor were expected to gradually build up as doctors express their interest and transition, the numbers of doctors expressing an interest and transferring to the new contracts are lower than anticipated. We will continue to monitor uptake.

The transition of SAS doctors to the new contract takes time. Once a SAS doctor has expressed their interest, they need to undergo a job planning discussion before deciding whether to accept or decline the offer from their employer.

In the BMA referendum, SAS doctors voted in favour of accepting the contract. For most specialty doctors, transferring to the new contract still represents a benefit in terms of their basic pay over their career. This is due to the agreed pay uplifts in years two and three (which are greater than year one), as well as the new flatter pay scale, which reduces the time taken to reach the top of the pay scale. The new shorter pay scale is more advantageous in a CARE pension scheme and supports the recommendations from the gender pay gap in medicine report. The new contract also introduces additional benefits such as increased on-call availability supplements,

additional annual leave, improved provisions for shared parental leave, and new safeguards to protect against the most onerous unsocial hours working patterns.

However, since the referendum a number of factors have contributed to SAS doctors deciding to remain on their current contract. The main contributing factor is the 3 per cent uplift in pay that was awarded to SAS doctors on the old contracts in 2021. This meant that basic pay was higher on the old contract compared to the new 2021 contract for specialty doctors on 16 out of the 18 pay points. It was the intention of all parties that no doctor would see a reduction in their pay as a result of transition to the new contract, however this is no longer the case.

Other factors impacting SAS doctors' decision to transfer to the new contracts include the COVID-19 pandemic and a lack of understanding of the new contract and how it benefits them personally. SAS doctors have been working tirelessly to maintain services and the feedback we have had is that SAS doctors have not had the time or energy to consider whether they would like to change contracts.

The pay journey for doctors transitioning to the new contract is complex. The shortening of the pay scale and its transitional nature mean that every pay point receives a different per cent uplift of pay and this varies in each year of the multi-year pay deal. The benefits of a shorter pay scale also go beyond the three years of the deal and are more difficult to see. These factors make it much harder for SAS doctors to quickly assess the benefits and require more thought and consideration of the wider reform package, including non-pay terms and conditions changes.

Securing the benefits associated with the introduction of the new SAS contract remains a priority for employers, and recommendations on future pay uplifts for SAS doctors should be prioritised onto the new contract and pay system. This will encourage movement of SAS

doctors over time onto the new contract and pay arrangements as originally expected and planned.

Specialist grade

The data shows a slow increase of doctors entering the new specialist grade. It was expected that this would take some time as this is a brand-new role in the NHS and the creation of specialist grade posts requires employers to review departmental workforce planning. Employers are creating and advertising for specialist posts where they identify a workforce need, which requires the development of business cases and funding.

We are encouraged by the number of enquiries we are receiving from employers looking to create these posts in their organisation. Employers are requesting support from us and from the Royal Colleges, to develop new job descriptions and start the recruitment process.

There has been confusion about specialty doctors being able to regrade into the specialist grade. This is because when the 2008 associate specialist grade was introduced, specialty doctors could regrade into that post. NHS Employers and the BMA have continued to reiterate that doctors can only enter a specialist post through a competitive recruitment process.

This new national contract will provide consistency in employment for senior SAS doctors, which has been lacking for many years, but also provide career progression, recognition and appropriate remuneration for SAS doctors working at a senior level. The introduction of the role will also help employers to attract, motivate and retain senior doctors and contribute to SAS grades being a positive and fulfilling career destination choice.

Career development and progression

In our 2020/21 evidence to the review body, we shared the results of an employer survey that highlighted career development and career progression as the top two reasons it was difficult to retain SAS doctors.

This has, in part, been addressed through contract reform, with the changes made to improve career development and progression for SAS doctors:

- The new pay progression system links progression to the development of skills, competencies and experience through the processes of job planning, appraisal and mandatory training. Pay progression will no longer be automatic and will only be achieved where the required standards have been met.
- The new specialist grade will provide career progression for specialty doctors and recognise them for their expert skills, knowledge and experience to work more independently alongside their consultant colleagues.
- The new SAS development fund provides additional funding for employers to support the development needs of their SAS doctors.
- Introduction of the SAS advocate role, which is primarily to support SAS doctors' health and wellbeing but can be used to support the development of SAS doctors in their organisation.

NHS Employers will continue to work with JNC (SAS) and other stakeholders on how development can be improved for SAS doctors.

Improving equalities and inclusion

The SAS workforce is one of the most diverse in the NHS, not only in its demographics but its wide range of medical experience. The GMC's 2019 SAS survey⁷⁰ showed:

- 66.7 per cent of the SAS workforce gained their primary medical qualification from outside of the UK
- 58 per cent of survey respondents were from BME backgrounds and 34.9 per cent were white
- 34.4 per cent of UK licensed doctors were BME and 53.2 per cent were white.

As noted in section 3, the July 2021 MWRES report⁷¹ shows that across almost all indicators, BME doctors reported a worse experience at work compared to white doctors and that urgent action by NHS trusts, educational institutions and regulatory authorities is needed to address inequalities.

The delivery of the new SAS contracts will not improve the experience of SAS doctors overnight and there is much more that needs to be done so that SAS doctors are equally supported and valued as members of the medical workforce.

Through SAS contract reform, parties made two changes to support improving equalities and inclusion.

The first is the introduction of the SAS advocate role. The role aims to promote and improve support for the health and wellbeing of SAS doctors and improve their visibility within the organisation. Evidence from a GMC survey⁷² shows that SAS doctors continue to report experiences of bullying and harassment and difficulties receiving adequate support for their health and wellbeing. Giving SAS doctors

⁷⁰ [General Medical Council \(2020\), Specialty, Associate Specialist and Locally Employed Doctors Workplace Experiences Survey: Initial Findings Report.](#)

⁷¹ [Ibid.](#)

⁷² [Ibid.](#)

access to an advocate shows the employer's commitment to improving their experience and will allow the sharing of good practice across the organisation and potentially across different organisations. JNC(SAS) is collecting examples of where employers have implemented the new role to show how it works well, to promote good practice.

The second change was to reform the specialty doctor pay scale to reduce the number of pay points and the length of time taken to reach the top of the pay scale. This reduced the journey by five years in total, from 17 years to 12 years. This will help reduce the gender pay gap, as recommended by the gender pay gap in medicine report.

Consultants

The tripartite negotiating group (NHS Employers, the BMA and HCSA) continues to progress the reform of local clinical excellence awards, with the aim of introducing new arrangements from 2022/2023. Currently, there isn't a mandate from government for any wider reform of the contract. However, an opportunity to modernise the consultant contract and reform the pay structure in a similar way to the SAS contract to secure system wide benefits, would be welcomed by employers. The current consultant contract was introduced in 2003 and would benefit from modernisation. Priorities for any wider contract reform include:

- shortening the pay scale to allow consultants to reach the top of the pay scale more quickly and help reduce the gender pay gap
- modernising the terms and conditions to make sure that they are fit for purpose under a changing NHS and provide greater consistency and alignment with other staff groups where appropriate.

We continue to support employers and discuss challenges facing the consultant workforce with staff side colleagues, including areas such as pension tax, health and wellbeing, flexible working and retention.

The consultant workforce has been integral throughout the COVID-19 pandemic response and like the rest of the workforce, the prolonged period of intense working has had a significant impact on them. Employers are reporting an increased number of consultants requesting a reduction in their working hours and asking to come off on-call rotas or step down from additional leadership roles. Pay does not seem to be the primary driver for these decisions, but an increased desire for better work-life balance.

Employers have relied on the goodwill of their consultants to meet the demands of services, but the workforce is tired and the desire to pick up additional work is fading, irrespective of the pay arrangements being offered. Provisions for remunerating additional work are set out in the terms and conditions of service. However, even before the pandemic, differing local and regional agreements which go above and beyond contractual entitlements have been in place to encourage take up of additional work to meet demand. This creates variation in the system. Employers are also now reporting that increased monetary incentives are not attractive enough for consultants to take on additional work.

Retaining consultants

Retaining senior and experienced doctors to deliver an increasing demand in services and catch up with developing backlogs is critical. Retention is a multifaceted issue with many factors affecting the choices of doctors at all stages of their career.

We reported in our evidence last year that increased flexibility would be a key factor that could influence consultant decisions to continue working, and based on the evidence collected this year, this remains

to be the case. Consultants want less intensity and more predictable working hours, especially those in the later stages of their career.

We have heard from trusts that are implementing flexible job planning to support doctors to continue working, but this has its own challenges, particularly for smaller organisations and those doctors working in specialties where there are significant on-call commitments required. It can be difficult to accommodate all requests when there are few novel solutions to design rotas in a more flexible way. Collaboration between organisations to allow for greater flexibility in rota design could help retain consultants, but it is widely recognised that this can be difficult to achieve in practice while maintaining services.

Even before the pandemic, increased workloads and pressures were impacting on consultants' health and wellbeing. The ongoing effects of the COVID-19 pandemic and its potential impact on retention is a concern. However, we feel it is still too early to understand the full scale of its effect. Addressing the wellbeing needs of staff and offering different flexible solutions should remain a priority for the system to help retain senior doctors in the NHS.

Tax reforms were announced in 2020, however the McCloud judgment and existing tax provisions remain contributing factors for doctors deciding to retire before they might have otherwise chosen. From 1 April 2020, HM Treasury (HMT) raised the income thresholds for annual allowance tapering by £90,000. DHSC estimates this means up to 98 per cent of consultants and up to 96 per cent of GPs will no longer be affected by the tapered annual allowance, based on their earnings from NHS work⁷³. These changes were welcomed and have reduced the impact of the tapered annual allowance on NHS staff. However, pension tax issues in relation to the standard annual allowance and lifetime allowance remain and there are still reports of senior clinicians opting out of the NHS Pension Scheme, reducing commitments and retiring early due to pension taxation.

⁷³ [GOV.UK \(2019\). NHS Pension Scheme: Increased Flexibility.](#)

Some consultants will be required to reassess their pension tax position for the seven-year remedy period following the McCloud judgment, particularly in relation to the annual allowance⁷⁴. As a result of this reassessment, a member may have overpaid or underpaid pension tax charges. Employers should consider adopting a flexible reward offer⁷⁵ to support staff impacted by annual and lifetime allowance issues, and to help retain them in the workforce and protect the delivery of clinical services.

From 25 March 2020, the UK government's emergency legislation suspended some of the NHS Pension Scheme regulations that may apply to staff who retire and return. This removed certain barriers to support retired staff to return to the NHS, to help the service respond to the challenges of the pandemic. The emergency legislation was designed to be time limited and will end on 24 March 2022. We support rationale to extend the suspension of these regulations as the pandemic continues.

Local clinical excellence awards (LCEA)

The ongoing impact of COVID-19 has meant that there weren't any LCEA rounds in 2020/21 or 2021/22. Instead, money allocated to LCEAs is being distributed equally among eligible consultants as a non-consolidated payment. This includes any funding from the previous three award rounds that may have not been run or completed so far.

While all parties know that this approach doesn't come without challenges, allowing clinicians and managers to focus on immediate priorities was the primary aim.

⁷⁴ [NHS Employers \(2020\), Annual Allowance.](#)

⁷⁵ [NHS Employers \(2020\), Pension Tax Local Options for Affected Staff.](#)

The design of the new reward system from 2022/2023 is ongoing, with the intention to negotiate and agree to a successor scheme that will supersede default arrangements in Schedule 30 of the consultant terms and conditions of service⁷⁶. The primary aim is to recognise and reward outstanding contributions more equally across all areas of consultant activity, making the scheme fair and open for all. The parties have been led by principles that aim to address issues with the current LCEA scheme, and create a scheme that:

- is more inclusive than the current scheme (and which seeks to address issues with gender and ethnicity pay gaps)
- encourages and rewards excellence and improvement
- is transparent and fair, to address the inequalities in process and outcome in the current scheme
- is flexible and future-proof, to reflect the differing and changing NHS priorities and available resources among trusts and their consultant workforce locally
- requires proportionate resource to administer it (proportionate to the funds/benefits)
- underpins the delivery of local or employer priorities.

Parties have made progress on the overall scheme design and how eligibility can be improved to maximise inclusion. However, there are still aspects of the design and implementation to work through in the coming months. Negotiations are planned to continue until the end of January 2022, with a view to implement from July 2022.

We will update the DDRB on the new LCEA scheme once an agreement has been finalised.

⁷⁶ [NHS Employers \(2020\), Consultant Contract 2003.](#)

Salaried primary care dentists

Salaried primary care dentists are a relatively small group of dentists spread across a varied group of providers within different sectors. As per last year, we have surveyed a small number of employers who each employ salaried dentists and received some anecdotal feedback. The size of the sample limits the extent to which any broad conclusions may be drawn, but instead provides a snapshot of some of the issues facing some employers of salaried dentists.

Recruitment

Everyone we talked to reported difficulties in recruiting salaried dentists. Some faced a shortage in all grades of salaried dentists.

One employer said that, particularly for band A, the salary was insufficient to tempt dentists away from dental practices. A different employer had good quality band A applicants coming through following dental core training pathways, who they hoped to retain and develop into band B dentists.

One respondent noted that it had been difficult to recruit to band C posts due to a lack of available workforce coming through the training pathways. Another agreed that specialist roles were particularly hard to recruit to and flagged that the contract cannot be met without these staff groups.

Location was a factor in recruitment for rural employers, with staff being distant from dental schools, tertiary care and family. Urban employers noted the issue of competing with local hospitals when recruiting to posts.

Retention

Retention was less of an issue than recruitment, but some respondents struggled to retain dentists, particularly in band C. The impact of work pressure was a key theme. Multiple factors, not all work related, were contributing to recent anxiety and burnout, which was a new and unwelcome trend. The disparity in pay with medics could be demotivating for dentists.

A few employers noted that dentists had left to retire, with some individuals retiring earlier than they had previously declared. A couple of respondents flagged a particular trend in band C dentists retiring or moving out of area for personal reasons or for career progression. Some dentists had left to undertake specialty training or to work in private practice.

Morale and motivation

The morale and motivation of salaried dentists was mixed, with some employers saying it was low and others saying it was good, despite the current challenges.

Dental teams have worked tirelessly and without a break, delivering face-to-face care through the pandemic. Most staff are physically and mentally exhausted. It was reported that the current urgent care demand was insurmountable due to a lack of capacity in primary care. If not addressed, employers warned that this will lead to more stress, loss of morale and reduced job satisfaction.

It was reported that dentists have had the opportunity to develop, work alongside specialists and supervise dental core training posts, but have found it difficult with key senior dentist posts being vacant for prolonged periods of time.

Supporting development

Employers fed back to us that they were supporting their dentists in a variety of ways. All respondents were actively encouraging their dentists to take up training opportunities and spend their annual indicative training allowance. Employers were developing individual training needs analyses and building a programme of support for dentists to develop and either stay in the service in general, or to progress into mentored band B posts.

Career structure, pay, terms and conditions

Employers noted particular issues with the career structure, pay and terms and conditions for salaried dentists. They said that the pay freeze has led to less favourable pay in comparison to practice posts, with annual leave also being less favourable.

One employer who had an issue in recruiting band A dentists said that the career structure and pay did not reflect the current realities for recruiting salaried dentists. Dentists in the area were not willing to take band A posts and did not have the community dental service (CDS) experience or relevant qualifications to work at band B.

Section 6: Pensions and reward

The NHS Pension Scheme

Member contributions

Members of the NHS Pension Scheme currently pay contributions on a tiered basis, designed to collect a total yield to HMT of 9.8 per cent of total pensionable pay. The employee contribution rates are outlined in table 1 below.

Table 1

Tier	Pensionable pay (whole-time equivalent)	Contribution rate from 2015/16 to 2021/22
1	Up to £15,431.99	5.0 %
2	£15,432.00 to £21,477.99	5.6 %
3	£21,478.00 to £26,823.99	7.1 %
4	£26,824.00 to £47,845.99	9.3 %
5	£47,846.00 to £70,630.99	12.5 %
6	£70,631.00 to £111,376.99	13.5 %

7	£111,377.00 and over	14.5 %
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DHSC is consulting on changes to the member contribution structure for the NHS Pension Scheme in England and Wales from 1 April 2022. The proposals include changes to the design features of the member contribution structure and the proposed new structure. We are currently engaging with employers for their views on the proposals and will submit a response to the consultation.

The following are included in the proposed changes to the design features of the member contribution structure:

- Contribution rates would be based on a member's actual pensionable pay. Currently this is based on notional whole-time equivalent (WTE) pensionable pay.
- The steepness of the tiering within the contribution structure would be reduced.
- Tier boundaries would be increased each year in line with Agenda for Change (AfC) pay award. This is because most scheme members are on agenda for change employment contracts. The consultation does not provide for boundaries to be changed in line with medical or dental pay awards.

The consultation proposes that new contribution rates are phased in over two years, with the final structure being in place from 1 April 2023, to help minimise impacts on take-home pay for those that will be paying higher pension contributions.

The changes to the design features involve a reduction to contribution rates for some scheme members, including higher earners. It should be noted that there is an increase to National Insurance contributions from 1 April 2022, which may remove advantages to take-home pay that members may anticipate from reduced pension contributions.

The NHS Pension Scheme must collect an average yield of 9.8 per cent from members of the scheme. If the value of contributions collected from scheme members falls below the yield, this can feed into the valuation as a cost pressure, which may lead to higher contributions for employers. Contribution rates in the new structure have therefore been adjusted and increased for some members to ensure the yield is collected once the changes are implemented.

Table 2 below sets out the current rates and proposed new rates according to the pensionable earnings.

Table 2

Pensionable earnings	Current rate (WTE pay)	Rate from 1 April 2022 (actual pay)	Rate from 1 April 2023 (actual pay)	Overall change to contribution rate for members working full time*
Up to £13,231	5.0%	5.1%	5.2%	+0.2%
£13,232 to £15,431	5.0%	5.7%	6.5%	+1.5%
£15,432 to £21,478	5.6%	6.1%	6.5%	+ 0.9%
£21,479 to £22,548	7.1%	6.8%	6.5%	- 0.6%
£22,549 to £26,823	7.1%	7.7%	8.3%	+ 1.2%
£26,824 to £27,779	9.3%	8.8%	8.3%	- 1.0%
£27,780 to £42,120	9.3%	9.8%	9.8%	+ 0.5%

£42,121 to £47,845	9.3%	10.0%	10.7%	+ 1.4%
£47,846 to £54,763	12.5%	11.6%	10.7%	- 1.8%
£54,764 to £70,630	12.5%	12.5%	12.5%	No change
£70,631 to £111,376	13.5%	13.5%	12.5%	- 1.0%
£111,377 and above	14.5%	13.5%	12.5%	-2.0%

*The figures in this final column will not necessarily apply to members that work less than full time, as rates from 1 April 2022 would be based on their actual pay and not notional WTE. Contribution rates are expected to decrease for many part-time employees across all tiers.

In the consultation document, DHSC provided examples to show the impact on members from across the NHS workforce, once the new rates have been phased in from 1 April 2023. The medical workforce example included is:

‘A consultant earning £114,003 would pay £85 less a month after tax relief, but would still be paying £160 a month more than if on the average 9.8 per cent rate. The same consultant working 60 per cent of full time would pay £51 a month less than they currently do, but still £96 more than if on the average 9.8 per cent rate.’

The NHS Pension Scheme advisory board (SAB) met in November 2021 to discuss the consultation proposals and were presented with a number of examples by First Actuarial, actuary to the board, of the impact of the proposals on take-home pay for staff members.

Medical pay examples are included in tables 3 and 4 below.

Table 3

Threshold 7 consultant

	Full-time			60% of WTE		
WTE pay	£107,721					
Actual pay	£107,721			£64,633		
Contribution rate	13.5%	13.5%	12.5%	13.5%	12.5%	12.5%
	Until 31 March 2022	1 April 2022 to 31 March 2023	1 April 2023 onwards	Until 31 March 2022	1 April 2022 to 31 March 2023	1 April 2023 onwards
Monthly gross pay	£8,977			£5,386		
Pension	(£1,212)	(£1,212)	(£1,122)	(£727)	(£673)	(£673)
Income tax	(£2,059)	(£2,059)	(£2,095)	(£816)	(£838)	(£838)
National insurance	(£503)	(£605)	(£605)	(£431)	(£488)	(£488)
Monthly net pay	£5,203	£5,101	£5,155	£3,412	£3,387	£3,387

Source: First Actuarial

It is helpful to note that, despite the reduction in employee contributions for the consultant example, take-home pay has still decreased overall due to increased National Insurance contributions, which also take effect from April 2022.

Table 4

Specialty doctor scale value 3

	Full-time			60% of WTE		
WTE pay				£58,756		
Actual pay	£58,756			£35,254		
Contribution rate	12.5%	12.5%	12.5%	12.5%	9.8%	9.8%
	Until 31 March 2022	1 April 2022 to 31 March 2023	1 April 2023 onwards	Until 31 March 2022	1 April 2022 to 31 March 2023	1 April 2023 onwards
Monthly gross pay	£4,896			£2,938		
Pension	(£612)	(£612)	(£612)	(£367)	(£288)	(£288)
Income tax	(£666)	(£666)	(£666)	(£305)	(£320)	(£320)
National insurance	(£421)	(£472)	(£472)	(£257)	(£284)	(£284)
Monthly net pay	£3,197	£3,146 -£51	£3,146 -£51	£2,009	£2,046 +£37	£2,046 +£37
	-£51 is due to higher NI rates			-£27 is due to higher NI rates		

Source: First Actuarial

022/23 and 2023/24 figures allow for 1.25% increase to National Insurance rates.

No allowance for pay rises or National Insurance threshold changes.

In some cases, a marginal change in pay may alter the contribution tier.

Take-home pay calculations assume a standard tax code and no other taxable income.

Rounding may mean that totals do not equal the sum of the parts.

Under new proposals, this full-time postholder would see a reduction in take-home pay as a result of increases to National Insurance contributions but would see no increase or decrease in their pension contribution. However, a part-time employee on the same scale would see an increase in take-home pay, which remains consistent over the phasing period.

McCloud remedy to age discrimination in public sector pension reform

The McCloud remedy is the process of removing the age discrimination from public service pension schemes, including the NHS Pension Scheme. This relates to the way some members were moved to the 2015 scheme when it was introduced, and others were allowed to stay in their 1995/2008 schemes. Members were treated differently dependent on their age, which was found to be unlawful discrimination.

Removing the past discrimination will be achieved by giving members a choice of which scheme their pension benefits for the remedy period are calculated. The remedy period is the seven years over which the discrimination took place, from 1 April 2015 to 31 March 2022.

Those retiring from October 2023 will be given the choice at retirement. Those retiring before October 2023 should retire based on their current scheme and will be given a retrospective choice after October 2023. They will be contacted directly by NHS Pensions to make that choice.

Removing age discrimination going forward involves all members currently in the 1995/2008 final salary schemes moving into the existing 2015 scheme, which is a career average scheme. Benefits already built up in the 1995/2008 schemes will remain in those schemes and will not be lost. Members do not need to retire prior to 1 April 2022 to retain their 1995/2008 scheme benefits. We are finding

that this is a common misconception that we are working with employers to dispel.

We continue to work closely with all relevant stakeholders including NHSEI, DHSC, NHS Business Services Authority / NHS Pensions, Electronic Staff Records, and employer representatives, through the NHS McCloud programme board. The board meets regularly to ensure a cohesive approach including agreeing communications for employers and staff and to ensure a smooth roll out of the remedy across the service, to staff and through local and national administration.

We are supporting employers through a range of web-based materials and resources to help them understand the McCloud remedy, communicate this effectively to staff and to prepare for the changes. Our resources include a summary, proposed remedies and a myth-busting resource⁷⁷.

The government laid proposed primary legislation, the public service pensions and judicial offices bill, before parliament to implement changes in public service pension schemes to remedy the discrimination identified by the McCloud judgment. DHSC published a consultation on 9 December 2021, which proposes changes to the NHS Pension Scheme that are necessary to deliver the requirements of the bill. The proposed changes to legislation will:

- facilitate closure of the 1995/2008 scheme to future accrual from 1 April 2022
- ensure all members of the 1995/2008 scheme become active members of the 2015 NHS Pension Scheme from 1 April 2022.

A second consultation is expected in spring 2022 that will amend the scheme regulations to give eligible members a choice over the

⁷⁷ [NHS Employers \(2021\), McCloud Remedy.](#)

benefits they wish to receive for any pensionable service during the period 1 April 2015 to 31 March 2022.

Pension tax

Over the last few years we have reported in our evidence submissions to the pay review bodies about the impact of the annual allowance and lifetime allowance pension tax limits. Previously, very few NHS workers were likely to exceed the tax thresholds, but changes made in recent years, and particularly the introduction of the tapered annual allowance, has meant that more staff were likely to be affected.

In our evidence last year, we reported that employers were particularly concerned about the impact on staff retention, with employees requesting to reduce their hours, refusing additional work, taking early retirement, and avoiding promotions due to pension taxation. This was having an impact on workforce capacity, service delivery and patient care.

During the 2020/21 scheme year, 17,467 members (approximately 1.19 per cent of the total membership) breached the annual allowance and 8,965 members (approximately 0.61 per cent of the total membership of 1,459,668) accrued benefits worth more than £1 million. The current lifetime allowance is £1,073,100.

In 2019/20, HMT undertook a review of the annual allowance taper and in the Budget on 11 March 2020 it was announced that the income thresholds associated with the taper would each be increased by £90,000. From 6 April 2020, these apply to those whose threshold income is greater than £200,000 and whose adjusted income is greater than £240,000. Those with a total income of less than £200,000 will now not be impacted by the taper, with modelling suggesting that 98 per cent of consultants and 96 per cent of GPs will now not be affected based on their NHS earnings. These changes apply to all parts of the economy and therefore to staff

groups across the NHS workforce, including those in clinical and non-clinical roles.

As we have reported previously, employers were taking a range of mitigating local actions to support staff affected by pension tax. However, since the changes to the taper, some of these initiatives have been withdrawn or reviewed. At our recent webinar on pension tax, 25 per cent of attendees reported that they recycle employer contributions. Our guidance, pension tax – local options for affected staff,⁷⁸ supports employers to assess whether recycling is appropriate for their trust and specific circumstances. Recycling unused employer contributions may be considered necessary to restructure the total reward package of staff who have opted out of the scheme due to pension tax issues and can, therefore, be a useful retention tool.

In the March 2021 Budget statement, it was announced that the lifetime allowance would remain at £1,073,100 until April 2026. A range of factors will contribute towards an employee exceeding the lifetime allowance. Employees that are most likely to breach the lifetime allowance and may be at risk of a lifetime allowance tax charge at retirement are those with:

- high incomes
- long service in the 1995 section
- pension benefits in other schemes.

It is anticipated that as we move nearer to 2026, more members of the NHS Pension Scheme will breach the lifetime allowance limit.

NHS Employers has published updated guidance on the optional measures that employers may implement to support staff and service delivery for those still impacted by pension tax. This includes an NHS

⁷⁸ [NHS Employers \(2020\), \[online\], accessed January 2022.](#)

Pension Scheme annual allowance and tax ready reckoner,⁷⁹ which is designed to help staff understand the benefits they are building up in the scheme and the annual allowance. We also hosted a webinar⁸⁰ on how employers can help staff who are facing pension tax issues, to support retention and service delivery. We continue to produce resources to raise awareness and improve understanding of the annual and lifetime allowance, including the changes that were announced in the March 2020 Budget.

Scheme flexibilities

We reported previously that DHSC consulted on proposals to change the NHS Pension Scheme, to address the impact of pension taxation on NHS staff, organisations and service delivery.

DHSC has announced that it will not implement proposals to offer senior clinicians more control over their pensions growth to manage their pension tax position, as the Chancellor's decision to raise the income threshold for annual allowance tapering from £110,000 to £200,000 from 6 April 2020 achieves the same intended aim.

We will continue to support the case for flexibilities for all members (not just limited to senior doctors) of the NHS Pension Scheme. The case for introducing scheme flexibilities is now greater, given the intention to move towards a flatter member contribution structure.

We believe flexible accrual rates would provide a clear solution to allow higher earners to control their pension growth and mitigate against pension tax charges if it is in their best financial interest to do so. To avoid decisions being made unnecessarily around reducing working hours or retiring early, and as pension tax is such a personal and complex issue, we also consider it crucial that higher earners

⁷⁹ [First Actuarial and NHS Employers \(2021\), NHS Pension Scheme Annual Allowance and Tax Ready Reckoner.](#)

⁸⁰ [NHS Employers \(2021\), NHS Pension Scheme – Pension Tax.](#)

have easy access to independent financial advice and education. This is particularly important in the context of needing to revisit previous pension tax positions due to the McCloud remedy.

Actuarial valuation 2016

In July 2020, HMT announced that the pause on the cost control element of the 2016 valuations should be lifted and completed. HMT concluded that the cost of the McCloud remedy should be included in the cost cap valuation. Provisional results now show no breach of the cost cap floor, meaning that no improvements to benefits or reduction in member contributions are required. Trade union colleagues are challenging this position. The results of the valuation are expected to be published imminently. The employer contribution rate will remain unchanged until the 2020 valuation is completed.

Actuarial valuation 2020

Work on the 2020 valuation will be progressed during 2022. The 2020 valuation will take into account changes to the cost control mechanism announced in the outcome of the recent HMT consultation. HMT is currently consulting on changes to the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate, which is a key assumption in determining the employer contribution in public service schemes. The outcome of the consultation on the SCAPE discount rate is expected in 2022 and any change to the discount rate will be included in the 2020 valuation. The new employer contribution rate will be effective from 1 April 2024.

Retention commission

We were commissioned to deliver a programme of work in support of the wider retention work of NHSEI, ahead of its national campaign in the autumn of 2021. Activities are focused on promoting the benefits

of being a member of the NHS Pension Scheme. There are four key priorities under which we have delivered a series of resources and webinars to support employers:

- Promoting the value of the NHS Pension Scheme⁸¹.
- Flexible retirement options⁸².
- Retire and return⁸³.
- Pension tax⁸⁴.

Total reward

More employers are adopting a strategic approach to reward, giving opportunities to demonstrate the entire scope and value of the employment package on offer. COVID-19 has had an impact on reward, with employers responding quickly to implement new ways of working to provide a positive staff experience.

Salary will of course always be the most important element of reward, as was seen with recent SAS contract reform, detailed in section five.

Recognition has also been key over the past year as a way for employers to show their appreciation of their employees. Non-monetary rewards such as virtual thank-you cards, staff positivity boxes, virtual reward ceremonies, pin badges and certificates have been used.

⁸¹ [NHS Employers \(2020\), Promoting the Value of the NHS Pension Scheme Videos and Presentation.](#)

⁸² [NHS Employers \(2021\), Flexible retirement, \[online\], accessed January 2022.](#)

⁸³ [NHS Employers \(2021\), Retire and Return, \[online\], accessed January 2022.](#)

⁸⁴ [NHS Employers \(2021\), Accessing Annual Allowance Ready Reckoner Tool and Demonstration, \[online\], accessed January 2022.](#)

The pandemic has shown the need to focus on staff wellbeing and their experience at work. Staff health and wellbeing is closely linked to patient outcomes and the NHS People Plan highlights many actions the NHS is already taking to improve in this area, as described in more detail in section four.

From January 2021 all jobs within the NHS are advertised with a flexible working option and current employees will be given the opportunity to discuss flexible working with their line managers. In doing this we can offer staff a better work-life balance. However, employers are facing some challenges around implementing flexible working, such as communication difficulties and employee isolation.

The NHS pension and reward package is one of the most all-inclusive and appealing packages available and many employers use this to their advantage when recruiting and retaining staff.

NHS organisations continue to go above and beyond for their employees, researching and listening to what their staff want and offering a diverse reward package, including childcare, discounts and buying/selling annual leave. These unique reward policies, which are not always offered outside of the NHS, play a key part in retaining our staff.

NHS Employers
2 Brewery Wharf
Kendell Street
Leeds
LS10 1JR

0113 306 3000
www.nhsemployers.org
@NHSEmployers

If you require this publication in an alternative format,
please email enquiries@nhsemployers.org

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