NHS EMPLOYERS’ SUBMISSION TO THE REVIEW BODY ON DOCTORS’ AND DENTISTS’ REMUNERATION (DDRB)

October 2015
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Key messages

Pay and contract reform

- NHS Employers’ priority is to ensure reform of national pay and conditions so that they are fit for purpose, with implementation in 2016 of new contracts for consultants and junior doctors in training.

- We recognise the importance attached to these essential reforms and getting the implementation of new contracts right. They will affect the medical profession as a whole and individual practitioners throughout their careers.

- We remain fully engaged in taking forward the recommendations and observations of the DDRB in its report Contract reform for consultants and doctors and dentists in training – supporting healthcare services seven days a week published on 16 July 2015.

- The case for change, which NHS Employers presented to the DDRB and which the report largely recognises, remains compelling. The status of discussions with the BMA are very different: the JDC has declined to enter negotiations and is balloting for industrial action, whilst the consultant committee has entered negotiations. As the DDRB rightly recognized, it is vital that the concerns of the BMA and its members be addressed in any new arrangements. Given the ongoing developments in each contract, we propose that we should update the DDRB on the very latest position during the course of presenting oral evidence.

- We expect that this will be the final year in which the DDRB will make recommendations on the current national contracts for consultant and junior doctors.

Pay award 2016/17

- The pay review for 2016/17 is set against the ongoing programme of work linked to essential pay and contract reform for consultants and junior doctors in training. The successful implementation of the proposed reforms to medical contracts will be key to defining the relationship between doctors and NHS employers and delivering increased productivity and efficiency from doctors in the NHS.

- Employers have told us that they would favour the same percentage increase being applied to all staff within the 1 per cent cap. Any pay uplift that is not fully funded through the tariff would create an additional cost pressure on employers. We are not aware of any labour market difficulties either at national or local level that would be resolved by differentiated pay awards for staff in 2016/17.
In general, employers in the NHS do not feel that an increase of 1 per cent provides scope for any meaningful targeting. They suggest that a differential pay award would be seen as inequitable and likely to have a negative impact on staff morale. This could also worsen an already difficult position on the work linked to pay and contract reforms.

The pay review for 2016/17 is set within the government’s public sector pay policy, set out in the 2015 Summer Budget, that pay increases across the public sector will be constrained to an average of 1 per cent for the next four years. Continued restraint of pay bill growth will help employers maintain the levels of frontline staff required to ensure continued delivery of high-quality patient services.

The NHS faces a number of significant challenges over the short, medium and longer term. Put broadly, these can be described as financial, transformational and workforce challenges.

Only by tackling these challenges in a co-ordinated and sustainable way can the NHS continue to deliver universal high-quality health care to all. Our evidence addresses each of these challenges in turn.

The financial challenge

The NHS is facing an unprecedented set of financial challenges. Funding is struggling to match growing demand for healthcare. The combination of a growing population, ageing demographics, a greater prevalence of long-term conditions and increasing pressures on prices and pay will put further pressure on available resources.

Estimates in the Five Year Forward View (5YFV) put this at £30 billion a year by 2020/21. An extra £8 billion will be made available to the NHS, leaving £22 billion that will have to be met elsewhere. If the funding is not found, then NHS organisations will need to find further efficiencies or cut services for patients.

As the NHS Confederation said in its representation to the Treasury for the 2015 Spending Review, ‘…the funding gap is a significant threat to the sustainability of the NHS … we can already see the impact it is having with almost half of NHS providers reporting a financial deficit and an accumulated deficit across the sector of more than £800 million in 2014/15’.1

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1 NHS Confederation representation to HM Treasury, Spending Review 2015.
The transformation challenge

- The 5YFV sets out a vision for new models of care, delivering a better NHS by 2020/21, transforming how care is delivered to better suit the needs of patients. It sees the traditional divide between primary care, community services and hospitals as a barrier to the co-ordinated and personalised health services patients need. The NHS will increasingly need to cross these boundaries so that services are integrated around the patient.

- This means helping patients to get the right care, at the right time, in the right place. It will mean ensuring that patients have access to seven-day services, where this makes a clinical difference to outcomes. Transformation of this scale and complexity depends on having a well-trained, well-motivated, modern and flexible workforce and this is central to our work on pay and contract reform.

The workforce challenge

- Doctors remain essential to the leadership, planning and delivery of efficient, innovative and effective models of patient care.

- The 5YFV acknowledges that new models of care cannot be designed unless we have the right number of staff with the skills, values and behaviours to deliver them.

- In particular, it notes that:
  “…NHS employers and staff and their representatives will need to consider how working patterns and pay and terms and conditions can best evolve to reward high performance, support job and service redesign and encourage recruitment and retention in parts of the country and in occupations where vacancies are...”

2 Performance of the Foundation Trust Sector, Monitor 2015
high’ (NHS England, Five Year Forward View, October 2014).³

- The Francis report⁴ noted that patients feel more vulnerable at weekends when ‘staff absence and shortages are more noticeable and it is becoming apparent that a five-day service model is no longer fit for purpose in meeting public expectation when it comes to providing safe, efficient care’.

- Doctors do not work in isolation to other staff groups and sectors. Employers recognise that doctors must work effectively in teams with other health and care workers if the service is to deliver high-quality patient care.

- The need to provide services in new and innovative ways across seven days in an affordable and sustainable way presents new challenges to employers and staff. This is at the centre of the proposed reform to contracts for consultants and junior doctors in training.

- Implementation of reforms to pay and conditions of service for consultants and junior doctors in training must ensure that the NHS continues to offer a competitive and fair employment package that allows for the recruitment and retention of the skilled and qualified doctors needed, whilst maximising their contribution and engagement.

We ask the DDRB to take this into account when reaching pay recommendations for 2016/17.

³ NHS England Five Year Forward View, October 2014 pp 30-31

⁴ The Francis Inquiry, (2013)
1. Informing our evidence

Introduction
We welcome the opportunity to submit evidence on behalf of healthcare employers in England for the 2016/17 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 medical workforce.

Our evidence has been informed by a regular programme of employer engagement with a full range of NHS organisations, on their priorities for pay and terms and conditions reform. We have held direct discussions, including one-to-one meetings with NHS chief executives, at regional network meetings of human resources directors, NHS Confederation and other employer networks throughout the year. There have been substantive discussions with members of the NHS Employers policy board, and with employer representatives on the various joint negotiation and consultation councils.

The information set out below has helped inform the evidence in this submission.

Pay and contract reform

1. Employers remain committed to reform and modernisation of the current contracts for consultant-graded doctors and doctors in nationally approved training programmes. As we made clear in our evidence to DDRB on their special remit, employers have told us for nearly 10 years that the current junior doctor contract is not fit for purpose.

2. Employers would like to see:
   - an end to the administratively burdensome and financially punitive banding system
   - financial incentives and disincentives within the current contract removed, as these continue to cause problems for staff and for patient safety
   - Higher basic pay and less variable pay
   - pay progression as a reward for achievement of competence and the taking on the ensuing additional responsibility.

3. Similar views exist about amending the current consultant contract, so that:
   - the right of consultants to opt out of non-emergency work at evenings and weekends is removed
   - there is a redistribution of hours defined as premium and plain time
• that pay progression is linked strongly to responsibility and current achievement of excellence and not to time served or past performance.

Differential pay awards

4. Employers have been clear that they do not believe that a differential award giving more to some groups than others is justified this year.

5. They generally report that 1 per cent would not in practice make any differentiation worthwhile and could have a negative impact on the morale of the workforce ahead of major pay and contract reforms.

6. Whilst continued pay restraint remains necessary on overall affordability grounds, there is an appreciation that it will have some impact on individual medical staff in relation to morale and staff engagement. Over the longer term it is important to balance affordability with risks, over time, that the value of the NHS employment proposition will erode and might eventually harm staff engagement and the ability to attract and retain highly skilled staff.

Pay settlement for 2015/16

7. In its remit for the 2015/16 pay round the DDRB was not asked to make any recommendations for salaried doctors and dentists in England. Instead, the Department of Health made arrangements under which salaried staff at the top of their pay scales and who were not eligible for an incremental pay increase received a non-consolidated payment of 2 per cent of pay, whilst other staff received incremental progression. The exception was those staff who reached the top of their pay scale in 2014/15, who received a non-consolidated payment of 1 per cent of pay for 2015/16.

DDRB remit 2016/17

8. The NHS has to continue to work within the constraints of public sector pay policy.

9. In the 2015 Summer Budget, the Chancellor announced that annual public sector pay awards would be constrained to 1 per cent in each of the next four years, starting from the 2016/17 pay award.

10. This position was confirmed by the Chief Secretary to the Treasury’s letter to chairs of the pay review bodies.5 This set out the need for continued pay restraint to help protect public sector jobs and confirmed that public sector pay will be increased by an

5 Chief Secretary to the Treasury letter to PRB chairs (August 2015)
average of 1 per cent for the four years starting from 2016/17. The pay review bodies were asked, in particular, to consider whether there was evidence to support targeting pay awards in a way that could support service delivery and, where needed, address recruitment and retention pressures.

11. The remit letter also confirmed the government’s commitment to reform of public sector pay and conditions, which included a renewed focus on linking pay to performance and responsibility – a position welcomed by employers in the NHS.

**NHS England’s Five Year Forward View**

12. NHS England’s Five Year Forward View (5YFV), published in October 2014, sets out the actions needed to ensure transformed care for patients and to avoid a growing health and care quality gap. It is a vision for how the NHS can continue to provide the care within available resources and how the future of the NHS can be assured.

13. The 5YFV outlines seven models for service provision, which NHS England wants local areas to choose, and actions needed on four fronts, including workforce issues.

14. The 5YFV supports a modern workforce, stating that the innovative new care models that NHS England proposes ‘simply won’t become a reality’ unless the NHS has a workforce with the right numbers, skills, values and behaviours to deliver it. In particular, it notes that:

> NHS employers and staff and their representatives will need to consider how working patterns and pay and terms and conditions can best evolve to reward high performance, support job and service redesign and encourage recruitment and retention in parts of the country and in occupations where vacancies are high.

[NHS England, Five Year Forward View, 2014]

**Seven-day services**

15. The further development of NHS services across a full seven days continues to be a priority for the NHS in England. Ten clinical standards have been published by NHS England that describe the standard of urgent and emergency care that should be available across the NHS.

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16. Extending NHS services across seven days where that is clinically desirable is a key driver behind the contract reforms being proposed for consultants and junior doctors in training.

17. The quality of service to patients should be consistent throughout the week, so that care can be actively progressed at weekends. To do this, service provision at times currently deemed as unsocial hours needs to be reformed and made more affordable. The additional costs associated with medical staff (consultants and junior doctors in training) working evening and weekends through current arrangements provide a financial disincentive to providing non-urgent care at some times of the week.

18. Our evidence to your special remit on contract reform set out in detail the challenges facing employers and the need for contract reform to support the extension of seven-day services. We welcomed the conclusions and observations made by the DDRB in its report, ‘Contract reform for consultants and junior doctors and dentists in training – supporting healthcare services seven days of the week.’

Devolution developments

19. The Cities and Local Government Devolution Bill, which is currently subject to the legislative process, will allow the devolution of powers from central government to cities and counties.

20. The means of delivering local devolution is intended to be subject to agreement with combined authorities and central government, such as the Greater Manchester Agreement. A clause of the proposed legislation seeks to allow local authorities to take on a share of the functions of other public authorities, including NHS organisations.

21. In July, the government indicated it is now working towards further devolution proposals in several new areas including Sheffield, Liverpool and Cornwall.

22. The government intends the bill to be a generic piece of enabling legislation that sets out the framework within which particular devolution arrangements can be implemented. Ultimately, these will require local, ministerial and parliamentary approval,

8 NHS Employers (2014) Reform of National Contracts for Consultant Doctors and Doctors in Training

9 Review Body on Doctors and Dentists Remuneration (2015), Contract Reform for Consultants and Doctors and Dentists in Training
as has been the case in Greater Manchester.

23. It is not yet known what the implications of these changes will be for the NHS workforce. It is clear that there will be no national blueprint and there may be different approaches across the regions. This supports local views that there needs to be more scope in national agreements for employers to tailor the employment package to meet local operational and organisational needs.

24. Some employers have suggested that the development of joint working with local authorities may mean that, in future, pay and conditions changes in both the NHS and local government may need to be considered together.

**The financial challenge**

25. The NHS continues to face an unprecedented financial challenge.

26. The last parliament saw one of the toughest funding settlements for healthcare in England, with additional resources lagging behind additional demand. On top of this, a tough spending review settlement is expected to remain throughout this parliament up to 2020.

27. A recent NHS Confederation survey demonstrates the continued pressure being applied to NHS leaders on the frontline, with 91 per cent of NHS leaders identifying that financial pressures facing their organisation have got worse in the last 12 months. Furthermore, 84 per cent of NHS leaders in the acute sector describe current financial pressures as the worst they have experienced in their NHS career.

28. NHS leaders are also concerned about the future, with 94 per cent thinking the financial pressures facing their organisation will increase. As a result, NHS leaders are pessimistic about whether their organisation will break even this year, with only 27 per cent of leaders in the acute sector confident in their ability to do so. Further survey data indicates confidence could be even worse and as many as 90 per cent of acute providers might end the year in deficit.

29. Monitor’s analysis of trusts’ performance between April 2015 and June 2015 reports a £445m deficit, with 118 foundation trusts (78 per cent) ending the period in the red. The analysis covers the period before action to limit the amount trusts spend on agency

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10 NHS Confederation (2015), Member survey
11 The King’s Fund (2015), Quarterly Monitoring Report
staff and management consultants was introduced. Key findings from the regulators’ analysis include:

- overall, the foundation trust (FT) sector reported a deficit of £445m, which is £90m worse than planned
- 118 FTs (78 per cent) ended the period in deficit, of which 75 per cent were acute or specialist trusts
- the FT sector’s wages bill was £7,411m, £59m more than planned (£7,352m)
- trusts made £232m worth of cost savings, which was £64m less than planned
- More detail is on the NHS Confederation’ website.¹²

30. The government has committed an additional £8 billion in this parliament. Depending on how this funding is delivered, this would represent up to 1.5 per cent a year real-terms increase.¹³ Nonetheless, demand in this parliament is expected to continue as the population grows by another 2 million people, including an additional 1.2 million people aged over 70.¹⁴ These demographics alone are estimated to add a 1.2 per cent real-terms cost pressure a year on the NHS budget.¹⁵

31. The 5YFV describes how £8 billion of additional funding requires the NHS to deliver £22 billion a year in improved productivity to meet the total funding gap expected by 2020/21. This would mean improved productivity of around 2.4 per cent each year, which is far above the long-run average of 1 per cent.¹⁶ Recent analysis also suggests a sharp fall in hospital productivity in recent years, bringing the average across the last parliament down to around 0.4 per cent a year.¹⁷

32. The review into operational productivity of NHS providers, led by Lord Carter of Coles, suggests more savings can be made in this parliament, specifically by enabling supply-side ‘catch-up’ in areas such as procurement and staffing. Lord Carter’s initial findings have identified potential savings of up to £5 billion a year by 2020/21, which

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¹² NHS Confederation(2015). FT deficit a symptom of problems across the entire system
¹³ Health Foundation (2015). Representation to the 2015 Spending Review
¹⁵ IFS (2015). IFS Green Budget
¹⁶ NHS England (2014). Five Year Forward View
¹⁷ Health Foundation (2015). Hospital finances and productivity: In a critical condition?
would represent around 23 per cent of the savings needed in total.18

33. Health spending increased in real terms by around 1.1 per cent a year in the last parliament, which is below the long-run average of 3.8 per cent each year.19 During that same period, demand pressures in hospitals have grown dramatically with:
   - a 7.5 per cent increase in operations
   - a 5.2 per cent rise in finished consultant episodes
   - 4.6 per cent more A&E attendances
   - a growth in hospital admissions of 3.8 per cent between 2010 and 2014.20

34. The pressure on the NHS budget is most noticeable from the financial position of NHS provider organisations, which continue to struggle to remain sustainable. A little under half of the providers ended 2014/15 with a budget deficit and the total deficit across the sector was £822 million.21 Much of this could be attributed to increasing staff costs, with providers spending £1.8 billion more on agency staff than planned.22

35. Other indicators point to the decline of NHS finances since 2010. For example, the average earnings before interest, taxes, depreciation and amortisation (EBITDA) margin in NHS foundation trusts, which is a good measure of profitability, fell to 3.8 per cent this year.23 In 2009/10, the average margin stood at 7.1 per cent.24

36. The sharp fall in this financial position demonstrates the challenge to NHS provider organisations in sustaining cuts in tariff prices year-on-year. Between 2010 and 2015 there was an efficiency factor of around 4 per cent applied each year, which accrues to a 7 per cent cut in tariff prices.25 This is one reason why 37 per cent of provider organisations, 75 per cent based on share of provision, objected to the prices proposed in the 2015/16 National Tariff.26

37. In its submission to the 2015 Spending Review, the NHS Confederation called for at least half of the additional £8 billion to be delivered by 2017/18; the social care funding gap to be addressed; public health spending to be protected and the FYFV transformation fund to be increased.27

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20 HSCIC (2014). Hospital Episode Statistics: Admitted patient care
21 Department of Health (2015). Annual report and accounts
25 King’s Fund (2014). Written Evidence to Health Select Committee Inquiry into Public Expenditure
27 NHS Confederation (2015). Representation to the 2015 Spending Review
Employer engagement

38. We carried out a short online survey of employer views during August and September, to compliment feedback received from the various network meetings referred to earlier.

39. In relation to pay for 2016/17, employers accepted the 1 per cent increase, as suggested by the public sector pay policy, for those medical and dental staff covered by the remit on current nationally agreed contracts.

40. The latest information published by Office for National Statistics (ONS) is that the CPI fell by 0.1 per cent in the year to September 2015.28 We note that the Bank of England’s August inflation report suggested that CPI inflation is projected to start to increase around the end of 2015. The Monetary Policy Committee (MPC) forecast that it is likely inflation will return to its 2 per cent target during 2017.29

Summary

In summary, our programme of employer engagement tells us that:

- NHS organisations are facing a growing and changing demand for care, at a time of tough financial pressure and growing employment costs
- available resources should be prioritised to retain key staff and support improvements in the delivery of patient services
- delivering pay and contract reform remains a priority
- they need contracts and conditions that are effective in helping deliver consistent high-quality services for patients.
- they support a general percentage increase to be made to all staff within the 1 per cent cap.
- There is no evidence to justify or support differential increases in 2016/17. To do so would be seen as inequitable and potentially damaging to staff morale ahead of a significant programme of contract reform.


2. Modernising contracts

The need for change to the current system

41. Patients’ needs and expectations have changed. The NHS is continually seeking new and innovative ways of delivering services to meet those needs in a financially sustainable way.

42. The current contracts for consultants and junior doctors in training need to change to support new ways of delivering care that are better suited to modern healthcare needs.

Consultants

43. The 2003 consultant contract includes provisions providing premium time rates for evening and weekend work and, more importantly, offers consultants the option to opt out of non-emergency work at evenings and weekends.

44. Although the existing opt-out clause may be rarely deployed, its existence can inhibit service planning and can also be used to increase the rate of payment for out-of-hours work.

45. Delivering high-quality services and improving outcomes for patients matters most, and must drive our decisions. This includes providing the same high standards of care seven days a week by using the resources of people, buildings and equipment as effectively and efficiently as possible.

46. As the consultant workforce continues to expand it is important that the resources available for pay are used to reward those who make the greatest contribution at the most onerous times, locations and intensity.

47. The current clinical excellence awards scheme needs to be replaced to recognise exceptional current achievement of excellence, rather than past performance. Pay progression should no longer be based on a time-served basis but should reward responsibility and achievement.

48. It is also important that greater consultant presence at evenings and weekends better supports the training and development of doctors in training.

Junior doctors

49. The ‘new deal’ junior doctor contract was designed to drive down the unacceptably long hours that had been worked by previous generations of doctors. Whilst this objective has largely been achieved, a number of legacy arrangements and rigid working practices remain that stand in the way of effective planning, service delivery and high quality training.
50. The current contract does not support proper professional engagement with junior doctors. Too large a proportion of junior doctor earnings remain variable, leading to unpredictable earnings for doctors and costs for employers. The BMA and the DDRB have been pressing for contract reform for several years.

51. A new contract must support the provision of high quality care by applying the highest standards of excellence and professionalism to enable junior doctors and their employers to meet their shared responsibilities to patients. Importantly for junior doctors it means making every moment count for their training and development.

52. It is also important that pay and reward reflects fairly the responsibility level of the junior doctor and the level of competences they apply at any given time in their progression through their approved national training programmes.

**Annex A and Annex B contain timelines, links to the Heads of Terms and the main DDRB recommendations for the junior doctor and consultant contracts.**

53. Ministers said that there should be implementation of new terms for new consultants from April 2016, the transfer of existing consultants by April 2017, and the introduction of a new junior doctor contract by August 2016.

**Progress to date**

54. NHS Employers subsequently held preliminary talks with the BMA about re-entering formal negotiations.

**Consultants**

55. We were pleased that the BMA consultants’ committee agreed to return to negotiations. We are now in an intense period of negotiation to agree a revised contract.

56. Detailed discussions are now focusing on:

- facilitating seven-day services and agreeing appropriate contractual safeguards
- introducing a revised pay structure
- a performance payment system in place of the current local CEA payments
- transitional arrangements and pay protection models to ease transition to the new contract.
57. We aim to conclude negotiations by the end of November. The BMA consultants committee will then ballot members early in 2016. We are working towards securing an agreed position prior to implementing the revised contract for new starters in April 2016.

**Junior doctors in training**

58. The BMA Junior Doctors' Committee (JDC) unfortunately concluded that it was not prepared to re-enter negotiations with NHS Employers.

59. NHS Employers as clear that many of the crucial details of the new proposed contract for junior doctors were open to negotiation, including rates of pay, pay point distribution, the periods classed as unsocial hours and the pay enhancements for these, and the allocation and value of flexible pay premia.

60. NHS Employers believed that by working together with the BMA JDC, we could deliver safer working hours for doctors in training, better stability of pay and agreed work schedules that took account of their educational commitments.

61. The BMA JDC took the view that they had in effect been presented with a 'done deal' and would not re-enter negotiations or be able to make progress without significant concessions on and round the following:

- Outline proposals to extending the plain-time window from 60 hours per week to 90.
- Removing vital safeguards that discourage employers from making junior doctors work dangerously long hours.
- Seeing pay no longer matching the experience junior doctors gain through their training.

62. In the absence of any further discussion there has been an extensive campaign by the BMA JDC (and junior doctors more generally) opposing the proposed terms of a new contract, regardless of the outcome of the remaining negotiable matters, and the prospect of it being imposed.

63. We recognise that this is a period of great uncertainty for junior doctors but we are concerned that the full facts of the proposed changes and contract reforms, based on the DDRB recommendations, have not been represented properly and as a result junior doctors might not have an opportunity to see the whole picture and fully understand the nature and detail of the proposed changes.
64. On 8 October 2015, the Health Secretary wrote to Dr Johann Malawana, chair of the BMA JDC, making a number of assurances on the impact of the proposed reforms.\(^\text{30}\)

We remain disappointed that the BMA JDC continues to stand by its decision to not re-enter negotiations and with its announcement on 21 October that ballot papers for industrial action over the proposed new contract for junior doctors in England will be issued on 5 November.

We will update the DDRB in writing or at the oral evidence hearing on the current position.

**Other groups in the remit**

65. The DDRB remit covers other groups including staff, associate specialist and specialty doctors (SAS), salaried primary care dentists and salaried general practitioners.

66. These groups are not currently included in the discussions around contract reform, although in the case of SAS doctors on national contracts these discussions may lead to consequential changes to their current national terms and conditions.

67. This will be addressed through our ongoing engagement with SAS doctors through the established joint negotiating committee.

**SAS doctors**

68. The SAS group is a diverse group representing a wide range of skills and experience. They are a highly valued group of staff who are in many cases able to provide autonomous care to patients.

69. The majority of SAS doctors are employed under the Terms and Conditions of Service for Specialty Doctors 2008. There is also a number of associate specialists employed under the Terms and Conditions for Associate Specialists 2008 and a smaller number who remain on the NHS Medical and Dental Terms and Conditions of Service 2002.

70. In December 2014 the BMA, Health Education England, the Academy of Medical Royal Colleges and NHS Employers worked in partnership to publish a [Charter for SAS](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/466589/Health_Secretary_to_JDC_Chair.pdf)
The Charter sets out what SAS doctors can expect of their employers and vice versa. It aims to promote a supportive environment to enable SAS doctors to work to the best of their ability, for their employers to provide and support the provision of high-quality patient care. There is a perception that there is a lack of opportunity for SAS career progression and that the development of SAS doctors is not always prioritised. This was an important piece of joint work to try to overcome this.31

71. We subsequently surveyed SAS doctor in relation to their development. Over 400 doctors returned the survey, the main findings from this sample of opinion were:

- 82 per cent of respondents said they work at a level appropriate to their competences / experience
- 67 per cent said they receive due recognition of their competences / experience
- 93 per cent said they receive a good, regular appraisal
- 74 per cent said they have an agreed job plan.

72. In general, these showed improvements over previous surveys and activities of the partner organisations. However, they also indicate that further progress remains possible and necessary.

73. The survey also flagged some challenges:

- 10 per cent of respondents said they do not have any SPA time (supporting professional activities) in job plans. In some cases SPA time is not given or is cancelled for service and not re-scheduled.
- Although 94 per cent get funded study leave, only 56 per cent use their full allowance.
- Only 60 per cent said they feel they get sufficient time for gathering evidence to support revalidation and appraisal.

74. The four partners delivered four regional workshops about SAS doctor professional development in March 2015.

75. The workshops, which were based on the survey outcomes, focused on identifying barriers and solutions to effective development, certificate of eligibility for specialist registration (CESR), credentialing, opportunities for SAS doctors in leadership roles and sharing local good practice.

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31 British Medical Association (2104) A charter for staff, associate specialist and specialty doctors
76. At the workshops we heard about good practice in SAS doctor development, but also found that there was a lack of consistency in how these doctors have been developed and supported across the country. Workshop participants, many of whom were SAS doctors themselves, suggested a number of areas where improvements could be made, such as effective representation of SAS doctors on committees and adequate clinical supervision to support SAS doctor development. These mirrored the issues flagged in the survey.

77. We are currently working with the other three partners to produce some online tools around SAS doctor development. This is still in development but is likely to feature actions that different staff groups – such as boards, medical directors, medical staffing colleagues and SAS doctors themselves – should take to allow SAS doctors to work to their full potential, and, where they wish to and are able to do so, to progress in their careers.

78. We asked employers for their views on how an increase of 1 per cent should be applied to SAS doctors on national contracts. Of those employers who provided a response, 44 per cent said that the award should be distributed evenly across all staff, 22 per cent said it should support recruitment and retention and 22 per cent said it should be used to reward performance.

79. A few respondents noted difficulties posed by national shortages, mirroring those in consultant specialties, and that as result of this, locally agreed on-call arrangements were made more financially generous.

**Salaried primary care dentists**

80. Salaried primary care dentists (or community dentists) were mainly employed by primary care trusts (PCTs). Since the abolition of PCTs, salaried dentists have been dispersed among those organisations who have assumed the functions previously provided by PCTs.

81. We are working to improve our intelligence about this group now that they are widely spread; not all NHS organisations will employ a salaried dentist. We aim to do this jointly with the British Dental Association through a renewed joint negotiating committee. Of those employers responding to our survey, most thought that the 1 per cent should be applied equally, with a minority suggesting that the award should be used to support recruitment or to reward performance.

82. A small number of respondents noted recruitment difficulties. This issue has been raised during previous rounds but we cannot say with any certainty whether this is due to shortages, pay or other recruitment and retention factors.
Salaried general practitioners

83. The original salaried GP model terms were designed for those GPs working in GP practices or in primary care organisations. As is the case with salaried dentists, salaried GPs other than those employed in practices now work in a number of different settings, including hospitals. Employers have said that it is not always clear on what terms they should be employed.

84. Of the 23 employers who expressed a preference in our survey, 18 (78 per cent) agreed with increasing the minimum and maximum of the pay range as in previous years. A small number of respondents said that the award should be used to reward performance. The application of a particular value within the range to individual salaried GPs is a discretionary matter for their employers. One respondent said that any increase should apply to each salaried GP’s pay value within the range and not just to the minimum and maximum of the range.

85. Some respondents disclosed that they were paying above the recommended maximum of the pay range to recruit salaried GPs, especially in London and in certain specialist roles. One commented that the model salaried GP contract needed to be reformed.

General practitioners

86. This evidence does not cover this part of the remit groups. In as much as this is addressed for England, evidence will be provided separately by NHS England in the light of current discussions between NHS Employers and the BMA General Practitioner Committee.

The use of locum doctors

87. The DDRB has previously asked about the use of locum doctors in the NHS.

88. The short timescale in which this submission was prepared has not allowed us to undertake an in-depth analysis of the current situation, but we took the opportunity in our survey of employers to seek their views on some general questions about the use of locums doctors.

89. Around 52 per cent said that they often relied on locums, with a further 16 per cent saying that they sometimes relied on locums.

90. We also asked how locums were used according to specialty. Of the 35 employers who responded to this question, all but three (91 per cent) said that locums were used
at least occasionally. However, on such a small sample it is difficult to draw any great conclusion with regard to specialties or the reason behind locum usage.

91. The reasons for locum use vary. Most common are shortages and general Recruitment and Retention Issues. Some employers ascribe this to gaps in training, fill rates, rota gaps and others to national shortages. Some said that variations in workload and acuity drive demand and some locum use is inevitably put down to sickness, annual leave and maternity leave. There is some consistency with national shortages, for example psychiatry. Of those responding, 44 per cent said that their use of locums was greater than a year ago, 7 per cent said it was less and 48 per cent said that it had stayed the same.

92. Staff costs are a significant matter for trusts. On 15 October 2015, Monitor and the NHS Trust Development Authority (TDA) published proposed rules and a consultation on the introduction of caps on the total amount trusts can pay per hour for all types of agency staff.\(^\text{32}\)

93. Under the proposed rules, from 1 April 2016, trusts would not be able to pay more than 55 per cent above the relevant national pay rates for an agency worker, employed either via an agency or engaged directly. The 55 per cent maximum premium on price would account for:

- employment on-costs including employer pension contribution
- employer national insurance
- holiday pay to the worker
- a modest administration fee / agency charge.

94. The consultation indicates that the aim is to introduce the proposed price caps on the 23 November 2015. Then, subject to monitoring, they would be reduced in two further stages so that by 1 April 2016, capped agency rates would lead earnings of flock doctors to be equivalent to NHS pay rates for substantive staff on nationally agreed contracts.

\(^{32}\text{Monitor (2015) Price Caps for Agency Staff; Proposed Rules and Consultation}\)
3. Workforce supply

95. Employers continue to provide anecdotal evidence on well-established difficulties in recruiting doctors in certain areas and in certain specialties. However, we have not submitted detailed evidence on workforce supply in relation to the medical workforce. The primary responsibility for evidence in this regard for the English NHS lies with Health Education England.

Staff numbers

Figure N1. Staff numbers (full-time equivalent) at 30 September\textsuperscript{33}

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>2013</th>
<th>2014</th>
<th>Change 2013-14</th>
<th>% change 2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>All medical staff</td>
<td>104,501</td>
<td>102,640</td>
<td>-1,861</td>
<td>-1.8%</td>
</tr>
<tr>
<td>Consultant (including Directors of Public Health)</td>
<td>40,443</td>
<td>39,014</td>
<td>-1,429</td>
<td>-3.7%</td>
</tr>
<tr>
<td>Registrars</td>
<td>39,846</td>
<td>39,407</td>
<td>-439</td>
<td>-1.1%</td>
</tr>
<tr>
<td>Other Doctors in Training and Equivalents</td>
<td>13,939</td>
<td>13,991</td>
<td>52</td>
<td>0.4%</td>
</tr>
<tr>
<td>Associate Specialist/Specialty Doctor/Staff Grade Doctors</td>
<td>8,982</td>
<td>8,887</td>
<td>-96</td>
<td>-1.1%</td>
</tr>
<tr>
<td>Hospital practitioners and clinical assistants (non-dental)</td>
<td>269</td>
<td>329</td>
<td>60</td>
<td>18.3%</td>
</tr>
<tr>
<td>Other staff</td>
<td>1,021</td>
<td>1,012</td>
<td>-9</td>
<td>-0.9%</td>
</tr>
<tr>
<td>GP Providers</td>
<td>23,763</td>
<td>24,043</td>
<td>279</td>
<td>1.2%</td>
</tr>
<tr>
<td>Other GPs (excl registrars and retainers)</td>
<td>8,865</td>
<td>8,032</td>
<td>-833</td>
<td>-10.4%</td>
</tr>
</tbody>
</table>

96. Overall, there were increases between 2013 and 2014 for non-registrar doctors in training and hospital practitioners and clinical assistants (non-dental) and decreases for all other grades and staff groups.

Turnover

97. The leavers rate for HCHS medical and dental staff between April 2014 and April 2015 was 7.2 per cent, whilst the equivalent rate for joiners was 9.9 per cent\[34\]. The leavers rate between April 2013 and April 2014 was 7.4 per cent and the joiners rate between April 2013 and April 2014 was 9.6 per cent, showing that the numbers of HCHS medical and dental staff continue to increase overall\[35\].

98. Figure N2 details the number of joiners and leavers in each quarter, alongside the annual pay uplift awarded to medical and dental staff for that year. With the exception of some seasonal variation (decreases in joiners and peaks in leavers between March to June), the moving annual average of joiners in 2014/15 has increased since 2011/12, in spite of there being pay freezes in three of the previous four financial years (2011/12, 2012/13, 2014/15). The moving annual average of leavers has also increased over the same period, but not as much as that of joiners. There is not a strong correlation between the number of joiners and the level of the pay award given at the time. There is also not a strong correlation between the leaving rate and the level of pay award given.

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Figure N2. NHS turnover rates by quarter compared to annual medical and dental pay.

36 Health and Social Care Information Centre. Monthly NHS Hospital and Community Health Service (HCHS) Workforce Statistics in England – April 2015, Provisional Statistics – Quarterly tables turnover, http://www.hscic.gov.uk/catalogue/PUB17807/nhs-work-stat-apr-2015-turn-tab-qrtly.xlsx Includes medical and dental staff. This data is not directly comparable with turnover data prior to September 2009 due to a change in the methods of analysis. The monthly workforce data is not directly comparable with the annual workforce census; it only includes those staff on the Electronic Staff Record (ESR) (i.e., it does not include primary care staff or bank staff).
Health and Social Care Information Centre workforce vacancy statistics

99. In August 2015, the Health and Social Care Information Centre published new hospital and community health services (HCHS) workforce vacancy statistics. The statistics were based on vacancy adverts published through NHS Jobs. Although the dataset currently only covers vacancies for one year (1 March 2014 – 28 February 2015), with incomplete data from February 2015, there could be much potential in the future in using the data to determine recruitment trends.

100. Whilst this new source of information is welcome, there are a number of limitations in this data. For example:

- One vacancy advert can be used to fill multiple vacancies of different staff groups and pay bands. They are not vacancy statistics as they relate to the number of vacancy adverts.
- A vacancy can be advertised more than once if there are insufficient numbers of applications received, or closed early if there is a high number of applications.
- The data cannot be linked to other HSCIC workforce publications as the occupation codes (and thus the staff groups) that could be used to identify the advert are not always recorded when the advert is created.
- It is not yet possible to determine how long vacancies are open for and therefore assess the extent of hard-to-fill vacancies.

101. There were 24,847 medical and dental vacancy adverts in 2014-2015 for 1,722 posts.

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4. Staff engagement and the NHS Staff Survey

102. In previous reports, the DDRB has highlighted the importance of effective staff engagement and asked for further information about developments in the NHS. We recognise that staff engagement is a key ingredient in helping the NHS meet the range of current challenges that it faces. By involving staff in decisions and communicating clearly with them, employers can maintain and improve staff morale, especially during periods of difficulty and change.

103. NHS Employers has continued its work to support and promote staff engagement through by providing advice and resources. This has included online products, webinars and podcasts, together with a programme of activities to exchange knowledge and share good practice.

Framework for staff engagement in the NHS

104. Since the DDRB’s previous review, there have been some further developments in the framework for staff engagement in the NHS:

- The NHS Constitution\textsuperscript{38} and the NHS Staff Pledges\textsuperscript{39} address the key drivers of staff engagement (the need for staff to be treated well at work, the need for well-designed work and their right to involved).

- Following the Francis report\textsuperscript{40} and a recommendation from the National Nursing Taskforce, a new emphasis has been given to the willingness of staff to recommend their employer. In addition to being measured in the national staff survey, this is also now measured via the Staff Friends and Family Test (a quarterly assessment of staff willingness to recommend the NHS).

- The CQC now includes data on staff engagement as part of its overall assessment of whether an organisation is well led. This acts as a catalyst for organisational action.

\textsuperscript{38} \textit{NHS Constitution, 2012}

\textsuperscript{39} \textit{NHS Staff Pledges}

\textsuperscript{40} \textit{The Francis Inquiry(2013)}
Measurement of staff engagement in the NHS

105. The NHS Staff Survey’s staff engagement index score provides the accepted indicator of staff engagement in the NHS. The NHS Staff Survey is the largest survey of staff opinion in the UK and may be the largest in the world. Each year, NHS staff are offered the opportunity to give their views on their experience at work. It uses a method of assessing overall NHS performance on people management to enable organisations to understand and compare their own performance. It also includes the CQC, which looks at the NHS in terms of delivery of patient care.

106. The questions are grouped around the key areas highlighted in the NHS Staff Pledges. It is a composite indicator based on answers to questions covering the three dimensions of staff engagement:

- Motivation/satisfaction - the degree to which staff are enthusiastic about their work and feel satisfied with it.
- Involvement - the extent to which staff feel involved in decision making within their organisation.
- Advocacy - the willingness of staff to recommend their employer as a place to work.

107. The NHS staff engagement index score does not directly measure factors such as communication, view on pay and conditions and overall people management, although there are questions in the staff survey that do relate to these factors. It does not include measures of job commitment. The staff engagement indicators and questions in the survey were developed with academic input to provide a broad and balanced indicator of staff engagement. It is broader than traditional measures, which focused on motivation or staff satisfaction only, and balances factors related to staff jobs with those related to organisational engagement.

108. It is for individual NHS organisations to decide their approach to developing and improving staff engagement. Employers across the NHS adopt a range of approaches according to their own local circumstances and context. Almost all have developed their own local values as the basis for staff engagement. Most have formal and informal methods for staff to be involved with decision making and many have formal staff recognition programmes. Around a third of NHS organisations have used the Listening into Action approach, working with an external specialist to develop an approach that

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41 NHS staff pledges

42 Listening into Action
fosters greater engagement. In the NHS, employers work on a partnership basis with staff side representatives to support and develop engagement. Case studies of approaches to engagement can be found on the NHS Employers website.\textsuperscript{43}

109. There has been a focus on seeking feedback from staff in recent years. Senior leaders have sought to increase their visibility and improve communication. Many trusts have developed suggestion schemes and other mechanisms for staff feedback, including over half that run their own local surveys as well as the national staff survey and the Staff Friends and Family Test. Many now have staff-led quality improvement programmes and suggestion schemes. In recognition of the role of the line manager in supporting staff engagement, NHS Employers worked with trusts in 2014 to develop ideas for supporting an engaging leadership style.

**Staff engagement trends in the NHS**

110. In 2014, following sustained improvement, the overall staff engagement index fell from 3.71 to 3.70. This was disappointing and does not reflect the hard work from organisations to develop and improve engagement with their staff. To sustain this level of engagement in the context of current pressure on the service is an achievement. The equivalent scores for medical and dental staff in 2014 stayed broadly similar to those of 2013, with a slight improvement for other medical and dental staff, including specialty doctors, hospital practitioners and clinical assistants.

111. The index remains higher than when it was introduced and higher than for comparable measures in the other large scale surveys. The fall was largely driven by falls in the component scores for motivation (made up of measures of enthusiasm and satisfaction) and willingness to recommend the service. Some questions related to involvement actually improved, reflecting the work in this area by employers.

112. Although the increasing demand for NHS services, higher workload and concern over staffing levels seem to have affected the motivation factors for the NHS as a whole, the trends for medical and dental staff did not always follow those of non-medical staff. Commitment to the job role remained high. Motivation scores for all medical and dental staff groups improved or stayed the same year-on-year between 2012 and 2014. Advocacy levels remained relatively positive as medical and dental staff were more willing to recommend their employer as a place to work in 2014 than in 2013.

113. However, there may have been a spill-over effect from unhappiness about pay levels, as the question on pay in the survey moved to net dissatisfaction for all medical

\textsuperscript{43} NHS Employers case studies on staff engagement
and dental staff groups except for doctors in training. On a more positive note, the percentage of medical and dental staff working extra hours fell from 84 per cent in 2014 to 83 per cent in 2013. In addition, the percentage of doctors in training working extra hours fell from 83 per cent in 2013 to 80 per cent in 2014.

114. The levels of involvement improved, although there remained a gap between satisfaction with levels of involvement at ward level and measures of involvement at organisational level. There is considerable scope for improvement in scores and the reduction in variation. NHS Employers is supporting employers to improve staff engagement levels through provision of resources and sharing of ideas.

115. By contrast, some indicators of staff involvement improved between 2013 and 2014. For example, the percentage of medical and dental staff who felt able to make suggestions for improvement rose from 74 to 78 per cent. More needs to be done to make staff feel involved in overall organisation decision making and improved communication.

116. There was also an improvement in the level of support score from managers to medical and dental staff, with this figure rising from 3.62 to 3.65. This may reflect the range of different initiatives available to support the work of managers across a range of trusts.

117. The latest available survey is the 2014 survey with data collected in October to November 2014. Data has been collected via the Staff Friends and Family test in 2015 showing a small improvement in willingness to recommend the service. This data is not collected in a way that allows comparison with the staff survey and is based on a relatively low response rate. It is too early to draw definitive conclusions from it.
5. Pensions and total reward

118. The overall reward package in the NHS remains competitive.

119. During a period of pay restraint, it is more important than ever that staff are fully aware of and understand the benefits available to them through working for an NHS organisation. There is an opportunity for employers to promote the unique selling points of their workplace and to be viewed as an employer of choice.

120. Staff in the NHS receive a broad range of valuable employment benefits, including a generous pension scheme.

121. In addition to benefits offered through national terms and conditions, employers have the opportunity to offer flexible benefits, designed to suit their local business needs and workforce priorities.

122. Reward can and should be used strategically to help support workforce priorities, though much depends on the capacity and capability of HR and reward experts to deliver this.

123. However, it can be challenging to ensure that staff are fully aware of their benefits when they have undergone reform, such as the case with the NHS Pension Scheme. In addition, external factors can impact on how reward is perceived and valued by staff, such as changes to taxation and national insurance.

124. Total reward statements are one of the tools available to employers to help reinforce the value of the range of benefits employees receive. The introduction of these has begun to help raise awareness of the value and range of benefits available through the NHS as an employer.

**NHS Pensions**

125. A key feature of the NHS reward package is the NHS Pension Scheme (NHSPS).

126. The NHSPS is an occupational, defined-benefit scheme, backed by the Exchequer. All eligible members of staff are automatically enrolled into the scheme at point of entry into NHS employment. However, membership is not compulsory and staff are free to opt out of the scheme at any time.

127. The NHSPS has recently undergone a major reform programme. In 2010, the government committed to review the sustainability and long-term affordability of public service pensions. Lord Hutton, chair of the Independent Public Service Pensions Commission submitted a report outlining the reform required. Following a consultation
and working with employers and trade unions, the Proposed Final Agreement (PFA)\textsuperscript{44} was published in July 2012, which outlined the agenda of pension reform and position on the design of a new scheme.

**2015 NHS Pension Scheme**

128. The new NHS Pension Scheme was introduced on 1 April 2015. The main features of the new scheme are:

- 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.

- Revaluation of active members benefits in line with the Consumer Price Index plus 1.5 per cent per annum.

- A build-up rate of 1/54\textsuperscript{th} of each year’s pensionable earnings with no limit on the number of years that can be taken into account. This is a higher build up rate of both the 1995 and 2008 sections of the NHS Pension Scheme.

- Normal pension age (NPA) at which benefits can be claimed, without reduction for early payment, will be linked at the same age as a member is entitled to claim their state pension.

- No limit on the number of years’ pension that can be built up.

- Final pension calculated by adding together all of the revalued pension earned in each year of membership.

- Protection of the accrued rights of current NHSPS members.

- Additional protection of future benefits for those members within 10 years of their current NPA as at 1 April 2012. Further limited protection with tapering is available to members in the 1995 section of the scheme, who are within a further three years and five months of their current NPA, i.e. up to 13 years and five months from their current NPA.

129. The current 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 NHSPS have been retained in the 2015 scheme.

\textsuperscript{44} NHS Pension Scheme Proposed Final Agreement (2012)
130. There is a new provision in the 2015 Scheme: early retirement reduction buyout (ERRBO). Taking benefits before NPA results in reductions in value for early payment. Members and/or employers can pay additional contributions through ERRBO to eliminate or lower the amount of reduction that would apply. This is restricted to a maximum of three years before the member reaches their NPA.

131. The 2015 scheme replaced the 1995 and 2008 sections, except where protection applies. Protection arrangements for members of the 1995/2008 scheme consist of:

- Full protection: members who were within 10 years of the NPA as at 1 April 2012 will remain in their current section until they retire, leave the scheme or choose to give up protection and will not automatically move to the 2015 Scheme.

- Tapered protection: members who were more than 10 years, but less than 13 years and 5 months from their NPA as at 1 April 2012 are entitled to tapered protection. This means they will move to the 2015 Scheme at a date later than 1 April 2015.

- No protection: members who, as at 1 April 2012, were more than 13 years and 5 months from the NPA have no protection and will move to the 2015 Scheme on 1 April 2015.

**Contribution rates**

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

133. Members of the scheme provide contributions on a tiered basis, to produce a total yield to HMT of 9.8 per cent of total pensionable pay. The employee contribution rates are outlined in the table below:

<table>
<thead>
<tr>
<th>Tier</th>
<th>Pensionable pay (whole time equivalent)</th>
<th>Employee contribution rate</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 £21,387.99</td>
<td>5.6 per cent</td>
</tr>
<tr>
<td>3</td>
<td>£21,388.00 to £26,823.99</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>
Scheme membership

134. The NHS Pension Scheme accounts 2014/15 provide information on scheme membership for England and Wales, including those who have chosen to opt out of the scheme during that year. An extract from the accounts has been provided in the table below.

<table>
<thead>
<tr>
<th>Details of active scheme membership as at 31 March 2015</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Active members at 1 April 2014</td>
<td>1,412,836</td>
</tr>
<tr>
<td>Adjustment (see note 1 below)</td>
<td>(21,244)</td>
</tr>
<tr>
<td>Restated active members at 1 April 2014</td>
<td>1,391,592</td>
</tr>
<tr>
<td>New entrants</td>
<td>136,996</td>
</tr>
<tr>
<td>Deferred members who re-join in the year</td>
<td>61,001</td>
</tr>
<tr>
<td>Re-employed pensioners</td>
<td>466</td>
</tr>
<tr>
<td>Retirements</td>
<td>(33,101)</td>
</tr>
<tr>
<td>Leavers with deferred pension rights</td>
<td>(99,820)</td>
</tr>
<tr>
<td>Members who opt-out with deferred pension rights</td>
<td>(28,323)</td>
</tr>
<tr>
<td>Deaths</td>
<td>(761)</td>
</tr>
<tr>
<td><strong>Active members at 31 March 2015</strong> (see note 2 below)</td>
<td>1,428,050</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 data used to produce the membership statistics was taken before the joiner and leaver information from Electronic Staff Records (ESR) was uploaded to Penserver. This approach was taken due to the implementation of Compendia and data migration. The total joiners were 21,055 and the total leaver 20,537. The revised position including these movements will be shown in the revised opening position in the 2015-16 Accounts.

135. As the NHSPS does not have a managed fund and is instead underwritten by the Exchequer, the number of members who choose to opt out of the scheme is important for the scheme’s future integrity. Changes to pension taxation and the new state pension could have implications for members and may lead to behavioural decisions to opt out of the scheme.

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45 NHS Pension Scheme Accounts, 2014/15
Pension taxation

136. Members of the NHS Pension Scheme could receive a tax bill if their pension savings exceed limits set by HMRC. These limits are known as:

- the annual allowance, which is calculated each year
- lifetime allowance, which is calculated based on overall pension savings.

137. Annual allowance is the limit on the amount of tax-relieved savings determined, for the NHSPS, by the growth in pension value in each year. When it was introduced in 2006 it affected very few people, and has previously been as high as £255,000 a year. It was reduced to £40,000 in 2014/15, which has the potential to impact high earners in the NHS.

138. The 2015 Summer Budget announced the introduction of pension tapered annual allowance from April 2016 (pending draft legislation). The intention is to cut pension tax relief for high earners by introducing a tapered annual allowance of those with adjusted incomes of over £150,000. In effect, this means that NHS Pension Scheme members earning over £128,000 are likely to be affected by tapered annual allowance.

139. The rate of reduction in the annual allowance (from the current maximum of £40,000) is £1 for every £2 that the adjusted income exceeds £150,000, up to a maximum reduction of £30,000 at £210,000. The definition of adjusted incomes includes salary and employee and employer pension contributions.

140. These changes to pension taxation may cause some high earners to consider whether it is worthwhile to remain in the scheme. It could lead to behavioural changes, such as opting out of the pension scheme, retiring, taking some form of flexible retirement, reducing their working hours or moving to part-time working.

141. 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 HMT receives. The NHS Pension Scheme is required to deliver an average yield of 9.8 per cent. If the yield received does not meet this average it 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.

Future changes to pension taxation

142. During the 2015 Summer Budget, the Chancellor announced the launch of a consultation to consider how people could be encouraged to save more into pensions.
The consultation document[^46], asks for consideration of a range of alternatives, potentially radical in their approach to how pension tax relief is applied. Any reform of pension tax relief will have implications for members of the NHS Pension Scheme. The consultation closed on 30 September 2015.

**New state pension**

143. From 6 April 2016, the current state pension will be replaced with a new one for those that reach state pension age on or after this date. The new state pension will replace the existing basic and additional state pension. Currently, employees who contribute to a contracted-out occupational pension scheme such as the NHS Pension Scheme do not receive the additional state pension and pay a lower rate of national insurance (NI) contributions, along with their employers.

144. The introduction of the new state pension will mean the end of contracting-out and will end the reduction in NI that contracted-out employers and employees pay. Employers will no longer receive the 3.4 per cent NI rebate and will 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 will also end.

145. The removal of contracting-out and the NI rebate means there are significant financial implications for employers. We understand that discussions to consider the implications for NHS finances are being undertaken with HM Treasury as part of the autumn 2015 Comprehensive Spending Review.

146. From April 2016, NHS Pension Scheme members will no longer receive their 1.4 per cent NI rebate and employers will need to help raise awareness of why this will be the case. Over recent years, staff have seen an increase in NHS Pension Scheme contribution rates whilst in a period of pay restraint. The loss of the NI rebate in 2016, potentially combined with future pay rises of 1 per cent and previous pension contribution rate increases, may lead to lower paid staff considering whether they are able to afford to continue to contribute to the NHS Pension Scheme.

[^46]: [Consultation: Strengthening the incentive to save: a consultation on pensions tax relief](#)
6. Earnings and pay bill

Pay bill metrics

147. The Department of Health's pay bill metrics show that the pay bill for HCHS medical and dental staff (excluding locums) grew by 3.0 per cent in 2014/15, while the size of this workforce increased by 2.0 per cent. This means there has been a 1.0 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 (0.5 per cent) towards a more senior/ experienced workforce.

148. Annex C, 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.

149. The revised metrics show that 0.5 percentage points of the pay bill growth in 2014/15 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 full-time equivalent (FTE). The grade mix of the medical and dental workforce is strongly influenced by changes to the consultant workforce.

Consultant workforce and pay growth

150. The consultant pay bill metrics (see Annex C1) show that the aggregate (non-locum) consultant pay bill grew by 4.2 per cent in 2014/15. This was primarily down to a growth in the consultant workforce of 3.7 per cent. With the consultant pay bill growing at a faster rate than the workforce, the pay bill per FTE has increased by 0.5 per cent. Annex C1 (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.

151. Growth of the consultant workforce has added a negative pressure to the basic pay per FTE metric. Newly qualified consultants joining 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

152. The NHS Information Centre produces quarterly estimates of NHS staff earnings, which show non-medical workforce earnings by grade taken from the Electronic Staff Record (ESR).

153. Annex D and Annex D1 show mean annual basic pay, and mean annual total earnings, for hospital and community health service (HCHS) medical and dental grades over time.

154. Annex D shows that the average basic pay per full-time equivalent increased between April 2013-March 2014 and April 2014-March 2015 for consultants, hospital practitioners & clinical assistants and other medical and dental staff, whilst decreasing for doctors-in-training grades.

155. Annex D1 shows that mean total earnings per member of staff increased between April 2013-March 2014 and April 2014-March 2015 for consultants, hospital practitioners & clinical assistants and other medical and dental staff, whilst decreasing very slightly for doctors-in-training grades.
Annexes

Annex A

This annex includes a timeline, a link to the Heads of Terms and the main DDRB recommendations for the junior doctor contract.

Junior doctors’ timeline


Sets out a vision and principles for a new contract emphasising:

- better patient care and outcomes
- doctors in training feeling valued and engaged
- affordability
- producing the next generation of medical professionals
- improving relationships (particularly among doctors, employers and deaneries).

**December 2012** - Health Minister accepted that the scoping study report provided the basis for negotiations. NHS Employers and BMA invited to discuss the prospects of negotiating change to the junior doctors contract.

**June 2013** - Heads of Terms agreed with the BMA for possible negotiations.

**October 2013** - NHS Employers mandated by all four UK health departments to begin negotiations with the BMA on a new contract for doctors and dentists in training; negotiations to be completed by October 2014 and implementation to begin in April 2015.

**February 2014** - Interim joint report submitted on the negotiations to Health Ministers.

Confirmed that both sides had agreed that the new contract must be:

- cost neutral
- that high level definitions of pay had been agreed
- discussions to develop a set of pay principles were continuing.

**October 2014** - BMA withdraws from negotiations.
BMA rationale:

- Negotiations had stalled due to a lack of credible evidence to support the changes being proposed.
- Concerned that it was being asked to make decisions that had the potential to make a considerable impact on: patient safety, doctors welfare and the sustainability of the NHS.

DDRB asked to make observations and recommendations on new contractual arrangements based on the work undertaken in the negotiations and with reference to the agreed Heads of Terms.


Key comment from DDRB report: “We consider that there is a sound basis for negotiation of the junior doctors’ contract, and make recommendations that we hope the parties will find helpful, in order to progress to negotiated agreement quickly.”


Letter to BMA: Lord Prior confirmed that health secretary was seeking a commitment that the BMA is prepared to:

- agree that the DDRB report is the basis for finalising new contractual arrangements
- re-enter formal negotiations with NHS Employers to finalise the details of the new contract by the end of December 2015
- put the resulting agreements to BMA members framed, at worst, as ‘the best achievable by negotiation’.

**August 2015** - BMA Junior Doctors’ Committee confirm not re-entering negotiations. Rationale: 10 reasons setting out their position

**26 September 2015** – BMA announces that junior doctors in England will be balloted on industrial action

**8 October 2015** – Secretary of State writes to JDC chair offering a range of reassurances and an invitation to return to negotiations

**12 October 2015** – JDC chair replies to Secretary of State seeking further clarification.

**21 October 2015** - BMA announces intention to ballot on industrial action from 5 November.

**DDRB conclusions**

DDRB recommendations included:
the ending of time-served incremental progression, with pay instead based on stages of training and actual progression to the next stage of responsibility

a supplementary pay structure in line with NHS Employers proposals, including additional hours, unsocial hours premium, availability allowance for on call, flexible pay premia for hard-to-fill specialties and other flexible pay premia for breaks in training for exceptional reasons that benefit the NHS

implementation of proposals on work scheduling, work reviews and exception reporting and an end to banding payments

a common definition of core time and unsocial hours for all NHS groups

GP trainees to be paid on the same basis as hospital trainees

a requirement to comply with Working Time Regulations or any successor legislation

reimbursement of relocation expenses incurred in the performance of the doctor’s duties

further sensitivity testing on the increase to basic pay and wider applicability of the proposals

data to be provided to DDRB on the outcomes of all work reviews

an agreed deadline for consideration of any outstanding issues and for early implementation of the new contract.

Further work is needed on some aspects including distribution of pay, matching pay progression to stages of training, issues impacting clinical academic and public health trainees, the pay level for dental foundation trainees and the final detail of contractual safeguards.
Annex B

This annex includes a timeline, a link to the Heads of Terms and the main DDRB recommendations for the consultant contract.

Consultants’ timeline

**July 2011** The Review Body submits its report on consultant compensation levels, incentives and Clinical Excellence Awards

**December 2012** The Secretary of State for Health accepts the report as the basis for negotiation and invites NHS Employers and the BMA to discuss prospects for changing the 2003 consultant contract

**July 2013** Draft Heads of Terms agreed

**October 2014** BMA withdraws from negotiations

**July 2015** DDRB report and recommendations published

**September 2015** BMA agrees to return to negotiations

**DDRB conclusions**

The DDRB concluded that:

- The key principles proposed by the government and NHS Employers are reasonable – to improve patient outcomes across the week and to reward greater responsibility and professional competence.

- The case for expanded seven-day services in the NHS, in order to address the ‘weekend effect’ on patient outcomes, to be compelling.

- The proposals should be viewed as a total package of reform across the two contracts.

- Changes are required to the antiquated approach for time served, mainly annual incremental progression in both contracts.

- The ‘night window’ for out-of-hours work should start at 10pm and that a common definition should be applied across all staff groups.

- The DDRB supported the proposed approach to the pay package for juniors, whilst it noted that the rates for unsocial hours and other elements were for the parties to agree. It also noted that total pay for juniors compares favourably with comparator groups and that, given the cost-neutral pre-condition for negotiations, that position will continue.
• Contractual safeguards are needed to ensure that consultants and junior doctors are not expected to work excessive hours, and can maintain a reasonable work-life balance.

• DDRB considers that removal of the opt-out is important and significant: “In our view, the current opt-out clause in the consultant contract is not an appropriate provision in an NHS which aspires to continue to improve patient care with genuinely seven-day services, and on that basis, we endorse the case for its removal from the contract.”

• There is scope for progressing some elements of consultant reform at different speeds, including early removal of the consultant opt-out.

• The DDRB supports the continuation of national CEAs. They believe that given the separation of local CEAs (to be reformed as performance pay, or payments for excellence), the value of national CEAs will need further consideration.
Annex C
DH Headline HCHS pay bill metrics: Estimated headline pay bill growth drivers - Total HCHS medical and dental staff (excluding locums)

<table>
<thead>
<tr>
<th>Paybill Growth Driver</th>
<th>Percentage change versus previous year</th>
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<tr>
<td>Headline Pay Award</td>
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<td>1.5%</td>
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<td>Basic Pay per FTE Drift</td>
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<td></td>
<td>0.7%</td>
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<tr>
<td><strong>Staff Group Mix Impact</strong></td>
<td>0.3%</td>
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<tr>
<td>Excluding Staff Group Mix Impact</td>
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<tr>
<td></td>
<td>0.4%</td>
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<tr>
<td>Basic Earnings per FTE Growth</td>
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<td>2.2%</td>
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<tr>
<td>Additional Earnings per FTE Drift Impact</td>
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<td>-0.4%</td>
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<tr>
<td><strong>Staff Group Mix Impact</strong></td>
<td>0.1%</td>
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<tr>
<td>Excluding Staff Group Mix Impact</td>
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<td>-0.5%</td>
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<tr>
<td>Additional Earnings per FTE Growth</td>
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<td>0.8%</td>
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<td>Total Earnings per FTE Drift</td>
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<td></td>
<td>0.3%</td>
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<tr>
<td>Paybill Growth Driver</td>
<td>Percentage change versus previous year</td>
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<tr>
<td>Staff Group Mix Impact</td>
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<tr>
<td>Excluding Staff Group Mix Impact</td>
<td>-0.1%</td>
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<tr>
<td>Earnings per FTE Growth</td>
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<tr>
<td>Pensions Contributions Drift Impact</td>
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<tr>
<td>National Insurance Contributions Drift Impact</td>
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<tr>
<td>Total On-Costs per FTE Drift Impact</td>
<td>0.0%</td>
</tr>
<tr>
<td>Staff Group Mix Impact</td>
<td>0.0%</td>
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<tr>
<td>Excluding Staff Group Mix Impact</td>
<td>0.0%</td>
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<tr>
<td>Employer On-Costs per FTE Growth</td>
<td>1.8%</td>
</tr>
<tr>
<td>Paybill per FTE Drift</td>
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<tr>
<td>Staff Group Mix Impact</td>
<td>0.4%</td>
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<tr>
<td>Excluding Staff Group Mix Impact</td>
<td>-0.1%</td>
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<tr>
<td>Paybill Growth Driver</td>
<td>Percentage change versus previous year</td>
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<tr>
<td>Paybill per FTE Growth</td>
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<td></td>
<td>1.8%</td>
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<tr>
<td>Average FTE Growth</td>
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<td></td>
<td>3.4%</td>
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<tr>
<td>Aggregate Paybill Growth</td>
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<td>7.6%</td>
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</tbody>
</table>

**Notes**

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

This methodology uses staff group categories consistent with HSCIC publications. As such, it does not identify pure unit cost effects. Workforce mix effects that operate within staff groups, such as band or increment mix changes, are not separately identifiable.

DH aim to develop further methodologies, using supplementary but unpublished data, to consider these detailed workforce mix effects in order to provide further intelligence on the drivers of pay drift and pay bill growth.

Headline Pay Award reflects the impact of, usually, annual central pay awards which are typically headline uplift applied to pay scales. 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.

Additional Earnings per FTE Drift Impact gives the impact of disproportionate growth in Additional Earnings per FTE, compared to Basic Pay per FTE, on Earnings per FTE Drift. This captures the effects of changing additional earnings patterns, such as changing use of overtime, including those driven by workforce mix changes.

Total Earnings per FTE Drift gives the growth in Total Earnings 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 as well as changes in additional earnings patterns.

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48 Department of Health, *HCHS Paybill Metrics & Paybill driver quantifications*, August 2015
National Insurance Contributions Drift Impact gives the impact of changes in National Insurance Contributions as a proportion of Earnings on Paybill per FTE Growth. This captures the effects of changes in National Insurance rates & thresholds and how changes in earnings and part time working patterns, including those driven by workforce mix changes, interact with the national insurance regime.

Pensions Contributions Drift Impact gives the impact of changes in Employer Pensions Contributions as a proportion of Earnings on Paybill per FTE Growth. This captures the effect of any changes in contribution rates as well as changes in scheme membership rates and pensionable earnings rates including those driven by workforce mix changes.

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.

Staff Group Mix Impact gives the impact of changes in the mix of staff across the broad staff groups used in HSCIC publications on the drivers of Paybill per FTE Growth. Relative shifts towards more expensive staff groups generate a positive Staff Group Mix Impact and vice versa.

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 C1 DH Headline HCHS pay bill metrics: Estimated headline pay bill growth drivers - Consultants (including Directors of Public Health, excluding locums)

<table>
<thead>
<tr>
<th>Paybill Growth Driver</th>
<th>Percentage change versus previous year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headline Pay Award</td>
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<tr>
<td>Basic Pay per FTE Drift</td>
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<tr>
<td>Staff Group Mix Impact</td>
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<tr>
<td>Excluding Staff Group Mix Impact</td>
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<tr>
<td>Basic Earnings per FTE Growth</td>
<td></td>
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<tr>
<td>Additional Earnings per FTE Drift Impact</td>
<td></td>
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<tr>
<td>Staff Group Mix Impact</td>
<td></td>
</tr>
<tr>
<td>Excluding Staff Group Mix Impact</td>
<td></td>
</tr>
<tr>
<td>Additional Earnings per FTE Growth</td>
<td></td>
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<tr>
<td>Total Earnings per FTE Drift</td>
<td></td>
</tr>
<tr>
<td>Paybill Growth Driver</td>
<td>Percentage change versus previous year</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td><strong>Staff Group Mix Impact</strong></td>
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</tr>
<tr>
<td><strong>Excluding Staff Group Mix Impact</strong></td>
<td>n/a</td>
</tr>
<tr>
<td>Earnings per FTE Growth</td>
<td></td>
</tr>
<tr>
<td>Pensions Contributions Drift Impact</td>
<td>0.0%</td>
</tr>
<tr>
<td>National Insurance Contributions Drift Impact</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Total On-Costs per FTE Drift Impact</strong></td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Staff Group Mix Impact</strong></td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Excluding Staff Group Mix Impact</strong></td>
<td>n/a</td>
</tr>
<tr>
<td>Employer On-Costs per FTE Growth</td>
<td>1.7%</td>
</tr>
<tr>
<td><strong>Paybill per FTE Drift</strong></td>
<td>0.4%</td>
</tr>
<tr>
<td><strong>Staff Group Mix Impact</strong></td>
<td>n/a</td>
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<tr>
<td><strong>Excluding Staff Group Mix Impact</strong></td>
<td>n/a</td>
</tr>
<tr>
<td>Paybill Growth Driver</td>
<td>Percentage change versus previous year</td>
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<tr>
<td>-----------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Paybill per FTE Growth</td>
<td>1.9%</td>
</tr>
<tr>
<td>Average FTE Growth</td>
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<td>Aggregate Paybill Growth</td>
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</tr>
</tbody>
</table>
## Mean basic pay per full-time equivalent during 12 month period ending in March (£)

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>All HCHS doctors (non locum)</td>
<td>55,451</td>
<td>56,663</td>
<td>57,475</td>
<td>57,916</td>
<td>58,555</td>
<td>59,008</td>
<td>59,342</td>
</tr>
<tr>
<td>Consultants (including Directors of public health)</td>
<td>85,337</td>
<td>86,975</td>
<td>87,089</td>
<td>87,150</td>
<td>87,211</td>
<td>88,732</td>
<td>88,982</td>
</tr>
<tr>
<td>Hospital practitioners &amp; clinical assistants</td>
<td>61,102</td>
<td>63,265</td>
<td>64,488</td>
<td>65,256</td>
<td>66,384</td>
<td>66,972</td>
<td>67,729</td>
</tr>
<tr>
<td>Other doctors in training</td>
<td>25,870</td>
<td>25,789</td>
<td>25,943</td>
<td>25,917</td>
<td>25,997</td>
<td>26,050</td>
<td>25,957</td>
</tr>
<tr>
<td>Other medical and dental staff</td>
<td>56,845</td>
<td>59,144</td>
<td>61,568</td>
<td>62,426</td>
<td>62,835</td>
<td>64,095</td>
<td>64,205</td>
</tr>
<tr>
<td>Registrars</td>
<td>36,034</td>
<td>36,545</td>
<td>36,979</td>
<td>37,059</td>
<td>37,146</td>
<td>37,383</td>
<td>37,327</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 D1

<table>
<thead>
<tr>
<th>Grade</th>
<th>Mean total earnings per person during 12 month period ending in March (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All HCHS doctors (non locum)</td>
<td>72,182</td>
</tr>
<tr>
<td>Consultants (including Directors of public health)</td>
<td>111,222</td>
</tr>
<tr>
<td>Hospital practitioners &amp; 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 2015. 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.

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