NHS EMPLOYERS’ SUBMISSION TO THE DOCTORS’ AND DENTISTS’ REVIEW BODY 2017/18

September 2016
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Key messages

Financial challenges

- The NHS continues to face unprecedented financial and service challenges. The majority of trusts fell into deficit during 2015/16 and the overall shortfall has now reached over £2.5 billion\(^1\), the highest level seen.

- The financial settlement for the NHS up to 2020 is extremely challenging, with employers set ambitious targets to deliver efficiency savings. At the same time, demand for services continues to rise. Performance indicators show the service is under great pressure as demands for care increase and other public services reduce provision.

- Concerns about NHS finances link through to pay decisions for NHS staff. Pay makes up more than two thirds of the budgets for most hospital costs. Changes in staff costs, above those already planned for, will have a significant impact on the financial viability and sustainability of NHS financial plans. Continuing to contain pay costs remains an integral part of addressing this financial challenge.

- This financial position sets a key context for this year’s evidence.

Transformation challenges

- A different approach is required to deliver a health and social care system that is capable of meeting the scale of the financial and sustainability challenge.

- National policy has identified the significant and necessary changes required to shift care from hospitals to the community, introduce new models of care that support the integration of health and social care, and support a focus on preventing illness and promoting health and wellbeing.

- Sustainability and transformation planning (STP) is helping to bridge the gap between health and social care, with 44 STP footprints charged with delivering plans that deliver transformation of the services provided to local communities.

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\(^1\) The Kings Fund (July 2016), *Deficits in the NHS 2016*
• It is expected that these transformation plans will improve outcomes for people accessing services, support greater efficiency and effectiveness in service delivery and deliver cost savings.

• Integrating care across organisations and sectors will lead to considerations around the current and future workforce. Opportunities to restructure and create new roles to meet changing needs, will need to be taken to support system integration. This requires a new and integrated workforce plan to be created (across boundaries).

**Workforce challenges**

• How the NHS plans, trains, regulates, supports, deploys and rewards its medical staff will be critical to the delivery of the triple aim identified in the Five Year Forward View (5YFV)\(^2\).

• The results of getting this workforce planning wrong are potentially very significant and will create further system instability in an already pressurised environment. Financial pressures will not be effectively and efficiently managed, including those linked to staff shortages, which historically have translated to higher costs through increases in agency spend.

• Senior policy makers from across the health system have recognised that a new approach is required to meet the scale of the challenge presented both now and in the future with regards to workforce.

• Employers welcome the development of a national workforce strategy set against the 5YFV and the creation of clear plans for service delivery. They will be looking for national actions which enable greater innovation in ways of working and enhance the broader reward and employment package for NHS staff.

\(^2\) NHS England (October 2014), *Five Year Forward View*
Pay and contract reform

- NHS Employers’ priority is for reform to national pay and terms and conditions so that they are fit for purpose. We have set out previously in detailed evidence to the DDRB what is, and still remains, a compelling case for medical and dental contract reform.

- The pay systems for medical staff, in particular those for consultants and doctors in approved training programmes, need to change to ensure that they properly support the NHS in the delivery of the priorities set out in the 5YFV and address quality and efficiency challenges for seven-day services, the changing needs of patients and new models of care.

- Employers are looking for a balanced package of reforms that would contribute to wider initiatives to increase capacity, reduce the costs of agency staffing, without creating new additional cost pressures. This should include changes to the pay structure and other terms and conditions for all doctors.

Doctors in approved postgraduate training programmes in England (junior doctors)

- The national discussions on the terms and conditions for doctors in nationally approved postgraduate training programmes ended when the BMA members rejected an agreed package during July 2016. Employers are to begin implementing the 2016 contract from 1 October 2016.

- Throughout this challenging programme of contract reform work, we have stressed the commitment (on behalf of employers) to ensure that the introduction of a new contract maximises benefits to junior doctors as well as allows proper scrutiny to be in place through a planned implementation process.

- We welcome the decision by the BMA to suspend the industrial action planned for October, November and December this year. This would have had a distressing impact on patients, their cares and families and other staff working across the NHS. We hope the BMA will work with us to oversee and review the implementation of the new contract.
Consultants

- National discussions with the BMA on pay reform of consultant terms and conditions continue. These talks have been constructive, but progress has been slower than anticipated. Reaching an agreement within the constraints of the government’s public sector pay policy and the wider financial challenges facing the NHS is challenging for all parties. It is now unlikely that a reform agreement will be possible for implementation by April 2017.

Pay award 2017/18

- The pay review for 2017/18 will be subject to the government’s public sector pay policy, set out in the 2015 Budget, that increases across the public sector will be constrained to an average of 1 per cent until 2020/21.

- In the absence of an agreement on pay reform, there is consensus amongst employers in favour of the same percentage increase for all staff within the 1 per cent cap. Any pay increase will add to the financial pressure for employers unless fully funded through the tariff.

- There is not sufficient evidence to justify differential pay awards to staff in 2017/18. The common view is that an envelope of 1 per cent would not in practice make any differentiation worthwhile and could have a negative impact on the morale of the workforce. We are not aware of any labour market challenges at national or local level that would be resolved by differentiated pay awards.

- The NHS continues to have a well-regarded package of valuable employment benefits, including a generous pension scheme. In addition to pay and benefits, we are increasingly seeing that employers in the NHS are broadening their definition of total reward to include recognition schemes, health and wellbeing initiatives and training and development programmes, among others.

- Further, employers remain committed to enhancing the package of measures that they can put in place to recruit, retain, deploy and develop the NHS workforce in a way that responds to their aspirations and personal and family priorities.
1. Informing our evidence

Introduction

1. We welcome the opportunity to submit our evidence on behalf of healthcare employers in England for the 2017/18 pay review. We continue to value the role of the DDRB in bringing an independent and expert view on remuneration issues in relation to the NHS workforce.

2. Our evidence has been informed by a continuous cycle of engagement with a full range of NHS organisations, about their priorities for pay and for terms and conditions reform. We have:

   - had direct discussions at one-to-one meetings with NHS chief executives, and at regional network meetings of human resources directors, NHS Confederation and other employer networks
   - carried out a short online survey of employer views, jointly with NHS Providers, during July 2016 to compliment other sources of employer opinion.

3. Last year our evidence was framed within the challenges faced by the NHS on finance, transformation and workforce. These remain and will become more intense, complex and urgent over the next few years.

4. The chief executive of NHS England has described the current priorities for the NHS as stabilising finances, implementing the 5YFV review and delivering on STPs. These are the challenges that employers in the NHS will face in the short and longer term.

5. Employer plans have been designed to deliver significant transformational change to services over the next three to five years. In compiling our evidence we have considered whether a longer term pay deal will provide employers with some stability and certainty.

3 In a speech to the NHS Confederation Conference in June 2016 https://www.england.nhs.uk/2016/06/simon-stevens-confed-speech/
The financial challenge

6. Increases in demand for NHS services continues to outstrip increases in NHS funding. Acute activity grows each year by around 2.5 per cent, while the pressure on prices increases by up to 3.7 per cent a year.\(^4\) In contrast, NHS funding will grow by a little under 1 per cent each year in this parliament.\(^5\) This creates a gap between funding and demand that needs to be met through efficiencies to maintain current services.

7. A £22 billion efficiency programme has been outlined and the NHS will be expected to deliver this by 2020. This includes £8.6 billion worth of hospital savings made up by productivity improvements of 2 per cent each year.\(^6\) This would be a significant step up from the long-run average in the NHS of around 1 per cent a year and would require a reversal in recent hospital productivity, which has been reducing for the last three years.\(^7\) In the latest NHS Confederation member survey, 96 per cent of NHS leaders had little or no confidence the efficiency savings set out in the 5YFV would be possible.\(^8\)

8. The consequence of not closing the funding gap is more financial pressure on local NHS commissioners and providers. Last year, NHS trusts and foundation trusts ended the year with a combined deficit of £2.45 billion and 157 of 240 trusts were in deficit. This end-year position would have been poorer were it not for a non-recurrent £950 million capital-to-revenue budget transfer.\(^9\) In 2016/17, £1.8 billion of additional funding has been agreed for providers as part of a

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4 NHS England (May 2016) *NHS Five Year Forward View: Recap briefing for the Health Select Committee on technical modelling and scenarios*

5 Written evidence submitted jointly by the Nuffield Trust, the Health Foundation and The King’s Fund to the Health Select Committee inquiry on the impact of the Spending Review on health and social care (January 2016)

6 NHS England (May 2016) *NHS Five Year Forward View: Recap briefing for the Health Select Committee on technical modelling and scenarios*

7 Health Foundation (March 2016) *A perfect storm: an impossible climate for NHS providers’ finances?*

8 NHS Confederation (March 2016) *2016 Membership Survey*

9 National Audit Office (July 2016) *Reports on Department of Health, NHS England and NHS Foundation Trusts’ consolidated accounts 2015-16*
sustainability and transformation fund.\textsuperscript{10} Despite this funding, NHS providers are still forecasting a deficit for this year of around £550 million, which national bodies are aiming to reduce to £250 million.\textsuperscript{11}

9. Staff costs represent 70 per cent of a typical hospital’s total costs. They are a key factor in the declining financial position of NHS providers. Between 2011/12 and 2014/15, the share of income spent by acute trusts on staff rose by 8.1 per cent. The growth in spending on non-permanent staff in particular has been significant in recent years with a 24 per cent increase, as a share of total income, between 2012/13 and 2014/15.\textsuperscript{12} Reports by the Health Foundation and the National Audit Office identify a strong association between spending on non-permanent staff and an organisation’s financial performance. For every percentage point in a trust’s staff costs accounted for by an agency, their net financial position is likely to fall by 0.4 per cent of their operating costs.\textsuperscript{13}

10. A cap on agency spending was introduced last year and has been fully operational since April 2016. This sets a ceiling for each trust on their total agency expenditure and requires the use of approved framework agreements to procure all agency staff.\textsuperscript{14} A new single oversight framework has been proposed that will enable regulators to mandate NHS Improvement support to help improve the quality and management of services where trusts have exceeded their agency cap by more than 25 per cent.\textsuperscript{15} Evidence suggests if trusts could achieve 70 per cent compliance with the rate caps, they could save 20 per cent of their annual locum bill.\textsuperscript{16}

11. During July 2016, national bodies announced a mid-year financial reset with the aim of restoring financial discipline and helping to ensure ongoing financial sustainability for the NHS. This has seen five providers and nine CCGs placed into a new financial special measures regime, while all providers and commissioners have agreed financial control totals that represent minimum

\begin{itemize}
\item \textsuperscript{10} NHS Improvement (March 2016) \textit{The Sustainability and Transformation Fund and financial control totals for 2016/17: methodology}
\item \textsuperscript{11} Letter from Jim Mackey to Chairs and CEO’s of Foundation Trusts and NHS Trusts on 2016/17 Financial Position (June 2016)
\item \textsuperscript{12} National Audit Office (December 2015) \textit{Sustainability and financial performance of acute hospital trusts}
\item \textsuperscript{13} Health Foundation (March 2016)
\item \textsuperscript{14} NHS Improvement (March 2016) \textit{Agency rules}
\item \textsuperscript{15} NHS Improvement (June 2016) \textit{Single Oversight Framework Consultation}
\item \textsuperscript{16} Liaison (June 2016) \textit{Taking the temperature: A review of NHS agency staff spending in 2015/16}
\end{itemize}
levels of financial performance they will be held accountable for.\(^{17}\) These totals will be maintained while the NHS prepares for a two-year planning and contracting round for 2017-19, which is due to be completed by December 2016.

12. This two-year planning round will be supported by a two-year national tariff, setting national prices until 2019.\(^{18}\) It will not be known until later in the year what level of efficiency factor will be set in tariff for the next two years, however it has been reported that there are no plans to set a target above 2 per cent.\(^{19}\) This is in line with the efficiency factor set in this year’s tariff, which was reduced from a 4 per cent factor for the previous five years.

13. The focus on a two-year planning round, supported by a multi-year tariff, will aim to support the implementation of STPs, which are intended to receive the bulk of additional funding committed in the 2015 Spending Review.\(^{20}\) This will depend on how far the deficit in the provider sector has been eliminated, which is the reason for concern about the carry-over of a deficit from 2015/16 into this year. The latest temperature check from the Healthcare Financial Management Association (HFMA) identifies that only 26 per cent of trusts who reported a deficit in 2015/16 expect to have a surplus in 2016/17 and that 30 per cent of trusts who reported a surplus in 2015/16 expect to have a deficit this year.\(^{21}\)

14. Adding further uncertainty is the UK’s vote to leave the European Union. While it is difficult to assess what impact this will have, a recent briefing by the Health Foundation suggested it could see funding decrease by an average of 0.4 per cent a year in real terms between 2016/17 and 2019/20.\(^{22}\)

\(^{17}\) NHS England (July 2016) “NHS action to strengthen trusts’ and CCGs’ financial and operational performance for 2016/17

\(^{18}\) NHS England and NHS Improvement (August 2016) National tariff proposals for 2017/18 and 2018/19

\(^{19}\) “NHS issues plan for two-year payment tariff” in Public Finance (02 August 16)


\(^{21}\) HFMA (July 2016) NHS financial temperature check

\(^{22}\) Health Foundation (July 2016) NHS finances outside the EU
The transformation challenge

15. In our evidence for 2015/16 we described the transformational vision set out in the 5YFV of new models of care delivering a better NHS by 2020/21. The emphasis has now shifted firmly towards implementation.

16. During December 2015, NHS England published planning guidance for 2016/17-2020/21 to help ensure that health and social care services are built around the needs of the population. The NHS has a clear set of plans and priorities for 2016/17 and NHS England has described these in a series of ‘must dos’.23

17. These include ensuring that 25 per cent of the population will have access to acute hospital services that comply with four priority clinical standards by March 2017 and reducing excess deaths by increasing the level of consultant cover and diagnostic services available to patients at weekends.

18. This will require each health and care system in England to produce a multi-year sustainability and transformation plan (STP) showing how local services will evolve and become sustainable over the next five years and deliver the 5YFV vision of better health, better patient care and improved NHS efficiency. STPs will need different thinking about workforce within a wider strategic plan.

19. Local must dos in the planning guidance for 2016/17 include restoring the system to aggregate financial balance, including delivering efficiency savings and complying with maximum total agency spend and maximum hourly rates set out by NHS Improvement.

20. The 5YFV recognises that making new care models a reality across the health, care and voluntary sectors depends on people:

   “Healthcare depends on people — nurses, porters, consultants and receptionists, scientists and therapists and many others. We can design innovative new care models, but they simply won’t become a reality unless we have a workforce with the right numbers, skills, values and behaviours to deliver it.”

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Integrating health and social care

21. The health and social care sectors are challenged by an increasingly ageing population; rising demand for care; increasing numbers of complex patients with multiple long-term conditions; moving care from hospitals to primary care; and poorly coordinated care, for example between community health services and hospitals and between the NHS and social services. Integrated care has therefore become an important aspect of healthcare reform.

22. At a national level this means investment in building the capacity and capability of the workforce to provide integrated care. Locally, this means a workforce that meets the needs of its citizens, and is equipped to deliver holistic, proactive and integrated care. The aim of this is for communities to have confidence that local systems are effective and offer value for money and that individuals are confident that local services are safe, effective, high quality and accountable.

23. The Cities and Local Government Devolution Act\(^2\) provides the legal framework for devolving healthcare functions to local authorities. Not all devolution plans currently include healthcare, but the Act provides an additional push towards integration of health and social care. Thus integration features as part of STPs and, significantly, a number of STP leaders come from local government.

Employer views

24. We asked employers for their views on the pay and workforce implications arising from system changes such as new care models and devolution.

25. They consistently highlighted the need for flexibility in pay, contracts and terms and conditions and for harmonising terms across organisations. Staff will have to work differently and could be accountable to more than one organisation. A common contractual framework across organisations and sectors could help mobility so that staff could work in a range of settings. One vanguard site for integrated primary and acute care systems (PACS) said that experience was beginning to show that common competencies, irrespective of employer, were beginning to emerge. This would need a common approach to job evaluation across organisational boundaries. A respondent from a clinical commissioning group commented:

\[^2\] \text{http://www.legislation.gov.uk/ukpga/2016/1/contents/enacted/data.htm}
“Devolution/STP requires a whole system approach and solutions to the provision of care. This requires flexibility in the workforce across health and social care but currently contracts and the law do not allow this to happen with ease.”

26. Respondents also noted the practical difficulties, including managing pay differentials and the potential for pay inflation where social care staff are currently paid less than their NHS equivalents for similar work. As one employer explained:

“We are moving towards integration with social care, but the base pay and pensions differentials are a stumbling block. A jointly recognised staffing and contractual structure would make the process of integrating teams much easier – as would transition funding.”

27. The ability to build flexibility and flexible working models into the system could support employer expectations of a younger and more diverse workforce. Local government organisations already have some experience of integrating NHS staff as the result of the transfer to local authorities of public health functions, which could provide a useful source of learning. However, there would be significant challenges to harmonising pension arrangements.

28. Employers have told us that responding to the need to work differently across organisations will present a major training and development challenge. One outcome might be generically skilled staff across health and social care, but pay and contracts would have to accommodate these roles.

29. Respondents also pointed out the considerable cultural and organisational change that would be required to bring about reorganisation on this scale.

**Seven-day services**

30. The need for contract reform is purposeful – it is about delivering the same high standard of care whatever the day of the week and, where appropriate, whatever the hour of the day, through delivering the agreed NHS Clinical Standards\(^{25}\). Transformation of the scale and complexity required depends on

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\(^{25}\) Seven Day Services Clinical Standards [http://www.nhsiq.nhs.uk/media/2638611/clinical_standards.pdf]
having a well-trained, well-motivated, modern and flexible workforce and this is central to pay and contract reform.

31. Employers are committed to this core government objective\(^{26}\) to ensure the reliable and safe care that all patients should reasonably expect from their national health service across all seven days of the week.

32. It will enable timely access to senior clinical decision making and intervention, enabling better patient outcomes, reducing avoidable mortality and avoidable patient harm across all seven days of the week, as well as improving patient experience. It allows for better use of the facilities, more speedy diagnosis, improves patient flow and avoids unnecessary admissions. It will help avoid delays and reduce waiting times.

33. The NHS England NHS Services, Seven Days a Week Forum examined\(^{27}\) the evidence base for seven-day services in hospitals. One of the conclusions of the forum was that ‘there is a large body of evidence associating timely consultant input to patient care with improved outcomes’. It also noted:

- variable staffing levels at weekend
- the absence of senior decision makers (consultants and other senior clinical staff)
- a lack of consistent specialist services (e.g., diagnostic) at weekends
- a lack of availability of specialist community and primary care services.

The forum produced the ten clinical standards for seven-day services.

34. From the ten produced by the forum, the four clinical standards that have been prioritised by the government are those which were considered (and endorsed by the Academy of Medical Royal Colleges) as being those most likely to tackle the risk of avoidable mortality and harm across all seven days of the week. The priority standards are:

- time to first consultant or senior-decision maker review – seen as soon as possible but at least within 14 hours of arrival at hospital

\(^{26}\)Health Committee (July 2016) Impact of the Spending Review on Health and Social Care

\(^{27}\)NHS England (December 2013) NHS Services, Seven Days a Week Forum summary of initial findings
• diagnostics – seven-day access to x-ray, ultrasound, CT, MRI, echocardiology, etc, within set timescales
• consultant-led intervention – 24-hour access to critical care, interventional radiology, interventional endoscopy, emergency general surgery etc
• ongoing review – all patients on Acute Medical Units, Surgical Assessment Units and Intensive Care Units must be seen and reviewed by a consultant, twice daily, and patients on general wards once daily, unless it has been determined that this would not affect the patient’s care pathway.

35. The key requirement is that, by the end of this parliament, all patients with similar urgent and emergency hospital care needs will have access to the same level of consultant (or senior clinical decision maker) assessment and review, diagnostic tests and treatment, seven days a week, as described by the four priority standards. Employers also expect by 2020 to be working towards implementation of all ten standards. This is being pursued through the standard NHS contract and NHS England’s strategic transformation plans.

36. Achieving the NHS clinical standards will take time and progress will be achieved by the employment of additional clinical staff and through continued productivity improvements. The NHS is developing its short and long-term workforce plans to enable this objective. It will not be achieved by simply diluting existing staff from Monday to Friday and redeploying them across the weekend.

37. It is recognised that doctors in training already are deployed across the seven days of the week. Whilst doctors in training will play their part in assuring the delivery of the NHS Clinical Standards, it is most likely that any additional contribution will not be as great as that expected through the employment and deployment of other staff, such as consultant medical staff, advanced nurse practitioners, radiographers, physiotherapists and pharmacists.

28 https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/stp/
The workforce challenge

Pay and contract reform

38. NHS Employers’ priority is to maintain and reform national pay and conditions so that they are fit for purpose. The case for medical and dental contract reform was set out in our previous evidence\(^\text{29}\) taking into account recommendations from the DDRB.

Consultant contract

39. NHS Employers and the BMA Consultant Committee have made significant progress and have continued to work closely and constructively on the detail of an offer to amend the 2003 consultant contract.

The national contract for doctors in approved postgraduate training programmes in England\(^\text{30}\)

40. Following the BMA’s withdrawal from negotiations in October 2014, the DDRB’s report *Contract reform for consultants and doctors and dentists in training – supporting healthcare services seven days a week*, and the government’s response to that report, the BMA and NHS Employers returned to formal negotiations on the junior doctor contract during autumn 2015. The BMA balloted their relevant members and gained approval for industrial action. They rejected an offer of a new contract during January 2016. Further talks took place, with industrial action suspended. During February 2016, the BMA rejected an improved contract offer, including the introduction of a post at each employer of a guardian of safe working hours. At this point the Secretary of State decided that the new terms and conditions should be introduced by employers on a phased basis from August 2016.

41. BMA members took industrial action during March and April 2016. Following the intervention of Professor Dame Sue Bailey, president of the Academy of Medical Royal Colleges, the Secretary of State agreed to pause the implementation of the contract and the parties agreed to return to talks. These

\(^{29}\) NHS Employers DDRB evidence 2015

\(^{30}\) We have used the shorthand term “junior doctor contract” throughout to mean “the national employment contract for doctors employed in approved post-graduate training programmes within England”.

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were facilitated by Sir Brendan Barber, chair of the Advisory, Conciliation and Arbitration Service (Acas). Agreement between the parties was reached on 18 May. The agreement included a new approach to pay and reward, actions to support equality aspects of the contract, refinements to rota rules, improvements to flexible pay premia (FPP) and other terms, clarification of the role of the guardian of safe working hours, and commitments from Health Education England and the General Medical Council on improving the overall training experience. Full details of the agreement can be found at Annex A.

42. The relevant members of the BMA rejected the agreement in a ballot. 68 per cent of those eligible to vote took part in the ballot. 58 per cent voted to reject the agreement, with 42 per cent voting to accept.

43. On 6 July the Secretary of State confirmed that employers would introduce the junior doctor contract that had been agreed with the BMA during May. The new terms and conditions of service (TCS) would be those which had been submitted to BMA members for ballot.

44. A phased implementation plan has been developed to allow employers to introduce the working patterns outlined in the contract. Doctors and dentists in approved postgraduate training programmes in England will begin to be moved onto the 2016 contract from October 2016, with the majority moving from their next available rotation date or during August 2017. They will retain their current contract until the date on which they transfer to the 2016 terms and conditions.

45. The timetable for transition to the 2016 TCS is:

- October 2016 – Obstetrics ST3 and above
- November/December – F1 taking up next appointments and F2 taking up next appointments and sharing rotas with F1 doctors
- February/April 2017:
  - Psychiatry trainees taking up next appointment (all grades)
  - Pathology trainees (lab based) taking up next appointment (all grades)
  - Paediatric trainees taking up next appointment (all grades)
  - Surgical trainees all disciplines taking up next appointment (all grades)
  - F2 and GP trainees ST1/2 taking up next appointment and sharing rotas with the above.
- August/October 2017 - all remaining trainees taking up next appointment and all new starters (all grades).
46. Arising from talks, facilitated by Acas, during December 2015, NHS Employers, the BMA and Health Education England (HEE) agreed a range of measures that, while not contractual in nature, could help to improve the quality of the training experience for junior doctors. These include:

- improving access to flexible training
- ensuring equity of study leave provision and definition of the categories of training which should be covered by study leave budgets
- addressing the escalating costs of training for junior doctors.

47. A working group is progressing these issues with representation from HEE, the BMA, NHS Employers and the Academy of Medical Royal Colleges.

48. In its July 2015 report on contract reform, the DDRB agreed with NHS Employers and recommended that ‘the contract should include the potential use of recruitment and retention payments (RRPs) or flexible pay premia’ to incentivise hard-to-fill specialty training programmes. The DDRB further recommended that, ‘For future rounds, the parties should submit evidence setting out what advice has been put forward on shortage specialties and RRPs (or flexible pay premia) so that we are able to review retrospectively the effective use of RRPs and make recommendations as appropriate’.

49. Flexible pay premia are now a feature of the 2016 contract arrangements and are being used to incentivise recruitment to general practice, higher training in emergency medicine and all levels of psychiatry. In future rounds, we (and other stakeholders) may submit evidence on the use of flexible pay premia, so that the review body can make appropriate recommendations on their application and value.

50. HEE and NHS Employers have also made a commitment to meeting the timelines set out in the code of practice for the provision of information. The code is currently being reviewed and strengthened to provide doctors with information about their placements as early as possible in the recruitment cycle. HEE is developing measures to ensure that it can deliver on this commitment. This will better enable employers to provide work schedule information eight weeks ahead of start dates to provide doctors with sufficient time in which to agree annual leave. These steps should end the need for fixed leave in rotas.

51. Subsequent negotiations during May 2016 identified further actions for HEE, including:

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31 NHS Employers 2016 what needs to be done before a junior doctor starts
the development of innovative approaches to training, to remove as far as possible the disadvantage of those who take time out due to, for example, caring responsibilities. This includes targeted accelerated learning to enable the person who has taken time out to catch up. It will involve access to mentorship, study leave funding and specially developed training inputs.

- a review of the processes that allow transfer between regions, joint applications between married couples (or those in a civil partnership), and defined travel time limits to training placements for those with caring responsibilities.

52. It has also been agreed that HEE and NHS Improvement will mandate the use of streamlining\(^{32}\) processes for junior doctors by April 2017, to reduce the burden of HR processes on doctors who frequently move among employers as they progress through training. NHS Employers is already supporting a number of regions to put streamlining in place for all staff and will continue to do so, encouraging and supporting employers in the areas who have not yet adopted this approach to initially agree regional pilot programmes for junior doctors within this timeframe.

53. It is vital that the contract is regularly reviewed and updated. NHS Employers and the BMA have agreed to commission a review by August 2018. This will consider the efficacy of the contract and identify any areas for improvement.

Impact on pay award

54. During the May Acas negotiations, the BMA asked for a multi-year pay deal to be included in the agreement. This would have the effect of making sure that annual uplifts were at least 1 per cent in 2016/17, 1 per cent in 2017/18, 0.9 per cent in 2018/19, and 0.8 per cent in 2019/20. The intention was to provide certainty of earnings and to help financial planning when other cost pressures required attention. This was the position that was set out in the proposed contract, which was subject to the BMA referendum.

Other groups in the remit

55. The DDRB remit also covers staff, associate specialist and specialty doctors (SAS), salaried primary care dentists and salaried general practitioners.

56. These groups are not currently included in the discussions around contract reform. In the case of SAS doctors on national contracts, the discussions may lead to consequential changes to their current national terms and conditions. This will be addressed through our ongoing engagement with SAS doctors through the established joint negotiating committee.

Staff grade, associate specialist and specialty (SAS) doctors

57. SAS doctors and dentists are a diverse group with a wide range of skills, experience and specialties. They work as staff grade doctors, associate specialists, specialty doctors, hospital practitioners, clinical assistants, senior clinical medical officers and clinical medical officers. This diversity is mirrored in the way that employers recruit, deploy and support SAS doctors.

58. There are almost 10,000 SAS doctors in the UK. This is about 20 per cent of the secondary care workforce. There are fewer opportunities for SAS career progression compared with other senior doctors, and the development of SAS doctors has not always been prioritised.

59. Good patient experience is strongly associated with a motivated and engaged workforce where every individual has the opportunity to work at their full potential. Ensuring that this group of doctors receives effective development will benefit patient safety, and employers, as well as the individual doctor.

60. The British Medical Association, Health Education England, the Academy of Medical Royal Colleges and NHS Employers have worked together to develop guidance on the development of SAS doctors in the NHS. This will help ensure that this important group of doctors are helped to remain fit to practice and develop in their careers. This guidance will be published shortly.

61. As well as consolidating existing resources on job planning and the SAS development charter, the guidance also covers:

- SAS autonomy and the benefits of encouraging autonomous practice
- the benefits of undertaking extended roles such as educational supervisors, and management roles such as medical directors or clinical directors
- the importance of effective clinical coding mechanisms to ensure that work is coded to the appropriate clinician rather than to the supervising consultant.

62. The underlying principles can also be applied to dentists working in the SAS grades and other doctors who are not in training and whose appointment does not require them to be on the General Medical Council’s specialist register, for example trust grade doctors.

63. The SAS development fund remains an important resource to support the development of SAS grade doctors and dentists working in England. It is used to support training, development, secondments, and clinical management and leadership skills. The 5YFV describes a number of new care models for the NHS in England that aim to break down the traditional divides between primary, secondary and community care, mental health and social care. The challenge of identifying new ways of working to support new care models will provide opportunities for enhancing and optimising the SAS workforce and for their career development.

64. The national specialty doctor contract has not featured in the current programme of medical contract reform. However, changes to the consultant contract may have some overlap with the SAS contract. We have agreed to keep this under review through the current JNC (SAS) negotiating body.

65. In our survey we asked employers if there were any recruitment or retention issues associated with SAS doctors. The majority said that there were issues but these seemed to be linked to particular specialties or locations. Some respondents put this down to the national labour market. Others had very specific issues, for example recruiting to fill posts relating to a particular disease pathway or where location had proved to be a factor. One employer explained that their trust’s specialist acute status resulted in difficulties in recruiting SAS doctors.

66. Employers cited a range of local initiatives to support recruitment efforts, including:

- regular engagement to support development activity
- improving study leave arrangements
- recruitment programmes
• joint campaigns with neighbouring trusts
• supporting progression through Certificate of Eligibility for Specialist Registration
• using social media
• financial incentives (golden hello).

67. One employer acknowledged that their SAS workforce was a potentially underdeveloped cohort and was working to support their professional development. A number of employers were addressing recruitment difficulties by considering new models of care and the development of new roles, or by aligning services through work on sustainability and transformation plans34.

Salaried primary dental care services dentists

68. The salaried primary dental care (SPDC) services national contract was agreed during 2008. At that time, most SPDC dentists were employed by primary care trusts (PCTs). PCTs were abolished on 31 March 2013. Their community service provision was distributed in various ways, to community trusts and other providers. Instead of being employed by a homogenous group of PCTs, SPDC dentists are now distributed across a range of different employers with different characteristics. Although the contract has remained largely unchanged, the environment in which SPDC dentists work has changed significantly.

69. The contract itself mirrors those for consultants or specialty doctors. However, one significant area of difference is the competency framework for Band A dentists, Band B senior dentists and Band C managerial or specialist dentists. This hasn’t changed since 2008, despite the changes in the NHS since then, and may need to be revisited to take into account that the majority of SPDC dentists are no longer employed in primary care organisations and that the criteria for progression through the bands does not reflect current structures. We are aware that dentists are concerned about the lack of opportunity for movement through the bands.

70. The majority of those employers who responded to our survey reported no significant issues regarding the recruitment and retention of SPDC dentists. However, this might be due to the fact that a relatively small body of staff is spread across a wide range of employers and there is the possibility that there could be issues in particular localities that have not been reflected in our survey.

*https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/stp/*
Salaried general practitioners (GPs)

71. There are model terms and condition for salaried GPs employed in primary care organisations and GP practices. The GP contract requires the model contract to be offered in practices. These model terms were agreed during 2004. There is no negotiating machinery for salaried GPs and as a result they have not been updated since.

72. As with SPDC dentists, the model contract was designed mainly for use where GPs were directly employed by PCTs, which have ceased to exist. Like SPDC dentists, salaried GPs are now employed by a range of different NHS organisations providing a range of services. As a result there has often been some confusion about which terms and conditions should apply to a GP employed by an NHS trust and whether the work they undertake meets the definition of primary care. Employers are also often unsure about the status of the salaried GP pay range and the extent of their discretion in applying the recommended pay range.

73. Around half of those employers who responded to our survey said that they had experienced some issues with the recruitment and retention of salaried GPs. Although some put this down to supply issues, there was no indication that remuneration was a significant factor. A clinical commissioning group pointed out that they are required to have a specific number of GPs on their governing body and that national shortages have meant that it has been difficult to fill those positions.

74. While the salaried GP contract within GP practices has always been an option, there have been some examples recently where contractor or partner GPs have opted for employed status. In Gosport, 11 practices were given the option of working under an employed status with the local community trust, which is a multispecialty community provider (MCP) under the vanguard programme. Six of those practices took up the offer of moving to an employed status under the MCP. The transformational and workforce challenges described earlier in this submission will apply equally to salaried GPs and their employers. It will be important to have a contractual framework that supports and encourages such new ways of working.
Pay award 2017/18

75. The pay review for 2017/18 will be subject to the government’s public sector pay policy, set out in the 2015 Budget, that pay increases across the public sector will be limited to an average of 1 per cent a year for four years.

76. Limiting pay bill growth seeks to help continued delivery of high-quality patient services, while minimising the loss of key frontline staff. Any increases in pay costs not fully funded through the tariff will create additional financial pressure for employers.

Employer views

77. In our survey we asked respondents to rank a series of options on how they would apply a 1 per cent pay award. The option of giving all staff 1 per cent was the highest ranked, with over half of employers selecting this as their highest choice. The four main reasons given for this were that:

- 1 per cent was insufficient to make significant change. One employer commented:

  “The amount is too small to make significant impact on recruitment and retention or a reward scheme. Differentials across types of post could develop variations in pay scales between different trusts and a departure from the national pay scales would create a competitive environment between trusts and be detrimental to recruitment and retention.”

- the effort required to work out alternative local options would be disproportionate to any gain:

  “as the pot is so restricted it is hard to justify putting a lot of effort into anything other than spread by same percentage…effort should go into finding ways of changing terms and conditions to release cash to spend on different priorities”

- the potential impact on staff motivation and morale for those not receiving an uplift:
“1 per cent is not a lot of money to work with… about keeping all staff motivated during a time when we are trying to do things differently and transform our services.

“The pay increase is small and not significant enough to motivate staff under a performance pay process. Staff at all levels suffer financially so we believe the fair way would be to award the increase across the board.”

- the annual uplift is a cost-of-living increase, rather than a reward payment which should be awarded to all staff.

78. Those respondents who selected other options highlighted using the 1 per cent to help address recruitment and retention issues, then giving more to lowest paid staff, giving more to high performers and giving more to staff at the top of their band/grade.

79. The results were consistent with views expressed during our other engagement work with employers during June and July 2016. The prevailing view supported awarding 1 per cent evenly. Most saw this as the most equitable option. Some employers were attracted to the possibility of making more creative use of the resource locally, but there was a recognition that this was dependent on sufficiently resourced and developed local performance management systems. Overall, there seemed to be little appetite for this at the moment. The effort to attempt something different within the limit of 1 per cent would not resolve any labour supply issues.

80. Some employers saw the risk of pay spiral and unnecessary competition if employers were encouraged to adjust pay locally. Other contributors said that the aim should be to reward as many staff as possible without rewarding poor performance. Some noted that the uplift was intended to recognise cost of living increases and was not designed to provide a reward system. Differentiated pay based on objective performance measures would be more acceptable to staff than arbitrary awards.

81. Contributors also noted that there would also be an adverse impact on morale if all staff were not treated the same, which could in turn could affect their willingness to engage with service redesign and transformation work.

82. We also asked employers about whether or not they would prefer a single or multi-year pay approach.
83. The majority of survey respondents said that they would prefer multi-year pay settlements for staff not already covered by pay agreements. Those in favour of a multi-year agreement highlighted the stability offered to employees and the ability to think strategically and plan ahead with regard to pay costs:

“provides stability and certainty… fits with the move towards longer term planning and settlements with trusts.”

84. Those in favour of a single-year agreement noted the uncertainty following the referendum on membership of the European Union, including the possible impact on recruitment and retention and the prospect of a multi-year deal becoming unaffordable:

“There is significant uncertainty at present and being tied into a multi-year pay deal may cause more problems than it resolves.”

85. Most of those employers who commented during our engagement work said that multiple year deals added stability and certainty for staff as well as for planning and budgeting. However, it was noted that where this had happened in the past it meant that nothing else had changed around the pay structure – it would be important to retain the ability to make changes where necessary.

86. Others noted the general level of uncertainty in relation to the impact of the sustainability and transformation work and the impact of the referendum on EU membership, and that in the current circumstances a single year deal would be preferable.

87. In our survey we asked how reform of the junior doctor contract would impact on financial pressures within organisations in the short, medium and long term.

88. Although reform was intended to be cost neutral, many employers felt it was a cost pressure that would continue after full implementation of the contract. One trust identified an additional £2.1 - £2.3 million additional cost pressure on 2018/19. A small number of trusts thought that once the contract had been implemented and pay protection had come to an end, costs would eventually reduce.
89. Some of the reasons given for increased pressure on costs include:

- unfunded costs for the guardian of safe working role
- short-term implementation costs
- difficulties in recruiting sufficient doctors and filling shifts at normal rates
- worsening recruitment and retention difficulties as the result of the new contract, combined with possible impact on EU staff, leading to higher agency and locum costs
- some rotas needing significantly more staff in specialties where there are already shortages.
2. Medical engagement in the NHS

90. The NHS Staff Survey’s staff engagement index score is the best available indicator of staff engagement in the NHS. Each year, NHS staff are offered the opportunity to give their views on their experience at work through the NHS Staff Survey. Within the survey there are questions on the three main dimensions of staff engagement: job motivation, levels of involvement and willingness to recommend the NHS as an employer. The answers to these questions are then converted into an overall score on a five-point scale. The score enables the NHS to track progress over time, compare levels of engagement by occupational group and enables individual employers to compare their relative performance. The latest available data is from the 2015 survey, published in March 2016. The 2016 survey will get underway in October 2016, with results available in March 2017.

91. The differing timescales of the NHS Staff Survey and the review body process mean that the 2015 survey was carried out before the escalation of the junior doctor contract dispute.

92. The GMC carries out an annual national training survey to give junior doctors an opportunity to provide confidential feedback on their perceptions of their local training post and programme. The GMC’s 2016 survey\textsuperscript{35} was published earlier this year and included the following findings from 98.7 per cent of junior doctors:

- 89 per cent of respondents felt that the general training environment was supportive, up from 86.7 per cent in 2015.

- 84.6 per cent of doctors rated the quality of clinical supervision in their post as good or excellent. This was a slight decrease from 84.9 per cent in 2015, and an increase from 83.3 per cent in 2014.

\textsuperscript{35}GMC training survey reports \url{http://www.gmc-uk.org/education/national_summary_reports.asp}
43.2 per cent described the rate of intensity of their work as heavy or very heavy - a substantial increase from 41.4 per cent in 2015 and 41.6 per cent in 2014. In contrast, 52.8 per cent described the intensity of their work as about right, a decrease from 54.2 per cent in 2015, and 53.9 per cent in 2014.

Medical staff engagement

93. Medical staff in the NHS have relatively high levels of staff engagement. For example, the average staff engagement score for all medical staff groups was 3.89 according to the 2015 NHS Staff Survey\textsuperscript{36}. This was higher than the overall score of 3.78\textsuperscript{37} and medical staff were one of the highest scoring of all occupational groups. This was also an improvement from the score of 3.82 in 2014.

94. The main driver of this improvement was a recovery in staff motivation, which had fallen in 2014. The staff motivation indicator rose from 3.99 to 4.05. There was also a notable increase in the willingness to recommend the service from 3.75 to 3.82. The scores for junior doctors were lower than for consultants but rose between 2014 and 2015. It is anticipated that there will be an impact on expressed opinions arising from the dispute over the introduction of new contracts for this group.

95. In some categories of the survey, medical staff engagement is lower than might be expected and there is room for further progress. 76 per cent of medical staff report that they are able to make improvements in their organisation (up from 75 per cent in 2014) and this does vary between organisations. In recent years there has been substantial research into the challenges of fostering engagement amongst medical staff. Employers in the NHS have implemented a range of initiatives to improve staff engagement, including for medical staff.

\textsuperscript{36} NHS Staff Survey 2015 Detailed Spreadsheets, Key Findings, http://www.nhsstaffsurveys.com/Caches/Files/NHS%20Staff%20Survey%202015%20keyfindings_sheet1_0_mean-3.xls

Barriers to staff engagement for medical staff

96. The NHS faces a range of challenges in fostering staff engagement amongst medical staff. These challenges are also experienced in other healthcare systems such as those of the USA and Australia. Medical staff tend to have very high rates of vocational job commitment and identify strongly with their profession. It can be a challenge to foster an equivalent level of engagement with their employer.

97. The development of new systems of management within the NHS has also contributed to a feeling of a loss of power and control by doctors. The separation between management of medical staff and non-clinical management structures may have added to this. Over the past ten years a number of organisations have sought to review their management structures and involve more senior clinicians in leadership positions. Although this has had some success, it in turn may have created new difficulties.

98. What is apparent from the data is that those doctors engaged in leadership at board or clinical director/divisional director level appear to be very engaged in the overall direction of their trusts. These doctors were cited as key individuals in the working of the trusts and seen as crucial factors in the delivery of high-quality services. However, there was often an engagement gap between these medical leaders on the one hand, and specialty leads and the general consultant body on the other.

99. A recent large scale study argued that:

“In many of the sites there was a distinction made in levels of engagement in terms of those doctors that are in formal medical leadership roles and the ‘rank and file’ consultant body who are seen as less engaged in the business of the trust as a whole. Those in medical leadership roles at a range of levels made sure that they attended regular trust update meetings, but the wider consultant body were less engaged and are often less positive about change or initiatives within their trusts. This was described in interviews as something of an ‘engagement gap’.”

http://www.netscq.ac.uk/hsdr/files/project/SDO_FR_08-1808-236_V07.pdf
100. The study went on to argue that organisations needed to take a wider view on how to encourage and support medical engagement:

"Medical engagement cannot be understood from consideration of the individual employee alone. Organisational systems play a crucial role in providing the cultural conditions under which the individual’s propensity to engage is either encouraged or inhibited. The measure must therefore simultaneously assess both the individual and cultural components of the engagement equation."

101. Based on the findings from this study and others, a new tool known as the medical engagement scale was developed and has been widely used across the NHS. It provides a more in-depth assessment of the degree of medical staff engagement and, in particular, levels of involvement. A large number of trusts have used this tool and adopted specific strategies to improve medical staff engagement. Leading examples are cited in the 2014 research report\textsuperscript{39} by the King’s Fund and include Northumbria Healthcare, University College London and Salford Royal, with a particular focus on giving greater budgetary control to clinicians. Other trusts have included medical staff in wider staff engagement work. For example, at Leeds Teaching Hospitals and Wrightington, Wigan and Leigh. NHS Employers highlights this issue and promotes these resources as part of our overall staff engagement work. NHS Employers recognises that employers will need to take action at local level.

\textsuperscript{39} Jon Clark and Vijayi Nath A journey not an event - Medical engagement Kings Fund 2014
Improving morale and motivation through staff health and wellbeing

Boorman

102. The 2009 Boorman review\(^40\) described the importance of prioritising staff health and wellbeing in the NHS. A healthier workforce means fewer avoidable days off sick, reduced levels of presenteeism and a more efficient workforce. The review outlined how to achieve a healthier workforce in 20 recommendations along with key actions. NHS Employers has developed a timeline\(^41\) that provides a summary of what has happened nationally as a result of the review against each of the recommendations. Organisations can use the tool to track their own progress made against the recommendations, allowing them to target their health and wellbeing activities.

NHS England Healthy Workforce Programme

103. The 5YFV made a commitment to ensure the NHS as an employer sets a national example in the support it offers its own staff to stay healthy. In September 2015, Simon Stevens announced further plans to support this commitment, which included a major drive to improve the health and wellbeing of NHS staff. NHS Employers is working with Dame Carol Black, NHS England, Public Health England and the Social Partnership Forum, along with 11 leading NHS organisations. A core wellbeing offer for staff is being developed and robustly evaluated to assist the NHS in developing staff wellbeing approaches that have a positive and sustainable impact.

104. NHS Employers will continue to work closely with NHS England as this programme develops, leading on line manager training and board/senior and clinical leadership, supporting the collective organisations, and sharing key learning and good practice.


Quality and innovation (CQUIN)

105. During March 2016, NHS England announced a Commissioning for Quality and Innovation (CQUIN) payment framework for health and wellbeing. CQUIN enables commissioners to reward excellence, by linking a proportion of English healthcare providers’ income to the achievement of local quality improvement goals. The framework aims to embed quality within commissioner-provider discussions and to create a culture of continuous quality improvement, with stretching goals agreed in contracts on an annual basis. It makes a proportion of provider income conditional on the achievement of ambitious quality improvement goals and innovations, agreed between commissioner and provider, with active clinical engagement.

106. To achieve the CQUIN, trusts are encouraged to take steps such as introducing health and wellbeing initiatives, increasing healthy food choices on premises and encouraging uptake of frontline staff receiving the flu vaccine. NHS Employers has been providing support, guidance and resources to organisations, including presentations and webinars.
3. Workforce supply

107. Health Education England has reported the fill rates for approved national training programmes for junior doctors. These show that fill rates have been generally satisfactory despite the public rhetoric during the high-profile dispute about the new national terms and conditions, which suggested that doctors would choose to leave the NHS including pursuing medical careers in other countries. For example, general practice training places have a higher fill rate than last year to a higher number of approved programmes.

108. It also appears that, where the fill rates are lower than last year and the number of acceptances are lower than last year, the phenomenon of doctors choosing location over specialty (which we have commented on in previous years) has come into play. So, in some cases programmes have vacancies because doctors have chosen to delay their entry into a particular level and work instead as trust doctors or in fellowship roles, hoping that their chosen specialty may be available in their preferred location in future years, or they have chosen a different specialty in the location they prefer. So, for example, some programmes continue to recruit strongly in London while leaving gaps elsewhere, despite the increased costs of living and working in London.

109. Such location-driven decisions will not be solved by pay solutions in terms of the values of pay points, although in some cases pay premia may help.

110. In some cases, fill rates are low because they are result of previous years’ low fill rates having a knock on effect in the current year. However action taken in year will feed better fill rates in the years ahead. For example, level 4 emergency medicine programmes have a fill rate of 26 per cent, albeit with a higher number of programmes accepted than last year and a higher fill rate. It means roughly 65 per cent of the maximum flow from level 3, which most regard an acceptable flow from the lower level of training. This year’s fill rate at level 3 combined with the additional flow via the HEE DRE-EM programme can be expected to increase the fill rate next year.

42 Defined route entry – Emergency Medicine (DRE-EM pathway)
111. Recruitment to emergency medicine programmes has been stronger in London than in other regions of England. This may reflect the reconfiguration of services providing emergency departments with better rota sizes, enabling the provision of effective training while allowing for an acceptable work-life balance.

112. In emergency medicine, the fill rate may understate the actual capacity at ST4 level. The emergence of the run-through programme for emergency medicine⁴³, as well as the defined route of entry into emergency medicine (DRE-EM) will also ensure that more vacancies are covered by doctors’ progression through the training programme without the need to go through the recruitment process. These will not be represented by HEE’s published recruitment fill rates, but will emerge as part of the HEE annual stocktake census later in the year.

113. Another programme that attracts a pay premium under the new junior doctor contract – psychiatry – has seen level 4 fill rates lead to increased acceptances compared with last year in child and adolescent psychiatry, general psychiatry and old age psychiatry, and in general psychiatry. Level 1 core psychiatry training has seen over 2 per cent more acceptances leading to more than 11 per cent more trainees starting in that programme compared with last year.

114. All the observations from employers continue to suggest that while medicine in general continues to be an attractive career, there are some areas where recruitment is less than optimum. However, those areas and specialties are not easily remediated by decisions on pay rates. Instead they require systems changes to service delivery and / or the design of the training programmes themselves.

115. A further issue to address is that of movement from England to other countries. It has been suggested that doctors will choose to relocate to Scotland as a result of contract changes introduced in England. This does not seem to be borne out by the fill rates reported by HEE, or the reports directly from the service. Doctors appear to be continuing to seek training programmes that meet their career aspirations in the location they wish to work in. For example, level 1 core psychiatry has filled at an ‘above par’ rate in the north east of England – thought to be the most vulnerable region to doctors choosing to move to Scotland.

⁴³ See: https://heeoe.hee.nhs.uk/em_specialist
Workforce directors in the north east have also told us that some doctors continue to choose to move from Scotland to the north east, seeking the opportunities that meet their career aspirations better. Pay and terms and conditions do not appear to be the driver of these career decisions.

116. In our survey of employers, we asked whether the agency cap had encouraged staff to work on a substantive basis. One employer said that although the cap had been successful in terms of nurse recruitment, there had been less effect on doctors who were prepared to travel much further for work or not work at all if the rates were not to their liking. Another employer said that conversations that they had held with staff in shortage areas revealed that staff enjoyed the flexibility that agency work gave them. Staff from overseas often came to work in the UK for short periods and long-term substantive employment was not always a priority.

117. We also asked employers about the use of recruitment and retention premia (RRPs) for consultant doctors. The majority of respondents said they didn’t use them. The reasons given for the use of RRPs for those employers that did use them included helping to recruit to shortage areas, and attracting overseas consultants with a package commensurate to what they might have earned if they had worked in the NHS.
4. Pensions and total reward

Total reward

Components of total reward in the NHS

118. The NHS continues to have a well-regarded package of valuable employment benefits, including a generous pension scheme. In addition to pay and benefits, we are increasingly seeing that employers in the NHS are broadening their definition of total reward to include recognition schemes, health and wellbeing initiatives and training and development programmes, among others.

119. In 2016, NHS Employers surveyed 100 employers on elements of their approach to reward strategy. In response to requests for examples of positive local reward initiatives, there was a variety of responses demonstrating this wider consideration of what comprises reward. However, the largest response related to recognition schemes/awards, reflecting an increasing focus on staff engagement.

120. The broader definition of total reward to consider elements outside of just pay and benefits is also represented through the NHS Employers total reward engagement network (TREN). TREN is a network facilitated by NHS Employers, open to NHS organisations engaged in total reward work, to give attendees the opportunity to discuss reward-related issues and share knowledge and experience with colleagues. NHS Employers uses the group to encourage engagement with the total reward agenda and provides a route to more closely understand strategic reward in the NHS, and enables the development of relevant products and tools to support reward initiatives.

121. NHS Employers also commissioned the Institute of Employment Studies (IES) to undertake an evidence review on the relationship between total reward and staff engagement44. This review indicated that the broader the definition of total reward that is adopted, the more significant the potential impact on employee engagement appears to be.

Total reward strategy in the NHS

122. The IES evidence-based review on the relationship between total reward and employee engagement reinforces that there is no one-size-fits-all approach to reward. This suggests that reward strategies should be designed to meet the unique needs of the employer and their staff.

123. The NHS Employers reward strategy survey explored how strategic total reward was being used in the NHS. Asked if their organisation had a reward strategy in place, only 15 per cent stated that they did. However, 51 per cent of those that did not, noted that one was currently in development.

124. Additionally, a significant proportion commented that although they did not have a specific reward strategy, they had elements of strategic reward in other workforce strategies, such as the people or organisational development strategy, health and wellbeing strategy or recruitment and retention strategy. 30 of the 100 respondents (the largest proportion) stated that resources not being available in the organisation was the main reason for not having a reward strategy.

125. A similar split is reflected by members attending the TREN, with some employers having a reward strategy, some having embedded it in other strategies and a large proportion currently in the process of developing a reward strategy.

126. This would indicate that strategic total reward as a concept is being applied but integrated more fully with other business approaches, particularly as a response to specific workforce challenges such as recruitment or retention.

Reward as a response to workforce challenges

127. The nature of strategic reward attempts to meet some form of business goal or objective. Our reward strategy survey sought to determine how employers were using reward to meet specific workforce challenges.

128. The largest response of 54 per cent stated that they were using reward to meet recruitment and retention issues. Remaining responses were spread over a variety of different priorities such as temporary staffing, staff engagement, training and development, recognition, productivity and health and wellbeing.
129. A quarter of respondents stated they were not using reward to meet specific workforce challenges, which suggests there could be more focus applied to ensuring reward return on investment.

**Local approaches to reward**

130. This increased focus on using reward to meet workforce challenges is reflected in some of the local reward initiatives being developed. Our reward survey and interactions through TREN show an increase in low cost or cost neutral developments such as recruitment refer a friend schemes, promotion of buying/selling annual leave, negotiated travel reductions, money advice services and relocation allowances.

131. The largest local reward initiatives appear to remain salary sacrifice arrangements, where individuals can sacrifice a proportion of their salary prior to tax and national insurance in order to receive a tax-free benefit. The most popular of these are childcare voucher schemes, but our engagement suggests that these are being used for a wider range of goods and services, including electronic goods and car lease schemes.

132. Whilst such schemes are attractive to employers due to the low cost of delivering them, there are challenges to the future delivery of these. The government intends to review the continued tax-free provision of salary sacrifice arrangements, and has recently published a consultation on salary sacrifice and benefits in kind.\(^{45}\)

133. Salary sacrifice schemes are only attractive if an individual has enough income to take advantage of them. The introduction of the living wage earlier this year has restricted access to salary sacrifice schemes for low earners. Employers are responsible for ensuring that the living/minimum wage is paid, and if salary sacrifice schemes take a staff member's take-home pay below this threshold then employers are liable to top up the remainder. This has meant some employers restricting access to these schemes.

134. The introduction of the 2015 NHS Pension Scheme as a career average revalued earnings (CARE) scheme, provides a different interaction with salary sacrifice than final salary schemes.

With a CARE scheme, each year of pension contributions adds to the final pension, so individuals in a salary sacrifice scheme would be adding less to their pension than they would otherwise, were they not in a salary sacrifice arrangement. This potentially reduces the perceived value of salary sacrifice arrangements and/or the NHS Pension Scheme.

Total reward statements

135. Total reward can only contribute to meeting workforce needs if staff are aware of them and engage with them. Total reward statements (TRS) are one way in which NHS organisations can promote benefits that they offer locally, as well as providing valuable information about the value of pensions through an annual personalised summary of the benefit package.

136. 2015/16 was the second year of rollout of TRS in the NHS. Information from the NHS Business Services Authority indicates that a total of 198,351 active NHS Pension Scheme members accessed their statement during the main rollout (up to 31 December 2015) in England and Wales. This was an increase of 26 per cent compared to the previous year.

137. Surveyed feedback on TRS indicates that 83 per cent of employees claimed to be aware of TRS, compared to 55 per cent in the first year of rollout. 70 per cent of employees who accessed their statement rated their overall experience of the TRS website as either very or fairly good. 88 per cent thought that the element of their statement relating to their membership of the NHS Pension Scheme was useful.

NHS Pension Scheme

2015 NHS Pension Scheme

138. The 2015 NHS Pension Scheme was launched on 1 April 2015, replacing the 1995 and 2008 sections (except where individual protection applied). The 2015 Scheme is a career average revalued earnings (CARE) defined benefits scheme, which pays a pension based on the average of a member’s pensionable earnings throughout their whole career, revalued in line with the Consumer Price Index plus 1.5 per cent per annum.
139. Normal pension age, the age at which benefits can be claimed without reduction for early payment, is now linked to the same age as a member is entitled to claim their state pension. A build-up rate of 1/54th of each year’s pensionable earnings applies to the new scheme, which is a higher build-up rate of both the 1995 and 2008 sections of the NHS Pension Scheme.

140. The flexibilities within the 2008 section of the scheme relating to early or late retirement factors, draw down of pension on partial retirement and return to the NHS Pension Scheme are retained in the 2015 scheme. There is a new provision for early retirement reduction buyout (ERRBO), where members and/or employers can pay additional contributions through ERRBO to eliminate or lower the amount of reduction that would apply, limited to a maximum of three years before the member reaches their normal pension age.

**Contribution rates**

141. The employer contribution rate for both the 2015 NHS Pension Scheme and 1995/2008 sections of the scheme are set at 14.3 per cent of pensionable pay. This rate is determined as part of the funding methodology applied by the scheme actuaries.

142. Members of the NHS Pension Scheme provide contributions on a tiered basis, to produce a total yield to HM Treasury of 9.8 per cent of total pensionable pay. The employee contribution rates are outlined below.

<table>
<thead>
<tr>
<th>Tier</th>
<th>Pensionable pay (whole-time equivalent)/earnings used to assess contribution rate</th>
<th>Contribution rate for scheme years 2015/16 through to scheme year 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Up to £15,431.99</td>
<td>5.0 per cent</td>
</tr>
<tr>
<td>2</td>
<td>£15,432.00 to £21,477.99</td>
<td>5.6 per cent</td>
</tr>
<tr>
<td>3</td>
<td>£21,478.00 to £26,832.99</td>
<td>7.1 per cent</td>
</tr>
<tr>
<td>4</td>
<td>£26,824.00 to £47,845.99</td>
<td>9.3 per cent</td>
</tr>
<tr>
<td>5</td>
<td>£47,846.00 to £70,630.99</td>
<td>12.5 per cent</td>
</tr>
<tr>
<td>6</td>
<td>£70,631.00 to £111,376.99</td>
<td>13.5 per cent</td>
</tr>
<tr>
<td>7</td>
<td>£111,377.00 and over</td>
<td>14.5 per cent</td>
</tr>
</tbody>
</table>

Source: [http://www.nhsbsa.nhs.uk/Pensions/4207.aspx](http://www.nhsbsa.nhs.uk/Pensions/4207.aspx)
143. The nature of tiered contribution rates means that increases to pensionable pay, such as through pay awards, can mean that a pay rise for pension scheme members could lead to a reduction in take-home pay. For example, the April 2016 pay rise of 1 per cent affected those at the top point of Band 8A in this way. The 01 per cent pay rise took those staff to a salary of £48,034 per annum. This caused them to cross into contribution tier 5, from 9.3 per cent to 12.5 per cent. This led to an annual pension contribution rise from £4,423 per annum to £6,004 per annum.

144. With the introduction of the 2015 NHS Pension Scheme, which is a CARE scheme, it is expected that future changes to the contribution tiers will ‘flatten’ with a long-term aspiration of a single contribution tier for all scheme members. However, whilst there are still members who have a mixture of final salary and CARE scheme benefits, there is a requirement to maintain a tiered approach to balance contributions versus received benefits.

**Scheme membership**

145. The NHS Pension Scheme accounts 2015/16 provide information on scheme membership for England and Wales, including those that have chosen to opt out of the scheme during that year. An extract from the accounts is below.

<table>
<thead>
<tr>
<th>Details of active scheme membership as at 31 March 2016</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Active members at 1 April 2015</td>
<td>1,428,050</td>
</tr>
<tr>
<td>Adjustment (see note 1)</td>
<td>(5,421)</td>
</tr>
<tr>
<td>Restated active members at 1 April 2015 (see note 2)</td>
<td>1,422,629</td>
</tr>
<tr>
<td>New entrants</td>
<td>162,458</td>
</tr>
<tr>
<td>Deferred members who rejoin in the year</td>
<td>55,030</td>
</tr>
<tr>
<td>Re-employed pensioners</td>
<td>415</td>
</tr>
<tr>
<td>Retirements</td>
<td>(32,874)</td>
</tr>
<tr>
<td>Leavers with deferred pension rights</td>
<td>(110,031)</td>
</tr>
<tr>
<td>Deaths</td>
<td>(792)</td>
</tr>
<tr>
<td><strong>Active members as at 31 March 2016</strong></td>
<td>1,467,102</td>
</tr>
</tbody>
</table>

Note 1. Member records are updated retrospectively after the year end, after the membership statistics are prepared for the scheme accounts. This is due to the volume of data required to be uploaded onto the pension administration systems from employers, and the resolution of any subsequent data errors. An adjustment will be required each year to show a revised opening position to reconcile to the movements and closing position for the year.

Note 2. The membership data at 31 March 2015 differs from that disclosed in the Report of the Actuary as the data extract provided to GAD was taken in November 2015, whereas these statistics were taken from a data extract provided in May 2016 and member data is continually updated after the year end.
Pension taxation

146. Any NHS employee who has pension benefits above tax thresholds may be liable to a tax charge. This has the potential to impact the perception of the NHS pension as a benefit and to impact workforce behaviour.

147. The two thresholds are annual allowance and lifetime allowance. It used to be the case that few NHS workers were likely to exceed the tax thresholds, but changes in recent years mean that more staff are likely to be impacted.

148. Annual allowance is the amount of pension savings an individual can make in one year before receiving a tax charge. The annual allowance limit is currently £40,000 in 2016/17, the same as in 2014/15, reduced from £50,000 in 2013/14.

149. In April 2016, the tapered annual allowance was introduced. This cuts pension tax relief for high earners by introducing a tapered annual allowance of those with ‘adjusted incomes’ of over £150,000. The rate of reduction in the annual allowance (from the current maximum of £40,000) is by £1 for every £2 that the adjusted income exceeds £150,000, up to a maximum reduction of £30,000 at £210,000. For example, at £210,000 the annual allowance is only £10,000.

150. Lifetime allowance reduced from £1.25 million to £1 million in April 2016. The lifetime allowance is the total amount that an individual can have in their pension savings, during their lifetime, without incurring a tax charge.

151. Defined benefit pension is tested against the lifetime allowance using the amount of pension, and lump sum if relevant. Defined benefit pensions are multiplied by a factor of 20 and any retirement lump sum is added to the result.

152. With 46 per cent of the NHS workforce aged 45 or above\(^\text{46}\), there are a significant number of staff who are at an age where they are considering their retirement options. Anecdotally, there is a perception that the change in public service pensions has led to a less desirable pension scheme, and this change to pension taxation, among others changes such as prolonged pay restraint; years of increased pension contribution increases and changes to state pension leading to increased National Insurance (NI) contributions, may lead people down the path of some form of retirement or flexible retirement.

\(^{46}\) Health and Social Care Information Centre, September 2015 provisional statistics
This will potentially have an impact on supply and demand, and associated factors such as staff experience and agency/locum spend.

153. As high earners contribute more through their higher rate of employee contributions, if a significant number of high earners opt out of the scheme, this will have an impact on the average overall yield that is received. The NHS Pension Scheme is required to deliver an average yield of 9.8 per cent. When the NHS Pension Scheme valuation exercise is undertaken (using data from 2016 and taking effect from 2019) this could mean an increase in employee contribution rates at all levels, including lower bands, which could potentially impact on the behaviour of other members and increase the general level of opt out. This has the potential to undermine the integrity of the scheme should such opt outs continue in significant numbers.

**Changes to state pension**

154. On 6 April 2016, the state pension was replaced with a new one for those that reach state pension age on or after that date. The new state pension replaced the previous basic and additional state pension. Employees who contributed to a contracted-out occupational pension scheme, such as the NHS Pension Scheme, did not receive the additional state pension and paid a lower rate of NI contributions, along with their employers.

155. The introduction of the new state pension meant the end of contracting-out and ended the reduction in NI that contracted-out employers and employees paid. Employers no longer receive the 3.4 per cent NI rebate and now pay the standard rate of 13.8 per cent of all earnings above the secondary threshold for all employees. The 1.4 per cent NI rebate for employees also ended.

156. The removal of the rebate for employees has been another cost pressure for members of the NHS Pension Scheme and contributes to impact on take-home pay. Although not directly related to the NHS Pension Scheme, individual members may perceive this as a further erosion in the value of the scheme, particularly following previous years of contribution rises and change to the 2015 CARE Scheme.
5. Staff numbers and paybill

157. Analysis of published NHS statistics provides evidence of the recruitment, retention and paybill cost trends that employers are reporting. In addition to the published statistics, NHS Employers has also undertaken its own analysis of workforce and payroll data to identify trends not evident in the published information. Against each of the areas of interest below, more detailed data tables have been provided in the annexes.

Staff numbers

158. Annex C\textsuperscript{47} shows that the number of consultants grew by 1,651 FTEs, (4.0 per cent) between September 2014 and 2015. There was also a greater number of foundation doctors in Year 1, up by 84 (1.3 per cent) to 6,370. In contrast, the total numbers of SAS doctors (8,916) and Year 2 foundation doctors (6,581) other and unknown HCHS doctor grades (1,515) in September 2015 were broadly the same, whilst the numbers of registrars decreased by 238 (0.6 per cent) to 38,785. There is variation within the grades, however. For example, the number of core medical trainees rose by 1.8 per cent whilst the number of core dental trainees decreased by 6.5 per cent. For numbers of doctors in approved national training programmes (i.e. they have unique national training numbers), the variations in numbers by specialty reflect the training programme commissions of Health Education England.

159. The new healthcare workforce statistics include the inclusion of grade as shown in Annex D. Figure 1 below shows the profile of full-time equivalents (FTE) profiled by grade and region/special health authorities and other statutory bodies. The table in Annex D and the chart below shows that there are proportionately more staff in training grades in London than in the other regions. Medical and dental staff in special authorities and other statutory bodies (central bodies and support organisations) were predominantly in career grades.

Vacancies

160. NHS Employers welcomes the new NHS Digital publication\footnote{NHS Digital, *NHS Vacancies Statistics England 2015, Provisional, Experimental statistics*, http://digital.nhs.uk/catalogue/PUB20132} which details an analysis of vacancies advertised on NHS Jobs. In the longer term this will assist in providing quantified evidence of the localised recruitment difficulties that employers inform us of. The new publication also details numbers of web hits, applications, shortlistings and total appointed. This will hopefully provide not only an assessment of vacancies, but also the number and quality of applications.

161. As this publication is in its first year, it is marked as experimental. We are cautious of over-interpreting this initial publication, because we are aware of inconsistencies in the way the data is recorded between staff groups and areas. Once a longer-term time series of vacancies data is available, it will be possible to make an assessment of whether the recruitment position is easing or becoming more difficult.

162. The table in Annex E shows the numbers of advertised vacancy FTE and accompanying information during February 2015 to March 2016 by staff group.

Turnover

163. Figure 2 (page 48) shows that the number of joiners continues to exceed the number of leavers, which is consistent with the workforce growth reported. Whilst the number of leavers is increasing slightly, this has been offset by greater increases in joiners.\footnote{NHS Digital}
Figure 2: HCHS Doctors - joiners and leavers rates, NHS trusts and CCGs

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Leavers</th>
<th>Joiners</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2010- March 2011</td>
<td>14.40%</td>
<td>15.80%</td>
</tr>
<tr>
<td>March 2011- March 2012</td>
<td>14.60%</td>
<td>15.50%</td>
</tr>
<tr>
<td>March 2012- March 2013</td>
<td>14.50%</td>
<td>15.50%</td>
</tr>
<tr>
<td>March 2013- March 2014</td>
<td>15.10%</td>
<td>16.70%</td>
</tr>
<tr>
<td>March 2014- March 2015</td>
<td>14.50%</td>
<td>16.30%</td>
</tr>
<tr>
<td>March 2015- March 2016</td>
<td>15.50%</td>
<td>16.20%</td>
</tr>
</tbody>
</table>

Pay bill metrics

164. The Department of Health’s (DH) pay bill metrics show that the pay bill for HCHS medical and dental staff (excluding locums) grew by 2.3 per cent in 2015/16, while the size of this workforce increased by 1.9 per cent. This means there has been a 0.4 per cent increase in the pay bill per FTE growth (the cost per unit of staff). This is partially due to a continuing shift in the staff group mix (0.7 per cent) towards a more senior/experienced workforce.

165. Annex F, from the DH headline HCHS pay bill metrics, details the contribution of changes to each of the pay elements to the change in pay bill per FTE. The revised metrics show that 0.3 percentage points of the pay bill growth in 2015/16 is due to basic pay drift. Basic pay drift includes the effect of incremental progression, and the changing distribution of staff across pay points and grades on the average basic pay per FTE. The grade mix of the medical and dental workforce is strongly influenced by changes to the consultant workforce.

Consultant workforce and pay growth

166. The consultant pay bill metrics (see Annex F1) show that the aggregate (non-locum) consultant pay bill grew by 4.0 per cent in 2016/17. This was primarily down to a 4 per cent growth in the consultant workforce (slightly greater than the growth in pay bill.) This means that the pay bill per FTE has decreased slightly by 0.1 per cent. Annex F1, from the DH headline HCHS pay bill metrics, details the contribution of changes to each of the pay elements to the reduction in pay bill per FTE.

167. Growth of the consultant workforce has contributed to a negligible pressure to the basic pay per FTE metric. The employment of newly qualified consultants who join the workforce at the bottom of the pay scales provides a downward pressure on consultant pay drift by reducing the average basic pay.
Staff earnings by grade

168. NHS Digital produces quarterly estimates of NHS staff earnings, which show medical and dental workforce earnings by grade taken from the Electronic Staff Record (ESR).

169. Annex G and Annex G1 show mean annual basic pay, and mean annual total earnings, for hospital and community health service (HCHS) medical and dental grades over time.

170. Annex G shows that the average basic pay per full-time equivalent:

- increased between April 2014-March 2015 and April 2015-March 2016 for hospital practitioners and clinical assistants and other medical and dental staff
- stayed much the same for registrars and consultants
- decreased slightly for other doctors in training over the same period.

171. Annex G1 shows that mean total earnings per member of staff:

- increased between April 2014 - March 2015 and April 2015 - March 2016 for hospital practitioners and clinical assistants and other medical and dental staff
- stayed much the same for training grades
- decreased very slightly for consultants over the same period.
Acas confirms the agreement between the BMA, NHS Employers and the Secretary of State for Health of negotiated terms which, subject to a referendum of relevant BMA members, form the basis for a new contract in 2016.

Over the last ten days both parties have resolved the outstanding issues taken forward from previous discussions, finalised and confirmed areas already agreed, and developed further measures which address the wider concerns of junior doctors. These are covered in this summary as per the Acas agenda we followed in the process.

A full contract agreed between the parties will be published at the end of May. The detailed contract will include a combination of agreed terms from February negotiations and the new provisions included in this statement. Issues resolved in the February talks and presumed to form the basis for these additional provisions include:

- an agreement to replace the banding system for rewarding unsocial hours with payment for all work done to support seven day service delivery
- a series of new limits on working hours
- the replacement of an incremental pay system with a series of nodal pay points based on attainment and responsibility rather than time served.

This agreement reflects therefore the commitment of the parties to the following:

- the safety of patients and junior doctors
- terms and conditions which appropriately respond to the diverse characteristics of the junior doctor community
- a healthy working environment for junior doctors which values their contribution throughout the week
- a high-quality training experience for junior doctors
- revisions and improvements to terms and conditions to address the ongoing need to properly reward, protect and retain a valued workforce.

This agreement is positively supported by all those involved in what have been constructive talks.
A. Equalities

The government, employers and the BMA are committed to supporting equality of opportunity for all medical staff and the wider NHS team. There is a recognition that junior doctors with caring responsibilities can face particular challenges during their training, but also that the NHS is committed to creating the best working environment for all its staff.

The parties have therefore agreed to support a range of initiatives:

1. Accelerated Training support

There is an agreement to develop innovative approaches to training, to remove as far as possible the disadvantage of those who take time out due to, for example, caring responsibilities. This approach would include targeted accelerated learning with the prime intention to enable the person who has taken time out to catch up. This will include access to mentorship, study leave funding and specially developed training inputs.

The Secretary of State has confirmed that this enhancement will be additionally funded from outside the contract pay bill. Both parties recognise the importance of ensuring that these arrangements do not disadvantage a junior doctor who does not take time out or training.

2. Deployment

HEE will lead a review of the processes which allow transfer between regions, joint applications between married couples (or those in a civil partnership), and training placements for those with caring responsibilities within defined travel times. The delivery of this work will form part of the mandate set by the Secretary of State for HEE to be completed by the end of March 2017.

3. Improving practice

NHS Employers will jointly review with the BMA approaches to good rostering practice, including the proper use of technology, which support greater flexibility for junior doctors and employers. Rostering experts will be engaged in this work to ensure that best practice can be applied, which will be completed by January 2017.
4. Contractual terms

The parties have agreed to improve the terms and conditions of service to make it clear that where trainees have to change training path due to caring responsibilities, then their previous nodal point pay will be protected. This is the same arrangement as put in place for those changing training programme due to disability related circumstances.

5. Governance

The Guardian role will include proper oversight of safe working practices, including associated diversity and equality issues. This will include liaison with the Director of Medical Education to ensure that a member of the educational faculty in the Trust is designated as a champion for flexible training.

Employers, HEE and the BMA will put in place comprehensive equalities monitoring mechanisms for all protected characteristics to be signed off via the JNCJ for implementation from April 2017.

6. Equalities Guidance & Schedules

Joint guidance will be developed by the BMA and NHS Employers to ensure the effective delivery of elements of the NHS-wide staff handbook for doctors on rotation. This guidance will cover Caring for children and Adults, Flexible working and balancing work and personal leave and will be explicitly referenced in the contract.

7. Pay System Improvements

In order to distribute pay more fairly the parties have agreed to further revise the nodal pay point structure.

B. The Guardian of Safe Working

The BMA JDC, the government and employers confirm their strong commitment to the jointly appointed Guardian, recognising the role’s importance in ensuring safe working for doctors in training. The parties have been able to work together to clarify some important details of the role. This aspect of the package of measures will be reviewed by the parties in August 2018.
1. Guardian Reporting

The frequency of the Guardian report to the board will be increased to at least once a quarter. It will include data on all rota gaps on all shifts. A consolidated annual report on rota gaps and the plan for improvement to reduce these gaps should be included in a statement in the Trust's Quality Account, which must be signed off by the Trust Chief Executive.

2. Liaison with doctors

Each Guardian and Director of Medical Education will jointly establish a Junior Doctors Forum (or fora) to advise them. This will include junior doctor colleagues from the organisation and must include the relevant junior doctor representatives from the LNC (or equivalent) as well as the Chair of the LNC. Doctors on the fora will be elected from amongst the trainees employed in the organisation (or organisations who share the same guardian). Where the guardian for safe working, covers specialties that are small or have specific employment requirements, the fora will include representatives of these groups. The group will also include relevant educational and HR colleagues as agreed with the group. The junior doctors forum or a sub-group it establishes will play a vital role in the scrutiny of the distribution of income drawn from fines.

3. Disbursement of Fines

The money raised through fines must be used to benefit the education, training and working environment of trainees. The guardian should devise the allocation of funds in collaboration with the trust junior doctors’ forum, or equivalent. These funds must not be used to supplement the facilities, study leave, IT provision and other resources that are defined by HEE as fundamental requirements for doctors in training and which should be provided by the trust as standard.

The details of the guardian fines will be published in the organisation’s annual financial report (accounts), which are subject to independent audit. The guardian’s annual report will include clear detail on what the money has been spent on.

4. Financial Penalties

In addition to the financial penalties already proposed in the contract, the parties have agreed that where breaks are missed on 25% or more of occasions, across a 4 week reference period, a guardian fine will apply at two times the rate for the time not taken as a break. Additionally, a work schedule review may be required to ensure that at least 75% of breaks are taken.
5. GP trainees

Where lead employer arrangements exist for GP trainees, the lead employer is responsible for appointing the guardian, who must either be familiar with the issues faced by GPs working in a practice setting or have access to support and advice on such issues. Where lead employer arrangements are not in place, employing practices with fewer than 10 GP trainees must either (a) jointly appoint an independent guardian with another similar employer or employers with fewer than 10 GP trainees such that an appointed guardian has responsibility for a minimum of ten trainees or (b) must enter into a contract with a neighbouring trust or foundation trust to provide the guardian function.

6. Guardian and lead employers

All Trusts and FTs must appoint a guardian. The guardian role will be established in host employers, and the arrangements made clear in the memorandum of understanding between the lead and host organisations. The host guardian will ensure information is available to the host organisation board as per this agreement, and the lead employer guardian must see guardian reports for all of the doctors under their employment.

7. Small employers

Non-hospital employers with fewer than 10 trainees (this could include but is not limited to public health, occupational health medicine and palliative care) must contract the guardian of safe working at a neighbouring NHS trust to oversee the safe working of their trainees. The trainees affected by these arrangements will be represented in the Junior Doctors Forum, and the Guardian must either be familiar with the issues faced by doctors working in the relevant setting or have access to support and advice on such issues.

8. Appealing the decision of the guardian

The final stage is a formal hearing under the final stage of the employer's local grievance procedure. This will be as per the ACAS guidance for grievances. Any appeal against the decision of the guardian will involve a representative from the BMA or other relevant trade union nominated from outside the Trust, and provided by the trade union within one calendar month.

9. Performance management of the guardian

It is agreed that there will be a system of performance management which will include the opportunity for representatives of the doctors in training to contribute to the assessment, for example, through a system of 360° appraisal. Where there are concerns regarding the performance of the guardian, the BMA (or relevant trade union) or the Junior Doctors Forum or any individual doctor in training should
raise those concerns with the Trust Medical Director. These concerns can be escalated to the senior independent director on the Board of Directors where they are not properly addressed or resolved.

C. Recruitment and Retention

This new contract ensures that doctors are incentivised to work in some areas of particular need for patients and services, whilst commencing and completing and training in ways which respect their skills and time.

1. FPP

The parties have agreed to increase the Flexible Pay Premia presently to be paid to those with a training number in OMFS, Emergency Medicine and Psychiatry to £20,000 for the duration of the training period, paid for the defined expected period of training (e.g. four year training programme = £5000 pa). The entitlement is to be pro-rata for less than full time trainees, and will remain within the £20,000 envelope. Where training takes longer, annual payments are to be received based on the averaged annual rate for the respective programme, except where the training is combined with that in another speciality where the FPP would be paid for the duration of the training in the shortage speciality. None of the FPP payments would be pensionable.

2. Streamlining

The parties acknowledge that the way that the NHS recruits and inducts all its staff can be improved in ways which are more considerate of the time of the employee as well as more efficient. They are grateful that NHS Improvement and HEE have undertaken to mandate all employers to establish regional streamlining processes by April 2017.

3. Period of grace

HEE commits to provide its share of salary funding for 6 months after any doctor has successfully completed their specialist training, though this continued employment will not necessarily be in the same place of work as their final training placement (though should be in the same LETB, unless the doctor agrees otherwise)
4. Changing training path

It is agreed that where a trainee changes training and career path due to a circumstance related to disability then the protection of their entitlement to nodal pay does not have a qualifying time period. In all other circumstances (change due to caring responsibilities, change to a shortage speciality) then the qualifying period is six months service. Where in this circumstance a trainee has missed the relevant application round, then they must gain a place within twelve months of leaving the original programme.

5. Mutual recognition of curricula

Following a discussion with the Secretary of State, the GMC has agreed to lead a review with the Royal Colleges, representatives of junior doctors and the organisations funding postgraduate medical education in the four countries across the UK to support appropriate recognition of competence where junior doctors change training paths. This review should enable quicker progress through training programmes and through the salary structure for doctors changing training path for reasons other than related to a disability or caring responsibility, or transferring into a shortage speciality. The GMC will complete this work by 31 March 2017.

D. Terms of Service

Through constructive discussion a number of clarifications and revisions have been made to terms and conditions of service which respond to questions raised by doctors.

1. Breaks

An agreement that breaks can be taken flexibly during a shift, and should be evenly spaced where possible. However where breaks are combined the contract will make clear that this must be taken as near as possible to the middle of the shift. No break should be taken within an hour of the shift commencing or held over to be taken at the end of the shift.

2. Pay for additional hours of work

The parties recognise that a doctor may consider that there is a professional duty to work beyond the hours described in the work schedule, in order to secure patient safety. In such circumstances, employers will appropriately compensate the individual doctor for such hours, if the work is authorised by an appropriate person. This authorisation would be given before or during the period of extended
working, or afterwards if this is not possible. These provisions will, it is agreed, also apply to additional hours of actual work over the prospective average estimate during non-resident on-call (as described in the work schedule).

Compensation will be made to the doctor by additional payment or by time off in lieu (TOIL), or by a combination of the two. Where payment is not authorized, the reason for the decision will be fed back to the doctor and copied to the Guardian for review.

TOIL arising from breaches in rest requirements must be taken within 24 hours unless the doctor self declares as fit for work and the manager agrees, in which case it can be accrued. TOIL arising from breaches of hours but not rest can be accrued. Accrued TOIL can be "banked" but should normally be taken within three calendar months of accrual.

In any circumstances where TOIL cannot be taken, payment will be made in lieu, at the prevailing hourly rate for the time where the additional work was undertaken.

Employers will introduce systems to support claims for payment which are simple to use.

3. Fidelity to the NHS

The parties have agreed that where a doctor intends to undertake hours of paid work as a locum, additional to the hours set out in the work schedule, the doctor must offer such additional hours of work exclusively to the service of the NHS via an NHS staff bank. The requirement to offer such service is for work commensurate with the grade and competencies of the doctor, though the doctor may choose to accept work at a lower grade, if they wish.

The doctor can carry out additional activity over and above the standard commitment set out in the doctor’s work schedule up to a maximum average of 48 hours per week (or up to 56 hours per week if the doctor has opted out of the Working Time Regulations). The employer will agree with the LNC local processes for the doctor to inform their employer of their intention to carry out such work.

This provision does not prevent paid work for non-locum activities outside the NHS.

Rates of payment for such work have been improved so that the doctor would receive a 22 per cent premium above the prevailing hourly rate.
4. Payment for work undertaken while on call

The work schedule of a doctor rostered to be on call will contain an average amount of time, calculated prospectively, for anticipated work during the on-call period. Such work includes any actual clinical or non-clinical work undertaken either on or offsite, including telephone calls and travel time arising from any such calls. Any such work is defined as working time for the purposes of the TCS. Any time during the on-call period when the doctor is not undertaking such work, is defined as non-working time for the purposes of the TCS.

5. Senior decision making

The parties recognise that there will be circumstances where the most senior trainees will be designated by their employer to undertake roles as senior decision makers, in line with appropriate clinical standards. It is agreed that there will therefore no longer be a fifth nodal point in the pay system, and this money will be used from (October 2019) to recognise those trainees who undertake a role as a senior decision maker.

6. Whistleblowing

All NHS staff must be able to raise concerns, and be protected for doing so in line with public interest disclosure (whistleblowing) legislation. This right is enshrined in the contract for junior doctors. They will also be given the ability to raise concerns regarding the work of HEE without detriment, from either the employer or HEE.

E. Working Week: affording and valuing weekends, nights and NROC

A new approach to the reward for and acknowledgment of the various demanding working patterns of doctors has been taken. This balances the strategic priorities of the government and NHS, to deliver the agreed NHS Clinical Standards for seven-day care, (assuring all patients can receive the same high standard of care whatever the day of the week), with the contribution that junior doctors make across the week, particularly valuing that contribution at weekends. This approach:

1. Recognises the working and completion of work overnight, with an agreement that any shift which starts at or after 8pm, lasts more than 8 hours (and within the 13 hour cap) and finishes at or by 10am the following day, should attract an enhanced pay rate of 37 per cent for all hours worked;
2. Establishes a weekend allowance paid when any doctor is rostered to work more than 6 weekends (in practice it is assumed that this will constitute but not be limited to 12 weekend days/ nights across a period of 6 weekends) per annum, with the supplement increased as the number of weekends worked increases. This supplementary allowance is applied as a percentage of basic pay. These rates will be set in accordance with the rates set out in the table below:

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 weekend in 2</td>
<td>10%</td>
</tr>
<tr>
<td>&lt;1 weekend in 2 – 1 weekend in 4</td>
<td>7.5%</td>
</tr>
<tr>
<td>&lt;1 weekend in 4 – 1 weekend in 5</td>
<td>6%</td>
</tr>
<tr>
<td>&lt;1 weekend in 5 – 1 weekend in 7</td>
<td>4%</td>
</tr>
<tr>
<td>&lt;1 weekend in 7 – 1 weekend in 8</td>
<td>3%</td>
</tr>
<tr>
<td>&lt;1 weekend in 8</td>
<td>No weekend allowance</td>
</tr>
</tbody>
</table>

3. Responds to the need for some doctors to be available for on call duties, with a system of payment which recognises the impact on lifestyle of availability for duty. This supplementary allowance is applied as 8% of basic pay over and above any weekend allowance payable.

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Weekend allowance</th>
<th>On-call availability allowance</th>
<th>Total allowances</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 weekend in 2</td>
<td>10%</td>
<td>8%</td>
<td>18%</td>
</tr>
<tr>
<td>&lt;1 weekend in 2 – 1 weekend in 4</td>
<td>7.5%</td>
<td>8%</td>
<td>15.5%</td>
</tr>
<tr>
<td>&lt;1 weekend in 4 – 1 weekend in 5</td>
<td>6%</td>
<td>8%</td>
<td>14%</td>
</tr>
<tr>
<td>&lt;1 weekend in 5 – 1 weekend in 7</td>
<td>4%</td>
<td>8%</td>
<td>12%</td>
</tr>
<tr>
<td>&lt;1 weekend in 7 – 1 weekend in 8</td>
<td>3%</td>
<td>8%</td>
<td>11%</td>
</tr>
<tr>
<td>&lt;1 weekend in 8</td>
<td>No weekend allowance</td>
<td>8%</td>
<td>8%</td>
</tr>
</tbody>
</table>

4. Ensures an average basic pay increase of between 10 and 11 per cent (subject to final modelling of values), maintaining the cost neutrality of the contract. At this stage it is proposed that nodal point values will be increased by at least 1 per cent in 2017/18, 0.9 per cent in 2018/19 and 0.8 per cent in 2019/20 reflecting the need to fund the national living wage in the NHS.
5. The rest periods which ensure the safe working of doctors will be as previously developed between the parties, with amendments to reflect feedback from doctors and their employers:

- there will be a 46 hour rest period after the completion of three or four night shifts
- junior doctors will not be required to work more frequently than 1:2 weekends
- where the work schedule of a doctor rostered for on-call duty on a Saturday and Sunday contains 3 hours or fewer of actual work on each day, and no more than 3 episodes of work on each day, then such duty is defined as low intensity. In such a working pattern a maximum of 12 shifts of any length can be rostered or worked on 12 consecutive days.

F. Implementation Process

1. BMA referendum

<table>
<thead>
<tr>
<th></th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agreed TCS</td>
<td>31 May 2016</td>
</tr>
<tr>
<td>Complete PSED</td>
<td></td>
</tr>
<tr>
<td>Agreed communications materials</td>
<td></td>
</tr>
<tr>
<td>JDC Meets</td>
<td>3 June 2016</td>
</tr>
<tr>
<td>Roadshows (with jointly agreed materials)</td>
<td>17 June 2016</td>
</tr>
<tr>
<td>Referendum</td>
<td>17 June to 1 July 2016</td>
</tr>
</tbody>
</table>

2. Contract implementation

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2016</td>
<td>All guardians appointed</td>
</tr>
<tr>
<td>26 July 2016</td>
<td>Guardian conference</td>
</tr>
<tr>
<td>3 August 2016</td>
<td>New contract “effective date”</td>
</tr>
</tbody>
</table>
### October 2016
Transition to the new terms and conditions of service for:
- F1s (all specialties)
- F2 (when sharing a rota with F1s)
- ST3/4 in general practice
- ST3+ in obstetrics and gynaecology training programmes.

### February – April 2017
All grades in:
- Psychiatry
- Public health
- All pathology and lab based specialties
- Paediatrics
- All dental training programmes (excluding orthodontics)
- Any F2 and GP trainees who share a rota with trainees above in this category

### April 2017
- All grades in all surgical specialties (including orthodontics)
- Any F2 and GP trainees who share a rota with trainees above in this category

### August 2017
- All remaining existing trainees
- All new entrants

### 3. Public Sector Duties
The government will publish an equality analysis document prior to the publication of the contract.

### 4. Transition
In order to support the effective implementation of the contract, the parties have agreed to extend the period of transitional pay protection by one year.
5. Ongoing role of JNC(J)

The agreement of this new contract would mean that the present employer based variation clause in the model contract would be replaced by a clause which confirms the national collective bargaining arrangements between employers and recognised trade unions vested in the JNC(J).

6. Seven-day services

The BMA will, along with other trade union colleagues, the professions and NHS representative bodies, be asked to join a group advising NHS England on the policy direction relating to seven-day services. In addition a sub-group of the Social Partnership Forum will be established to consider and monitor how seven day service policy impacts on the workforce.

7. Joint contract review

It is agreed that the regular review and updating of the contract is vital so that none of the parties find themselves in a protracted dispute. It is agreed therefore that the BMA and NHS Employers jointly commission in August 2018 a review of the efficacy of the contract, to identify any areas for improvement to the contract terms. Priority areas for inclusion in this review have been agreed but there is no wish to restrict the terms of any review at this stage.
Annex B. Results from NHS Provider/NHS Employers workforce survey

What would you do if you were free to decide how to apply a 1 per cent pay award in 2017/18 (total respondents = 51)?

(The chart reflects the sum of rank values - Highest Ranked option = 5, 2nd ranked = 4, Lowest Ranked = 1, Not ranked = 0)
For remaining remit groups would you prefer the current approach of single year or a multi-year pay approach? (Total respondents = 51)

- Current approach of single-year settlement: 37%
- Multi-year pay settlement: 4%
- Don’t know: 59%

What has happened to your organisation’s overall agency/locum spend since the introduction of the price caps? (Total respondents = 47)

- Higher agency/locum spend: 61.70%
- No change: 31.91%
- Lower agency/locum spend: 6.38%

Has the agency cap encouraged staff to work for your organisation on a substantive basis? (Total respondents = 46)

- Yes: 15.22%
- No: 28.26%
- Don’t know: 56.52%
Are there any issues related to the recruitment, retention, pay and development of doctors?

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes (%)</th>
<th>No (%)</th>
<th>Total Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultants</td>
<td>73%</td>
<td>27%</td>
<td>41</td>
</tr>
<tr>
<td>Salaried Primary Care GPs</td>
<td>19%</td>
<td>81%</td>
<td>16</td>
</tr>
<tr>
<td>Salaried GPs</td>
<td>56%</td>
<td>44%</td>
<td>25</td>
</tr>
<tr>
<td>SAS Doctors</td>
<td>71%</td>
<td>29%</td>
<td>41</td>
</tr>
</tbody>
</table>

Does your trust use recruitment and retention premia for consultant doctors? (Total respondents = 46)

- Yes: 85%
- No: 15%
# Annex C. Time series of medical and dental staff by grade

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All Medical and Dental staff</td>
<td>95,952</td>
<td>97,770</td>
<td>99,098</td>
<td>100,231</td>
<td>101,854</td>
<td>104,027</td>
<td>105,470</td>
<td>1,442 1.4%</td>
</tr>
<tr>
<td>Consultant (including Directors of Public Health)</td>
<td>35,324</td>
<td>36,798</td>
<td>37,877</td>
<td>39,090</td>
<td>40,195</td>
<td>41,652</td>
<td>43,303</td>
<td>1,651 4.0%</td>
</tr>
<tr>
<td>Specialist and Associate Specialist Doctors</td>
<td>8,768</td>
<td>8,762</td>
<td>8,911</td>
<td>8,915</td>
<td>8,864</td>
<td>8,944</td>
<td>8,916</td>
<td>-28 -0.3%</td>
</tr>
<tr>
<td>Associate Specialist</td>
<td>3,358</td>
<td>3,332</td>
<td>3,292</td>
<td>3,100</td>
<td>2,861</td>
<td>2,646</td>
<td>2,434</td>
<td>-212 -8.0%</td>
</tr>
<tr>
<td>Specialty Doctor</td>
<td>3,314</td>
<td>4,222</td>
<td>4,920</td>
<td>5,331</td>
<td>5,603</td>
<td>5,937</td>
<td>6,080</td>
<td>143 2.4%</td>
</tr>
<tr>
<td>Staff Grade</td>
<td>2,096</td>
<td>1,208</td>
<td>699</td>
<td>485</td>
<td>400</td>
<td>361</td>
<td>403</td>
<td>42 11.5%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>37,100</td>
<td>37,476</td>
<td>37,803</td>
<td>38,003</td>
<td>38,435</td>
<td>39,023</td>
<td>38,785</td>
<td>-238 -0.6%</td>
</tr>
<tr>
<td>Specialty Registrar</td>
<td>29,644</td>
<td>29,171</td>
<td>29,222</td>
<td>29,204</td>
<td>29,627</td>
<td>30,171</td>
<td>29,847</td>
<td>-325 -1.1%</td>
</tr>
<tr>
<td>Core Medical Training</td>
<td>5,835</td>
<td>6,992</td>
<td>7,373</td>
<td>7,683</td>
<td>7,772</td>
<td>7,945</td>
<td>8,090</td>
<td>145 1.8%</td>
</tr>
<tr>
<td>Core Dental Training</td>
<td>1,622</td>
<td>1,312</td>
<td>1,207</td>
<td>1,115</td>
<td>1,035</td>
<td>907</td>
<td>848</td>
<td>-59 -6.5%</td>
</tr>
<tr>
<td>Foundation Doctor Year 2</td>
<td>6,158</td>
<td>6,344</td>
<td>6,415</td>
<td>6,439</td>
<td>6,451</td>
<td>6,601</td>
<td>6,581</td>
<td>-19 -0.3%</td>
</tr>
<tr>
<td>Foundation Doctor Year 1</td>
<td>6,102</td>
<td>6,155</td>
<td>6,166</td>
<td>6,154</td>
<td>6,387</td>
<td>6,286</td>
<td>6,370</td>
<td>84 1.3%</td>
</tr>
<tr>
<td>Other and unknown HCHS Doctor Grades</td>
<td>2,501</td>
<td>2,233</td>
<td>1,925</td>
<td>1,631</td>
<td>1,524</td>
<td>1,522</td>
<td>1,515</td>
<td>-8 -0.5%</td>
</tr>
<tr>
<td>Hospital Practitioner / Clinical Assistant</td>
<td>1,185</td>
<td>1,006</td>
<td>783</td>
<td>638</td>
<td>570</td>
<td>561</td>
<td>552</td>
<td>-9 -1.6%</td>
</tr>
<tr>
<td>Other and Unknown HCHS Doctor Grades</td>
<td>1,316</td>
<td>1,227</td>
<td>1,143</td>
<td>992</td>
<td>954</td>
<td>962</td>
<td>963</td>
<td>1 0.2%</td>
</tr>
</tbody>
</table>
Notes to Annexes C and D

Following the recent consultation by NHS Digital into the publication of NHS workforce statistics in England[^50], a number of developments have been implemented to the way non-medical staff are counted in time for the annual publication of staff numbers. Because of these changes, these statistics are currently classed as experimental. Key developments are:

- Only paid staff are counted.
- Staff groups have been redefined.
- Headcount and FTE staff numbers for support organisations and central bodies considered to be outside the NHS, such as Health Education England, National Institute for Health and Care Excellence, NHS Blood and Transplant and NHS England, are published separately to those of NHS CCGs and trusts.

Because of these and other changes, the staff number publications are no longer equivalent to the annual workforce censuses used in previous submissions to the Review Body. In addition, as headcount for support organisations and central bodies is published separately to that of NHS CCGs and trusts, we have not included aggregate headcount in the table in Annex C due to the small risk of double counting those staff with assignments at both types of organisations. We have also not included staff from organisations in the independent sector.

### Annex D. Medical and dental staff by region, September 2015

<table>
<thead>
<tr>
<th>Medical and Dental Grade</th>
<th>North</th>
<th>Midlands and East</th>
<th>South</th>
<th>London</th>
<th>Special Health Authorities and other statutory bodies</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foundation Doctor Year 1</td>
<td>1,962.00</td>
<td>1,795.61</td>
<td>1,557.63</td>
<td>1,048.50</td>
<td>6.00</td>
<td>6,369.73</td>
</tr>
<tr>
<td>Foundation Doctor Year 2</td>
<td>1,957.95</td>
<td>1,877.17</td>
<td>1,564.55</td>
<td>1,176.70</td>
<td>5.00</td>
<td>6,581.37</td>
</tr>
<tr>
<td><strong>Foundation Year Doctors</strong></td>
<td><strong>3,919.95</strong></td>
<td><strong>3,672.77</strong></td>
<td><strong>3,122.18</strong></td>
<td><strong>2,225.20</strong></td>
<td><strong>11.00</strong></td>
<td><strong>12,951.10</strong></td>
</tr>
<tr>
<td>Specialty Registrar</td>
<td>7,851.25</td>
<td>7,051.63</td>
<td>6,991.21</td>
<td>7,563.43</td>
<td>389.10</td>
<td>29,846.62</td>
</tr>
<tr>
<td>Core Medical Training</td>
<td>2,711.32</td>
<td>1,885.80</td>
<td>1,634.00</td>
<td>1,832.55</td>
<td>26.00</td>
<td>8,089.67</td>
</tr>
<tr>
<td>Core Dental Training</td>
<td>277.70</td>
<td>247.13</td>
<td>113.83</td>
<td>207.69</td>
<td>2.00</td>
<td>848.35</td>
</tr>
<tr>
<td><strong>Registrars</strong></td>
<td><strong>10,840.27</strong></td>
<td><strong>9,184.56</strong></td>
<td><strong>8,739.04</strong></td>
<td><strong>9,603.67</strong></td>
<td><strong>417.10</strong></td>
<td><strong>38,784.63</strong></td>
</tr>
<tr>
<td>Associate Specialist</td>
<td>688.09</td>
<td>675.96</td>
<td>632.01</td>
<td>419.45</td>
<td>18.00</td>
<td>2,433.50</td>
</tr>
<tr>
<td>Specialty Doctor</td>
<td>1,681.06</td>
<td>1,791.77</td>
<td>1,629.02</td>
<td>962.30</td>
<td>15.68</td>
<td>6,079.83</td>
</tr>
<tr>
<td>Staff Grade</td>
<td>72.52</td>
<td>116.28</td>
<td>45.09</td>
<td>167.92</td>
<td>0.70</td>
<td>402.51</td>
</tr>
<tr>
<td><strong>SAS Doctors</strong></td>
<td><strong>2,441.67</strong></td>
<td><strong>2,584.01</strong></td>
<td><strong>2,306.12</strong></td>
<td><strong>1,549.67</strong></td>
<td><strong>34.38</strong></td>
<td><strong>8,915.84</strong></td>
</tr>
<tr>
<td>Hospital Practitioner / Clinical Assistant</td>
<td>196.71</td>
<td>97.14</td>
<td>139.73</td>
<td>55.50</td>
<td>62.64</td>
<td>551.71</td>
</tr>
<tr>
<td>Other and Unknown HCHS Doctor Grades</td>
<td>307.80</td>
<td>264.17</td>
<td>195.44</td>
<td>149.38</td>
<td>46.22</td>
<td>963.01</td>
</tr>
<tr>
<td><strong>Other/unknown HCHS Medical Grades</strong></td>
<td><strong>504.50</strong></td>
<td><strong>361.31</strong></td>
<td><strong>335.16</strong></td>
<td><strong>204.88</strong></td>
<td><strong>108.87</strong></td>
<td><strong>1,514.73</strong></td>
</tr>
<tr>
<td>Consultants</td>
<td>12,854.35</td>
<td>11,283.32</td>
<td>10,051.64</td>
<td>8,713.57</td>
<td>400.55</td>
<td>43,303.43</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>30,560.75</strong></td>
<td><strong>27,085.97</strong></td>
<td><strong>24,554.13</strong></td>
<td><strong>22,296.99</strong></td>
<td><strong>971.89</strong></td>
<td><strong>105,469.73</strong></td>
</tr>
</tbody>
</table>
## Annex E. Advertised vacancies by region

<table>
<thead>
<tr>
<th>Health Education England Area</th>
<th>Numbers</th>
<th>Ratio of advertised vacancy FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Web Hits</td>
<td>Applications</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>17,039,883</td>
<td>151,396</td>
</tr>
<tr>
<td>North East</td>
<td>662,672</td>
<td>4,456</td>
</tr>
<tr>
<td>North West</td>
<td>2,173,700</td>
<td>17,102</td>
</tr>
<tr>
<td>Yorkshire and the Humber</td>
<td>1,289,884</td>
<td>10,123</td>
</tr>
<tr>
<td>East Midlands</td>
<td>1,067,583</td>
<td>10,186</td>
</tr>
<tr>
<td>West Midlands</td>
<td>1,555,262</td>
<td>14,800</td>
</tr>
<tr>
<td>East of England</td>
<td>1,850,419</td>
<td>16,584</td>
</tr>
<tr>
<td>North Central and East London</td>
<td>1,462,478</td>
<td>14,466</td>
</tr>
<tr>
<td>North West London</td>
<td>891,360</td>
<td>10,555</td>
</tr>
<tr>
<td>South London</td>
<td>1,230,338</td>
<td>14,470</td>
</tr>
<tr>
<td>Kent, Surrey and Sussex</td>
<td>1,367,241</td>
<td>12,562</td>
</tr>
<tr>
<td>Thames Valley</td>
<td>533,173</td>
<td>4,802</td>
</tr>
<tr>
<td>Wessex</td>
<td>648,123</td>
<td>7,101</td>
</tr>
<tr>
<td>South West</td>
<td>1,435,279</td>
<td>12,154</td>
</tr>
<tr>
<td>Special Health Authorities and other statutory bodies</td>
<td>872,371</td>
<td>2,035</td>
</tr>
</tbody>
</table>

Annex F. Paybill metrics for HCHS Doctors (non-locum)\textsuperscript{51}

<table>
<thead>
<tr>
<th>Paybill metric/change versus previous year</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headline Pay Award</td>
<td>1.5%</td>
<td>0.4%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>1.0%</td>
<td>0.1%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Basic Pay per FTE Drift</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>\hspace{1cm} Staff Group Mix Impact</td>
<td>0.7%</td>
<td>0.8%</td>
<td>0.7%</td>
<td>0.7%</td>
<td>0.1%</td>
<td>0.6%</td>
<td>0.3%</td>
</tr>
<tr>
<td>\hspace{1cm} Excluding Staff Group Mix Impact</td>
<td>0.4%</td>
<td>0.3%</td>
<td>0.3%</td>
<td>0.4%</td>
<td>-0.2%</td>
<td>0.1%</td>
<td>-0.4%</td>
</tr>
<tr>
<td>Basic Earnings per FTE Growth</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>\hspace{1cm} Staff Group Mix Impact</td>
<td>0.1%</td>
<td>0.1%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>\hspace{1cm} Excluding Staff Group Mix Impact</td>
<td>-0.5%</td>
<td>-1.7%</td>
<td>-1.2%</td>
<td>-0.1%</td>
<td>0.0%</td>
<td>0.4%</td>
<td>-0.1%</td>
</tr>
<tr>
<td>Additional Earnings per FTE Drift Impact</td>
<td>-0.4%</td>
<td>-1.6%</td>
<td>-1.2%</td>
<td>-0.1%</td>
<td>0.0%</td>
<td>0.4%</td>
<td>-0.1%</td>
</tr>
<tr>
<td>\hspace{1cm} Staff Group Mix Impact</td>
<td>0.1%</td>
<td>0.1%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
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</tr>
<tr>
<td>\hspace{1cm} Excluding Staff Group Mix Impact</td>
<td>-0.5%</td>
<td>-1.7%</td>
<td>-1.2%</td>
<td>-0.1%</td>
<td>0.0%</td>
<td>0.4%</td>
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</tr>
<tr>
<td>Total Earnings per FTE Drift</td>
<td>0.3%</td>
<td>-0.8%</td>
<td>-0.5%</td>
<td>0.6%</td>
<td>0.1%</td>
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<td>0.2%</td>
</tr>
<tr>
<td>\hspace{1cm} Staff Group Mix Impact</td>
<td>0.4%</td>
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<td>0.5%</td>
<td>0.4%</td>
<td>0.3%</td>
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<td>0.7%</td>
</tr>
<tr>
<td>\hspace{1cm} Excluding Staff Group Mix Impact</td>
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<tr>
<td>Earnings per FTE Growth</td>
<td>1.8%</td>
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<td>-0.5%</td>
<td>0.6%</td>
<td>1.1%</td>
<td>1.1%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Pensions Contributions Drift Impact</td>
<td>0.0%</td>
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<td>-0.2%</td>
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</tr>
<tr>
<td>National Insurance Contributions Drift Impact</td>
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</tr>
<tr>
<td>Total On-Costs per FTE Drift Impact</td>
<td>0.0%</td>
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<td>0.6%</td>
<td>-0.1%</td>
<td>0.1%</td>
<td>-0.1%</td>
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<td>\hspace{1cm} Excluding Staff Group Mix Impact</td>
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<td>0.1%</td>
<td>0.5%</td>
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<td>0.1%</td>
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<td>-0.7%</td>
<td>0.1%</td>
<td>0.6%</td>
<td>0.2%</td>
<td>0.9%</td>
<td>0.3%</td>
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<td>0.6%</td>
<td>0.5%</td>
<td>0.4%</td>
<td>0.3%</td>
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</tr>
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<td>\hspace{1cm} Excluding Staff Group Mix Impact</td>
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<td>-1.3%</td>
<td>-0.4%</td>
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<td>-0.4%</td>
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<td>-0.3%</td>
<td>0.1%</td>
<td>0.6%</td>
<td>1.2%</td>
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<td>1.9%</td>
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\textsuperscript{51} Department of Health (August 2016) HCHS Paybill Metrics and Paybill driver quantifications,
<table>
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<tr>
<th>Paybill metric/change versus previous year</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
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<td>0.2%</td>
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<tr>
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<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Excluding Staff Group Mix Impact</td>
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<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
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<td>n/a</td>
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</tr>
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<td>Basic Earnings per FTE Growth</td>
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<td>0.0%</td>
<td>1.4%</td>
<td>0.2%</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Staff Group Mix Impact</strong></td>
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<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
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</tr>
<tr>
<td>Excluding Staff Group Mix Impact</td>
<td>n/a</td>
<td>n/a</td>
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<tr>
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<td>-0.2%</td>
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<td>0.4%</td>
<td>-0.3%</td>
</tr>
<tr>
<td><strong>Staff Group Mix Impact</strong></td>
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<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Excluding Staff Group Mix Impact</td>
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<td>n/a</td>
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<td>-0.8%</td>
</tr>
<tr>
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<td>0.4%</td>
<td>-1.6%</td>
<td>-1.2%</td>
<td>-0.2%</td>
<td>0.4%</td>
<td>0.6%</td>
<td>-0.3%</td>
</tr>
<tr>
<td><strong>Staff Group Mix Impact</strong></td>
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<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Excluding Staff Group Mix Impact</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
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<td>1.9%</td>
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<td>-1.2%</td>
<td>-0.2%</td>
<td>1.4%</td>
<td>0.7%</td>
<td>-0.2%</td>
</tr>
<tr>
<td>Pensions Contributions Drift Impact</td>
<td>0.0%</td>
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<td>0.0%</td>
<td>-0.2%</td>
<td>0.0%</td>
<td>-0.2%</td>
<td>0.1%</td>
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<td>National Insurance Contributions Drift Impact</td>
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<td>0.6%</td>
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<td>0.0%</td>
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</tr>
<tr>
<td><strong>Total On-Costs per FTE Drift Impact</strong></td>
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<td>0.1%</td>
<td>0.6%</td>
<td>-0.2%</td>
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<td>-0.2%</td>
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<tr>
<td><strong>Staff Group Mix Impact</strong></td>
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<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Excluding Staff Group Mix Impact</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
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</tr>
<tr>
<td>Employer On-Costs per FTE Growth</td>
<td>1.7%</td>
<td>-1.1%</td>
<td>2.2%</td>
<td>-1.1%</td>
<td>1.2%</td>
<td>-0.6%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Paybill per FTE Drift</td>
<td>0.4%</td>
<td>-1.5%</td>
<td>-0.6%</td>
<td>-0.4%</td>
<td>0.4%</td>
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<tr>
<td><strong>Staff Group Mix Impact</strong></td>
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<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Excluding Staff Group Mix Impact</td>
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<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Paybill per FTE Growth</td>
<td>1.9%</td>
<td>-1.5%</td>
<td>-0.6%</td>
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<td>1.4%</td>
<td>0.5%</td>
<td>-0.1%</td>
</tr>
<tr>
<td>Average FTE Growth</td>
<td>4.6%</td>
<td>4.4%</td>
<td>3.4%</td>
<td>3.3%</td>
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<td>3.7%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Aggregate Paybill Growth</td>
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<td>2.8%</td>
<td>2.9%</td>
<td>3.5%</td>
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<td>4.0%</td>
</tr>
</tbody>
</table>

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52 Department of Health (August 2016), *HCHS Paybill Metrics and Paybill driver quantifications*
Notes to Annexes F and F1

Derived from DH’s Estimated Headline HCHS Paybill Metrics (see separate notes on the construction of this data set).

Headline Pay Award reflects the impact of, usually, annual central pay awards which are typically headline uplift applied to payscales. If uplifts differ across staff groups, it reflects a weighted average.

Basic Pay per FTE Drift gives the growth in basic pay per FTE after allowing for the impact of the Basic Pay Settlement. This captures the effects of pay progression & increment mix, pay band mix and staff group mix.

Employer On-Cost per FTE Drift Impact gives the combined effect of the National Insurance and Pensions Contribution per FTE Drift Impacts. It reflects the impact of changing on-cost patterns on Paybill per FTE Growth.

Paybill per FTE Drift gives the growth in Paybill per FTE after allowing for the impact of the Basic Pay Settlement. This captures the effects of changes in workforce mix, additional earnings patterns and on-cost patterns.

The driver quantifications excluding the Staff Group Mix Impact show the residual impact of the driver after allowing for changes in the mix of staff across the broad staff groups used in HSCIC publications.

Average FTE Growth compares the average numbers of FTEs over the period, assessed using monthly snapshots, to the average numbers of FTEs over the equivalent period the previous year.
### Annex G. Time series of mean basic pay by medical and dental grade

<table>
<thead>
<tr>
<th>Grade</th>
<th>Mean basic pay per full-time equivalent during the 12 month period ending in March (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All HCHS doctors (non locum)</td>
<td>55,451</td>
</tr>
<tr>
<td>Consultants (including Directors of public health)</td>
<td>85,337</td>
</tr>
<tr>
<td>Hospital practitioners and clinical assistants</td>
<td>61,102</td>
</tr>
<tr>
<td>Other doctors in training</td>
<td>25,870</td>
</tr>
<tr>
<td>Other medical and dental staff</td>
<td>56,845</td>
</tr>
<tr>
<td>Registrars</td>
<td>36,034</td>
</tr>
</tbody>
</table>

### Notes:
Mean earnings have been estimated using 12 months of data to improve accuracy. The tables and charts below are therefore based on 12 month periods ending in March 2009 to March 2015. Under the 2012 methodology, basic pay is shown per full-time equivalent.
Annex G1. Time series of mean total earnings by medical and dental grade

<table>
<thead>
<tr>
<th>Grade</th>
<th>Mean total earnings per person during the 12 month period ending in March (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All HCHS doctors (non locum)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>72,182</td>
</tr>
<tr>
<td>Consultants (including Directors of public health)</td>
<td>111,222</td>
</tr>
<tr>
<td>Hospital practitioners and clinical assistants</td>
<td>15,685</td>
</tr>
<tr>
<td>Other doctors in training</td>
<td>36,924</td>
</tr>
<tr>
<td>Other medical and dental staff</td>
<td>58,790</td>
</tr>
<tr>
<td>Registrars</td>
<td>54,751</td>
</tr>
</tbody>
</table>

Notes:
Mean earnings have been estimated using 12 months of data to improve accuracy. The tables and charts below are therefore based on 12 month periods ending in March 2009 to March 2016. Under the 2012 methodology, total earnings are shown per person using the new methodology, as some payments (such as temporary benefit allowances) are based on a flat rate regardless of whether the recipient is full-time or part-time.

Sources for Annexes G and G1